GWASANAETH TROSEDDAU IEUENCTID CWM TAF
CWM TAF YOUTH OFFENDING SERVICE
GWEITHIO GYDA PHOBL IFANC A'U CYMUNEDAU
WORKING WITH YOUNG PEOPLE AND THEIR COMMUNITIES

Pathways and Planning (AssetPlus): Trauma Recovery Model Planning and Intervention Tool

This intervention tool is underpinned by the Trauma Recovery Model (TRM) (developed by Dr Skuse and Jonny Matthew in 2015). The TRM is a six-stage model based on Maslow's hierarchy of needs which suggests that healthy psychological growth can only occur where basic safety needs have been met. The Model links the child's presenting behaviours to underlying need with the type of intervention required to meet that need.

The practitioner will need an understanding of the child's position on the TRM and can use the interventions listed in the corresponding level in the tool below. For example, practitioners working with children assessed at Level 1 (Instability/Inconsistent) will choose interventions listed in Level 1 (yellow: cognitive, social or emotion) of the tool. The interventions are also catergorised according to the primary skills practitioners seek to develop within the child (cognitive, emotional or social). This may be significant for children who are functioning at a much lower age in one or more developmental area. For example, a child may be assessed to be have cognitive skills that are age appropriate but emotionally be functioning at much younger age. However, the practitioner does not need to be overly concerned with these divides, the main priority should be sequencing interventions according to the child's stage on the TRM.

Please refer to the Model for full details of the behaviour indicators that relate to the above levels.

The child may cycle between the different TRM levels many times during recovery. The recommendations are not exhaustive and intended as ideas/suggestions that should be used with other tools and external controls (actions taken by persons other than the child to address the key areas of intervention). Their appropriateness needs to be carefully considered whilst tailoring them for the child's developmental age, interests, context and nature of agency provider. They may be adjusted, changed and overlapped depending on the response of the child.

These interventions are not meant to replace the usual multi agency planning forums or the need to seek specialist advice with regard to any presenting concerns.

For children assessed at level one of the Trauma Recovery Model the associated recommendations for that level may be the main or only focus of the intervention. Other interventions may be added as the child progresses or begins to recover from traumatic experiences. It may also be appropriate to undertake interventions listed in higher levels at earlier stages, depending on the child and their unique needs and how they are engaging with the overall process. However, it is important to highlight that the general principles outlined below should be built upon rather than removed or replaced by additional interventions. For example, the need to offer consistency in terms of appointments should apply to all children at all stages not just those identified at level one of the TRM.

The child's plan/tasks should be kept simple and based on their unique goals and interests. The interventions below are suggestions for practitioners (to be contained in parts of the plan the child does not see).

Cognitive *Interventions to develop the child's ability to learn, think, reason, understand, remember, problem solve, use logic, decision make, pay attention, shift from one task to another, multi task, follow instruction.*	**Emotional** *Interventions to develop the child's ability to deal with, discuss and control their emotions (ability to self-regulate), how they experience emotions and react to other people's feelings and other people's feelings towards them. Their resilience, patience, confidence and self-esteem.*	**Social** *Interventions to develop the child's ability to interact and act appropriately in social contexts. Make friends, maintain friendships, speak to adults, their assertiveness, coping skills, communication skills, body language, flexibility, co-operation, recognition of social cues. Their sense of self and personal identity.*	**Target** *Indicators that the child has met this developmental stage*
TRM LEVEL 1 (Instability/Inconsistent)			
Boundaries, requirements, rules and consequences - need to be set and help to provide a safe base in which to deliver other interventions. It is important that the boundaries and consequences are outlined when the child is in a calm state and not when angry/agitated or stressed or have just breached/broken a boundary. Boundaries, rules and	**Responding to challenging behaviour** -Safety and practical considerations should be prioritised over consequential thinking. Problem solving and de briefing should happen once the child had calmed. Focus on the emotion underlying the issue rather than the consequence (see resource catalogue/TRM level1 Jen Taylor 2015)	**Identify key workers-** one safe attachment figure (adult) to deliver the primary intervention. Where change is unavoidable ensure other aspects of the plan remain consistent. **Creating a safe base** -Offer consistency, predictability and reliability (CPR) by: • Offering appointments at	Practitioners may focus on these interventions until the child is willing to meet with one key worker on a regular basis. The practitioner may need to be flexible with appointments, e.g. if the child forgets the scheduled appointments re-arranging it for a different date the same way week. The targets would be for the child to be keeping most of the appointments (if offered on a

