Adversity, Trauma and Resilience

Bristol, North Somerset & South Gloucestershire Webinar Series

Trauma Informed Practice in Criminal Justice

Professor Kieran McCartan

16th November 2020

Welcome to Zoom

A few pointers…

- Mute buttons and video

- Breakout rooms

- Chat function

- Feedback opportunities

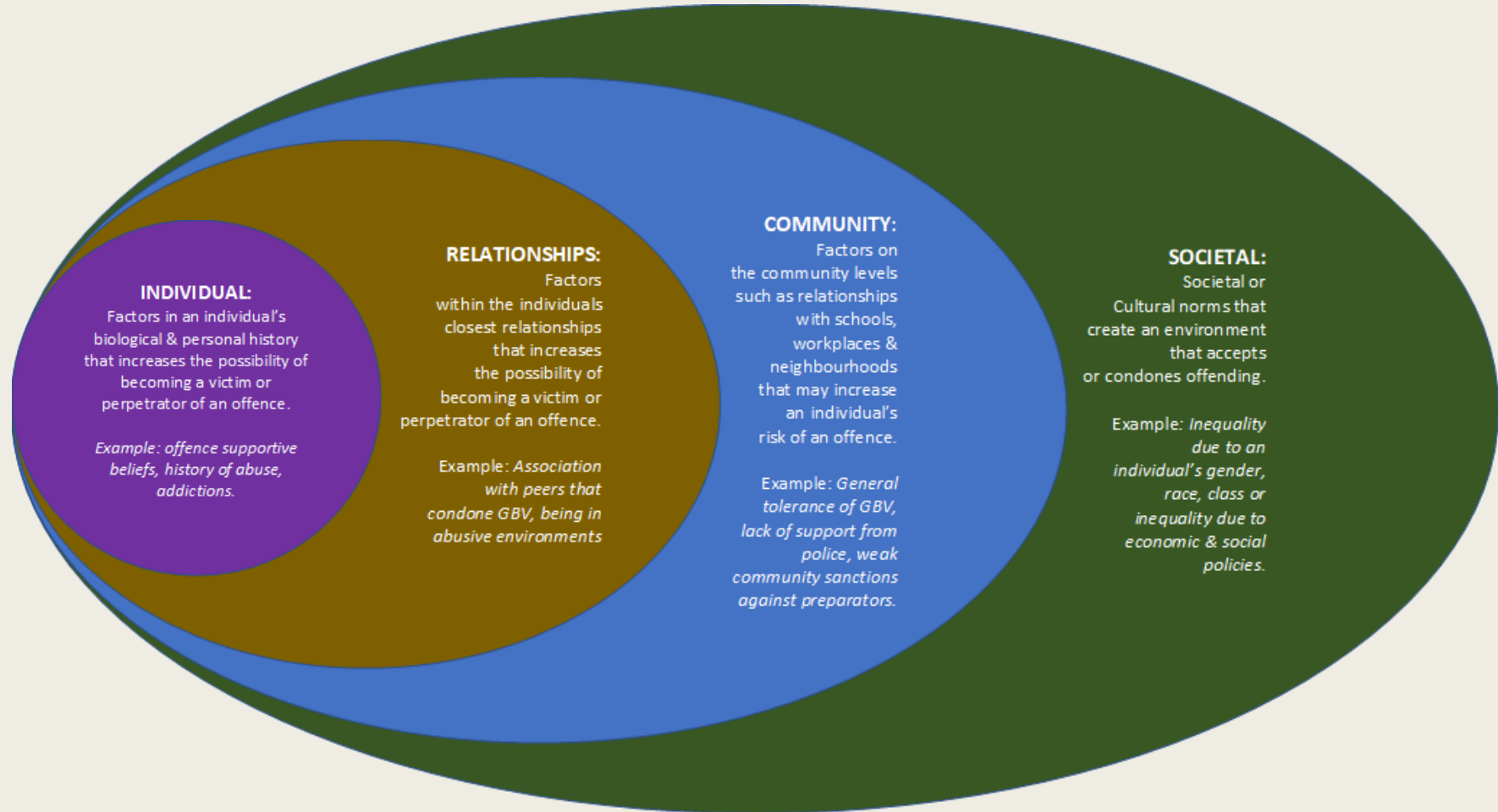- Confidentiality in discussions

- Twitter: #ACEHIT

Structure

- **PART 1** - What are ACE's and trauma, as well as their impact on developmental and life-course criminology as well as psychology.

- **PART 2** - The impact of trauma in the lives of people who have offended, learning from research & practice

- **PART 3** - How you use trauma informed practice in the community integration of people who have offended
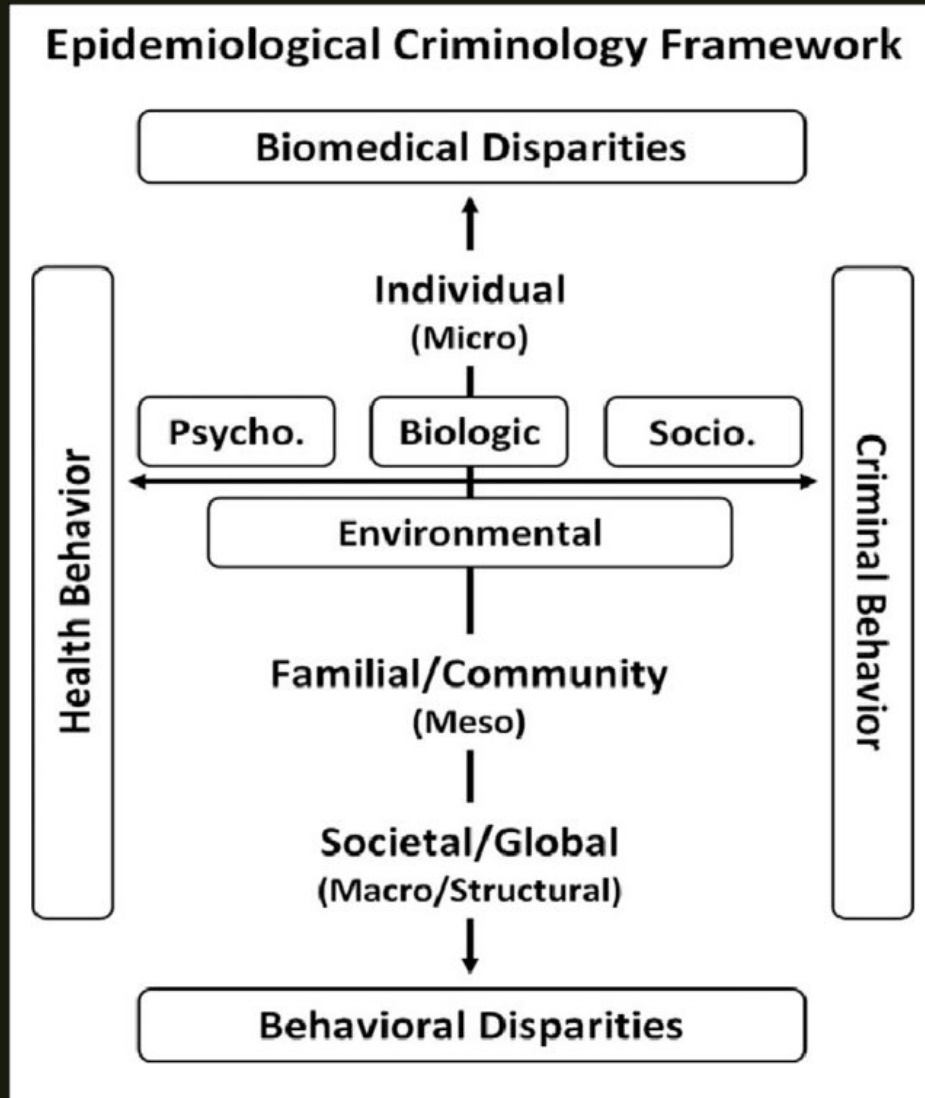
- Q&A/ Discussion

PART 1

WHAT ARE ACES AND TRAUMA?

