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**Unit manager perspectives of a trauma-specific programme
across Scotland's secure estate**

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Abstract

Purpose

The current case study sought to assess unit manager perspectives on the introduction of a group-based trauma-specific programme delivered across Scotland's secure estate. As this was the first time such an estate-wide initiative had occurred, it was important to identify the **benefits/challenges** at a strategic level.

Design

An exploratory qualitative case study was utilized involving semi-structured interviews with five senior unit managers in three secure units to discover their perceptions of the benefits and challenges of implementing Teaching Recovery Techniques. A quasi-qualitative analysis was used to quantify and give meaning to manager responses. Inter-rater reliability of analysis was assessed.

Findings

Unit managers perceived **gains in trauma-informed knowledge for themselves, and knowledge and skills gains** for programme workers, care staff **and adolescents**. Challenges **involved: managing a shift in paradigm to include a trauma-specific programme; the** limiting context of competitive **tendering; short** duration placements; and the need for psycho-education for staff, parents, and agencies.

Research implications

Large sample sizes are likely to identify further issues for unit managers. Manager perceptions need **directly** compared with staff and adolescent perceptions and included in randomised control trials of trauma-specific **programmes**.

Practical implications

Managers perceived TRT needed to be delivered within trauma-informed organizations and identified the need for manager training in traumatization, trauma recovery and organizational implications to guide strategic planning. Managers emphasised the need for psycho-education for families, staff and agencies.

Originality

The current study is the first in Scotland to explore unit manager experience of introducing a trauma-specific programme across the secure estate.

Key words: secure units; traumatization; youth; recovery.

Unit manager perspectives of a trauma-specific programme across Scotland's secure estate

The current study explores unit manager perspectives on the introduction of a group-based trauma-specific programme delivered for the first time across Scotland's secure estate, comprising four secure accommodation units. Secure accommodation in Scotland is located within residential child care (Scottish Executive, 2006) and is defined as "accommodation provided for the purpose of restricting the liberty of children in a residential establishment" (Scottish Government, 2013). Secure accommodation in Scotland, however, has been criticised for its ambiguity of purpose (Trulson, Marquart, Mullings, & Caeti, 2005). Within secure accommodation a tension exists between custodial, criminogenic, and behaviour risk models compared to an emerging focus on mental health, and specifically, youth traumatization and recovery (Barron & Mitchell, 2017a). Custodial approaches seek to be a punitive deterrent and deny an adolescent their liberty for a specified period. Criminogenic approaches aim to identify factors in the environment that lead to criminal behaviour, such as gang cultures, and behaviour risk models assess and aim to reduce dangerous behaviour towards self and others. Within Scotland cognitive behavioural and behaviour risks models were found to be the most prominent in one unit (Barron, Mitchell & Yule, 2017). Policy wise government, regulatory bodies, and child advocacy agencies are increasing expecting secure accommodation to achieve better outcomes and to do so in closer collaboration with families, and with reduced costs (Whittaker et al., 2016). The task of managing secure accommodation is therefore complex and is reflected in a diversity of literature related to managing secure units and the 'need and risk' literature that comments on the heterogeneity of the young people within those units (Harder, Knorth & Kalverboer, 2014).

The nature of trauma exposure for young people

Part of the complexity and heterogeneity of young people in secure accommodation is related to the debate regarding whether young people have been traumatised and to what degree they are responsible for risky behaviour. Only two studies in Scotland frame abuse across the life course experienced by young people in secure accommodation, as cumulative trauma exposure. Barron and Mitchell (2017a) identified through trauma history interviews that young people ($n = 17$) experienced nine traumatic events on average. Events included a range of abuse and neglect, parental imprisonment, hospitalisations from

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3 self-harm and attempted suicide, siblings going into care, the young person going into care for the first
4 time as well as being placed in secure accommodation. Similarly, an unpublished study at Kibble
5 Education and Care Centre (KECC, 2011) found fifteen different types of abuse, loss and neglect in
6 young people's lives.
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11 As a comparison, juvenile detention studies in the USA have also found that significant numbers of
12 adolescents (90%) experience high levels of trauma exposure. This compares to only a third of young
13 people in the general population experiencing such events (Dierkhising, Ko, Woods-Jaeger, Briggs, Lee,
14 & Pynoos, 2013). The recent Adverse Childhood Experiences (ACE) study identified that juvenile
15 offenders (n = 64,329) experienced a range of adversity including sexual abuse, emotional abuse
16 physical abuse and assault, neglect, family violence, substance use, and having a relative imprisoned
17 (Baglivio et al., 2014). Girls in juvenile detention reported significantly higher levels of sexual abuse than
18 boys (Dierkhising, et al., 2013) and once in juvenile detention adolescents can experience violence from
19 peers and staff (Sickmund & Puzanchera, 2014).
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30 **The consequences of cumulative trauma**

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33 The consequences for young people who experience cumulative violence from caregivers has been
34 conceptualized by Bessel van der Kolk (2009) as developmental trauma disorder (DTD). DTD refers to an
35 extensive array of symptoms including posttraumatic stress disorder (PTSD), depression, anxiety,
36 dissociation, relationship and behaviour difficulties, criminality, sexual promiscuity/dysfunction,
37 educational difficulties, physical symptoms as well as a triggered pattern of emotional dysregulation.
38
39 Within Scotland 65% of young people in secure accommodation report posttraumatic stress disorder
40 (PTSD) and depression and 18% report dissociation (Barron & Mitchell, 2017b). An earlier large scale
41 survey of children in England identified 8.8% of children in residential (rather than specifically secure
42 accommodation) presented with PTSD, 22% presented with emotional difficulties and 56.2% were
43 identified as having a conduct disorder (Meltzer, Gatward & Corbin, 2003). In contrast, the levels of PTSD
44 in juvenile detention in the US are over 50% (Wood, Foy, Goguen, Pynoos, & James, 2008; Stimmel,
45 Cruise, Ford, & Weiss, 2014) and suicide rates are higher than in the general population (Bhatta, Jefferis,
46 Kavadas, Alemagno, & Shaffer-King, 2014). PTSD symptoms have been found at least 5 years following
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3 detention indicating the limited effectiveness of juvenile detention and the long term nature of
4
5 posttraumatic stress (Abram et al., 2015).
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8 **Punitive/behavioural approaches and poor outcomes**

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10 Despite the severity and range of mental health difficulties, most adolescents in Scotland, the rest of the
11 United Kingdom, and the US are placed in secure accommodation because of behavioural difficulties and
12 the risk they pose to themselves and others. In the US, juvenile **detention** sits within criminal justice as
13 opposed to residential child care **and despite the emergence of a range of treatment facilities** many
14 **facilities still maintain a punitive focus** (Mears, Cochran, Greenman, Bhati, & Greenwald, 2011). Given the
15 mismatch between **punitive approaches** and mental health, it is perhaps not surprising that **such facilities**
16 **have resulted in high recidivism rates and continued mental health difficulties for young people** (Abram et
17 **al., 2015**). This is particularly so for young people with PTSD (Trulson et al., 2005; Harris & Timms, 1993).
18 Theoretically, Mears and colleagues (2011) argue that unless the underlying trauma **driving behavioural**
19 difficulties is recognised and addressed, it is unlikely that secure accommodation will lead to significant
20 change. Where behavioural change has occurred Abram and colleagues (2015) argue this is likely to be
21 time limited.
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35 Perhaps as a consequence of **a** focus on behaviour, **some** professionals have failed to sufficiently attend
36 to what has happened to young people as well as their internal states (Havens et al., 2012; **Barron &**
37 **Mitchell, 2017a**). As a result young people have been blamed for their behavioural difficulties and
38 received ineffective behavioural programmes (Havens et al., 2012; **Barron & Mitchell, 2017a; Barron,**
39 **Mitchell & Yule, 2017**). The failure to assess trauma exposure has also led to the misdiagnosis of
40 symptoms as medical syndromes, e.g. Attention Deficit Hyperactivity Disorder (van der Kolk et al., 2009).
41 In turn, there is a lack of screening and assessment of trauma in secure accommodation (Ford,
42 Chapman, Connor, & Cruise, 2012; **Barron & Mitchell, 2017a**), little development of trauma-sensitive
43 environments (Hodgdon, Kinniburgh, Gabowitz, Blaustein, & Spinazzola, 2013) and few trauma-specific
44 programmes tailored to the secure accommodation context (**Barron, et al., 2017**), **all of which are** all part
45 of a trauma-informed approach (Ford et al., 2012). Over recent years, **however, there has** been a gradual
46 shift in focus in the US, and Scotland from behavioural interventions **to criminogenic understandings and**
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3 other approaches that seek to address the causes of delinquency to trauma-informed understandings
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5 (Marrow, Knudsen, Olafson, & Bucher, 2012; Barron et al., 2017).
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8 Trauma-specific programmes in secure