consequences provide the framework in which to deliver interventions and can help a child to feel safe/contained but should not be the focus of the interventions delivered. **Format/Session-times -**It's important to create some consistency, routine and structure within the session (but with a flexible approach), a beginning, middle and end and the same format each time. The child may not comprehend the passage of time so it may be useful to have a clock timer or countdown. **Flexible** – Expectations need to be set but offer alternatives and tell children what they can do rather than what they can't, e.g. "You have to attend an appointment this week, but if Wednesday is a bad day I could change it to a Thursday". **Safety tours –** Ensure environments are trauma informed. Talk about and make the sense of safety explicit in the different environments the child is accessing. Provide the child	**Traffic-light systems(school/training)**- Speak to the child about safety. The child should have a physical place of safety. Explore ways the child can communicate they need their safe place, e.g. red cards/traffic light cards. **Create an imaginary safe space** – e.g. assist the child draw or make a poster/model of a safe space. **PACE-** Dan Hughes (2005) Playfulness, Acceptance, Curiosity and Empathy strategies	the same time each week • Being on time • Planning activities in advance • Keeping the structure of the appointment the same e.g. check in, do an activity, talk about the activity, arrange the next appointment (beginning, middle, end). **Normalise mistakes-** Children who have experienced trauma may catastrophise mistakes. Professionals to acknowledge, own, highlight and apologise for their own mistakes. **Interactive repair -** It may be helpful for all those supporting the child to be mindful of the need to repair the relationship at times when he/she has behaved inappropriately (interactive repair). The consequences for actions may remain, however the relationship with the child should be deliberately re-established shortly after the incident and when the child is feeling calm. **Persistence** – when faced with non-	flexible basis) and perhaps responding to text/calls when they miss appointments. The child's behaviour is likely to continue to be challenging, defensive, hostile or withdrawn but there will be some willingness to at least present/attend/allow you to visit/open the door/answer the phone. At this stage practitioners can shift the focus of the intervention to Level 2 TRM interventions whilst ensuring these fundamental interventions remain in place.

with a tour of the building showing the security, alarms, locks, windows, toilets, CCTV, explain who is in the building. **Reframing** – finding positive ways to reframe the behaviours, e.g. what happened to you rather than what you did or in conversation with other professionals reframe, 'attention seeking' is 'attachment seeking', 'manipulative' to 'she has learned different ways to get her needs met', 'resistant' is 'cautious and hesitant'.		engagement/reluctance/hostility be persistent and continue to attend the home/agreed location at same time each week regardless of whether they engage. **Sideways Approach** -Children may find face to face contacts intensive/intimidating and may not have reached the developmental stage that enables them to engage with this process. Consider less intensive ways to initiate contact where necessary, e.g. texts, notes, Whatsapp messages or offering to transport the child. **Education, Training and Employment interventions** - • Arrange alternative lunch and break time provision (children with trauma may struggle to manage unstructured time). • Explore ways the child can communicate they need their safe place, e.g. red cards/traffic light cards.	

		• Allocate a key worker for the child that they have easy access to • Reduce school expectations to match the child's developmental profile • Remove children from situations/classes they are not managing	
COGNITIVE	**EMOTIONAL**	**SOCIAL**	**TARGETS**
TRM LEVEL 2 (Trust/Relationship Building)			
1:1 time with trusted adults - The child needs continued, consistent support from trusted attachment figures to begin to believe that the world around them is safe enough, that they can make sense of their own experience, and that they are valued and worthy. Beliefs change by addition (e.g. providing 1:1 time with trusted adults) and not by subtraction (telling the child not to associate with anti-social	**Naming and labelling of feelings -**Children learn how to self sooth, recognise and manage their feelings through the people surrounding them. Therefore, professionals should deliberately and openly (where appropriate) name the feelings in the child, themselves, and in others. Everyday scenarios/conversations should be used to identify and discuss feelings. For example, "You are smiling today, you look really	**Shared activities** -Trust can be developed further through activities/tasks that require joint interest, shared goals, and collaboration. This may also serve the purpose of lowering the intensity of interactions. The child will learn self-regulation through co-regulation. **Games** that promote turn-taking, listening, shared control, playing catch, board games, starting a story and letting the child add to	The child will name some emotions in conversation The child engages consistently with one or more workers Smiles and laughs more in sessions Willingness to comply with routines/rues.

