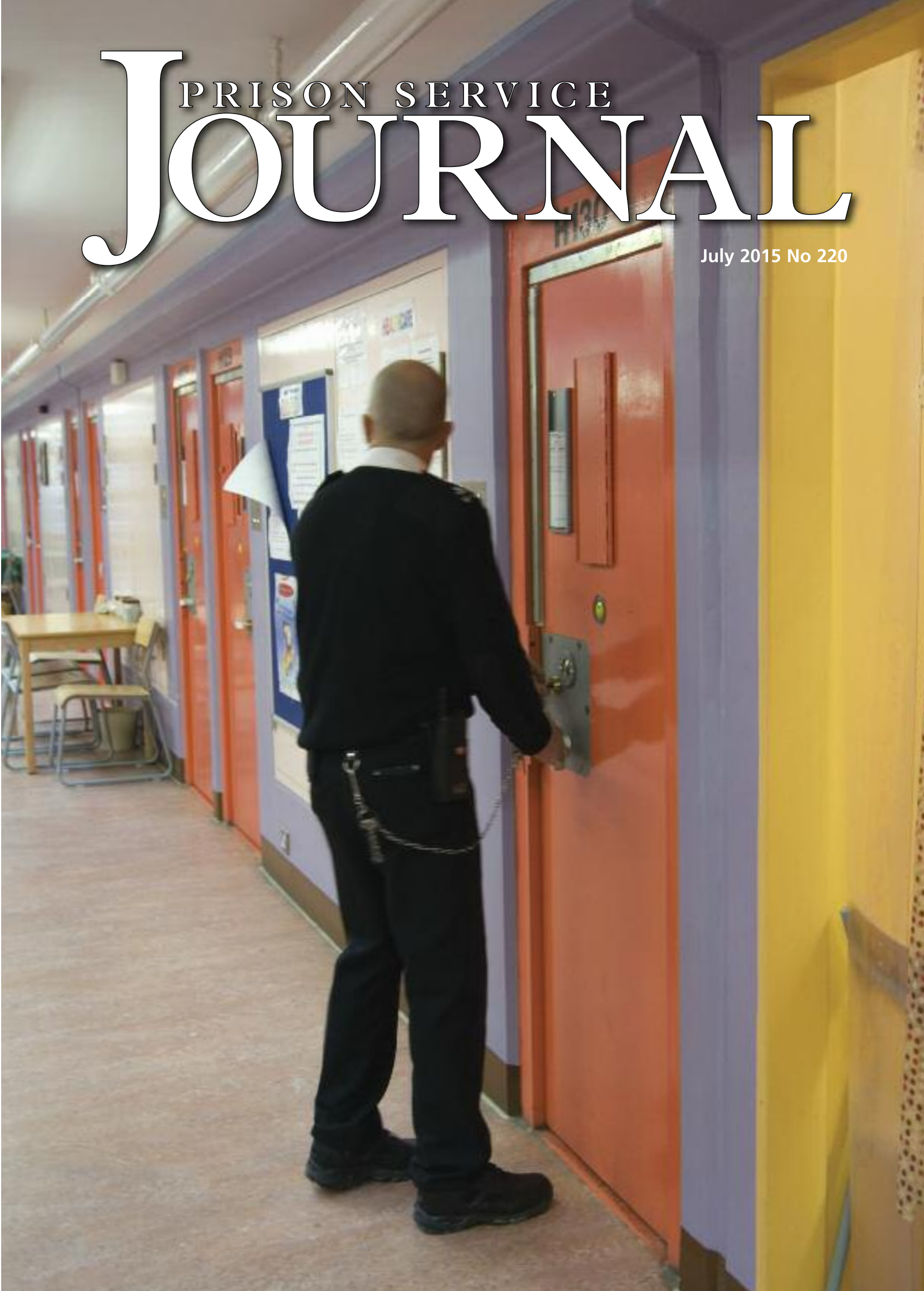

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The Trauma Recovery Model:

Sequencing Youth Justice Interventions For Young People With Complex Needs

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'These are particularly challenging times for researchers and practitioners who seek to work with offenders in ways that will assist them to live better lives.'[2]

Introduction

This paper deals with serious young offenders in a secure children's home. It lays out a theoretical model for drawing together thinking from the criminological, psychological and child development fields to posit a way of understanding the aetiology and treatment resistance of serious youth crime. We then suggest that interventions, rather than addressing offence-related topics, should first be sequenced to take account of young people's history and development. This model was developed in practice and the paper reflects this emphasis.

Offender treatment is a crucial part of the efforts of state to protect the public through the reduction of re-offending. To this end, best use must be made of time spent in custody by the most serious offenders. Arguably, this is particularly the case in times of financial austerity, when state funds spent on managing young people who offend-estimated at £1 billion in 2011-are subject to additional scrutiny in the drive to achieve value for money.[3] The public needs protection and successful offender rehabilitation of those in custody offers a key means of achieving this. With a youth custody population of 1,177 the potential for reoffending on release back into the community is significant. Youth Justice Board statistics for 2012-2013 state a reoffending rate of 69.3 per cent for young people released from custody.[4] This being so, it would appear that current intervention programmes are not delivering a sufficient reduction in recidivism.[5]

Successful treatment programmes are premised on the notion that offenders are engaged with them and will complete the course, though this is not always the case in reality. McMurran and Theodosi[6] found non-completion among community samples were as high as 50 per cent. Whilst, perhaps unsurprisingly, the non-completion rate is lower in custodial settings, 9 per cent for adults and 14 per cent for young people[7] community non completion rates represent a substantial waste of resources. Indeed, McMurran and Thedosi[8] have questioned whether offenders are being appropriately selected for treatment, whether the programmes are relevant to the needs of individual offenders and how well the treatments are organised and delivered. So, there is some evidence to suggest that re-offending rates are higher for those who failed to complete treatment than for those who never entered it.[9] Whilst this may not be the case for all offenders and all programmes, ensuring the completion

