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Trauma-informed practice

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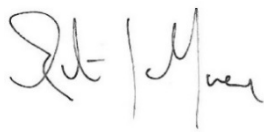
Contents

Foreword.....	3
1. Introduction	4
2. Trauma and adverse experiences	5
2.1 Definitions, models and impact.....	5
2.2 Being trauma-informed in practice and in policy.....	8
3. Conclusion	10
References	11

Foreword

HMI Probation is committed to reviewing, developing and promoting the evidence base for high-quality probation and youth offending services. *Academic Insights* are aimed at all those with an interest in the evidence base. We commission leading academics to present their views on specific topics, assisting with informed debate and aiding understanding of what helps and what hinders probation and youth offending services.

This report was kindly produced by Kieran McCartan, summarising the evidence base around trauma and Adverse Childhood Experiences in the lives of people who have committed offences. A trauma-informed approach is promoted which seeks not to re-traumatise with blame and sanction, but to recognise individual strengths and skills, build confidence and re-educate. It is a person first, service user centred approach that is rooted in desistance and strengths-based models, recognising that the causes and impact of trauma are individualised. To fully adopt such an approach requires organisations to think carefully in terms of policy, practice, place and people. Crucially, staff need to be supported, supervised, and enabled in a pro-active way, while individual service users need to be at the centre of the process, allowing their voices to be heard and enabling them to move forward at a sustainable pace.



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The views expressed in this publication do not necessarily reflect the policy position of HMI Probation.

1. Introduction

Offending behaviour does not happen in isolation, there is always a context to it. Understanding what contributes to people's offending behaviour enables us to prevent offending from happening, respond effectively, and manage people at risk of committing a future offence – understanding the aetiology of offending behaviour thus enables us to better prevent (future) offending and protect the public.

In the social sciences we have long debated the impact of nature versus nurture on our behaviours, including offending behaviours. Research and practice tell us that criminogenic behaviour is often impacted by:

- (i) **risk factors** (i.e., factors that increase the likelihood of committing an offence); and/or
- (ii) **protective factors** (i.e., factors that reduce the likelihood of committing an offence)

Increased risk factors and reduced protective factors play a role in whether someone commits a criminal offence or not (Farrington, Loeber and Ttofi, 2014; Serin, Chadwick and Lloyd, 2015). However, less clear is the degree to which these factors play a role in a person's behaviour and the volume of factors needed to impact any given individual. Unfortunately, there is not a simple solution, or a one size fits all model. We need to consider each person who commits an offence as an individual, viewing their own risk as well as protective factors.

The causes of offending behaviour are social, developmental, health and psychological in nature and so we need a multi-disciplinary approach. This means that offending behaviour is linked to an individual's life-course and development, with past experiences having an impact upon current and future behaviour (Le Blanc, 2012). If we can recognise and understand the impact of past events on the lives of people who commit offences, we can support their desistance and help to pro-socially integrate them into society post-conviction.

In this *Academic Insights* paper, the focus is upon the evidence base around Adverse Childhood Experiences and Trauma in the lives of people who have committed offences, how these have shaped them, and how we can work with them in a trauma-informed way to reduce their reoffending and focus on desistance. Additionally, the paper will consider how we can better prepare staff to be more trauma-informed in their practice and how to engage the service user more effectively.

2. Trauma and adverse experiences

One of the most significant and far reaching studies of the causes of criminal behaviour in the UK, supported by international research, has been the long running Cambridge study of crime by West and Farrington (Farrington and West, 1990; Farrington et al., 2006). This longitudinal study on the causes and consequences of criminality has demonstrated that the main aetiological factors are socio-economic status, major life events, personality, childhood development, health, socialisation (community, family, and peers), intelligence and impulsivity. The study demonstrates that the causes of offending behaviour are a blend of nature and nurture, with childhood playing a significant role in determining later behaviour.

Research and existing good practice also demonstrate that the more protective factors you have, the less likely you are to demonstrate criminogenic behaviour (Farrington, Loeber and Ttofi, 2014; Sapona et al., 2015). Therefore, having a positive, pro-social environment is more likely to mitigate risk of offending behaviour and enable crime prevention and desistance. Which means that criminality is, in part, a learned behaviour which can be unlearned. Rehabilitation is thus possible for most, and proactive risk management is possible for others, with the appropriate tools and necessary support.