WHAT IS THEIR IMPACT ON DEVELOPMENTAL & THE LIFE-COURSE.
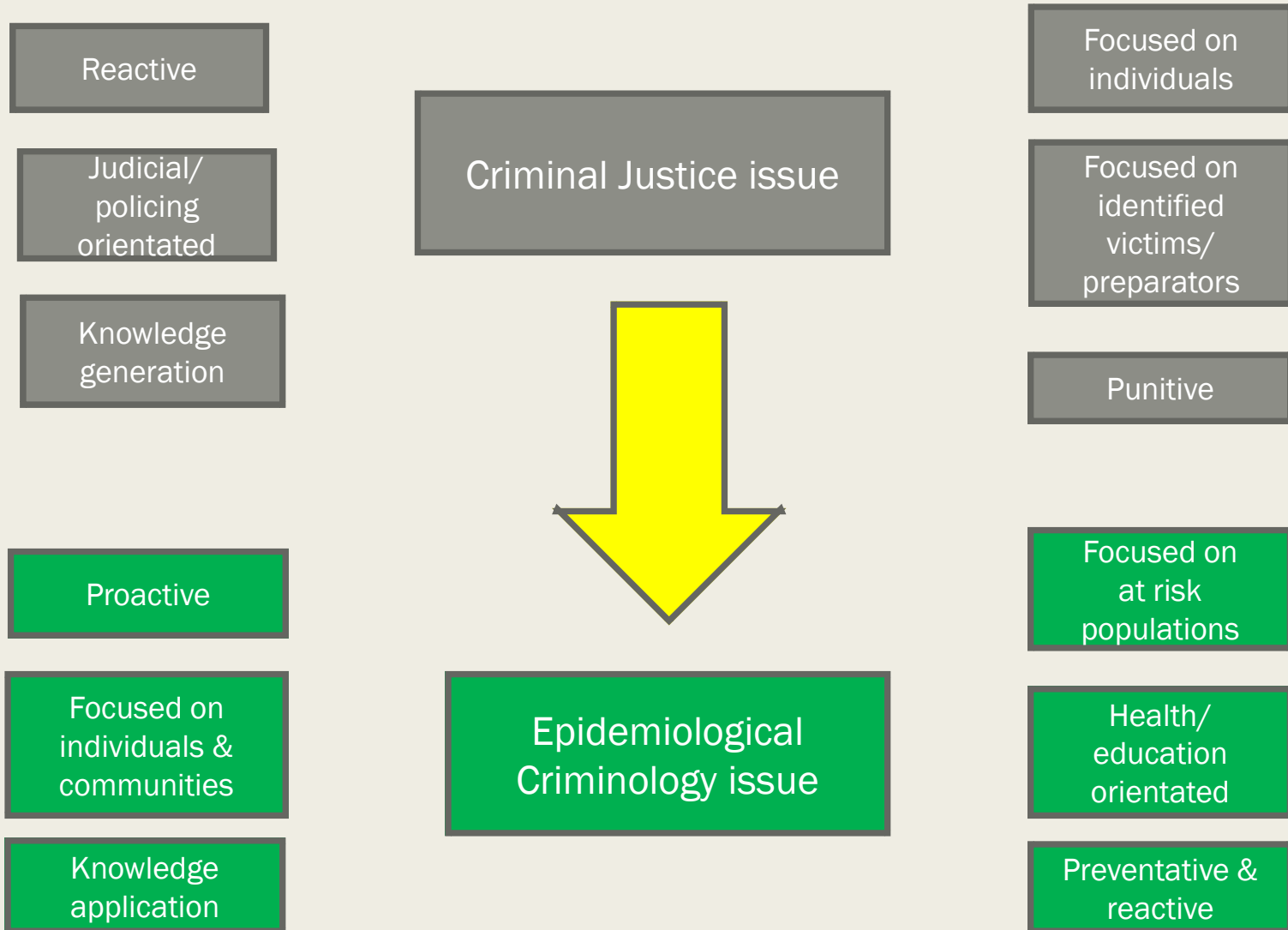
Socio-Ecological Model & criminogenic behaviour

INDIVIDUAL:
Factors in an individual's biological & personal history that increases the possibility of becoming a victim or perpetrator of an offence.

Example: offence supportive beliefs, history of abuse, addictions.

RELATIONSHIPS:
Factors within the individuals closest relationships that increases the possibility of becoming a victim or perpetrator of an offence.

Example: Association with peers that condone GBV, being in abusive environments

COMMUNITY:
Factors on the community levels such as relationships with schools, workplaces & neighbourhoods that may increase an individual's risk of an offence.

Example: General tolerance of GBV, lack of support from police, weak community sanctions against preparators.

SOCIETAL:
Societal or Cultural norms that create an environment that accepts or condones offending.

Example: Inequality due to an individual's gender, race, class or inequality due to economic & social policies.

Epidemiological criminology (EpiCrim)

Epidemiological Criminology Framework

Biomedical Disparities

↑

Individual (Micro)

| Psycho. | Biologic | Socio. |

Environmental

Familial/Community (Meso)

Societal/Global (Macro/Structural)

↓

Behavioral Disparities

Health Behavior — Criminal Behavior

- Understanding that the fields of criminology and health come together in allowing us to understand the causes and consequences of offending behaviour better (Lainer, 2014).

- Reinforcing a life course perspective.

- Committing an offence, as a life course issue means that this behaviour is viewed as a product of someone's experiences, mental health, wellbeing, individual differences, and personality.

The shift to an Epidemiological Criminology approach

Reactive

Judicial/ policing orientated

Knowledge generation

Criminal Justice issue

Focused on individuals

Focused on identified victims/ preparators

Punitive

Proactive

Focused on individuals & communities

Knowledge application

Epidemiological Criminology issue

Focused on at risk populations

Health/ education orientated

Preventative & reactive

McCartan, Meridian, Perkins & Kettlebrough (2017)

Primary Prevention

preventing first time offending

- **Public Health** - "Action to prevent disease in people who feel well"

- **Criminal Justice** - "Action to prevent criminogenic &/or risky behaviour in people who are not criminogenic &/or risky".

Secondary Prevention

preventing first time offending

- **Public Health** - "Action to detect disease at an early stage in people who feel well"

- **Criminal Justice** – A behaviour at an early stage in people without a criminal conviction".

Tertiary Prevention

preventing reoffending

- **Public Health** - "Action to reduce symptoms and complications of disease in people who feel sick "

- **Criminal Justice** - "actions, treatments and/or interventions to reduce criminogenic &/or risky behaviour in people with a conviction".

Quaternary Prevention

preventing reoffending

- **Public Health** - "action taken to protect people from interventions that are likely to cause more harm than good"

- **Criminal Justice** - "action taken to protect individuals with a criminal conviction from criminal justice interventions that would result in future criminogenic &/or risky behaviour".

Do we engage at all 4 levels of prevention?