1. We would like to thank everyone who has encouraged us with this project, not least the young people from our local secure children's home and the committed staff who serve them. Our gratitude also goes to Professor Mike Maguire and Dr Jonathan Evans from the University of South Wales for their helpful critiques of earlier versions of this paper.
2. Day, A.; Casey, S.; Ward, T.; Howells, K. & Vess, J. (Eds)(2010) *Transitions to Better Lives: Offender Readiness and Rehabilitation*, Collumpton, Willan p.3.
3. National Audit Office, (2011) The Cost Of A Cohort Of Young Offenders To The Criminal Justice System. Technical Paper – June 2011 p.25.
4. Youth Justice Board (2014) Youth Justice Board/Ministry of Justice, Youth Custody Report – March 2014. Downloaded on 13 May 2014 from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/309665/youth-custody-report-march-2014.xls p.53
5. Karnik, N. & Steiner, H. (2007) Evidence for Intervention for Young Offenders. *Child and Adolescent Mental Health* 12, 4. 154-159.
6. McMurran, M. & Theodosi, E. (2007) Is Treatment Non-completion Associated with Increased Reconviction Over No Treatment? *Psychology Crime and Law* 13: 333-354.
7. Cann, J., Falshaw, L., Nugent, F., & Friendship, C. (2003) Understanding What Works: Accredited cognitive skills programmes for adult men and young offenders. Findings, No. 226. London: Home Office.
8. McMurran & Theodosi (2007) see n.6.
9. Ibid.

of treatment wherever possible is nevertheless a salient issue for the reduction of re-offending.

In practice, readiness to engage in the treatment process has not always been recognised as important; however, readiness to change is now considered to be a necessary prerequisite of successful outcomes for the offender.[10]

The constituents of readiness are therefore key to ensuring that resources are targeted and applied appropriately. According to developmental psychology children's cognitive abilities undergo significant change during adolescence. Given that Youth Justice Board for England and Wales covers children and young people between 10 and 17 years of age, interventions should be developed with an eye to child development and the range of young people's cognitive abilities.

Piaget's theory holds that formal operational thought does not appear until the age of 15 or 16.[11] The achievement of these cognitive skills brings the ability to manipulate logical concepts simultaneously; predict the impact of time upon events and relationships; logically think through the consequences of actions; identify inconsistencies in arguments; and identify how situational factors may influence the self and others.[12]

Whilst there is a continuing debate about exactly when young people acquire the ability to think hypothetically, adolescence is clearly a period of significant change and development in cognitive functioning. Recent advances in neuroimaging techniques have allowed researchers to have a much clearer understanding of neurological changes during the adolescent period.[13] These changes have a marked impact on individual behaviour, functional abilities and the development of relationships with others. Importantly, even when a young person has acquired formal operational thought and, with it, an appreciation of risk and probable outcome, their ability to apply these skills is often unsophisticated and inconsistent.[14] If interventions are to be effective, it is vital that not only are programmes matched to the cognitive abilities of this population but they are flexible enough to adapt to the changing needs. The fact that the necessary skills to think abstractly may not yet have developed for many young people, raises questions about the suitability of many offender intervention programmes which often rely heavily on these skills.

Intervention programmes with young offenders have focused on the criminal status rather than either the chronological or the functional age of the individual involved. This has resulted in interventions being drawn from those in place with adult offenders, rather than from those serving children and young people. Programmes for young offenders commonly focus on behaviour management/regulation rather than the roots of the behaviour itself. For example, anger management, consequential thinking and victim empathy programmes are frequently recommended and used. Implicit in this is the assumption that changing offenders' thinking about the effect of their behaviour on others will reduce future offending behaviour. As Lamb and Sim[15] point out, neurobiological research indicates that the executive functioning skills needed for these tasks do not reach maturity until around 20 years of age, making such interventions beyond the reach of the majority of young people involved in the criminal justice system. Moreover, such programmes are often designed to address behaviour rather than the underlying developmental and psychological drivers. Thus, the therapeutic needs of young offenders, particularly those in custody for serious offences, often remain unaddressed.

If interventions are to be effective, it is vital that not only are programmes matched to the cognitive abilities of this population but they are flexible enough to adapt to the changing needs.

When therapeutic interventions are available they are often based on cognitive behaviour therapy (CBT)[16] and 'thinking about thinking' and are aimed at challenging automatic negative cognitions. Whilst CBT is widely used within mainstream therapeutic contexts

10. Day, Casey, Ward, Howells & Vess (2010) see n.2.
11. Steinberg, L. (1993) *Adolescence*, 3rd edn. London. McGraw-Hill; Elkind, D. (1967) Egocentricism in Adolescence. *Child Development,* 38, 1025-1034.
12. Carr, A. (1999) *The Handbook of Child and Adolescent Clinical Psychology: A contextual approach*. Hove. Brunner-Routledge;
13. Delmage, E. (2013) The Minimum Age of Criminal Responsibility: A Micro-Legal Perspective. *Youth Justice* 13, 2, 102-110.
14. Lamb, M.E. & Sim, M.P.Y. (2013) Developmental Factors Affecting Children in Legal Contexts. *Youth Justice* 13(2), 131-144.
15. Ibid.
16. Feilzer, M., Appleton, C., Roberts, C. & Hoyle, C. (2004) *The National Evaluation of the Youth Justice Board's Cognitive Behaviour Projects*. Youth Justice Board & Centre for Criminological Research, University of Oxford.