In this paper, we are going to focus on one set of risk factors, trauma, and adversity, and how they impact offending behaviour, as well as how we can implement protective factors to counter them.

2.1 Definitions, models, and impact

The ability to recognise psychological and emotional trauma has vastly improved since the mid-20th century through increased research and evidence-informed practice. We now have an improved understanding on the psychological, health, social and behavioural impact of trauma upon individuals as well as broader cultural, socio-economic, and socio-political populations. Despite this, while we may be aware that people who have committed criminal offences have trauma in their lives (even through the extent, nature and impact of that trauma changes with the individual), we do not always acknowledge this in sentence planning, risk management or use it effectively in rehabilitation or reintegration. However, in recent years this has started to change at a policy, practice, and personal level.

Explaining trauma

Trauma is a broad and varied concept, but fundamentally is a severely distressing or disturbing experience that has an impact on an individual or their broader social network (Mind, 2020; Substance Abuse and Mental Health Services Administration, 2014). This means that trauma can be psychological, emotional or physical in nature, with examples including societal events/experiences (i.e., natural disasters, terrorist attacks, COVID-19, etc) or personal events/experiences (i.e., interpersonal violence, sexual abuse, break up/divorce, neglect, disabling conditions, etc). Also, trauma can be linked to:

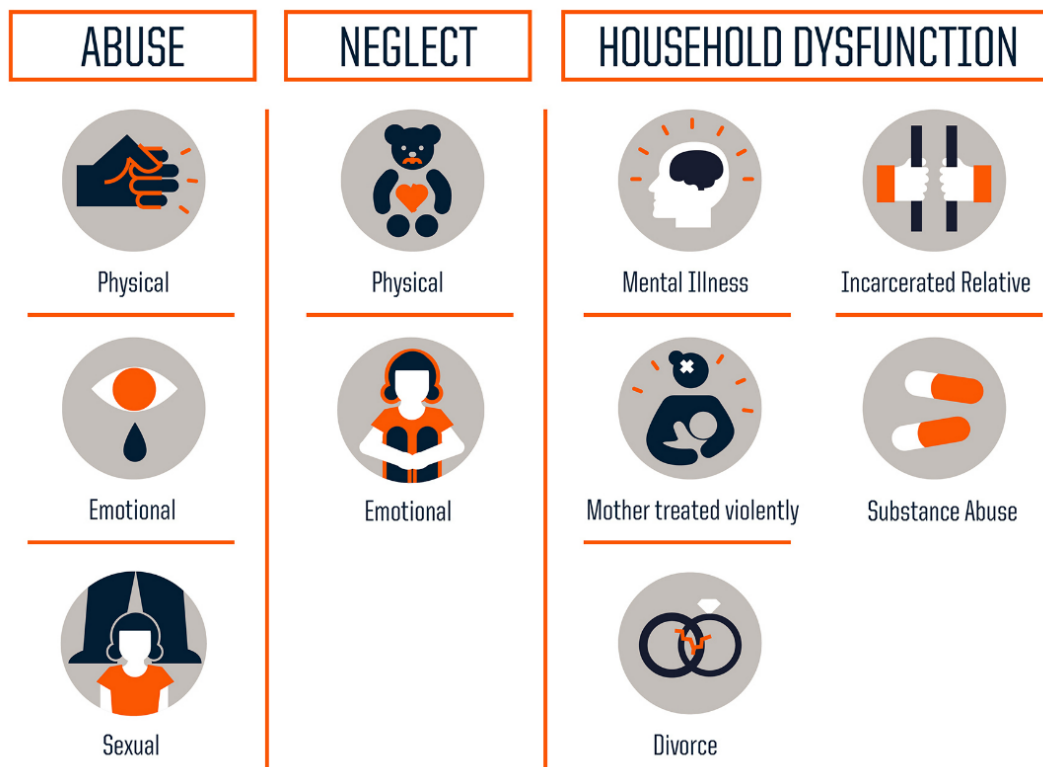
- a one-off event (i.e., being a victim of a terrorist attack, a rape);
- a series of similar events (i.e. ongoing child sexual abuse or neglect); or
- a combination of a series of diverse events (i.e., being a victim of neglect, childhood sexual abuse and parental divorce)

Therefore, the causes and impact of trauma are individualised.