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10 Trauma-specific programmes seek to identify what adolescents have experienced (trauma exposure) in
11
12 order to understand their symptoms (behaviour, posttraumatic stress etc.) and address the underlying
13
14 trauma (Ford et al., 2012). As trauma-specific programmes are in their infancy within secure
15
16 accommodation in Scotland, research into the delivery of such programmes has been sparse. Studies
17
18 that have been conducted, however, have found promising results. A randomised control trial of the
19
20 Teaching Recovery Techniques programme in one secure unit found a significant reduction in
21
22 adolescents' internal distress (TRT: Barron et al., 2017) and a case study of a suicidal female adolescent
23
24 who experienced individualised delivery of TRT resulted in a dramatic cessation of suicidal ideation and
25
26 suicide attempts that was maintained at three month follow-up (Barron & Hodgkiss, 2017). Utilising a
27
28 novel brief exposure approach (Progressive Counting) a cluster-case study of a novice therapist with
29
30 three male adolescents in another secure unit also found significant reductions in boys internal
31
32 disturbance as well as observable prosocial behaviour change (Barron & Tracey, 2017).
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36 In the US, research into the efficacy of trauma-specific programmes in juvenile detention is more
37
38 developed but still in its infancy. Results of studies suggest trauma-specific programmes lead to a range
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40 of gains for young people. Marrow, Knudsen, Olafson and Bucher (2012) in a non-randomized study of 38
41
42 adolescents who experienced the Trauma and Affect Regulation programme (TARGET: Ford & Hawke,
43
44 2012; Marrow, Knudsen, Olafson, & Bucher, 2012) found significant reductions in depression, threatening
45
46 behaviour and restraint as well as increases in hopefulness compared to a treatment as usual group.
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48 Ford and Hawke (2012) with the same programme discovered a 54% reduction in behaviour incidents
49
50 and reduced recidivism. A small scale pilot study ($n = 24$) of the Structured Psychotherapy for
51
52 Adolescents Responding to Chronic Stress (SPARCS: Habib, Labruna, & Newman, 2013) found young
53
54 people made gains in anxiety, depression, physical complaints and prosocial behaviour and
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56 implementation of the Trauma and Grief Component Therapy for Adolescents ($n = 77$) and whole staff
57
58 training using Think Trauma led to significant reductions in PTSD, depression and anger (Olafson et al.,
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3 2016). The Sanctuary model that focuses on developing trauma-sensitive milieu has also been found to
4
5 increase institutional capacity to help young people focus on safety, manage emotion, and deal with loss
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7 (Rivard, Bloom, Mccorkle, & Abramovitz, 2005; Rivard et al., 2003). Ford and Bleustein (2013) conclude
8
9 that compared to behaviour oriented approaches trauma-specific programmes appear to lead to better
10
11 behaviour and mental health outcomes for young people in secure accommodation.
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13 14 **Absence of unit manager perspective**

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17 Perhaps because of the small number of trauma-specific programme studies in Scotland, no study to date
18
19 has reported on unit managers perceptions of implementation issues. Walker et al., (2006) in a Scottish
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21 Executive funded review of research into secure accommodation roles with alternative services did
22
23 include unit manager and social work manager views, however, in contrast to social work managers, unit
24
25 managers were rarely cited and explicit reference to adolescent traumatisation in the study was
26
27 characterised by its omission. The study did, however, highlighted the lack of alternatives to secure
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29 accommodation and emphasised the importance of community services being available at post-
30
31 placement transition.
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34 Other Scottish studies have addressed a range of issues for unit managers but again have failed to be
35
36 explicit about adolescent trauma or mention trauma-specific recovery programmes. Studies have focused
37
38 on the importance of quality relationships between key workers and young people (McKellar & Kendrick,
39
40 2013); the risks associated with locking up young girls (Schiele, 2015); the nature of decision-making in
41
42 risky situations (Roesch-Marsh, 2013); the development of alternative services to secure units (Mitchell,
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44 Roesch-Marsh & Robb, 2012; Barclay & Hunter, 2008; Walker et al., 2006); what counts as achievable
45
46 outcomes (Kendrick et al., 2008), and the supply, demand and scope of secure units (Scottish Executive,
47
48 2001). A particular concern in Scotland is related to the unintentional exposure of vulnerable young
49
50 people to negative influences through peer associations. While it is recognized there are strengths and
51
52 limitations to all settings based interventions including family, foster family and residential, there is a clear
53
54 managerial and leadership role in identifying what these risks are and in designing countermeasures
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56 (Whittaker et al., 2016).
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3 Most secure unit manager studies have been conducted in the US where a range of issues have been
4 explored. The current authors, however, are not aware of any US studies that focus specifically on
5 **juvenile detention** manager views of youth traumatised and the implementation of trauma-specific
6 programmes. Studies conducted include: comparing private and public management where profit run
7 models have led to higher recidivism rates (Bayer & Pozen, 2003); the recognition of negative
8 consequences and dangers for youth in detention (Holman and Ziedenberg, 2004); the challenges of
9 anticipating youth numbers and space needs (Butts and Adams, 2001); and how to work with alternative
10 provision to juvenile detention (Vanderhaar, Munoz, & Petrosko, 2015). **A study more closely related to**
11 **the current research was by** Caeti, Hemmens, Cullen, and Burton (2003). **The study** investigated the
12 differences between juvenile detention centre director and prison governor attitudes to the roles and
13 demands in custodial settings. The authors concluded the former had a greater emphasis on
14 rehabilitation and higher resultant job satisfaction. A major challenge for managers was found to be
15 resisting societal demands for punitive approaches **which** in turn contributed to manager and staff role
16 conflict and stress. More recently, Caeti (2013) explored secure unit organizational responses to complex
17 behaviour problems and discovered staff training, support, and job security were protective factors.

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34 In conclusion, Whittacker and colleagues, recognizing similar complexity for UK managers in secure units
35 commented "the sheer range and variability of service components, change theories, frequency, intensity
36 and duration of specific intervention strategies, organizational arrangements, staff training and
37 development, integration of ongoing systemic evaluation....all argue for increasing precision and
38 specificity in both description and analysis" (Whittacker, Del Valle & Holmes, 2014:329). In response to
39 Whittacker and colleagues conclusion, the current study provides a specific focus on manager
40 perceptions of trauma-specific programmes and adopts a systematic approach to analysis. The aim is to
41 discover the complexity of issues identified by managers in **order to generate future questions for**
42 research and practice.

51 52 **The current study**

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54 In light of the extensive nature of trauma exposure and mental health symptoms for adolescents in secure
55 accommodation and the ongoing debate about the role and purpose of units, it is surprising studies have
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not been conducted into the views of unit managers regarding trauma-specific programmes. Such a study is particularly compelling at this time following Scotland's First Ministers announcement (October 2016) of a 'root and branch' review of support for children in care which will focus on practices, culture and ethos. Addressing a conceptual gap, the current case study is the first in Scotland, and to the authors' knowledge, internationally, to explore unit manager experience of introducing a group-based trauma-specific programme (TRT) into secure accommodation. The current case study provides a methodological rigor in the exploration and analysis of secure estate unit manager views. Semi-structured qualitative interviews were used with managers from three secure units to explore the perceived benefits and challenges of introducing a trauma-specific programme into a context that had mostly utilised behaviour risk, cognitive behavioural, and criminogenic models (reported to the authors by programme staff across the secure estate during trauma recovery training). Quasi-qualitative analysis involving the identification of codes and themes, cross-question analysis and inter-rater reliability were used to bring rigor to data analysis.