with children[17] and is an intervention approach recommended by NICE (National Institute for Health and Care Excellence), its delivery is amended and edited according to the specific abilities of the young people involved. It is not a straightforward translation between the adult and adolescent contexts: CBT with adults requires abstract thinking and logical analysis and the teaching of general principles so that the client can transfer these to a range of situations. CBT with children and adolescents has tended to use a wider and more diverse range of techniques,[18] and interventions often have limited the cognitive component to focusing on one specific problem or the use of one specific technique, such as self-talk, to help amend behaviour.[19]

Anger management and victim empathy programmes require the ability to analyse, explain, reframe and regulate difficult or new feelings. Therefore, such approaches are premised on the notion that clients can think through and can verbally express and analyse their experiences with another individual. Those who haven't attained a normative level of cognitive development are necessarily disadvantaged in their efforts to benefit from such treatment modalities. Indeed, the likelihood of completing treatment may well be compromised, bringing with it a heightened potential for drop-out and recidivism. To be successful therefore, treatment approaches need to take account of clients' progress through cognitive development if they are to minimise drop-out, maximise completion rates and reduce reoffending. Moreover, an increased recognition of the complexity of young people's lives, particularly those who have experienced impaired or traumatic development, is necessary if interventions are to move beyond the superficial.[20]

Not only is there a need to use more child-orientated adaptations within criminal justice settings, but rehabilitative efforts need to be more tailored to the specific needs of children and young people. An understanding of cognitive age is essential to any clinical intervention to ensure that the focus of intervention is matched to the individual's cognitive development. For example, it is likely to be unhelpful and dispiriting to employ strategies that rely heavily on the ability to generate and derive guiding principles when the young person is not yet capable of abstract thought. Other clinical considerations include the need to match the intervention techniques to young person's dominant psychosocial developmental tasks. That is, during early adolescence a key task is to move from the external regulation of behaviour (by parents and teachers) to self-regulation. This naturally occurs as the individual develops introspective skills and cognitive and social maturity.

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Mental Health

The link between poor mental health and serious offending has been well established. Kroll et al[21]

17. Graham, P. (1998) *Cognitive Behaviour Therapy for Children and Families*. Cambridge. Cambridge University Press; Graham, P.J. (2005) Introduction. In P.J. Graham (Ed.) *Cogntive Behaviour Therapy for Children and Families*. 2nd edn., (pp.1-8.) Cambridge. Cambridge University Press; Nelson, W.M. & Finch, A.J. (2000) Managing Anger in Youth: A cognitive-behavioural intervention approach. In P.C. Kendall (Ed.) *Child and Adolescent Therapy: Cognitive-Behavioral Procedures*, 2nd edn, pp.129-170. New York. Guildford Press; Roth, A. & Fonagy, P. (2005) *What Works for Whom? A critical review of psychotherapy research*, 2nd ed. London. Guildford Press; Spence, S. & Reinecke, M. (2004) Cognitive approaches to understanding, preventing, and treating child and adolescent depression. In M. Reinecke & D. Clark (Eds.) *Cognitive Therapy Across the Lifespan: Evidence and Practice* (pp.358-395). Cambridge. Cambridge University Press; Stallard, P. (2002) Cognitive Behaviour Therapy with Children and Young People: A selective review of key issues. *Behavioural and Cognitive Psychotherapy*, 30, 297-309; Stallard, P. (2005a) Cognitive behaviour therapy with prepubertal children. In P.J. Graham (Ed.) *Cognitive Behaviour Therapy for Children and Families*, 2nd edn., pp.121-135. Cambridge. Cambridge University Press; Stallard, P. (2005b) *A Clinicians Guide to Think Good, Feel Good: Using CBT with children and young people*. London. Wiley.
18. Graham (2005) see n.17.
19. Ronen, T. (1998) Linking developmental and emotional elements into child and family cognitive-behavioural therapy. In P. Graham (Ed.) *Cognitive Behaviour Therapy for Children and Families* (pp.1-17). Cambridge. Cambridge University Press; Stallard (2002) see n.17.
20. Perry, B.D. (2013) The Neurosequential Model of Therapeutics: Application of a Developmentally Sensitive and Neurobiology-Informed Approach to Clinical Problem-Solving in Maltreated Children. In Brandt, K et al (Eds) (2013) *Infant and Early Childhood Mental Health: Core Concepts and Clinical Practice, Chapter 2, American Psychiatric Press Inc. Washington D.C. pp. 21-50*; Greenwald, R. (2000) A Trauma Focused Individual Therapy Approach for Adolescents with Conduct Disorder. *International Journal of Offender Therapy and Comparative Criminology*. 44; 146-163.
21. Kroll, L., Rothwell, J., Bradley, D., Shah, P., Bailey, S. & Harrington, R.C. (2002) Mental Health Needs of Boys in Secure Care for Serious and Persistent Offending: A Prospective, Longitudinal Study. *The Lancet* 359, 1975-79. www.thelancet.com

reviewed a sample of 97 boys admitted to secure care and found that at the point of admission 22 per cent were assessed as having major depression and 17 per cent presented with generalised anxiety disorder. Moreover, interventions to ameliorate these conditions were limited or absent. Harrington et al[22] note that in their 2 year follow up of these boys the mental health condition had commonly persisted or worsened. 39 per cent (32/81) were rated at follow up as having a poorly assessed or treated mental health problem (depression, anxiety, post-traumatic stress, obsessional and hyperactive problems). Kurtz, Thornes and Bailey reported that,