peers). Healthy core beliefs form, and then it is possible to let go of trauma-based thinking. **Reflective practice** - Practitioners should consider how to share the child's identified positive attributes with them. This can be achieved by finding ways to notice, celebrate and praise the child's positive skills, qualities, talents and attributes, e.g. school reports, positive work portfolios, reward/thank you letters, certificates, session journals, postcards, core groups, progress/court/panel reports, review meetings, stickers, conversations about them to others (that they witness), treats. Practitioners should make deliberate time to reflect and notice with the child the positives and what is going well.	happy to have a day off school" or "if I was in your shoes , I might feel really nervous about going to court next week", or "your friend looked really sad, has he argued with his mum again?". **Creative feelings activities** Children who enjoy creative activities could make a feelings dictionary such as A is for Angry, B is for bored or make a feelings container(box/jar) filled with feelings cards and take it in turn to deserve/act or draw it. Blank heads with speech marks can be drawn where the child can label different thoughts. Make feelings jewelry with different beads. Answering quiz type questions like "think of a time when you were ….", "I am happiest when….", think of a feeling beginning with B" (Karen Treisman, 2003 p28). **Multi Agency work** - The key worker should predict/highlight to family members/carers/professional's that the child may revert to challenging behaviour as they progress with their recovery from trauma and when this happens	it. **Repairing the relationship** Key workers to be mindful of the need to repair the relationship at times when the child has behaved inappropriately (interactive repair). The consequences of actions may remain, however the relationship with the child should be re-established shortly after the incident and when the child is feeling calm. This will communicate that relationships continue even though caregivers may not approve of the behaviour. **Keeping the child in mind-** An important relationship building tool can be showing the child that they are important and that you have actively kept them in mind (e.g. noticing if they didn't attend, remembering things they have said to you, texts messages out of hours to ask about a specific event they told you about, buying the biscuits/food they like, sending a birthday card/postcard with a relevant message/picture).	

	the care plan should remain consistent. **Responding to fantasy** -If the child tells 'lies', try to understand the purpose this is serving for the child/focus on the emotion underlying the information. Travel alongside the child rather than correcting misinformation.	**Practicing social interactions** can be rehearsed/role played, e.g. "asking for help", "saying no to friends". Practicing pulling different face- how we show emotions in our faces to other. **Social skill modelling -** The professional can also seek to model these feelings (e.g. showing concern when they tell you stories about their peers/family) or showing kindness to others in the child's presence (e.g. offering to share biscuits, opening doors). Pulling cautionary facial expressions when they child expresses their intention to engage in a behaviour that may be risky (mimics behaviour correction in early years between the caregiver and baby). **Community reparation -** delivered via 1:1 work with a trusted adult and focus on moving forward (not paying back) and deliberately identifies child's strengths may be appropriate as it helps to offer structure, promote a positive internal working model and for the child to see their value in the	

		community/the worth they have to others.	
COGNITIVE	**EMOTIONAL**	**SOCIAL**	**TARGETS**
TRM LEVEL 3 (Working Through Trauma)			
Feelings work - Encourage child to see how anger is hurting them/hindering them, e.g. listing advantages/disadvantages of aggression. **Creative activities -**Create an aggression metaphor, e.g. what is it called? what does it look like? what does it say? (draw, paint sculpt, worksheets). **Self-esteem work** -Narrative therapy/desistance theory – Identify the time the child overcame a problem or when the problem was not present, less noticeable. E.g. "Tell me about an incident that made you cross this week but where you didn't lose your temper". **Panels/Reviews**- Case managers may be able to acknowledge/identify very difficult incidents that the child	**Monitoring emotions arousal** - Key workers to reduce arousal. Teaching breathing exercises or grounding exercises can help. Do an activity that raises emotions in a safe environment and then help the child restore to calm (e.g. ball game, card game). Being with a safe person who can attune to the panic and reliably self-regulate. Emotions thermometer/volcano exercises/scaling exercises or yoga **Feelings are accepted -** Showing the child that it is normal to experience a range of feelings and that these can be tolerated. The child be supported to notice that they may have mixed feelings. This can be through verbal statements such as "I can imagine you are relived you didn't have to go to Court but	Ensure the child has consistent support networks surrounding them to assist them cope with the emotions that arise from interventions. Use established relationships to introduce new workers (where necessary) in a gradual phased manner. **Bereavement/Counselling-** Referral to a local service provider.	The child will seek support from the key worker in times of crisis. The child will answer questions about feelings. The child will start to process trauma (talk about the past/make connections between past and current behaviour). The child may revert to challenging/rejecting or clingy behaviour during this phase. Disclosures or the child may start to test out professional's reactions should they make a disclosure (telling lies/stories about peers). Childs behaviour may become challenging/revert to challenging behaviour Child may become clingy or