Methods

Ethics and research design

University Research Ethics Committee approval was received for the secure estate case study. Participation was voluntary, and involved active informed consent. Participants could pull out at any time. The case study sought to explore manager perspectives of TRT implementation in secure accommodation across Scotland's secure estate. The research design was qualitative and involved interviews with managers from three secure units. Analysis was quasi-qualitative and thematic, and included a frequency count of statements and codes.

Participants

Participants were three programme managers and two Chief Executive Officers (CEOs) from three secure units in Scotland. A fourth unit did not implement TRT as trauma-focused cognitive behavioural therapy was already provided by unit psychologists on an individual basis. One CEO (female) delegated their interview to the programme manager within the unit because of the extent of other work demands. Programme managers have responsibility for overseeing effective delivery of programmes, including staff

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3 recruitment, training, supervision, and unit programme policy development. CEOs have overall
4 management and financial responsibility for units.
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8 Participants were experienced managers ranging from 9 to 20 years. All participants were male. The
9 three units had charitable status and were of a similar size ($n = 18$, $n = 18$ and $n = 24$ young people).
10 Young people were placed in each unit from all over Scotland and a small number from England. Funding
11 for young people's placements was mainly from Scottish local authorities and the Scottish Government
12 funded young people who had been sentenced by the court. Units operated behaviour risk, cognitive
13 behavioural and criminogenic models of intervention and had volunteered to explore the implementation
14 of TRT following an initial project that had demonstrated the positive impact of TRT (Barron et al., 2017).
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22 Intervention

23 TRT was selected for a number of reasons. There is empirical evidence for the effectiveness of TRT with
24 adolescents with PTSD and developmental trauma (Barron, Abdallah & Smith, 2013) including a pilot
25 randomised control trial in one facility in Scotland (Barron, et al., 2017); the group-based delivery fitted
26 with the programme culture in the Scottish secure estate; and a manualised programme enabled rapid
27 learning and programme implementation for busy professionals. TRT is based on cognitive behavioural
28 theory and includes psycho-education on the nature of traumatic events, trauma symptoms, and triggers,
29 and teaches coping strategies for dealing with post-traumatic stress symptoms. TRT aims to reduce the
30 symptoms of intrusions, hyperarousal and avoidance (Smith, Dyregrov & Yule, 2010).
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40 TRT can be adapted from group to individual delivery. Seven sessions of 50 minutes were recommended
41 for delivery in secure accommodation. Programme managers identified two to three programme workers
42 in each unit to be trained in TRT. Training was delivered by Professor William Yule, a world leader in child
43 trauma recovery and one of the TRT authors. Three half day group supervision sessions were provided
44 by the principal researcher, a reader and educational psychologist, who had trained in TRT and delivered
45 TRT for both groups and individuals. Supervision was group-based for TRT practitioners, cognitive
46 behavioural in approach, and mirrored TRT activities including modelling, role play, and feedback. Three
47 supervision sessions were held over the course of programme delivery.
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3 One unit delivered TRT to $n = 5$ youths as individuals (3 males and 2 females, 12-17 years), another to
4 youths as a pair (2 males, 15-16 years), and another to two groups of youths (7 male, 3 female, 14-18
5 years and 4 male, 3 female, 14-18 years). All adolescents experienced cumulative trauma exposure and
6 were placed in secure because their behaviour was a risk to themselves (self-harm/suicide attempts) and
7 others (violence). All were from families in absolute to relative poverty. Previous studies of TRT in secure
8 accommodation have found reductions in suicidal ideation and subjective disturbance (Barron &
9 Hodgkiss, 2017; Barron et al., 2017), and improved prosocial behaviour (Barron et al., 2017). In the latter
10 study 90% of adolescents reported TRT as a positive experience.
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20 Interviews

21 Interviews were conducted by telephone by the principal researcher and lasted 45-50 minutes. Questions
22 were open ended and addressed gaps in the literature. Questions explored manager perceptions of the
23 benefits and challenges of implementing TRT; as well as the impact of TRT on the awareness of trauma
24 for: (i) managers; (ii) programme workers; (iii) care staff; (iv) the secure youth community; and (v) parents.
25 Questions also covered how much TRT stimulated discussion of trauma: across units; within placement
26 transition meetings; in networking meetings with stakeholders, and with agencies. Managers were asked
27 to give recommendations for future TRT practice. All interviews were digitally recorded. Transcription of
28 interviews was conducted by an independent transcription company. Accuracy of transcription was
29 checked by the principal researcher.
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40 Analysis

41 Quasi-qualitative analysis of data facilitated: (i) participant responses to be quantified and themed for
42 meaning; (ii) responses to be compared across-questions; (iii) a measure of inter-rater reliability to be
43 conducted; and (iv) a comparison of findings to other studies of therapist and adolescent perceptions of
44 trauma-specific programmes in Scotland where quasi-qualitative analysis had been used (Barron et al.,
45 2017; Barron & Mitchell, 2017b). Analysis of interview data was by the principal researcher. The quasi-
46 qualitative approach involved a six-step systematic thematic analysis (Braun & Clarke, 2006). The term
47 quasi-qualitative refers to the counting of statements and codes. The procedure for analysis is as follows:
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56 1. Familiarization involved re-reading the data and noting initial ideas for patterns of meaning; 2. Initial
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3 codes were systematically generated from the data with statements of meaning collated under each code.
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5 Codes were named using participants' words; 3. Codes were collated with the set of statements into
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7 identified themes; 4. Codes and statements were counted and themes were reviewed and checked
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9 against participant statements. 5. Themes were finalized; 6. Report writing enabled a further level of
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11 analysis with the identification of exemplifying statements (quotes) for codes and themes. Code names
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13 are reported along with the number of statements for each code. The number of codes is totalled per
14
15 theme. Cross-question analysis was conducted on codes and themes. Because of the small sample size
16
17 and location, no identifiers were used for quotes. Inter-rater reliability involved a research assistant, a
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19 psychology post-doctoral researcher independently reviewing the codes and themes.
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22 Results

23 Benefits

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27 Nine codes were identified from 21 statements resulting in the theme of: *Paradigm shift with a perceived*
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29 *growth in staff trauma-informed knowledge and motivation.*
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32 Codes were: despite novice presenters, adolescents benefitted ($n = 4$). TRT was straightforward to
33
34 deliver ($n = 4$); and a fantastic motivating opportunity to hear from people leading the field and us
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36 delivering on site ($n = 3$). Dedicated staff was important ($n = 2$). Short programme duration and group
37
38 delivery fitted into current practice ($n = 2$). TRT was useful for increasing shared theory across disciplines
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40 ($n = 2$) and TRT has led to the need for a paradigm shift and new services ($n = 2$). One manager was
41
42 confident in his staff skills and another reported there was still "a way to go".
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47 The exemplar quote captures the growth in shared understandings and trauma-informed services as well
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49 as the need for a paradigm shift as a result of delivering a trauma-specific programme. "TRT brought a
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51 more common form blend to the work practitioners do, not only in terms of attachment and neurobiology
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53 in the programmes but associated elements such as screening tools. There was a recognition that we
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55 needed to make a profound paradigm shift in service delivery. The practitioners became very keen to
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3 develop our specific services. We have trauma-specific services now, but I think we've still got some way
4 to go to be fully trauma-informed."
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7 8 **Challenges**

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10 Nine codes were identified from 22 statements. The theme was: *Senior managers need to take the lead*
11 *for system wide change to address policy and practical barriers.*
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14 Codes were: difficulties occurred in working around staff shifts to release staff ($n = 4$). The development
15 of a core team helped ($n = 3$), however, there is a need to have unit managers at training to understand
16 how to support this work ($n = 3$), and to have an overview to shape trauma-informed policies ($n = 2$). Not
17 all staff are using it ($n = 2$) because of pressures of work ($n = 2$), conflicting policy and short stay
18 placements ($n = 2$). Using dedicated staff can lead to missing out on information from care staff ($n = 2$).
19 Finally, adolescents need to know TRT is an important part of their care plan ($n = 2$).
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23 **The** exemplar quote highlights some of the challenges of conflicting practice demands, i.e. "You don't
24 want the young people to miss it. So they're encouraged to attend but as soon as there is a staffing issue
25 ... so that supports how it should be delivered by dedicated intervention people ...In that context you then
26 miss out on all that information care staff have. It's pros and cons with it."
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29 30 **Impact on management and practice**