> *…factors that are strongly associated with mental health problems, such as childhood trauma in the form of abuse, and/or loss and frequently both, were found in 91 per cent of Section 53 [young] offenders...*[23]

Similar high rates of mental health problems among incarcerated offending young people have also been noted in The Netherlands, Germany, Greece and the USA.[24]

Of particular concern are those who are incarcerated whilst displaying symptoms of PTSD. Harrington, Kroll, Rothewell, McCarthy, Bradley and Bailey[25] reported that 9 per cent of their sample of young men in secure care demonstrated symptoms of PTS. There are some indications that for young women the rates are even higher. In Dixon et al's[26] sample of 100 female juvenile offenders in Australia, 37 per cent met the criteria for a diagnosis of PTSD. Golzari, Hunt and Anoshiravani[27] review article report a higher prevalence of mental health problems among incarcerated young women across the board, when compared to young men.

The impact of developmental trauma

In recent years another major contraindication for the automatic transfer of adult models of intervention has emerged from the literature. With advancements in technology and brain imaging there has been a burgeoning of information about the impact of trauma on neurobiological development. Prolonged exposure to stress hormones and the neuro-toxicity of repeated and chronic experiences of threat and harm, alters the morphology and functioning of the brain over time, and the individual's adaptive responses are shaped accordingly.[28]

Researchers generally conclude that trauma in early development and impairment in the attachment relationship between child and caregiver, often results in deficiencies in executive functioning (attention, concentration, anticipation, planning, abstract reasoning, cognitive flexibility, impulse control); verbal IQ; verbal memory and expressive and receptive language skills.[29] These factors have significant implications for how to work and intervene with young people with histories of trauma and of poor attachment to caregivers.

Studies have suggested that a range of disorders find their root in these early developmental experiences.

Studies have suggested that a range of disorders find their root in these early developmental experiences. Whether such responses are focussed inwardly (anxiety, depression, suicidal ideation, PTSD, dissociative states,

22. Harrington, R.C.; Kroll, L.; Rothwell, J.; Mccarthy, K.; Bradley, D. & Bailey, S. (2005) Psychosocial needs of boys in secure care for serious or persistent offending. Journal of Child Psychology and Psychiatry. 46:8, 859-866.
23. Kurtz, Z., Thornes, R. & Bailey, S. (1998) Children in the Criminal Justice and Secure Care Systems: How Their Mental Health Needs Are Met *Journal of Adolescence* 21, Issue 5, 543-553. doi: 0140-1971/98/050543+11/$30.00/0 p.543
24. Teplin, L.A., Abram, K.M., McClelland, G.M., Dulcan, M.K. & Mericle, A.A. (2002) Psychiatric disorders in youth in juvenile detention. Arch Gen Psychiatry. 2002 Dec;59(12):1133-43; Maniadaki, K. & Kakouros, E. (2008) Social and Mental Health Profiles of Young Males in Detention in Greece. Criminal Behaviour and Mental Health 18, 207-215. doi: 10.1002/cbm.698; Kohler, D., Heinzen, H., Henrichs, G., & Huchzermeier, C. (2009) The Prevalence of Mental Disorders in a German Sample of Male Incarcerated Juvenile Offenders. International Journal of Offender Therapy and Comparative Criminolology, Vol. 53, No. 2, pp211-227 doi:10.1177/0306624X07312950
25. Harrington, Kroll, Rothewell, McCarthy, Bradley & Bailey (2005) see n.22.
26. Dixon, A.; Howie, P. & Starling J. (2004) Psychopathology in female juvenile offenders. Journal of Child Psychology & Psychiatry. 45: 6. 1150-1158.
27. Golzari, M., Hunt, S.J. & Anoshiravani, A. (2006) The Health Status of Youth In Juvenile Detention Facilities. *Journal of Adolescence* 38, 6, 776-782. doi: 10. 1016/j.jadolhealth.2005.06.08
28. Perry, B.D. (2001) The Neuro-developmental Impact of Violence in Childhood. *In Schetky, D. & Benedek, E.P. (2001) Textbook of Child and Adolescent Forensic Psychiatry, Chapter 18, American Psychiatric Press Inc. Washington D.C. pp. 221-238*.
29. Teicher, M. (2000) Wounds That Won't Heal, *Cerebrum*, Vol. 2, No. 4, pp50-67; Creeden K. (2004) The Neurodevelopmental Impact of Early Trauma and Insecure Attachment: Re:Thinking Our Understanding and Treatment of Sexual Behaviour Problems. *Sexual Addiction and Compulsivity* 11, 223-247.

etc.) or outwardly (offending, hyperactivity, aggression, violence, drug and alcohol abuse, impulsivity, etc.), the genesis springs from the early developmental context experienced by the child.[30] Whilst such functioning may be seen as is 'adaptive' during the period in which the child is exposed to the harmful environment. However, in another context the functioning is seen as maladaptive leading them into contact with the health and criminal justice systems.