– *Primary and tertiary prevention are easily identified and relatively well supported, especially in terms of funding, public relations, and outcomes; with primary prevention normally being funded via education and tertiary funded via criminal justice.*

– *Secondary prevention is often seen as an emerging and novel approach that is poorly funded as well as inconsistently viewed politically, socially, and in the media; and*

– *Quaternary prevention is often not understood or easily identified by the public, policymakers, or professionals.*

– *Quite often in criminal justice tertiary and quaternary prevention are the same process ("treatment and reintegration") whereas they are two different processes ("treatment" and "reintegration").*
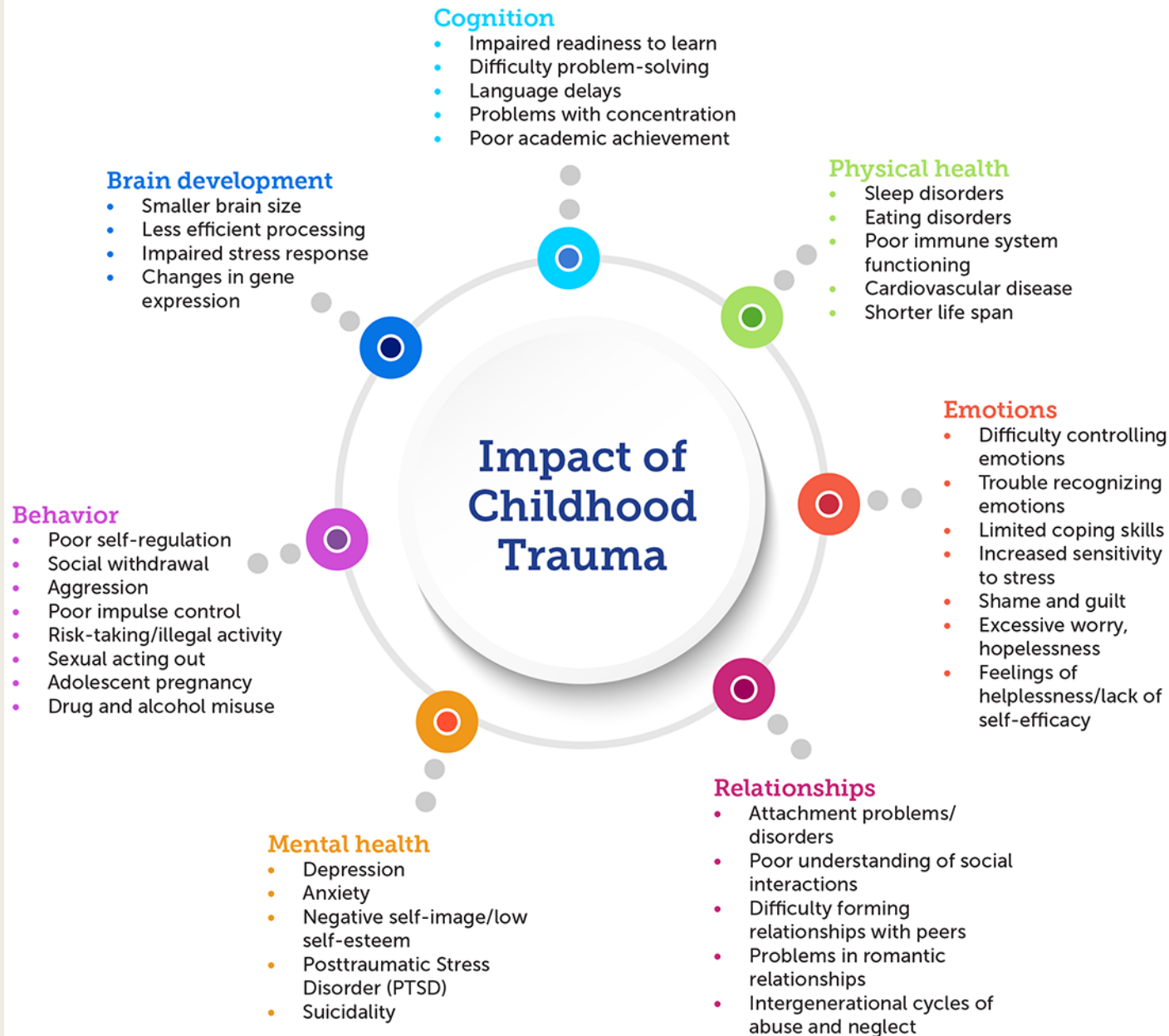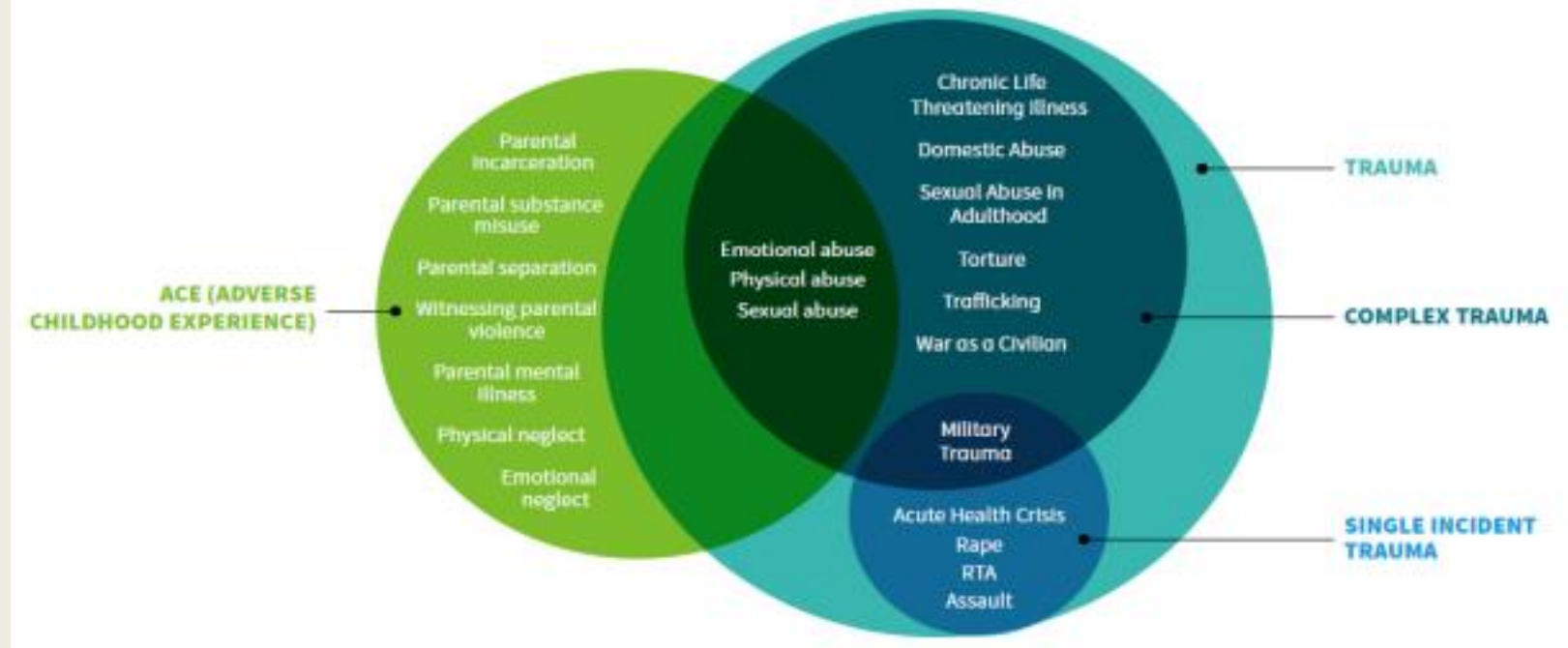
Adverse Childhood Experiences

ABUSE	NEGLECT	HOUSEHOLD DYSFUNCTION

ABUSE
- Physical
- Emotional
- Sexual

NEGLECT
- Physical
- Emotional

HOUSEHOLD DYSFUNCTION
- Mental Illness
- Incarcerated Relative
- Mother treated violently
- Substance Abuse
- Divorce