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32 Ten codes were identified from 30 statements. The theme was: *Increased trauma knowledge within a*
33 *public health approach leading to reorganising, employing psychologists, providing trauma training for all*
34 *staff and educating stakeholders.*
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38 Codes were: managers were more trauma-informed and supportive, and experiential knowledge helped
39 this ($n = 5$). Units are re-organising programme delivery to treat trauma within a more coherent public
40 health perspective ($n = 5$). Units are developing trauma-informed policies and creating new psychologist
41 and intervention posts ($n = 5$). Dissemination of trauma understandings is occurring across the
42 organization, including whole staff training and conference attendance ($n = 4$). As a result, care staff are
43 asking more insightful questions ($n = 3$). Programme staff are continuing to deliver TRT ($n = 2$) and we
44 are putting trauma on our marketing materials ($n = 2$). There was the challenge of matching interventions
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3 with adolescents and whether all adolescents should go through TRT ($n = 2$). Other gains have been
4 connecting to national and international experts ($n = 1$) and receiving a CARE Accolade with the pilot
5 project ($n = 1$).
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10 Exemplar quotes highlight a paradigm shift and the resultant impact on daily practice. "I think it's had an
11 enormous impact, the notion that we should treat trauma as a public health problem and shift our systems
12 to be trauma-informed, I think we're on that journey. We have good key elements of it, but some of our
13 policies and practices don't fit what it takes to be a trauma-informed organization. I'm in a better position
14 to do things about that now. Managers are much more trauma-informed than they were two or three years
15 ago, significantly more."
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20 "With it being out at grass roots level, we have staff trained to recognize it but there should be some
21 practice improvements to come along. In terms of young people's behaviour and acting out, you know the
22 young person is actually traumatized. Something's behind the behaviour, rather than force the sanctioned
23 disciplinary route. It's maybe that time to say, 'so what's really bugging you'. I've seen more of that going
24 on."
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33 **Impact on programme teams**

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35 Nine codes were identified from 48 statements. The theme was: *Practitioners increased the time*
36 *delivering therapy as knowledge, skills and confidence improved.*
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39
40 Codes were: There was a sense of achievement ($n = 8$), and confidence is building for staff in dealing
41 with trauma ($n = 8$). Conceptually staff have a deeper grasp of trauma-informed practice including
42 dissociation and sleep difficulties ($n = 8$). They continue to use TRT and apply on individual basis too with
43 a growing familiarity with different parts of TRT ($n = 6$). Staff need to 'believe' in TRT for adolescents ($n =$
44 5). Research evidence and programme structure has helped plan the match between adolescent with
45 intervention ($n = 5$). Programmes teams have increased therapy time and are more visible with trauma
46 coming through in report writing ($n = 4$). Programme staff are more confident in providing
47 psychoeducation for care staff and networking with agencies about trauma ($n = 3$), however, they feel
48 less certain when adolescents don't respond ($n = 1$).
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3 The exemplar statement emphasizes the growth in time spent delivering therapy, the growth in skills and
4 the greater attunement between workers and adolescents. "We've been operating TRT and have
5 continued at least on an individual basis for a number of young people. The programme team have an
6 easy familiarity with the elements of TRT, know how it hangs together, know why they're doing particular
7 things at a particular time, and have the certainty of safety and stabilization techniques. They're much
8 more fluent around dissociation, and when there is no sleep for the young person, they're more attuned in
9 response. You see the attunement coming through in their writing and description of the young people's
10 programme and behaviours."

19 20 **Impact on care staff**

21 **Eight** codes were identified from 32 statements. *Care staff gained a reframe in understanding behaviour*
22 *but need training in trauma-sensitive environments and how to support trauma-specific programmes.*

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28 Codes included training care staff in trauma-sensitive environments and how to enable adolescents to
29 generalise TRT skills to unit settings ($n = 6$). Significant knowledge gains were achieved as a result of
30 whole staff training ($n = 5$), e.g. staff are more aware of vicarious trauma and how to address this ($n = 5$).
31 There has also been a recognition that some staff left because of vicarious trauma ($n = 4$) and there is a
32 need to explore incident debriefing ($n = 4$). Trauma-informed training needs to be in place for new staff (n
33 = 3) and opportunities are in place for care staff to come to the interventions team to see trauma-specific
34 practice ($n = 3$). This helps care staff understand and respond to behaviour from a trauma perspective (n
35 = 2).

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45 The exemplar quote highlights manager perceptions that training in a trauma-informed perspective is
46 important for care staff supporting adolescents and trauma-specific programmes as well as for staff
47 mental health. "We had a good start that coincided with the whole staff approach and doing the trauma
48 lens work. That was fantastically well received. It meant we had a care and education team who were
49 familiar with the elements of what a trauma lens looked like and it hit off a number of light bulbs in
50 people's heads. Giving explanations to what they were managing and better ways of doing that. It
51 certainly brought to people's attention vicarious trauma and that trauma is pervasive in this population.
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3 Some of our colleagues probably were and are experiencing vicarious trauma and how we can ameliorate
4 that.”

7 **Impact on the adolescent secure unit community**

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9 Only 3 codes were identified from 10 statements. The theme was: *There is a need to explore the impact*
10 of **TRT on self-harm and utilise group work for efficient practice**

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14 Codes were: we plan to look at the evidence of change in self-harm ($n = 4$) and we need to re-organise
15 and plan for more opportunities for group work ($n = 3$). Group work is perceived to be a more efficient way
16 of delivering support ($n = 2$) leading to a reduction in behaviour incidents within the units ($n = 1$).
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21 The exemplar quote makes the connection between manager hoped for gains in reduced violence within
22 the adolescent unit community and the delivery of group-based TRT as an efficient way to achieve this.

23
24 “Within the units, the aim is for a reduction in behavioural incidents. With the crisis intervention team there
25 will be more opportunities for group work, going to be organizing things slightly differently. Whereas one
26 to **one is** not that efficient with the numbers of staff we have. Inevitably we will have to return to a group
27 work model ... TRT certainly be part of the development plan for the crisis intervention service.”
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32 **Impact on parents**

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35 Eight codes were identified from 17 statements. The theme was: *The impact on parents is unknown,*
36 *however, supporting parents is recognized as important for an adolescent's transition to the community.*
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40 Codes were: Parents were invited into sessions ($n = 3$) but did not attend ($n = 3$), **however, parents** were
41 aware of the **programme** ($n = 2$). Perhaps parents did not want to appear ignorant ($n = 2$). Managers
42 consider parental awareness important because of future community re-integration ($n = 2$) and
43 recognised parents need in grasping a trauma-informed perspective ($n = 2$). There was an expressed
44 need to develop parent friendly spaces in secure units to encourage parental contact ($n = 2$). Unit
45 managers received no **parent** comments **on** TRT ($n = 1$).
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53 The exemplar quote highlights managers' aim of increasing parental understanding and involvement. “We
54 hope to bring parents on board more than we have in the past, so we want the family to be more aware of
55 what we're doing so that any skills that they can pick up about how they would best support the young
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3 person in the community when they're home. That's becoming more a focus for us. We would like parents
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5 to be part of the sessions we were doing, that they were able to take part and they would be able to
6
7 understand why the young person is saying certain things or doing certain things."
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10 **Discussions across secure units**

11 Six codes were identified from 18 statements. The theme was: *Little communication between units*
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13 *beyond training and supervision other than checking where others are at which appears to have*
14
15 *constrained development.*
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19 Codes were: There was little sharing of experience between units beyond training and supervision ($n = 7$).
20
21 There was pressure for parity of TRT delivery across units ($n = 3$) and as a result units monitored each
22
23 other, and norming became counterproductive ($n = 3$). Because it was approaching the competitive
24
25 contracting year, this led to closing down of communication ($n = 2$). Some Unit managers discussed the
26
27 confusion of criteria for staff qualifications ($n = 2$). Unhelpfully some managers got caught up in the
28
29 politics ($n = 1$).
30