For such young people, successful treatment and rehabilitation programmes must address the source of the maladaptive behaviour, if the behaviour itself is to be mediated successfully.[31]

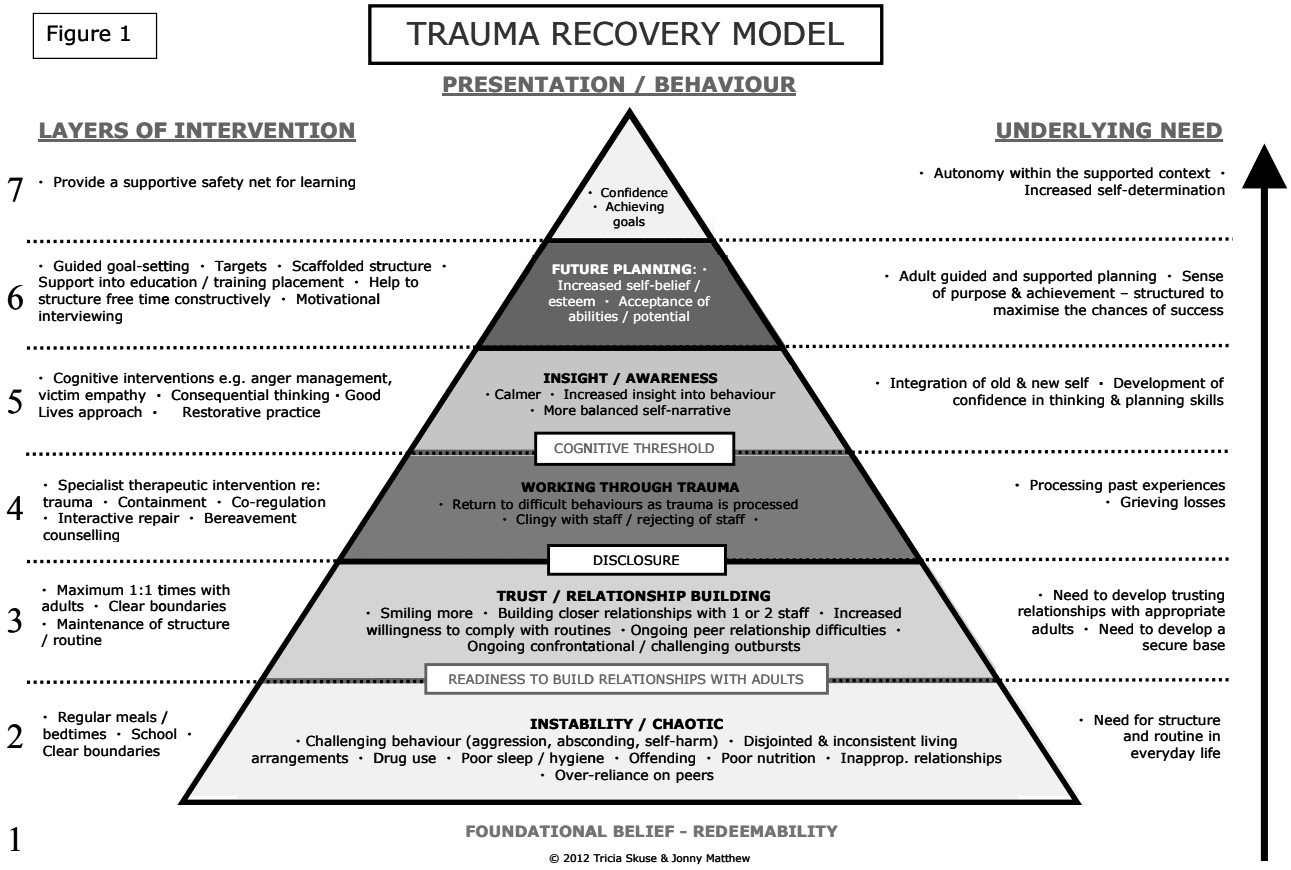
The Trauma Recovery Model (TRM)

The understanding of serious young offenders outlined above draws on a range of psychological and criminological approaches, however there is no overarching model which knits these together and applies them in practice. The Trauma Recovery Model (TRM) is an attempt to do this. It has evolved from working with young offenders in a secure children's home, many of them convicted of sexual offences. Such settings accommodate young people with both prolific and/or serious offending histories who are also deemed too young or too vulnerable to be housed in young offender institutions.

The TRM presents a series of layers of intervention that are sequenced according to developmental and mental health need. It indicates that the focus should be on relational therapy to mediate the impact of trauma before cognitive interventions can be fully effective. There are three aspects to the interpretation of the model. The central feature (contained within the triangle of the model, see Figure 1) relates to the behavioural presentation of the young person concerned. The model also highlights the underlying developmental need and the type of intervention best suited to address the need within the residential setting.

The key belief upon which the TRM is built is an assumption that young people involved in the criminal justice system are redeemable and that they can positively reintegrate back into the community and desist from offending. It has long been known that most offenders desist from crime by the age of 30.[32]

Figure 1



30. Karnik & Steiner (2007) see n.5;Teicher (2000) see n.29.
31. Greenwald (2000) see n.20; Karnik & Steiner (2007) see n.5.
32. Farrington, D. P. (1995) The Development of Offending and Antisocial behaviour from Childhood: Key findings from the Cambridge Study in Delinquent Development. Journal of Child Psychiatry and Psychology, 36, 929-964; Giordano, P.C., Cernovitch, S. A, Rudolph, J.L. (2002) Gender, Crime, and Desistence: Towards a Theory of Cognitive Transformation. *American Journal of Sociology*, 107,4, 990-1064.

However, whilst maturation is a helpful factor, agencies need other inputs if the desistance process is to speed up. Research indicates that optimism about offenders' redeemability can influence their ability to transform their lives;[33] such optimism is a foundational belief underpinning the TRM.

The lower levels of the model draw on Maslow's hierarchy of needs[34] which posits that healthy psychological growth can only occur where basic physiological and safety needs have been met. Such have not been a feature of the early life histories of many of the offending young people we have encountered,[35] particularly those in secure children's homes. Thus, the first layer of intervention would be to facilitate structures that provide for these needs. At the basic level this would be safe accommodation with regular meals and other structures that might be commonly regarded as normal routine parenting behaviour; for example regular bedtimes; personal hygiene; educational routine; consistent boundaries and expectations of behaviour. There may be other needs that are specific to individual young people such as drug and alcohol detox and regular medication where prescribed. The focus on routine and structure effectively puts the brake on the often disorganised lifestyles that children experience prior to a period in secure accommodation.

