



Seirbhís Phríosúin na hÉireann
IRISH PRISON SERVICE



AN ROINN DLÍ AGUS CIRT AGUS COMHIONANNAIS
DEPARTMENT OF JUSTICE AND EQUALITY



An tSeirbhís Phromhaidh
The Probation Service



Irish Youth Justice Service
Seirbhís na hÉireann um Cheartas i leith an Aosa Óig



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5th ANNUAL IRISH CRIMINAL JUSTICE AGENCIES [ICJA] CONFERENCE



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*Toward a Trauma-Responsive
Criminal Justice System: Why, How
and What Next?*

DUBLIN CASTLE CONFERENCE CENTRE
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Conference Welcome and Setting the Scene

Michael Donnellan, Director General, Irish Prison Service

There are ten Adverse Childhood Experiences or 'ACEs' as identified in the seminal work in the US known as the CDC-Kaiser Permanente Adverse Childhood Experiences Study. ACEs include physical abuse, persistent emotional abuse, contact sexual abuse, physical neglect and emotional neglect, the presence of an alcoholic/drug abuser in the home, presence of a depressed, mentally ill or suicidal family member, domestic violence, loss of/separation from parent(s) and imprisonment of a family member.

These ten ACEs are major contributors to negative later life health and wellbeing including chronic physical and mental illness such as heart and liver disease, obesity, chronic anxiety and depression and Obsessive Compulsive Disorder (OCD), addiction, and early death. In the study a dose-response relationship was found between ACEs and negative health and wellbeing outcomes across the lifespan, in that the more ACEs the more negative the outcomes.

Of the 17,000 people interviewed for the study, a quarter of people reported experiencing one ACE and over a fifth experienced three or more ACEs. The original study did not include research subjects from psychiatric hospitals, prisons, or those accessing homeless services, [where the rate of child neglect and abuse is higher](#) than in the general population. [In a Welsh study of ACEs by Public Health Wales \(2015\)](#), 47 percent of the 2,028 adults surveyed reported having experienced at least one ACE and 14 percent experienced four or more ACEs. In this study, those who experienced four or more ACEs were 14 times more likely to have been a victim of violence over the last twelve months; 15 times more likely to have committed violence against another person in the last twelve months; 16 times more likely to have used crack cocaine or heroin and twenty times more likely to have been incarcerated at any point in their lifetime.

[Recent](#) investigation into the prevalence of ACEs among [Cork Simon Community](#) homeless service-users yielded fascinating results. Fifty service-users were surveyed and 77 percent had four or more ACEs, while eight percent had ten ACEs. The figures are staggering.

Criminal behaviour can undoubtedly be added to the host of negative outcomes associated with scores on the ACE Questionnaire. Childhood adversity is associated with increased likelihood of juvenile arrest and adult criminality. Yesterday's traumatised become today's traumatisers.

Consider this morning, 10 million people woke up in prison around the world. These 10 million people report nearly four times as many ACEs than their community counterparts, with significantly higher levels in this group reporting eight out of ten ACEs. Consider these statistics in terms of the people we work with. I'm not making excuses for people who hurt

others. I am not asking you to use this information to make excuses for people either. What I am saying is that this information should inform the way we work with people who come in contact with the Criminal Justice System if we are serious about creating less victims now and in the future.

Consider also the often unpalatable, but very real, possibility that contact with the Criminal Justice System can and sometimes does re-traumatise already traumatised people: arrest, being locked in a small cell with other traumatised and sometimes angry and violent people, the sound of banging doors and gates, jangling keys, name calling, violence in prison, a lack of reliability and consistency, isolation. All of this can trigger angry, violent, impulsive, defensive or detached reactions by already hypervigilant and emotionally overwhelmed people.

We work in a sometimes high risk environment. We hear about, witness and sometimes become victim to violence. We ourselves can be traumatised. Traumatic events impact our own reactions to other people, including toward the people who are in our care and custody.