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32 The exemplar code highlights the minimal contact between units and the negative impact of a competitive
33
34 commercialised context. "Minimal contact appears to have occurred out with the planned project.
35
36 However, provision seem to monitor each other and keep abreast of where other units are at, locating
37
38 their own position within this. This appears to be a norming process which has not helped TRT. The way
39
40 secure is set up, it's almost as if you were to phone and ask 'what do you offer', that's the competition sort
41
42 of thing."
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44 **Placement transition**

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47 Five codes were identified from 18 statements. The theme was: *There was increasing recognition of*
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49 *attachment, separation and trauma for the transition process.*
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52 Codes were: There is increasing recognition of trauma in placement move discussions whereas
53
54 previously trauma was often avoided or assumed dealt with or will be addressed when it comes up later
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56 ($n = 5$). Managers have also become better at arguing the case for addressing trauma in secure ($n = 5$).
57
58 There is uncertainty, however, regarding how helpful community mental health services are in terms of a
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3 trauma-informed lens ($n = 3$). Overall staff are more confidence in talking about trauma in placement
4 transition meetings including the dilemma of attachment and separation in secure, and giving reasons for
5 attachment work within trauma ($n = 3$). There continues to be a need for outside agencies to recognize
6 how important attachment and trauma and involving the adolescent in the process ($n = 2$).
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11 The exemplar statements highlight outside agencies difficulties in recognising the importance of
12 attachment and trauma in placement decision making and the sense of progress made within secure
13 accommodation in recognising and talking about adolescent trauma. "We're more confident about talking
14 about the trauma of placement moves, and the trauma of breaching relationships. One of the things that
15 are regularly reported to me was that a young person was gonna be moved by their case holding social
16 worker because the young person had formed relationships, so I think there's a whole pile of arguments
17 that we now give for young people not being moved for these reasons, but they still are despite us being
18 better able at marshalling our argument."
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29 "The other bit is about how helpful or otherwise our community mental health colleagues are. I'm not
30 really seeing that despite some pretty proactive invitations by us to include community mental health staff
31 who we know have a professional interest in trauma. They haven't taken that up and I think are still very
32 diagnostic in their approach. Where we're stronger is, we're much more confident about arguing against,
33 not the diagnosis per se, but presenting another view that a trauma lens that might also account for some
34 of the young people's issues as opposed to a diagnosis."
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41 **Networking with stakeholders**

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43 Fourteen codes were identified from 48 statements. The theme was: *Trauma understandings are more*
44 *embedded in secure accommodation and stakeholder discussions, although not all are on board.*
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48 Codes were: A menu of trauma services are now in a leaflet, website and in marketing brochures
49 including the evidence base and winning the CARE accolade ($n = 8$). There is a need to give an
50 explanation of why it's trauma rather than another approach ($n = 6$) and increasingly we are talking about
51 trauma in post admission meetings ($n = 4$). Social work, however, are weighing up the professionalism of
52 unit staff and psychiatry, and sadly often choose psychiatry causing case management, political and
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3 ethical dilemmas ($n = 4$). Unfortunately, community mental health services have been reluctant to take on
4 a trauma-informed lens ($n = 3$) despite the government wanting new programmes, rather than more of the
5 same focus on behaviour ($n = 3$). As trauma is much more embedded in provision ($n = 3$) stakeholders
6
7 are asking us questions about what we offer ($n = 3$).
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11 But what we offer has to fit with the length of stay ($n = 2$). It's gradually filtering through to stakeholders
12 that they need to look at the trauma underlying the behaviour ($n = 2$). There is a need to affirm staff can
13 do this and it will help adolescents ($n = 2$). Social work is concerned about cost ($n = 2$) and in support of
14 secure accommodation we have high programme attendance compared with the community ($n = 2$).
15
16 Stakeholders appear to understand a phased approach to trauma and are looking for training for working
17 with young children ($n = 2$).
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19

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21 The exemplar statements emphasise the changing nature of secure accommodation in relation to
22 adopting a trauma-informed perspective and the need to provide psychoeducation for other agencies to
23 try and foster shared understandings. "At the moment we suffer from the age old thing about exactly what
24 does secure care do. There's an ambiguity about secure care staff, and all of a sudden, some of us in
25 secure have become clear about what it is we can do in terms of trauma assessment and intervention
26 and in a lot of ways, the rest of the childcare system's universal services need to catch up."
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30 "Social work has received the trauma lens reasonably well. When we're talking about trauma, we have to
31 give an explanation about why the presenting difficulties might be associated with trauma rather than
32 something else. When you explain the phased approach, being stabilization, the process, and then
33 integration, people absolutely get it. I think for us that the critical role for TRT and stabilization, we have to
34 explain what that is, how it operates, and why we need to do that. We still have to do that with social
35 workers. A lot of attunement and socialization into what this is about."
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38 39 40 41 42 43 44 45 46 47 48 49 50 **Cross question analysis**

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52 Analysis of themes across questions indicate managers recognize a trauma perspective as a paradigm
53 shift that requires managers to take the lead in policy development, and the identification and problem-
54 solving of barriers (see Table 1). Manager responses suggest TRT needs to be set within a public health
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3 approach that involves addressing organizational issues such as psychologist staffing and training for
4 staff and stakeholders. Prioritizing time for therapy is perceived as leading to increases in knowledge,
5 skills, and confidence in programme staff. Managers also identified a role for themselves in helping care
6 staff (i) understand that behaviour difficulties are caused by underlying trauma; (ii) create trauma-
7 sensitive environments, and (iii) support adolescents receiving trauma-specific programmes. Managers
8 acknowledged there need to explore the impact of TRT on the adolescent community within units.
9 Managers appeared to want to encourage placement and transition meetings to be more trauma focused.
10 Issues included discussion of attachment, separation, and trauma as well as providing psychoeducation
11 to parents, and stakeholders. Managers reported they needed to be alert to the negative impact of
12 competitive tendering on communication between units for the benefit of adolescents and staff.
13 Competitive tendering involves the periodic submission of unit plans and budgets to the Scottish
14 Government in order for contracts to be renewed or otherwise. In short, a survival oriented competitive
15 market economy.
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30 INSERT Table 1