Explaining Adverse Childhood Experiences

Building on the research and work on previous trauma and developmental criminology is the idea of Adverse Childhood Experiences (ACEs) (Public Health Wales, 2015; Scottish government, 2018; British Psychological Society, 2019; Centers for Disease Control and Prevention, 2019). ACEs are negative childhood experiences that can, but do not necessarily, impact a person’s behaviour, health, and psychology across their lifespan. The ACEs can be direct or indirect revolving around abuse, neglect, and household dysfunction.

Figure 1: Three types of ACEs



(Centers for Disease Control and Prevention)

While anyone can have one or multiple ACEs, there is a relationship with socio-economic and socio-political factors (Public Health Wales, 2015; Scottish government, 2018). Research shows that some populations (i.e., vulnerable populations and populations with a lower social-economic static status) are more likely to have ACEs, with the impact of those ACEs likely to be greater (Walsh et al., 2019).

Impact of trauma and adverse experiences

Trauma can directly impact individual mental/emotional health and brain functioning (Fox et al., 2014), with research indicating that trauma and ACEs rewire brain structure through conditioning (Centers for Disease Control and Prevention, 2019; Metzler et al., 2017), resulting in a permanent state of arousal, i.e. fight, flight, freeze etc. The psychological and emotional impact of the trauma, including ACEs, may emerge at different times in a person's life; therefore, not necessarily directly after the traumatic experience but possibly months, years or decades later. Trauma may impact differently on the individual with outcomes including, but not limited to:

- (1) addiction (including, substance abuse or alcoholism)
- (2) sexual problems
- (3) inability to maintain healthy close relationships, friendship and social interactions
- (4) hostility and/or anti-social behaviour
- (5) social withdrawal
- (6) self-destructive behaviours
- (7) impulsive behaviours
- (8) reactive thoughts
- (9) feelings of depression, shame, hopelessness, or despair.

(Substance Abuse and Mental Health Services Administration, 2014a).

Even though research demonstrates a link with anti-social behaviour, violent crime, sexual offending, and domestic violence (Levenson et al., 2014; GIG Cymru and NHS Wales, 2019; Wilkins et al., 2014; Baglivo et al., 2014), it is important to note that not everyone who experiences trauma, including ACEs, has a negative outcome. Instead, experiencing trauma makes people more at risk of a negative outcome.

With trauma, and ACEs, impacting upon people individually, it means that it is not cumulative (i.e., the more trauma or ACEs that you have the more that you are impacted) or type dependent (i.e., the more severe the trauma or ACE is the worse impact it has) in its impact. Therefore, a person could be severely adversely impacted by one traumatic event, while another person may not be adversely impacted by multiple traumatic events. While research does indicate that the more ACEs you have, the more likely you are to be at risk of adverse outcomes (Zelichoski, 2016; Public Health Wales, 2015; Scottish government, 2018; British Psychological Society, 2019; Centers for Disease Control and Prevention, 2019), this is not an exact science and we would warn against seeing it as such.

Instead, trauma and ACEs should be viewed as a warning sign that the individual in question has been in a traumatic situation and that they may need help and support to enable them to move forward in a healthy fashion. Therefore, the impact of trauma, and ACEs, can be reduced through effective and appropriate interventions (Rowles and McCartan, 2019). Reducing the impact of ACEs takes time and may not totally eradicate harmful behaviour for everyone. For most, we can expect harm reduction, for many desistance, and for some we anticipate risk management, not cure. But ***the earlier we introduce holistic, supportive, and appropriate social-emotional interventions, the greater likelihood of reducing the impact of ACEs and trauma across the lifespan.***

2.2 Being trauma-informed in practice and in policy

Being aware of past trauma means that we can understand why some individuals engage in criminogenic behaviour, in relation to both initial offending and reoffending. But how do we adapt our practice to reflect this?

What is a trauma-informed approach?

Being trauma-informed means recognising the impact that trauma, including but not limited to ACEs, has on an individual and in acknowledging this, providing appropriate support to that person. A trauma-informed approach is a change of perspective from “What’s wrong with you?” to “What happened to you?”. A trauma-informed approach seeks not to re-traumatise with blame and sanction, but to recognise strengths and skills, build confidence and re-educate – embedding new coping skills to enable recognition and regulation of behaviour (Substance Abuse and Mental Health Services Administration, 2014b). Therefore, it fits into the traditional ‘Advise, Assist and Befriend’ mandate of probation and operates within the ‘What Works’ framework to help us address the individual needs of the service user and enable them to desist from offending.