Adverse Childhood Experiences

Lifespan Impacts of ACEs

Source: Family Policy Council, 2012

10

Impact of Childhood Trauma

Cognition
- Impaired readiness to learn
- Difficulty problem-solving
- Language delays
- Problems with concentration
- Poor academic achievement

Brain development
- Smaller brain size
- Less efficient processing
- Impaired stress response
- Changes in gene expression

Physical health
- Sleep disorders
- Eating disorders
- Poor immune system functioning
- Cardiovascular disease
- Shorter life span

Behavior
- Poor self-regulation
- Social withdrawal
- Aggression
- Poor impulse control
- Risk-taking/illegal activity
- Sexual acting out
- Adolescent pregnancy
- Drug and alcohol misuse

Emotions
- Difficulty controlling emotions
- Trouble recognizing emotions
- Limited coping skills
- Increased sensitivity to stress
- Shame and guilt
- Excessive worry, hopelessness
- Feelings of helplessness/lack of self-efficacy

Mental health
- Depression
- Anxiety
- Negative self-image/low self-esteem
- Posttraumatic Stress Disorder (PTSD)
- Suicidality

Relationships
- Attachment problems/disorders
- Poor understanding of social interactions
- Difficulty forming relationships with peers
- Problems in romantic relationships
- Intergenerational cycles of abuse and neglect

Impact of Childhood Trauma

ACE'S & TRAUMA

PART 2

THE IMPACT OF TRAUMA IN THE LIVES OF PEOPLE WHO HAVE OFFENDED:
LEARNING FROM RESEARCH & PRACTICE

The aetiology of offending behaviour

■ People who commit crime are quite diverse, although there are some character traits and lifestyle variables that many offenders have in common

■ Dynamic & Stable risk factors

■ Risk factors vs Protective factors
  – *Antisocial values and beliefs (criminal thinking)*
  – *Antisocial peers*
  – *Personality traits*
  – *Family dysfunction*
  – *Low self-control*
  – *Substance abuse*

■ There are factors, warning signs and issues that can alert us to potentially problematic behavior.

■ Craig et al (2017) ACEs were found to increase the likelihood of offending throughout the life course. Across two operationalizations of risk, a number of protective factors were identified including low troublesomeness, low daring, and low hyperactivity.

Developmental Theories of Crime and Delinquency

KEY RESULTS FROM THE FIRST FORTY YEARS OF THE CAMBRIDGE STUDY IN DELINQUENT DEVELOPMENT

David P. Farrington

Institute of Criminology, University of Cambridge

Revised November 2001

The importance of the life course

■ Cambridge study of crime by West and Farrington (Farrington and West, 1990; Farrington et al., 2006) demonstrates that the main etiological factors in criminogenic behaviour are

SOCIO-ECONOMIC STAUS	MAJOR LIFE EVENTS	PERSONALITY	INTELLIGENCE
CHILDHOOD DEVELOPMENT	HEALTH	SOCIALIZATION	IMPULSIVITY

■ The study demonstrates that the causes of offending behaviour are a blend of nature and nurture, with childhood playing a significant role in determining later behaviour.

■ Research and existing good practice also demonstrates The importance of risk and protective factors (Farrington, Loeber and Ttofi, 2014; Sapona et al., 2015).

   risk factors (i.e., increase the likelihood of committing an offence);

   protective factors (i.e., reduce the likelihood of committing an offence)

■ Which means that criminality is, in part, a learned behaviour which can be unlearned. Rehabilitation is thus possible for most, and proactive risk management is possible for others, with the appropriate tools and necessary support.

Adverse Childhood Experiences & criminogenic behavior

What have ACEs got to do with Justice?

1

Everything. This paper sets out a summary of the evidence on the links between childhood adversity and victimisation and criminality in adulthood. It makes a strong case for preventing crime by targeting those most at risk of experiencing adverse childhoods, and supporting people in the Justice System whose lives have been affected by adverse childhood experiences (ACEs) in order to reduce reoffending and prevent intergenerational crime and victim-isation. It argues that this will require a coordinated and collaborative effort across government.

Most of the recognised ACEs (and other adversities) impact on the Justice System.

Children and adults with experience of ACEs may come into contact with the criminal justice system - both as victims or witnesses and perpetrators of crime. They may also interact with the civil justice 'family law' system.

The justice system therefore has a key role in preventing and, in particular, mitigating the impact of ACEs.

Preventing ACEs could provide a significant opportunity to reduce crime in Scotland. Some studies have estimated that preventing ACEs could halve violence perpetration and in-carceration. (Bellis et al., 2014)

Research consistently shows a strong association between ACEs and crime. People who experience multiple ACEs are more likely to engage in risk taking behaviours which are harmful to health and – significantly for Justice – some-times associated with criminal be-haviour. The Welsh ACEs Study (Public Health Wales NHS Trust, 2015) report-ed that compared with people with no ACEs, those with 4+ACEs were:

×14 times more likely to be a victim of violence in the last 12 months

×15 times more likely to be a perpetrator of violence in the last 12 months

×20 times more likely to have been incarcerated in their lives

10 most commonly measured Adverse Childhood Experiences (ACEs)

---- ABUSE ----

Physical

Verbal

Sexual

--- NEGLECT ---

Physical

Emotional

HOUSEHOLD ADVERSITIES

Mental Illness

Incarcerated relative

Domestic violence

Parental Separation

Substance abuse

How can a harsh childhood lead to criminal behaviour?

- ACEs theory is consistent with the-ories of crime which have proven links between childhood factors and adulthood criminality and vic-timisation. (e.g. Agnew, 1985; Far-rington et al, 2006)
- Prolonged exposure to stress in childhood disrupts healthy brain development. This can manifest as emotional and conduct problems in childhood, and risk-taking and criminal behaviours in adulthood. (Levenson et al, 2016)

- The more ACEs someone experiences the more detrimental the effect on their well-being (known as a 'graded dose-response'). (Centers for Disease Control and Prevention, 2015)
- ACEs have been linked to many 'criminogenic' risks (factors that in-crease risk of offending) including substance and alcohol abuse, depri-vation, poor educational attain-ment, and mental health problems. (Centers for Disease Control and Prevention, 2015)

POINTS FOR REFLECTION

The evidence does not prove causality. Not all children who experience multiple ACEs become victims or perpetrators of violence in adulthood, but they are statistically more likely to than people with no ACEs.

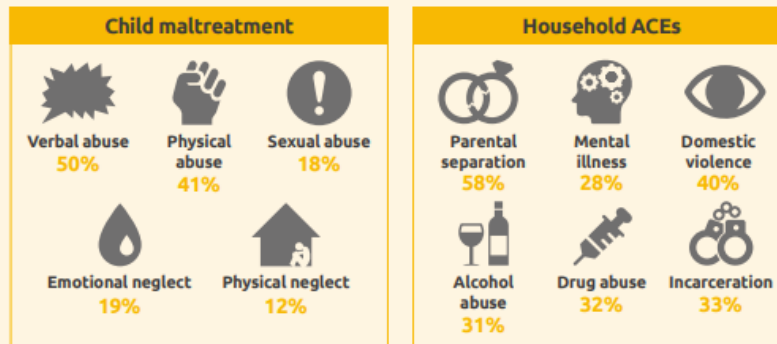**What is predictable is also preventable.** (Dr R. Anda)

https://www.basw.co.uk/system/files/resources/basw_50051-7.pdf

Wales prisoner ACE study (2019)

Adverse childhood experiences (ACEs) in an offender population in Wales

The Prisoner ACE Survey interviewed 468 adults (aged 18-69)[a] in a Welsh prison between February and June 2018. Participants were asked about their exposure to 11 ACEs in childhood, their offending history and recent involvement in violence.