31 Discussion

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35 The current study was the first to explore unit manager perceptions of introducing a trauma-specific
36 programme delivered by programme staff across secure units in Scotland. Although a range of issues
37 were identified, these were not shared by all managers. Codes taken collectively, however, suggest
38 managers perceive that TRT has the potential to impact secure units in a variety of ways. TRT, for
39 example, was seen as facilitating the reframing of behaviour for staff as driven by underlying trauma
40 rather than young people being blamed and responsible for their behaviour. This reflects a core theme
41 within the growing trauma literature in secure and residential child care (Stimmel et al, 2014; Barron &
42 Mitchell, 2017a). The most frequent codes suggest managers see the benefits of TRT delivered by
43 programme staff as: (i) managers being more trauma-informed and aware of embedding trauma into
44 public health policy; (ii) the growth in programme staff knowledge, skills and confidence including
45 discussion of trauma in transition placement meetings; (iii) knowledge and skill gains for adolescents; (iv)
46 the utilisation of a variety of ways to communicate with stakeholders about trauma; (v) that TRT is
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3 straightforward to deliver and needs a core team and; (vi) where necessary, the creation of psychologist
4 posts with a focus on a trauma perspective. Further, care staff who observed TRT delivery were seen by
5 managers as more aware of how to support young people receiving TRT as well as more able to create a
6 trauma-sensitive environment back in the care setting. In short, managers focused on strategic
7 organisational issues to achieve a coherent approach throughout their unit. Manager identified roles
8 included providing policy on integrating a trauma-specific programme, supporting benefits achieved and
9 removing barriers to effective TRT delivery.
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13 Managers' views both supported and contrasted with the results of a qualitative study of therapist
14 perceptions of Progressive Counting, an individualised brief exposure approach, delivered in secure units
15 in Scotland. Although a different trauma-specific programme, Barron and Mitchell (2017b) reported that
16 therapists identified gains for themselves, youth and units as a whole. Therapists gained trauma-specific
17 knowledge, skills and confidence and young people were described as more motivated, less emotionally
18 dysregulated and more able to problem-solve. Organisationally, therapists' perceived secure units to
19 make improvements in screening, assessment, treatment planning, and the development of trauma-
20 sensitive environments. Managers' positive perceptions of the impact of TRT also compliment and
21 contrast with young people's views of TRT in a RCT in one unit in Scotland. Young people reported that
22 they learned to: (i) talk about troubling past experiences; (ii) find new ways of dealing with difficult
23 thoughts and feelings; and (iii) were able to put difficult images into the past (Barron et al., 2017). Young
24 people's perceptions therefore included their internal experience, a factor mostly omitted from manager
25 perceptions.
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46 In seeking to facilitate secure unit change, managers identified a range of barriers in implementing TRT.
47 High frequency comments included the challenges of enabling adolescents to generalise new skills, an
48 issue for many programmes where skills are learned out with the original setting (Fuggle, Dunsmuir &
49 Curry, 2012). The competitive tendering environment was perceived to undermine communication across
50 units, creating a culture of watchfulness of other units, and leading to norms of practice driven by financial
51 survival. Economic pressures constraining new practice is, however, not a new problem (Community Care
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3 Providers Scotland, 2007). Specific frustrations mentioned by managers were community mental health
4 services that did not take a trauma-informed perspective and social workers who relied on psychiatric
5 diagnosis rather understanding, or being persuaded by the arguments for a trauma-specific perspective.
6
7 Such a finding supports an analysis of agency reports within secure accommodation files where there
8 was little to no mention of trauma (Barron & Mitchell, 2017a). As part of addressing such issues the
9 National Child Traumatic Stress Network emphasise the need for psychoeducation for agencies, secure
10 staff and parents if trauma-specific programmes are to be embedded and sustained within secure settings
11 (Ford, 2013). Finally, managers identified vicarious trauma for care staff as a consequence of working
12 with traumatized children in a custodial context, including burn out and leaving the unit. The importance of
13 recognising the signs and having strategies to address vicarious trauma has been described as an ethical
14 and practical issue (Ford, 2013).
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27 In comparison to managers, therapists who delivered a brief exposure therapy in secure units reported
28 both similar and distinct barriers. Therapists, as with managers, reported limited therapy time and short
29 duration placements but also reported feeling de-skilled by complex adolescent difficulties (Barron &
30 Mitchell, 2017b). Therapists, as with young people, therefore, included their own internal experience as
31 one of the barriers, albeit with a different trauma therapy. Further, in contrast to managers and therapists
32 young people in a TRT RCT in Scotland uniquely reported group experience and specific programme
33 activities as barriers. The latter included problems with imagining images, other adolescent behaviour and
34 preferring individual rather than group support with sensitive issues (Barron et al., 2017). In short,
35 although managers appear to be aware of a range of organisational barriers to delivery of a trauma-
36 specific programme within secure units, other studies suggest therapists and young people hold
37 distinctive perspectives on barriers that also need to be considered for effective programme
38 implementation. Parents, care staff, and outside agencies are other perspectives that need explored.
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52 Within the current study, the exploration of managers' specific experience and concerns provides useful
53 information towards anticipating and planning for gains, facilitative factors and potential barriers for
54 trauma-specific programmes (Whittaker, Del Valle & Holmes, 2014). From cross-question analysis, it
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3 was apparent managers were able to identify a range of issues related to the complexity of adolescent
4 problems and unit limitations (Caeti, 2013). The identification of these and other reported factors highlight
5 the importance of robust research to assess the strategic role for managers in facilitating change in
6 secure units. The latter is supported by recently expressed comments by the international working group
7 for therapeutic residential child care: "We view an ultimate epistemological goal for therapeutic residential
8 care as the identification of a group of evidence based models or strategies for practice that are effective
9 in achieving desired outcomes for youth and families, replicable from one site to another, and scalable i.e.
10 sufficiently clear in procedures, structures and protocols to provide for full access to service in the given
11 locality, region or jurisdiction" (Whittaker et al., 2016:98).
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23 Limitations

24 The current study sought to understand unit manager perception of delivering TRT, a trauma-specific
25 programme, into secure units across Scotland. A more robust research model would be needed to
26 explore findings beyond perceptions to analyse behaviour of managers and others. The focus on
27 manager views limits the generalisation of findings as comparisons are needed with other stakeholder
28 perceptions. The sample size was small and therefore all issues for managers may not have been
29 identified. It is also unknown whether the one unit not involved would have responded any differently. All
30 managers were male and therefore female manager views need to be assessed. The challenges and
31 benefits of implementing TRT may be specific to this programme and other trauma-specific programmes
32 may generate other issues. Further, managers were not asked about the differences in operational issues
33 between introducing a trauma-specific programme into secure accommodation compared to other
34 therapeutic interventions. Indeed, other approaches might achieve similar outcomes without being
35 labelled trauma-specific. Quasi-qualitative analysis can be criticized for over-compartmentalized
36 meanings. Finally, as this study explored perceptions of change, important questions remain as to
37 whether a trauma-specific model is effective and will have a positive effect on young people's
38 experiences and outcomes. As initial studies in Scotland indicate trauma-specific programmes lead to
39 reduced subjective disturbance and behavioural incidents as well as moves to lower levels of care,
40 trauma-specific approaches are worth continued exploration (Barron et al., 2017; Barron & Tracey, 2017).
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Conclusions

The current study brings the perspective of managers to a small but growing number of studies that explore the process of implementing trauma-specific programmes and outcomes for young people in secure accommodation in Scotland. Managers across secure units identified a range of benefits and challenges in the transition from behaviour risk, cognitive behavioural and criminogenic models to include a trauma-specific programme. Managers perceived gains in trauma-informed knowledge and confidence for themselves and staff and adolescents were also perceived to achieve skill gains. Challenges to overcome were reported as significant and included a political context of competitive tendering for contracts that limited the risks managers were willing to take with new initiatives; a lack of understanding of trauma for parents and agencies, some of whom were as yet unconvinced by the approach; and the need to reorganise units in a way to facilitate trauma-specific programme delivery. The latter involved the challenge for staff in deciding how ongoing approaches and new trauma-specific activities fit together. As part of addressing these challenges managers emphasised clear policy development, training in traumatisation and recovery for all unit staff and psychoeducation for stakeholders. In the absence of global literature, findings may be relevant to the US context of juvenile detention.

Manager identified need for future practice

Given the qualitative and exploratory nature of the study, recommendations are tentative. Managers perceived the need for greater awareness for all unit staff of young people's traumatization and recovery in order to understand potential implications for organisational development. The planning of engagement and understanding of a trauma-specific programme with stakeholders (e.g. what to present to whom and when) was perceived to reduce the threat of non-commissioning of services by social work for example. Experience of delivering TRT highlighted the importance of assessment and case management being closely aligned to facilitate programme delivery and time was needed to be protected for staff to fully deliver TRT. Managers reported that TRT needs to be set within trauma-informed organizations including psychoeducation for families, fit with placement duration, and staff recruitment needs to prioritise candidates with trauma-informed understandings. All these perceptions stimulate future research questions.

Recommendations for research

Continuing research is needed into manager perceptions and actions regarding TRT and other trauma-specific programmes in secure accommodation. Larger samples are likely to identify further benefits and challenges for managers. Cross-cultural studies could broaden and deepen the analysis. Manager perceptions of TRT and other trauma-specific approaches need to be compared with staff and adolescent perceptions. Future research needs to move from perception to evaluation of manager and organisational behaviour change as a consequence of delivering TRT/trauma-specific programmes. Manager views need to be incorporated into more robust designs such as randomised control trials where there could be a closer connection between TRT/trauma-specific programmes, young people's outcomes and managers' views. Longitudinal studies would enable the assessment of the impact of TRT/trauma-specific approaches on unit managers and others over time. The organisational implications of introducing TRT/trauma-specific programmes into secure accommodation, compared to introducing other types of therapeutic intervention needs to be explored.