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At the point of admission young people can often be angry, confrontational and aggressive. Our experience suggests that for a majority of young people, this period of initial stabilisation can take a number of weeks. At that point their behaviour becomes more settled, less problematic and therefore more easily managed, although problems associated with peer relationships sometimes persist. Once the young person becomes more settled and attuned to the living environment they begin to develop an emotional readiness for relationships with adults.

The second layer of intervention would build on the structure and routine of the previous stage but places greater emphasis on containment and relationship building between the young person and staff. Commonly, young people will begin to appear more cheerful, demonstrate an increased willingness to comply with boundaries and routines, and begin to orientate themselves towards building relationships with one or two key members of staff. However, previous adaptive responses continue to be present in the form of confrontational behaviours and challenging outbursts. Young people's underlying need for a secure base remains although the ability to develop more appropriate and trusting relationships with adults has begun to emerge.

As these relationships of trust begin, the process of dealing with strong emotions and previous negative coping adaptations can take place. The focus of the intervention work at this stage is on intersubjectivity (attunement, shared attention and shared goals) and interactive repair.[36] Interactive repair is a way of reconnecting with a young person after a relationship has been 'broken' or interrupted following, for example, his being disciplined. The overall aim is to help the individual to successfully *'connect-break-reconnect'*, and to give the child experiences of attuned and responsive parenting that they missed. If this process is repeated often and consistently, new neural pathways and associated psychological functioning can develop. This in turn challenges the young person's internal working model (IWM) and promotes the establishment of alternative templates of interaction with adults.

Human beings are not born with the ability to regulate their own emotions.[37] In infants this process is learned through co-regulation of affect offered via the relationship with a parent or caregiver:

> *A dyadic regulatory system evolves where the infant's signals of moment to moment changes in his state are understood and responded to by the caregiver, thereby achieving regulation. The infant learns that*

33. Maruna, S. (2001) Making Good: How ex-convicts reform and rebuild their lives. Washington, DC. American Psychological Association; Maruna, S.; LeBel, T.P.; Naples, M. & Mitchell, N. (2009) Looking-Glass Identity Transformation: Pygmalion and Golem in the Rehabilitation Process. In Veysey, B.M.; Christian, J. & Martinez, D.J. (Eds) How Offenders Transform Their Lives. Cullompton: Willan Publishing.
34. Maslow, A.H. (1943) A Theory of Human Motivation. *Psychological Review*, 50, 370-396.
35. Golding, K. & Hughes, D. (2012) Creating Loving Attachments. London. Jessica Kingsley.
36. Golding & Hughes (2009) ibid.
37. Fonagy, P. Gergely, G. Jurist E. & Target M. (2002) *Affect Regulation, Mentalisation and the Development of the Self*. New York. Other Press.

the arousal in the presence of the caregiver will not lead to disorganisation beyond his coping capabilities. The caregiver will be there to re-estabiish equilibrium.[38]

Children who find themselves in a secure children's home have typically missed out on this process to a greater or lesser degree. Their relationships with trusted adult staff provide an opportunity to undergo this learning. The challenge for staff is to help adolescents undergo a process that is usually learned in infancy. It is not a simple translation of using the same skills to soothe an adolescent as one would an infant. Challenging outbursts provide an opportunity for interactive repair and co-regulation, but doing so in a way that takes account of young people's chronological age is demanding and requires high levels of flexibility, emotional literacy and attunement from staff.

This is a highly complex set of skills, as in order to do this effectively staff must be simultaneously aware of the behavioural presentation and the risks posed therein, be attuned to the underlying emotional need behind the behaviour, suppress their own emotional responses to any distress or aggression posed and respond in a way that co-regulates the young person's emotional affect. This level of skill might be normally expected of experienced therapeutic staff but may not be so familiar to an often therapeutically unqualified workforce. Therefore, high quality training of staff and matching staff skills to young people's needs is essential. It also requires the organisation to free up keywork staff to spend time on a one-to-one basis with young people wherever possible. The nature of the activities undertaken during such time is not the principal issue; rather staff are free to engage in whatever they feel the young person is most positively disposed towards (e.g. computer games, listening to music, sport and fitness, arts and crafts or simply watching television together).

Over time—sometimes a very protracted period—this yields opportunities to talk in more depth, to discuss pertinent issues that arise and to revisit difficult life experiences. It is not until young people have successfully negotiated the first two layers of the model that they feel safe enough, perhaps for the first time, to begin to think about and articulate what has happened to them in the past. The sorts of disclosures that typically emerge include complex bereavement, abuse, neglect, maltreatment, exploitation, incest and domestic violence.

Specialist therapeutic intervention can often be required to work through traumatic experiences and losses. Importantly, therapy can take place within the context of safe and supportive relationships with staff (e.g. a keyworker), rather than expecting the young person to singlehandedly translate insights gained in therapy to their everyday lives. Crucially, young people are not left alone in dealing with their feelings. Rather the processing of past experiences that goes on *in between* therapy sessions is contained and understood, allowing the young person to feel as emotionally safe as possible and subsequently maximising the beneficial effects of therapy. The ongoing co-regulation of affect with trusted staff is crucial in this continuing process, as individuals will have a tendency to revert back to old coping strategies when processing distressing material.