How many prisoners reported each ACE?

Child maltreatment

- Verbal abuse 50%
- Physical abuse 41%
- Sexual abuse 18%
- Emotional neglect 19%
- Physical neglect 12%

Household ACEs

- Parental separation 58%
- Mental illness 28%
- Domestic violence 40%
- Alcohol abuse 31%
- Drug abuse 32%
- Incarceration 33%

Over 8 in 10 prisoners reported at least 1 ACE, and nearly half had 4 or more ACEs[b]

	0 ACEs	1 ACE	2-3 ACEs	≥4 ACEs
	16%	18%	21%	46%

Prisoners with 4 or more ACEs were 4 times more likely to have ever served a sentence in a young offender institution (YOI) than those with no ACEs

Of the 46% of prisoners who had ever served a sentence in a YOI:

9 in 10 had **at least 1 ACE** compared to 8 in 10 of those who did not spend time in a YOI

6 in 10 had **4 or more ACEs** compared to 3 in 10 of those who did not spend time in a YOI

Compared with prisoners with no ACEs, those with 4 or more ACEs were:

- **3x** more likely to have ever been convicted of **criminal damage**
- **3x** more likely to have ever been convicted of **violence against the person**
- **3x** more likely to have ever been convicted of **theft**
- **2x** more likely to have ever been convicted of **drugs offences**

Those with 4 or more ACEs were also 3.5 times more likely to be prolific offenders[c]

Of the 39% of prisoners categorised as prolific offenders:

9 in 10 had **at least 1 ACE** compared to **8 in 10** of those not categorised as prolific offenders

6 in 10 had **4 or more ACEs** compared to **4 in 10** of those not categorised as prolific offenders

The proportion of individuals reporting 4 or more ACEs increased with number of times in prison

	0 ACEs	1 ACE	2-3 ACEs	≥4 ACEs
First time in prison	25%	29%	21%	25%
≥7 times in prison	13%	8%	20%	59%
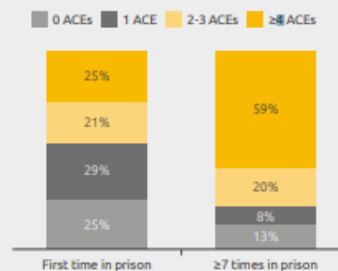
ACEs substantially increased the risks of recent[d] violence involvement

% reporting recent violence involvement

	0 ACEs	≥4 ACEs
Violence perpetration	23%	47%
Violence victimisation	22%	49%
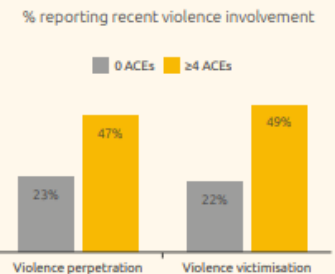
[a] Seven in 10 participants were Welsh, 25% were aged 18-24, 84% were white and almost a third reported that they had no educational qualifications, see main report.
[b] ACE counts do not add up to 100% due to rounding. In comparison, ACE prevalence figures for males in the general population were 54% 0 ACEs, 19% 1 ACE, 16% 2-3 ACEs, 12% ≥4 ACEs, see main report.

http://orca.cf.ac.uk/134524/1/Prisoner%20ACE%20Survey%20Report%20E.pdf

ACEs & Trauma in adults who commit sexual offences

- People who commit sexual offences have been shown to have particularly extensive ACEs and past trauma (Drury, Heinrichs, Elbert, Tahja, DeLisi, & Caropreso, 2017).

- The prevalence of the ACE of sexual abuse among people who have committed a sexual offence has been estimated to be 15 times higher compared to those in the general population (Cohen et al., 2002).

- Males and females convicted of a sexual offence have significantly higher ACE scores than individuals in the general population (Levenson et al., 2014; Levenson, Willis, & Prescott, 2015; Reavis, Looman, Franco, & Rojas, 2013; Weeks & Widom, 1998).

- The prevalence of adverse childhood experiences is higher for females convicted of a sexual offence than for nonoffending women (Gannon, Rose, & Ward, 2008; Levenson et al., 2015; Turner, Miller, & Henderson, 2008; Wijkman, Bijleveld, & Hendriks, 2010).

ACEs & Attachment?

Grady, Levenson, & Bolder (2016)

maltreatment and other adverse experiences disrupt children's socioemotional development (e.g., empathy and self-regulation) and their understandings of themselves (i.e., attachment formation), which then puts them at risk for later relational difficulties and possibly sexual offending.

ACE → Insecure Attachment → Criminogenic Needs → (Sex) Offending Behaviours
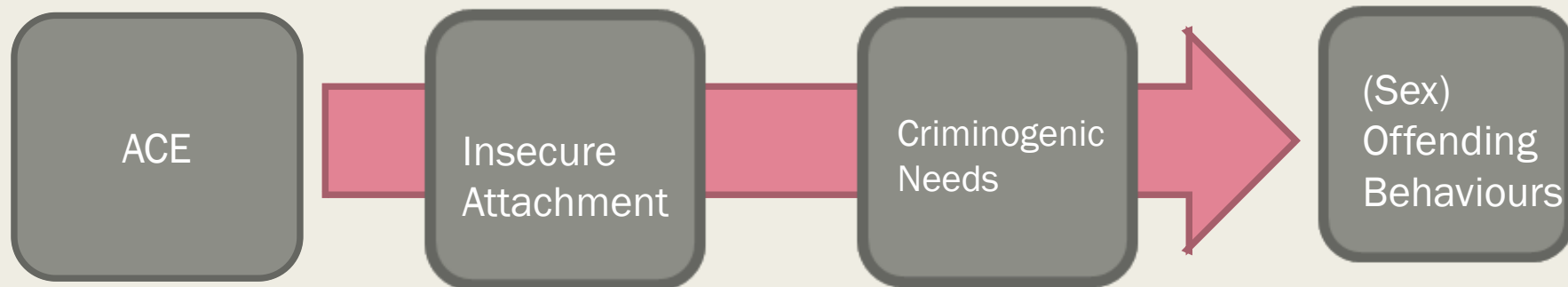
But wait....

■ Finklehor (2018) argues that it is premature to start widespread screening for ACEs in health care settings until we have answers to several important questions:

– *1) what are the effective interventions and responses we need to have in place to offer to those with positive ACE screening,*

– *2) what are the potential negative outcomes and costs to screening that need to be buffered in any effective screening regime, and*

– *3) what exactly should we be screening for? The article makes suggestions for needed research activities.*

■ Which raises questions about the reality of screening in criminal justice?

PART 3

HOW YOU USE TRAUMA INFORMED PRACTICE IN THE COMMUNITY INTEGRATION OF PEOPLE WHO HAVE OFFENDED

- The criminal justice landscape is changing with a greater focus on health, public health, and multidisciplinary working.

- Crime is a multi-faceted issue, therefore we need to look holistically at people who commit offences.

- The importance of multi-agency working, shared terminology, visions, and beliefs.

- The importance of taking a person centred approach.

- Need to balance punishment and rehabilitation in working with people who have committed offences [*sometimes in the face of challenging socio-political arenas*].

- Understanding that desistence is a journey that involves harm reduction, support, accountability, and challenges; therefore to understanding "stopping" offending we need to understand how they "started" and "maintained" there offending.