has survived/overcome. **Sharing positives** about someone whilst they are in earshot. This can also include providing feedback in core groups, to carers after YOT sessions, breach reports/PSRs/ court **Non-verbal feedback** – thumbs up, smiling. Sending text messages/practice feedback letters, engagement panels, certificates. **Positive comments jar** or a letter for them to look at a time of their choice **Confidence building activities** -Identifying and doing activities you know the child will be good at, e.g. referring a child who is good at football to Football Foundation project, a child who is creative to make bird boxes for reparation. **Opportunities for mastery** – Finding ways the child can feel valued and listened to, e.g.	are nervous about having to work with the YOT and meet new people", or " I imagine you are angry you were excluded from school but relived you don't have to go back tomorrow". **Body Links** -Where possible support the child making links between their feelings and their bodily sensations. This can be done via verbal statements "I notice you are clenching your fists and breathing fast", or "sometimes when I am angry my heart beats really fast". A body mapping exercise can also be completed. **Empathy** -The practitioner accepts how the child is feeling about the event/experience. They do not try and persuade the child out of having this feeling. Rather they acknowledge, validate and accept what the child is feeling. When a child's distress is met with empathy, it develops the child's ability to empathise. **Honouring loss- T**he child may prefer to complete bereavement work with those with whom they		rejecting of staff.

setting their own targets for a referral order panel, choosing their own reparation, trusting them to do an activity. E.g. record their own reparation hours. Highlight an area where you have made a mistake or are not good at something and allow them to teach you something. **Self Esteem creative activities**. E.g. Positive quality list use the letters of the child's name to spell out something positive about them or positive affirmations worksheets. **Make explicit links between trauma and impacts upon the body/behaviour-** make the link between trauma and behaviour explicit for the child so they can grasp for themselves the relevance to their own experience. **Dr Siegals Hand Model of the Brain (Dr Siegal, 2020).**	have an established relationship. It's recommended that practitioners find out key information such as the name of bereaved, the date of death/how/why they died and offer to help the child honour the anniversary of the loss or other key dates. Offering to assist or enable the child to mark any significant dates or visit graves/memorials/special places may also be valuable. **Physical activities** - Physical activities that help to remove children from the demands of everyday life that help raise and lower emotions in a safe and nurturing environment. **Modifying traumatic memories** It is important to highlight that the child will already be thinking about the traumatic experience even if they are not talking about it. Often when bad things happen children will think it is their fault, their inner thoughts may be more horrific than the reality of the situation. The child needs to know that the trusted adult can hear the information and doesn't confirm their skewed perception		

	that they are mad/bad/naughty and that what happened is their fault. **Conversations that heal** - Research shows that just listening brings down stress levels (Dr Sunderland, 2015). Validating the child's emotions rather than outlining consequences or providing solutions. **Empathy-**The objective in terms of empathy at this stage is for the practitioner to accept/tolerate the feelings the child is having regarding the traumatic experience as explained above, but it is also of note that practitioners should not try to persuade the child out of the feelings they are having or try and persuade them to consider the feelings of others. The child will only learn to do this through experience – through them having their own experience of being a victim validated by a trusted adult.		