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Cognitive readiness threshold

In our view, until young people have transcended the first three stages of the Trauma Recovery Model they are not yet cognitively able to embrace their current situation, their behaviour or to address the impact or implications of their offences. Expecting a young person to use consequential thinking skills, have empathy for the victim/s and be able to plan and act differently when they are still in a state of trauma and survival is unrealistic and unattainable.

The first three stages of the Trauma Recovery Model facilitate the emotional stabilisation of the young person and provide a basis upon which improved functioning can begin to occur; they also support cognitive maturation. Many young offenders have become adapted to life in a traumagenic environment. This has necessarily given rise to neurological adaptations that are attuned to threat and danger. The first three layers of the Trauma Recovery Model allow time for them to adjust to a non-threatening environment and begin to process

38. Ibid p.37.

trauma. With continued exposure to relational interventions alternative response habits are developed which in turn influence emotional and cognitive functioning. Over time hyper-vigilance/sensitivity dissipates, behaviour calms and space is provided for improved cognitive behaviour. We have observed that young people tend to be calmer, less emotionally driven, and demonstrate greater insight into their own behaviour following this period of stability and relational intervention. Therapeutic interventions at this stage can then focus on the integration of an individual's personal history with a revised self-concept and understanding of relationships. One could argue that this represents, to some extent, a remapping of the internal working model. It is not until this point that cognitive interventions such as anger management, victim empathy, offence specific programmes, restorative justice, enhanced thinking skills, etc. can be used in anything other than a psychoeducative/information-giving way. In order for a young person to be able to use the cognitive components of such interventions as a practical tool to alter their subsequent behaviour, there must be a sufficient level of emotional regulation in place to allow for a higher level of cognitive functioning to occur. Interestingly, we have often observed that young people demonstrate greater insight and awareness, often reflecting on their offence without prompting or assistance from staff. Supporting a young person to get themselves to a point where they naturally reflect on their offence will undoubtedly have a more lasting impact on a young person's behaviour than any number of prematurely provided worksheets and offence related courses/programmes. Strategies from the Good Lives approach[39] lend themselves to this phase of the TRM as they involve a re-examination of underlying needs *(Primary Goods)* and more functional ways of meeting them in future.[40] The Good Lives approach is aspirational and has its roots in positive psychology which fits with young people's cognitive functioning at this level of the TRM.

By the penultimate layer of the Trauma Recovery Model young people have developed an increased sense of self-belief and a greater acceptance of their abilities and potential.

By the penultimate layer of the Trauma Recovery Model young people have developed an increased sense of self-belief and a greater acceptance of their abilities and potential. Nevertheless, it is important to remember that this is still in its fledgling state and young people require a significant amount of support in the form of guided goal setting, support into education and a scaffolded approach to structuring free time and community living in order to maximise the chances of sustained success. The desistance literature suggests that many ex-offenders cease to offend as a result of maturation and/or other significant life events, what Giordano et al refer to as *Hooks for Change*.[41] Non-offending lifestyles within the community and the opportunities to adopt them are more likely to be available and attainable to young people who have processed some of their own experiences and who have an ongoing supportive relationship with an adult or agency who can guide them.

With time, practice and support, especially through mistakes, young people are then able to move onto the final layer of the model which sees them achieve more socially acceptable goals. This can still be a challenging time for young people as they are returning to a level of autonomy that was previously difficult for them. Old adaptive patterns may recur, triggered by the anxiety of new situations and a new sense of freedom, responsibility and self-determination. A supportive safety net remains key to maintaining a forward trajectory and a successful rehabilitation.

Many of the young people who are placed within secure settings come to the end of their sentences before they attain the higher levels of the Trauma Recovery Model. Indeed one could argue that the upper stages of the model are best negotiated in the community in the context of 'real life' situations. However, the more dynamic and changeable nature of community life may mean that the scaffolded structure and support, whilst available, are less easily and consistently managed and available than they would be in custody.

39. Ward, T. (2002) Good Lives and the Rehabilitation of Offenders: Promises and Problems. Aggression and Violent Behaviour. 7, 513-528
40. Print, B. (2013) The Good Lives Model for Adolescents Who Sexually Harm. Brandon, Vermont; Safe Society Press; Ward, T. & Marshall W.L. (2004) Good Lives, aetiology and the rehabilitation of sex offenders; a bridging theory. Journal of Sexual Aggression. 10, 2. 153-169; Ward, T. & Stewart, C.A. (2003) Good Lives and the Rehabilitation of Sex Offenders. In T. Ward; D.R. Laws & S.M. Hudson (eds) *Sexual Deviance: Issues and Controversies* (pp 21-24). Thousand Oaks, CA: Sage.
41. Giordano, Cernkovich & Rudolph (2002) see n.32.

Discussion

There is increasing agreement that attachment difficulties lie behind many of the behaviours presented by some of society's most troubled children and across offender sub-types.[42] Interventions that work towards repairing young people's relatedness to others are necessarily crucial to the way forward. It is interesting to note that although developed in isolation the TRM mirrors the similar models developed by authors in other settings.[43]

The appetite for improved outcomes for incarcerated young people is high. The Youth Justice Board and Ministry of Justice strategy document, *Developing the Secure Estate for Children and Young People in England and Wales. Plans until 2015*,[44] lays an emphasis upon the rehabilitation of young offenders and the long term reduction in offending rates. The 2012 Wales Green paper, *Proposals to improve services in Wales to better meet the needs of children and young people who are at risk of entering, or are already in, the Youth Justice System*,[45] has a similar focus.