Trauma Informed Care/Practice

In the simplest terms, the concept of trauma-informed care is straightforward. If professionals were to pause and consider the role trauma and lingering traumatic stress plays in the lives of the specific client population served by an individual, professional, organization, or an entire system, how would they behave differently? What steps would they take to avoid, or at least minimize, adding new stress or inadvertently reminding their clients of their past traumas? How can they better help their traumatized clients heal? In effect, by looking at how the entire system is organized and services are delivered through a "trauma lens," what should be done differently?

Wilson, Pence, and Conradi (2013)
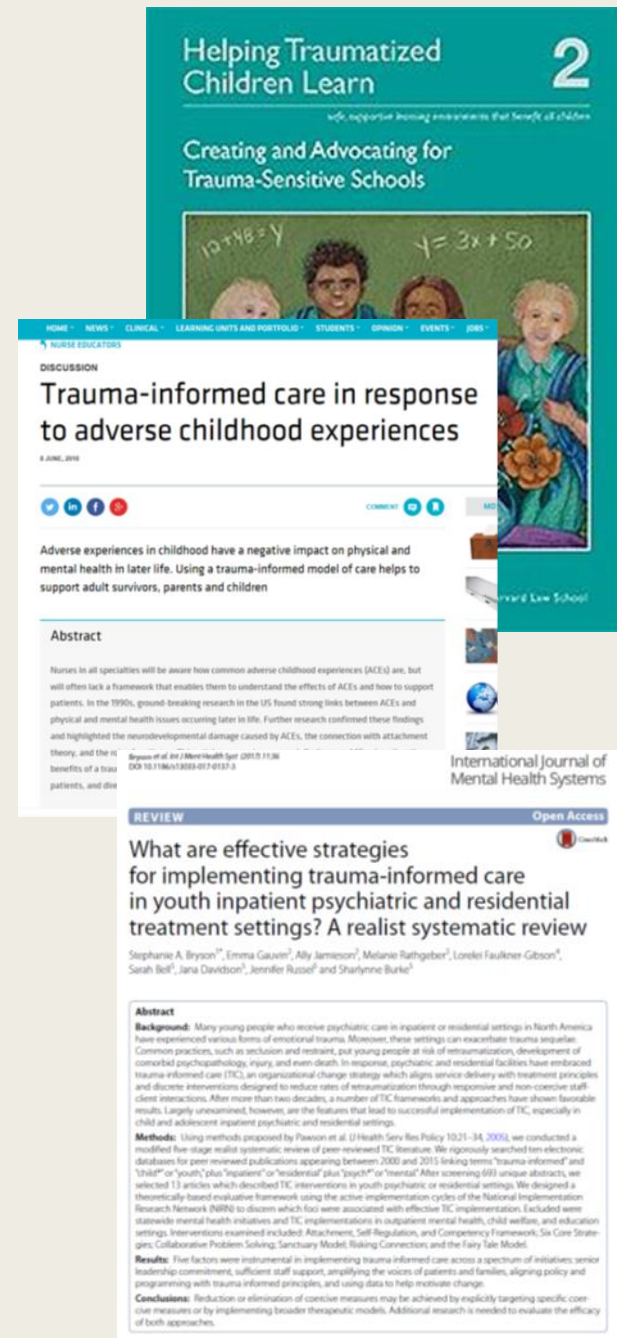
TAKING A NURTURING APPROACH

Understanding the "offender" as the service user?

■ The criminal justice system rarely seeks out the perspective of those subject to it.

■ Thus, it is impossible to apply a "one size fits all" approach to understanding who commits sexual offenses, why they do it, what services they need, or how those services can help.

■ This is largely a product of the research that has, thus far, focused on the service itself not the lived experience of the actual users or the impact that the process has on the individual.

■ Importance of the service user voice in:
  – *Prevention*
  – *Management*
  – *Desistence*
  – *An evidence base*
  – *Effective policy & practice*

(McCartan, Harris & Prescott, 2019)

Seen and Not Heard: The Service User's Experience Through the Justice System of Individuals Convicted of Sexual Offenses

International Journal of Offender Therapy and Comparative Criminology
1–17
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DOI: 10.1177/0306624X19851671
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Kieran F. McCartan[1], Danielle A. Harris[2], and David S. Prescott[3]

Treatment, desistence & management

Strengths based approaches, recovery capital, the service user voice & Desistence
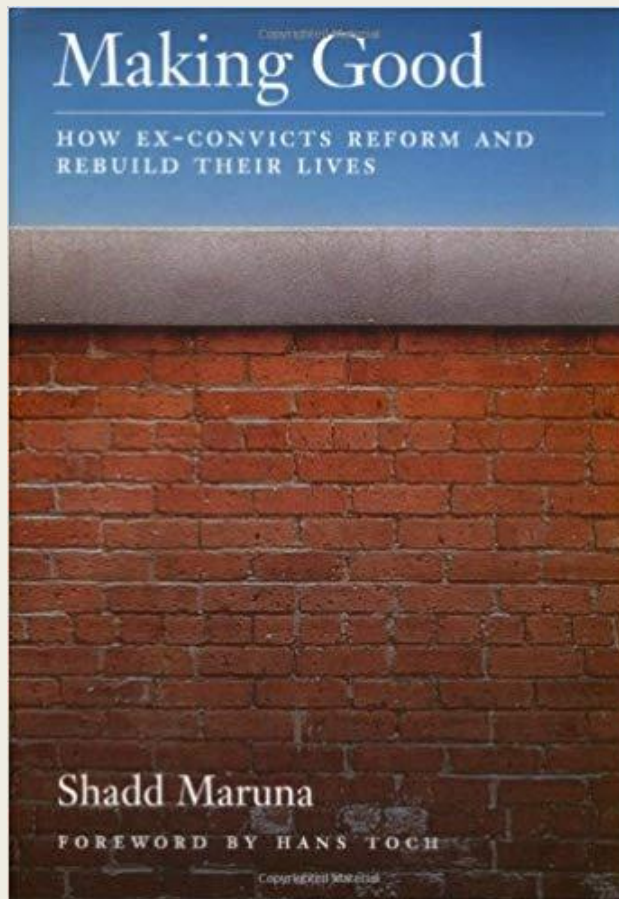
Treatment, desistence, harm reduction & recovery capital

Social capital: relationships, and the connections to groups that they belong too.

Cultural capital: pro-social values, beliefs & attitudes

Recovery Capital

Physical capital: income, property, assets used to increase recovery options.

Human capital: Skills, personal resources (i.e., coping mechanisms, resilience, hope & positive aspirations)