COGNITIVE	EMOTIONAL	SOCIAL	TARGETS
TRM LEVEL 4 (Insight/Awareness) **(STANDARD YOUTH JUSTICE PRACTICE MAY NOW BE APPROPRIATE)**			
Future Thinking- Children who have experienced trauma will have put all their energy into surviving day by day. Professionals can assist children wherever possible to think about their futures, e.g. reflecting with them on what their futures could be - like/hopes/goals/wishes dreams. This will be new territory for children, and they will require encouragement and support. Goals/hope/targets identified by the child may be unrealistic, but professionals should travel alongside rather than trying to replace or advise on the unrealistic nature of the goals. Goals and hopes will naturally become more realistic as the child reaches the next developmental stage. Writing a letter from the future self to the current self (Karen Treisman, 2017) **Why/What If Tree**-mapping the roots of a present issue or		**New workers** can be introduced via established workers **Cycle of change exercises** (Drs. Prochaska and DiClemente, 2005)- To build on normalising mistakes. Failure is part of success. **Role Plays -**Rehearsing responses to situations that may trigger the child's emotional dysregulation in a playful way. Rehearse repeatedly with a more positive outcome. Cartoon strip drawings can be appropriate. Ask the child to a pick a different way they could have responded to a situation or use third party stories (television, or peer experiences).	Periods of desistance Insight Awareness of problematic aspects of behaviour or past behaviour Calmer More balanced self-narrative Planning skills Talks about the difference between improved current behaviour and past behaviour/new self /old self – "do you remember when I…"

problem (the whys). The child identifies the most obvious causes and is then helped to reflect on the reasons for those causes, back-tracking as far as is useful. Some causes will be stop points – things that cannot be changed – while others will be susceptible to change. The 'what if' element enables the child to project into the future and to model scenarios of what might happen to them if they persist with certain sorts of negative behaviour or, conversely, what might happen if they desist from certain forms of behaviour and engage with more positive. **Restorative justice**- Focus on moving forward. Restorative conference with the victim of the offence. Letter of apology to the victim of the offence. **Offending/specific programmes** (e.g. knife crime, car crime awareness etc) **Cognitive interventions** - Interventions based on consequence/punishment/reward (by saying *if (this) then (that)*).			

Thoughts, feelings and behaviour programmes. **Good Lives model (Ward, et al, 2021)** **Substance misuse harm reduction/education programme**			
COGNITIVE	**EMOTIONAL**	**SOCIAL**	**TARGETS**
TRM LEVEL 5 & 6 (Future Planning and Moving On) (CHILDS NEEDS CAN BE MET VIA MAINSTREAM PROVISIONS)			
Adult guided and supported planning. De Shazers (1998) Miracle Question Education, training and employment provision put in place Standard YOT practices		Needs will be met through independent social network/community groups/activities Mentors Attending education, training and employment provision	Adverse outcomes/Future behaviour assessed as unlikely to occur or would have slight/minor impact. Acceptance of praise Acceptance of abilities Plans for the future Solves problems independently Achieves goals Engages with education, training or employment

REFERENCES

De Shazer, (1998) *Solution Focused Therapy:* available from Solution Focused Therapy (getselfhelp.co.uk); retrieved on 14th February 2021

Hughes, D. (2021) *DDP Network What I meant by PACE*: available from <What is meant by PACE? - DDP Network: retrieved on 14th February 2021

Purvis, M & Ward, T. (under review) *The Good Lives Model of offender rehabilitation*. In R. D. Morgan (Ed.), The Sage Encyclopaedia of Criminal Psychology. CA: Sage

Drs. Prochaska and DiClemente, (2005) *Drs. Prochaska and DiClemente, 2005* retrieved on 14th February 2021 from -<Chapter-3-Cycle-of-Change-Model-handout.pdf (relational-integrative-psychotherapy.uk)>

Shanker, S and the Mehrit Centre (2016) *What is self reg?* Self Regulation Infographic/Understanding Stress Behaviour February 2016 graphic: available from Self-Reg 101 - Self-Reg (self-reg.ca): Retrieved 10th February 2021,.

Dr Siegal. (2020) *Dr Siegals Hand Model of The Brain* by social work shots; available from https://www.socialworkshorts.co.uk: retrieved on 14th February 2021

Taylor, J. (2015) *Why traditional parenting doesn't work with traumatised kids*: available from Jentaylorplaytherapy.com: *retrieved on 14th February 2021*

Treisman, K. (2016) *Working with Relational and Developmental Trauma in Children and Adolescents:* London: Routledge 1st Edition.

TRM academy. (2016) *TRM Academy Resources/The training room* available from https://trmacademy.com/trmlms/mod/page/view.php?id=140: retrieved 20th November 2020

Ward, T. (2021) *Good Lives Model 2021*: available from The Good Lives Model of Offender Rehabilitation - Home: retrieved on 14th February 2021

YJB, Guidance. (2020) *Implementing the approach* Enhanced Case Management: London: YJB