In our setting (Wales) where the UN Convention on the Rights of the Child is enshrined in law, there is now a legal obligation to give due regard to the needs of young people who have been the subject of abuse, maltreatment or neglect. The balance between public protection and rights of the child will require creative efforts to improve interventions.

With falling numbers of young people in the criminal justice system[46] those that do make it into custody come with very complex needs. For example, there is increasing awareness of neurodisability in young people who offend.[47] Similarly, there is a growing acknowledgement that many young people who offend have complex emotional and mental health needs that cannot be addressed with manualised interventions alone. Similarly as more and more girls enter the criminal justice system, at an increasingly young age[48] intervention strategies are needed to address the consequences of histories often characterised by abuse.[49] The Trauma Recovery Model is an attempt to provide a theoretical framework upon which practical interventions can be tailored to the individual and sequentially applied. Many of the ideas discussed in this article are not new. However, there continues to be a failing within services for young people who offend to bring together current thinking on child development and attachment with a model that can be practically applied in a secure setting. We believe the Trauma Recovery Model helps to address this.

Interventions that work towards repairing young people's relatedness to others are necessarily crucial to the way forward.

What this approach to intervention with troubled young people offers, is a model of working that is grounded in psychological theories of attachment and child development. This means that, rather than intervention being a scatter-gun of short term efforts to address different symptoms, including offending, we strive to understand the causes of behaviour and target these in a coordinated way. If interventions are sequenced appropriately, this can ensure the most efficient and effective use of available resources, as well as maximising the opportunities for young people to succeed in the longer term.[50]

42. Smallbone, S.W. & Dadds, M.R. (2000) Attachment and Coercive Sexual Behavior. Sexual Abuse: A Journal of Research and Treatment, Vol. 12, No. 1, 2000; Johnson, R.M.; Kotch, J.B.; Catellier, D.J.; Winsor, J.R.; Dufort, V.; Hunter, W. & Amaya-Jackson, L. (2002) Adverse Behavioral and Emotional Outcomes From Child Abuse and Witnessed Violence. CHILD MALTREATMENT, Vol. 7, No. 3, August 2002 179-186; Stirpe, T.; Abracen, J.; Stermac, L. & Wilson, R. (2006) Sexual Offenders' State-of-Mind Regarding Childhood Attachment: A Controlled Investigation. Sex Abuse (2006) 18:289–302; Creeden, K. (2013) Taking a Developmental Approach to Treating Juvenile Sexual Behaviour Problems. International Journal of Behavioural Consultation and Therapy, Vol.8, No.3-4.
43. Perry (2013) see n.20; Golding & Hughes (2012) see n.35; Creeden (2013) see n.42; Ryan, T. & Mitchell, P. (2011) A collaborative approach to meeting the needs of adolescent offenders with complex needs in custodial settings: An 18-month cohort study. *The Journal of Forensic Psychiatry & Psychology,* Vol. 22, No. 3, June 2011, 437–454.
44. Available at http://yjbpublications.justice.gov.uk/en-gb/scripts/prodView.asp?idproduct=502&eP=
45. Available at http://gov.wales/docs/dsjlg/consultation/120918youthjusticeen.pdf
46. Youth Justice Board (2014) Youth Justice Board/Ministry of Justice Statistics Bulletin 2012/13. London. Ministry of Justice.
47. BPS (2015) Position Paper: Children and Young People with Neuro-Disabilities in the Criminal Justice System. Leicester. British Psychological Society; Hughes, N., Williams, H., Chitsabesan, P., Davies, R. & Mounce, L. (2012) Nobody Made the Connection: The Prevalence of Neurodsiability in Young People who Offend. Children's Commissioner for England.
48. Youth Justice Board (2009) Girls and Offending – Patterns, Perceptions and Interventions. YJB for England & Wales.
49. Austin, A. (2003) Does Forced Sexual Contact have Criminological Effects? An empirical test of derailment theory. Journal of Aggression, Maltreatment and Trauma 8: 4, 1-66.
50. Greenwald (2000) see n.20; Perry, B.D. (2006) The Neurosequential Model of Therapeutics: Applying Principles of Neuroscience to Clinical Work with Traumatized and Maltreated Children. In Webb, N.B. (Ed.)(2006) *Working with Traumatized Youth in Child Welfare. New York: Guildford. pp27-52*; Perry, B., & Hambrick, E. (2008). The Neurosequential Model of Therapeutics. *Reclaiming Children and Youth, 17*(3), 38–43.

Most young people do not become involved with youth justice services. For those that do, most will move away from offending as they mature.[51] The TRM offers a theoretical model about how best to intervene during their period of involvement with the youth justice system and aims to address underlying causes for their offending behaviour, supporting them to be able to make a more positive contribution to society.

Implementation of the TRM is not without its challenges. It requires a unified approach from staff and support from senior management and a willingness to refer back to the model when young people's behaviour becomes challenging, rather than resort to behavioural approaches used historically. This has necessitated the provision of an ongoing training programme for staff about attachment as well as training in the model itself. However, early anecdotal evidence of effectiveness is encouraging. The model has logical appeal to staff as it puts child welfare at the heart of interventions with complex cases. Briggs[52] argues that despite the increasing focus upon risk in the youth justice agenda, many practitioners maintain an essentially welfare-based orientation to their work with young offenders. We believe that the sequential approach to intervention offered in the TRM provides a theoretical framework that balances the welfare needs of young people with due consideration to risk.

51. Giordano et al (2002) see n.32.
52. Briggs, D.B. (2013) Conceptualising Risk and Need: The Rise of Actuarialism and the Death of Welfare? Practitioner Assessment and Intervention in the Youth Offending Service. *Youth Justice* 13(1) 17-30.