References

- Abram, K., Zwecker, N. Welty, L., Hershfield, J., Dulcan, M., & Teplin, L. (2015). Comorbidity and continuity of psychiatric disorders in youth after detention: a prospective longitudinal study. *JAMA psychiatry*, 72(1), 84-93. doi:10.1001/jamapsychiatry.2014.1375
- Baglivio, M. T., Epps, N., Swartz, K., Huq, M. S., Sheer, A., and Hardt, N. S. (2014). The prevalence of adverse childhood experiences (ACE) in the lives of juvenile offenders. *Journal of Juvenile Justice*, 3(2), 1-23. Retrieved from <http://www.journalofjuvjustice.org/JOJJ0302/article01.htm>
- Barclay, A., and Hunter, C. (2008). Blurring the boundaries: The relationship between secure accommodation and 'alternatives' in Scotland. In A. Kendrick (Ed.), *Residential child care, prospects and challenges* (pp. 166-182). London: Jessica Kingsley Publishers.
- Barron, I. G., Abdallah, G., and Smith, P. (2013). Randomized control trial of a CBT trauma recovery program in Palestinian schools. *Journal of Loss and Trauma*, 18(4), 306-321. doi: 10.1080/15325024.2012.688712

- 1
2
3 Barron, I.G. and Hodgkiss, J. (2017). Suicide prevention in secure care: Teaching Recovery Techniques.
4
5 Submitted to *Residential treatment for Children and Youth*.
6
7 Barron, I.G. and Mitchell, D. (2017a). Adolescents in secure accommodation in Scotland: Exposure and
8
9 impact of traumatic events. *Journal of Aggression, Maltreatment and Trauma*. In press.
10
11 Barron, I.G. and Mitchell, D. (2017b). The Fairy Tale Model: Secure facility therapist perceptions.
12
13 Submitted to the *Journal of Child and Adolescent Trauma*. Manuscript submitted for
14
15 publication.
16
17 Barron, I.G. Mitchell, D. and Yule, W. (2017). Pilot study: RCT of a group-based psychosocial trauma
18
19 recovery program in secure accommodation in Scotland", to *Journal of Family Violence*.
20
21 Submitted to the *Journal of Family Violence*. In press.
22
23 Barron, I.G. and Tracey, K. (2017). Quasi-qualitative evaluation of Progressive Counting in Secure
24
25 Accommodation in Scotland. An exploratory cluster case study. *Journal of Child and*
26
27 *Adolescent Trauma*. In Press.
28
29 Bayer, P. and Pozen, D. (2003). *The effectiveness of Juvenile Correctional Units: Public Versus Private*
30
31 *Management*. Yale: Economic Growth Center. Retrieved from <http://ssrn.com/abstract=441881>
32
33 Bhatta, M. P., Jefferis, E., Kavadas, A., Alemagno, S. A., & Shaffer-King, P. (2014). Suicidal
34
35 behaviours among adolescents in juvenile detention: role of adverse life experiences. *PloS*
36
37 *one*, 9(2), e89408. Retrieved from
38
39 <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0089408>
40
41 Braun, V. and Clarke, V., 2006. Using thematic analysis in psychology. *Qualitative research in*
42
43 *psychology*, 3(2), 77-101. doi.org/10.1191/1478088706qp063oa
44
45 Butts, J.A. and Adams, W. (2001). *Anticipating space needs in juvenile detention and correctional*
46
47 *units*. US Department of Justice, Office of Justice Programs, Office of Juvenile Justice and
48
49 Delinquency Prevention.
50
51 Caeti, T., Hemmens, C., Cullen, F., and Burton, C. (2003). Management of juvenile correctional units.
52
53 *The Prison Journal*, 83(4), 383-405. doi: 10.1177/0032885503260175
54
55
56
57
58
59
60

1
2
3 CCPS (2007). *Competitive tendering in social care and support services: A position statement*.

4
5 Community Care Providers Scotland. CCPS: Edinburgh. [http://www.ccpscotland.org/wp-](http://www.ccpscotland.org/wp-content/uploads/2014/03/Tendering-CCPS.pdf)
6
7 content/uploads/2014/03/Tendering-CCPS.pdf
8

9 Dierkhising, C. B., Ko, S. J., Woods-Jaeger, B., Briggs, E. C., Lee, R., and Pynoos, R. S. (2013). Trauma
10 histories among justice-involved adolescents: findings from the National Child Traumatic Stress
11 Network. *European Journal of Psycho-traumatology*, 4, 1-12. doi.org/10.3402/ejpt.v4i0.20274
12
13

14
15 Ford, J.D. and Bleustein, M.E. (2013). Systemic self-regulation: A framework for trauma-informed
16 services in residential juvenile justice programs. *Journal of Family Violence*, 28(7), 665-677.
17
18 doi: 10.1007/s10896-013-9538-5
19

20
21 Ford, J. D., Chapman, J., Connor, D. F., and Cruise, K. R. (2012). Complex trauma and aggression in
22 secure juvenile justice settings. *Criminal Justice and Behaviour*, 39, 694-724.
23
24 doi: 10.1177/0093854812436957
25

26
27 Ford, J. D., and Hawke, J. (2012). Trauma affect regulation psychoeducation group and milieu
28 intervention outcomes in juvenile detention facilities. *Journal of Aggression, Maltreatment &*
29
30 *Trauma*, 21(4), 365-384. doi: 10.1080/10926771.2012.673538
31

32
33 Fuggle, P., Dunsmuir, S., and Curry, V. (2012). *CBT with children, young people and families*. Thousand
34
35 Oaks: Sage.

36
37 Habib, M., Labruna, V., and Newman, J. (2013, this issue). Complex histories and complex
38 presentations: Implementation of a manually-guided group treatment for traumatized
39 adolescents. *Journal of Family Violence*, 28(7), 717-728. doi: 10.1007/s10896-013-9532-y
40
41

42
43 Harder, A.T., Knorth, E.J. and Kalverboer, M.E., (2014). Risky or needy? Dynamic risk factors and
44 delinquent behaviour of adolescents in secure residential youth care. *International journal of*
45
46 *offender therapy and comparative criminology*, p.0306624X14531036.
47

48
49 Harris, R., and Timms, N. (1993) *Secure Accommodation in Child Care 'Between Hospital and Prison or*
50
51 *Thereabouts?'* London: Taylor & Francis.

52
53 Havens, J., Gudino, O., Biggs, E., Diamond, U., Weiss, J. & Cloitre, M. (2012). Identification of
54 trauma exposure and PTSD in adolescent psychiatric inpatients: an exploratory study.
55
56 *Journal of Traumatic Stress*, 25, 171-178. doi: [10.1002/jts.21683](https://doi.org/10.1002/jts.21683)
57
58
59
60

- 1
2
3
4
5
6 Hodgdon, H. B., Kinniburgh, K., Gabowitz, D., Blaustein, M. E., & Spinazzola, J. (2013). Development
7
8 and implementation of trauma-informed programming in youth residential treatment centers using
9
10 the ARC framework. *Journal of Family Violence*, 28(7), 679-692. doi: 10.1007/s10896-013-9531-
11
12 z
- 13
14 Holman and Ziedenberg, (2004). *The Dangers of Detention: The Impact of Incarcerating Youth in*
15
16 *Detention and Other Secure Settings*. Washington DC: A Justice Policy Institute Report.
- 17
18 KECC (2011). *Adolescent Profile Report: A Brighter Future for Young People*. Paisley: Kibble Education
19
20 and Care Centre.
- 21
22 Kendrick, A., Walker, M., Barclay, A., Hunter, L., Malloch, M., Hill, M., and McIvor, G. (2008a). The
23
24 outcomes of secure care in Scotland. *Scottish Journal of Residential Child Care*, 7(1), 1–13.
25
26 Retrieved from https://www.celcis.org/files/2414/8475/3535/2008_Vol_07_1_Kendrick_Walker_
27
28 [Barclay_Hunter_Malloch_outcomes_of_secure_care.pdf](https://www.celcis.org/files/2414/8475/3535/2008_Vol_07_1_Kendrick_Walker_Barclay_Hunter_Malloch_outcomes_of_secure_care.pdf)
- 29
30 Kibble Education and Care Centre (2011). *Adolescent Profile Report: A Brighter Future for Young People*.
31
32 Paisley: Kibble.
- 33
34 Marrow, M., Knudsen, K., Olafson, E., & Bucher, S. (2012). The value of implementing TARGET within a
35
36 trauma-informed juvenile justice setting. *Journal of Child & Adolescent Trauma*, 5(3), 257-270.
37
38 doi.org/10.1080/19361521.2012.697105
- 39
40 Mears, D., Cochran, J., Greenman, S., Bhati, A., & Greenwald, M. (2011). Evidence on the
41
42 effectiveness of juvenile court sanctions. *Journal of Criminal Justice*, 39(6), 509-520.
43
44 doi:10.1016/j.jcrimjus.2011.09.006
- 45
46 Meltzer, H., Gatward, R. and Corbin, T. (2003). *The mental health of young people looked after by local*
47
48 *authorities in England*. London: Crown Copyright.
- 49
50 McKellar, A. and Kendrick, A., (2013). Key working and the quality of relationships in secure
51
52 accommodation. *Scottish Journal of Residential Child Care*, 12(1), 46-57.
53
54 Retrieved from <http://strathprints.strath.ac.uk/id/eprint/44011>
55
56
57
58
59
60