(McCartan & Kemshall, 2020)
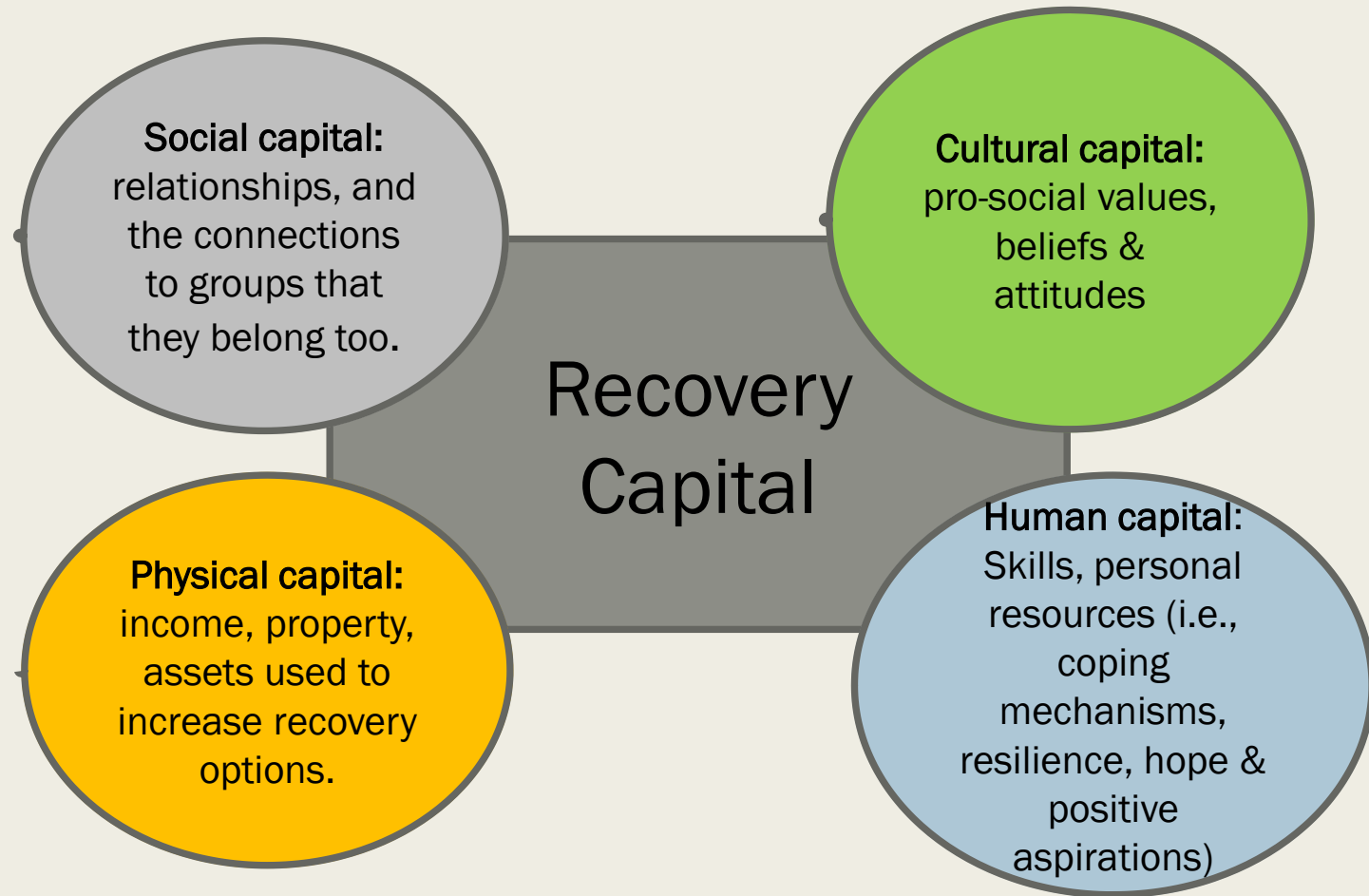
Risk management & prevention

Primary	- Raise public awareness of the reality of crime, especially youth crime, and dispel common myths about victims and individuals. - Enable individuals and communities to be better at identifying crime, risky behaviors and be better able to support people impacted by criminality. - Increased education leads to increased awareness and more proactive behavior.
Secondary	- Enable "at risk" populations to understand their potential risks, triggers and their potential outcomes/impacts. - Enable them to seek appropriate support and be empowered to seek help. - Individuals and communities better understand risk and therefore are better able to help people manage their own (potential) risk.
Tertiary	- Working with people, especially youths, convicted of crime to hold them accountability for their past problematic behavior, get support and move forward, integrate back into their communities. - Help people to move people towards an offense-free lifestyle and encourage desistence. - Assist & empower people manage their own risk.
Quaternary	- Enables people to successfully integrate back into the community by protecting them from the collateral consequences for risk management policies and practices. - Done through supportive integration programs that help the person who has committed an offence, aid their entry and support them pro-actively to negative the range of policies and practices that negate their integration.

Avoiding traumatization

Retraumatization

WHAT HURTS?

SYSTEM (POLICIES, PROCEDURES, "THE WAY THINGS ARE DONE")	RELATIONSHIP (POWER, CONTROL, SUBVERSIVENESS)
HAVING TO CONTINUALLY RETELL THEIR STORY	NOT BEING SEEN / HEARD
BEING TREATED AS A NUMBER	VIOLATING TRUST
PROCEDURES THAT REQUIRE DISROBING	FAILURE TO ENSURE EMOTIONAL SAFETY
BEING SEEN AS THEIR LABEL (I.E ADDICT, SCHIZOPHRENIC)	NONCOLLABORATIVE
NO CHOICE IN SERVICE OR TREATMENT	DOES THINGS FOR RATHER THAN WITH
NO OPPORTUNITY TO GIVE FEEDBACK ABOUT THEIR EXPERIENCE WITH THE SERVICE DELIVERY	USE OF PUNITIVE TREATMENT, COERCIVE PRACTICES AND OPPRESSIVE LANGUAGE

Adversity & Trauma Informed Principles (BNSSG Trauma subgroup, 2020)

1. **Safety** (physical, emotional & psychological)
2. **Choice & Clarity**
3. **Collaboration**
4. **Trustworthiness**
5. **Empowerment**
6. **Inclusivity**

* Developed in collaboration with people with lived experience, with staff & clinicians & based on principles developed by the Substance Abuse & Mental Health Services Administration (SAMHSA, 2014) & the Institute on Trauma & Trauma Informed Care (ITTIC, 2015)

Benefits of trauma informed care

Clients
- Feeling safe and supported;
- Increased engagement;
- Understanding that symptoms may be linked to childhood trauma;
- Care experiences that do not add to previous trauma;
- Starting on a recovery journey;
- Improved outcomes.

Staff
- Better understanding of patients' behaviors;
- Increased compassion, hope and resilience;
- Reduced stress and burnout;
- An improved ability to take a less 'black-and-white' approach.

Agencies
- A clear framework for the values and philosophy of care
- Better engagement with clients;
- Better staff retention;
- Reduced staff sickness and absence;
- The creation of insightful and compassionate workplaces.

(Gilliver, 2018)

Developing a trauma-informed workforce
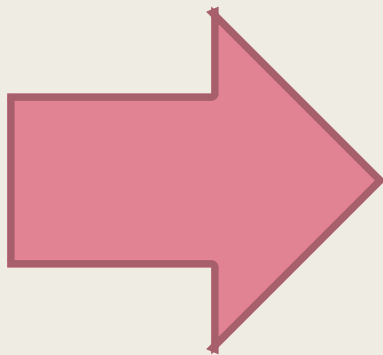
Policy

Practice

Place

People

However, community management and integration of people who have a criminal conviction back into the community is a multiagency issue...