The importance and use of person first language

In recent years, we have started to adapt the way that we think about the people that we work with; we are becoming more person centred rather than label orientated. The criminological literature often talks about the negative impact of labelling people who have committed offences (Bernburg, 2009; Bedell et al, 2019), indicating that referring to people by their offence, as an offender, increases the likelihood that they will always see themselves in this light and, therefore, be less likely to change and desist from future offending (McCartan, Harris and Prescott, 2019). Taking a person first approach thus means that:

- you are person centred;
- you recognise that the person is more than their offence; and
- you believe that the individual can change.

A person first approach is in line with a trauma-informed approach, recognising that a person’s behaviour (in this instance their criminal behaviour) is a cumulation of their experiences, and that by confronting past trauma and ACEs they can desist from offending in the future.

The link between being person first, trauma-informed and desistance

Trauma-informed approaches are rooted in strength-based research and practice (i.e., Risk Need Responsivity and the Good Lives Model) which emphasise that offending behaviour is only one part of the characteristics of an individual (Willis and Ward, 2013). Strengths-based interventions highlight that to reduce reoffending, we need to focus on the positive aspects of the individuals that we work with, their protective factors, not just the risk factors (Kewley, 2016).

Desistance is rooted in the life course and development of an individual and focuses on the way that they can learn to stop offending and change their lives (Maruna and Mann, 2019). This is important in terms of reintegration as many people, because of past trauma and ACEs, may not have been fully or appropriately integrated in the first place. Taking a trauma-informed approach enables the service user to recognise that they are being heard,

supported, and enabled to change which means that they can own their desistance (Rowles and McCartan, 2019).

Additionally, there are benefits to staff who become enablers of change rather than managers of change. They become fully aware of how desistance can feed into prevention and a reduction in first time offending.

Developing a trauma-informed workforce

In developing a person first, trauma-informed workforce we need to place the individual service user at the centre of the process, allowing their voice to be heard and enabling them to move forward at a sustainable pace; promoting desistance, behaviour change, harm reduction and prevention. A trauma-informed approach can be framed in terms of policy, practice, place, and people:

- **Policy:** Workplaces need to have trauma-informed practice embedded at a policy level, ensuring it is a key plank in all organisational policies and factored into the development of new policies. An organisation can then demonstrate that being trauma-informed is at the core of its ethos and business.
- **Practice:** Being trauma-informed should be part of the day to day practice in an organisation; it should be constantly considered and developed. It should be written into all aspects of the organisation's activities and be reflected in development, planning and maintenance of all working practices. It should be the subject of clear leadership in all parts of the organisation. This may mean that trauma-informed practice is recognised as a Key Performance Indicator against which all practice is measured.
- **Place:** Being trauma-informed means that you develop a space for service users that is not trauma inducing or triggering, and where they feel able to engage with treatment, rehabilitation or supervision without feeling that they are at risk of relapse. This is a challenge in criminal justice settings, but one that needs to be considered as the shape, layout and flow of a building may have a traumatic impact on service users in general; especially if their traumatic experiences were criminal justice related.
- **People:** Being trauma-informed means training staff in how best to communicate and interact with service users. This involves staff training, appropriate leadership and awareness raising. Being trauma-informed needs to be at the forefront of practice in all forms of communication, support, and interactions, especially with challenging and difficult service users. In addition, having a trauma-informed workforce means a reflective workforce that is supported, supervised, and enabled in a pro-active way.

3. Conclusion

Understanding the role of developmental experiences in offending is not a new phenomenon, but it has become apparent that it is a central and essential one. We need multidisciplinary and multi-agency approaches to preventing as well as responding to crime through streamlined services that enable holistic responses. This approach emphasises the importance of being person centred and trauma-informed. If we look at offending behaviour as an outcome based on life course experiences then past trauma, ACEs and other experiences become important. Being trauma-informed is not being overly sympathetic to the person who has committed an offence and does not take away from the victim's experiences. Instead, being trauma-informed supports reintegration by helping a person to have a better understanding of why they committed their offences, enabling them to change their behaviour.

Trauma-informed organisations lead by example and are reflective in all that they do – with changes being made to working cultures and practices where required. In a criminal justice setting, this means taking a person first, service user centred approach that is rooted in desistance through strengths-based models. Crucially, staff are enabled to work in a trauma-informed way, with sufficient training and supervision in place, and service users are heard and supported to move forward at a sustainable pace.

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