- 1
2
3 Mitchell, F., Roesch-Marsh, A., and Robb, L. (2012). Taking stock of alternatives to secure
4 accommodation or custody for girls and young women in Scotland. CJSW report 08/12. University
5 of Edinburgh, Edinburgh
6
7
8
9 Olafson, E., Boat, B., Putnam, K., Thieken, L., Marrow, M., & Putnam, F. (2016). Implementing Trauma
10 and Grief Component Therapy for Adolescents and Think Trauma for traumatized youth in secure
11 juvenile justice settings. *Journal of interpersonal violence*, doi: 0886260516628287
12
13
14 Rivard, J., Bloom, S., Abramovitz, R., Pasquale, L., Duncan, M., McCorkle, D., and Gelman, A. (2003).
15 Assessing the implementation and effects of a trauma-focused intervention for adolescents in
16 residential treatment. *Psychiatric Quarterly*, 74(2), 137- 154. doi: 0033-2720/03/0600-0137/0
17
18
19 Rivard, J., Bloom, S., Mccorkle, D., and Abramovitz, R. (2005). Preliminary results of a study
20 examining the implementation and effects of a trauma recovery framework for adolescents in
21 residential treatment. *The International Journal for Therapeutic and Supportive Organizations*,
22 26(1), 83-96. Retrieved from
23
24
25 <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.470.8025&rep=rep1&type=pdf>
26
27
28
29
30 Roesch-Marsh, A. (2013). Risk assessment and secure accommodation decision making in
31 Scotland: Taking account of gender? *Child Abuse Review*, 23(3), 214-226.
32
33
34
35
36
37
38 Schiele, A.K. (2015). Locking up children and young people: Secure care in Scotland. *Geographies of*
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
Scottish Executive (2006). *Secure accommodation in Scotland, its role and relationship with*
'alternative' services. Edinburgh: Scottish Executive Education Department, Information and
Analytical Services Division.
Scottish Government (2013). Good practice guidance: Implementation of secure accommodation
authorisation (Scotland) regulations. Edinburgh: Scottish Government.
Sickmund, M., and Puzanchera, C. (2014). Juvenile offenders and victims: 2014 national report.
<http://www.ojdp.gov/ojstatbb/nr2014/downloads/NR2014.pdf>
Smith, P., Dyregrov, A. and Yule, W. (2010). *Teaching Recovery Techniques*. Bergen. Children and War
Foundation.

- 1
2
3 Snow, K. (2006). Bilingualism: The two languages of young people in care. *Scottish Journal of Residential*
4
5 *Child Care*, 5(2), 45–55. Retrieved from
6
7 <https://www.celcis.org/files/1214/3818/0813/vol5no2bilingualism.pdf>
8
- 9 Stimmel, M. A., Cruise, K. R., Ford, J. D., & Weiss, R. A. (2014). Trauma exposure, posttraumatic stress
10
11 disorder symptomatology, and aggression in male juvenile offenders. *Psychological trauma:*
12
13 *theory, research, practice, and policy*, 6(2), 184-191. doi.org/10.1037/a0032509
14
- 15 Trulson, C., Marquart, J., Mullings, J., and Caeti, T., (2005). In between adolescence and
16
17 adulthood recidivism outcomes of a cohort of state delinquents. *Youth Violence and*
18
19 *Juvenile Justice*, 3(4), 355-387. doi: 10.1177/1541204005278802
20
- 21 Vanderhaar, J., Munoz, M., and Petrosko, J. (2015). Reconsidering the alternatives: The relationship
22
23 between suspension, disciplinary alternative school placement, subsequent juvenile detention,
24
25 and the salience of race. *Journal of Applied Research on Children: Informing Policy for Children*
26
27 *at Risk*, 5(2), Article 14.
28
29 <http://digitalcommons.library.tmc.edu/cgi/viewcontent.cgi?article=1218&context=childrenatrisk>
30
- 31 Van der Kolk, B. A., Pynoos, R. S., Cicchetti, D., Cloitre, M., D'Andrea, W., Ford, J. D., and
32
33 Teicher, M. (2009). Proposal to include a developmental trauma disorder diagnosis for children
34
35 and adolescents in DSM-V. *Unpublished manuscript*. Retrieved from [http://www.cathymalchiodi.](http://www.cathymalchiodi.com/dtd_nctsn.pdf)
36
37 [com/dtd_nctsn.pdf](http://www.cathymalchiodi.com/dtd_nctsn.pdf).
38
- 39 Walker, M., Barclay, A., Hunter, L., Kendrick, A., Malloch, M., Hill, M., and McIvor, G. (2006). *Secure*
40
41 *accommodation in Scotland; Its role and relationship with 'Alternative' services*. Edinburgh:
42
43 Scottish Executive.
44
- 45 Whittaker, J.W, Del Valle, J.F., & Holmes, L. (Eds.). (2014). *Therapeutic residential care with children and*
46
47 *youth: Developing evidence-based international practice*. London and Philadelphia: Jessica
48
49 Kingsley Publishers.
50
51
52
53
54
55
56
57
58
59
60

1
2
3 Whittaker, J.K., Holmes, L., del Valle, J.F., Ainsworth, F., Andreassen, T., Anglin, J., Bellonci, C.,
4
5 Berridge, D., Bravo, A., Canali, C. and Courtney, M. (2016). Therapeutic residential care for
6
7 children and youth: a consensus statement of the International Work Group on Therapeutic
8
9 Residential Care. *Residential Treatment for Children & Youth*, 33(2), 89-106.
10
11 doi: 10.1080/0886571X.2016.1215755
12

13
14 Wood, J., Foy, D., Goguen, C., Pynoos, R., & James, C. (2008). Violence exposure and PTSD among
15
16 delinquent girls. *Journal of Aggression, Maltreatment and Trauma*, 6(1), 109–126.
17
18 doi:10.1300/J146v06n01_06
19
20
21
22
23
24
25
26
27
28
29
30
31
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Table 1

Cross-question analysis of themes

Questions/issues	Themes
Benefits	Paradigm shift across disciplines; Growth in staff trauma-specific knowledge and motivation.
Challenges	Senior managers need to take the lead for system wide change to address policy and practical barriers.
Manager gains	Increased trauma knowledge in a public health approach leading to the need to reorganize, employ psychologists, provide ongoing training for all staff in trauma, and educate stakeholders.
Practitioner gains	Increased time delivering therapy as knowledge, skills and confidence improved.
Care staff gains	A reframe in understanding behavior though a trauma lens; Training in trauma sensitive environments; How to support trauma-specific programs.
Adolescent community	Need to explore the impact of TRT on self-harm .
Parental impact	Impact unknown, however, supporting parents is recognized as important for adolescent transition to the community.
Facilities contact	Little communication between provisions beyond training/supervision, other than checking where other provisions are at, which limited development.
Placement meetings	Increasing recognition of the centrality of attachment, separation and trauma for the transition process.
Stakeholder experience	Trauma understandings are more embedded in secure and stakeholder discussions, although not all are on board.