Developing a trauma-informed workforce

- Policy
- Practice
- Place
- People
- Partners

VALUING PROFESSIONAL KNOWLEDGE AND WORKING

(RISK) MANAGEMENT OF PEOPLE WHO HAVE AN OFFENCE CONVICTION

REHABILITATION /TREATMENT OF PEOPLE WHO HAVE AN OFFENCE CONVICTION

UNDERSTANDING CRIMINOLOGENIC BEHAVIOUR & THE PEOPLE WHO COMMIT IT

CRIME PREVENTION
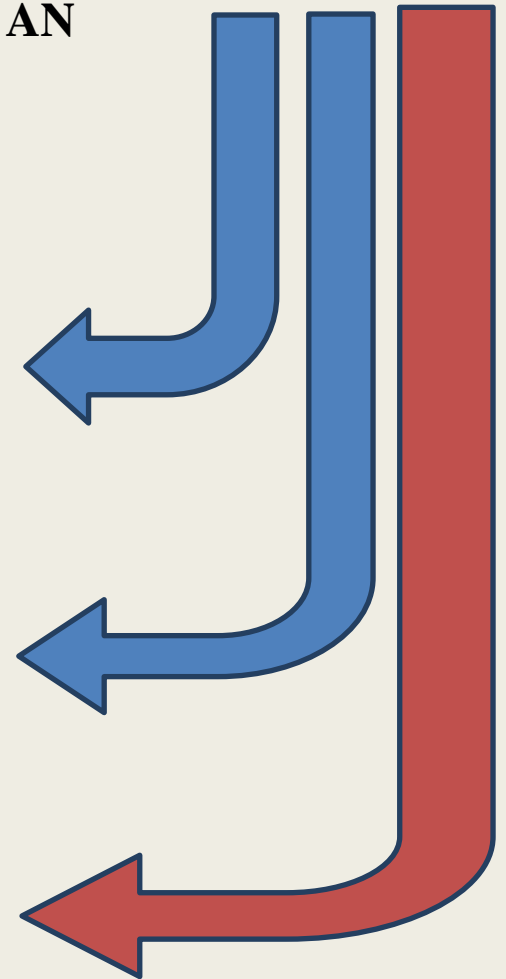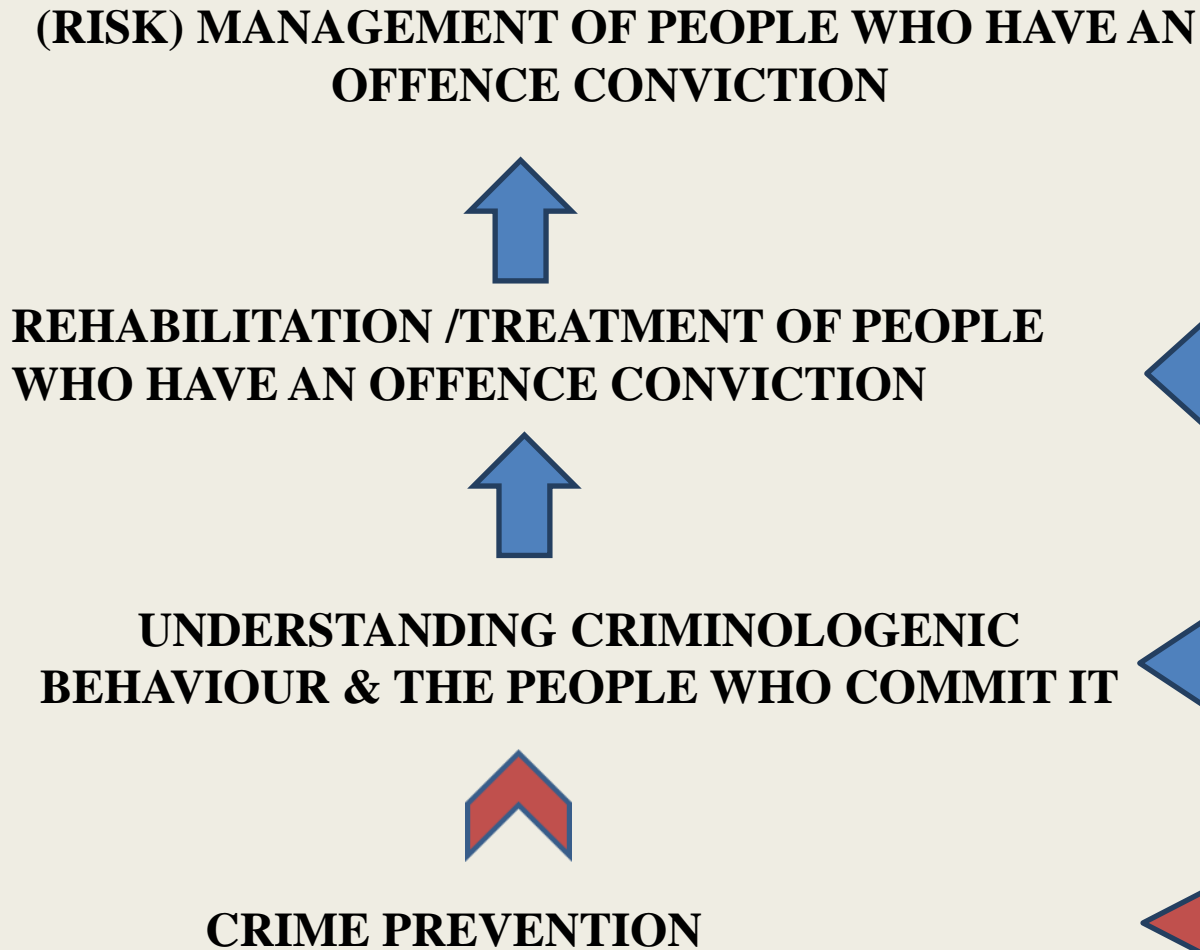
Developing a trauma informed approach

1. Lead and communicate about being trauma-informed
2. Engage patients in organizing and planning
3. Train both clinical and non-clinical staff
4. Create a safe physical and emotional environment
5. Prevent secondary traumatic stress in staff
6. Build a trauma-informed workforce
7. Involve patients in the treatment process
8. Screen for trauma
9. Train staff in trauma-specific treatments
10. Engage referral source and partner organizations

Menschner & Maul (2016). *Key Ingredients for Successful Trauma-Informed Care Implementation*. Center for Health Care Strategies.

	SAFETY	CHOICE & CLARITY	COLLABORATION	TRUSTWORTHINESS	EMPOWERMENT	INCLUSIVITY
Policy						
Practice						
Place						
People						
Partners						

Developing a trauma informed approach

Your role...

- Trauma informed care is a policy, a practice, a process, and a product (i.e., deliverable). It can be measured and reported on by services, and therefore they can be rated upon their success in achieving it.

- Trauma informed care is integrated into and part of every accepts of treatment, rehabilitation, and community [re]integration; therefore it is central to your work.

Considerations….

- Defining and qualifying ACEs, Trauma, & Trauma-Informed Practice.

- Learning from other organizations on their approach to defining and reporting on Trauma, as well as Trauma-Informed Practice.

- Having a multi-perspective approach on the use and impact of Trauma-Informed Practice (service user, staff, partner).

- Reporting on Trauma-Informed Practice as a Key Performance Indicator.

- Trauma informed practice is embedded throughout the rehabilitation and [re]integration process, not just an after thought.

- Identifying recommendations and guidelines for the use of trauma informed practice in policy, administrative, and practical ways.

ACEs, Trauma & Trauma-informed practice in the "new normal"

- What are the traumatising aspects of COVID- 19 and how have they impacted clients, staff, services, and partners?

- Do staff and organisations understand the traumatising impact of COVID-19?

- Has COVID-19 led to a cut in or reduction in treatment, rehabilitation, reintegration and other partner services?

- Has COVID-19 resulted in increased desistence or a relapse in offending behaviour?

- Will the training, management, and care of staff shift to what they are witnessing and reporting on?

- What impact has COVID-19 had on the client-professional relationship?

- What can be achieved via remote/at a distance working and what needs to change? What can remain?

Thank you!

Questions??

Contact information:

Kieran.mccartan@uwe.ac.uk

Thank You

- Please complete the evaluation form via the link in the 'chat'

- You can join the mailing list via the evaluation form to receive a copy of the BNSSG Adversity and Trauma Knowledge and Skills Framework once published, and to hear about future events.

Area Contacts

- North Somerset: Kate Wilcox

  Kate.wilcox@n-somerset.gov.uk

- South Gloucestershire: Lynn Gibbons
  Lynn.Gibbons@southglos.gov.uk

- Bristol: Bonnie Curran

  Bonnie.curran@bristol.gov.uk

  Bristol resource pages:

  https://bristolsafeguarding.org/policies-and-guidance/adverse-childhood-experiences-and-trauma-informed-practice-in-bristol/