Unwittingly, the Criminal Justice System may at times maintain or exacerbate rather than reduce the symptoms of trauma, meaning it is possible we are in fact less likely to achieve our common goals of less victims and a safer Ireland.

Our clinical and research colleagues argue that traditional Criminal Justice System interventions to reduce risk are not as effective if underlying ACEs and related trauma symptoms are not treated. This makes sense. People who have done wrong cannot really look at themselves, recognise the hurt they have caused, allow people to challenge them and finally work to build themselves up into safer, happier, more rounded, connected citizens if their automatic trauma response to any challenge or perceived criticism is to become increasingly dysregulated, angry, violent, defensive or to shut down? Clearly these responses are fundamental targets in the first instance before we try anything else.

Attachment theorists and developmental or child psychologists highlight for us the importance of providing children with a 'secure base' so that they feel safe to explore and develop. Typically this means a safe home and at least one loving adult with whom they can depend on reliably. Mental health experts in prisons argue the same for people in contact with the Criminal Justice System. Traumatized people need to be provided with a secure base – a safe place and people whom they feel safe with, in order to explore what has happened to them.

Importantly, as you will hear today, being a trauma informed workforce or being trauma informed in your everyday work does not mean having to perform complex psychological or

medical interventions. There are so many small things we can do in our working (and our personal) lives that can make a difference to someone. We may be working this way already. Do you follow through on what you say you will do? Do you tell someone when you can't do something? Do you speak to people respectfully? Do you give short, clear instructions? Do you tell people what to expect in new situations? Do you give people choice? Do you close doors and gates without banging them? Do you give people realistic hope? Do you ensure contraband searches are done for a safer working environment? Do you do your daily and nightly checks reliably? All these seemingly small tasks provide for that secure base and a trauma informed way of working. You are here today ... and the fact that tickets for this conference sold out in less than 24 hours tells me that a wide variety of people within the Criminal Justice System and related agencies are willing and perhaps ready to hear what has to be said today.

The difference between hope and hopelessness can be just one person. People need people. It can be difficult to fathom why or how we might provide a trauma-informed approach with someone who has done untold harm to others, someone who has left multiple, now traumatised victims. But ignoring the facts, ignoring the statistics, ignoring the clinicians and researchers will only leave us less and less likely to achieve a safer country for ourselves, our family, friends, loved ones and neighbours. We are wasting money and resources. Potentially and unintentionally we may be creating more victims in a never ending cycle of trauma and violence if we turn a blind eye to the need for a trauma informed response to those we work with and preventative measures for children and young people at risk of, or experiencing ACEs today and in the future.

Conference Opening

Charles Flanagan TD, Minister for Justice and Equality

Colleagues,

I would like to thank you for the invitation to open the 5th Annual Criminal Justice Agencies Conference here today in Dublin Castle.

It is so important that I am here today, to lend support and encouragement to you all who work in the broad spectrum of Criminal Justice Agencies in our country. You work with very complex and challenging situations in the name of supporting the Government to keep Ireland and its people safe. You work with people who come into contact with the Criminal Justice System, many of whom have multiple complex needs and sets of circumstances that you must navigate. Faced with these sets of complex and at times risky circumstances, it is essential that the decisions you make, and the policies and procedures you follow, are based on sound study and research. Without this - we are just 'winging it' in our jobs.

This is why this conference and others like it, facilitated by the Association for Criminal Justice Research and Development, are so important. To remind you all, the ACJRD was developed to promote study and research in the field of criminal justice and to share results of that research in order to advance our agencies and ultimately benefit our community. What does this actually mean? It means taking the learning from research and getting it out there so that

people working in the field of Criminal Justice, supported by my Department, can continually develop and implement more and more effective work practices in their agencies and across agencies for a safer Ireland.

The ACJRD also provides a forum where experienced staff working in or having worked in the Criminal Justice System and associated professions can talk through in an informal setting, problems and methods of working to the advancement of community welfare. This opportunity to network, learn from each other and work together is so important. Surely it's the bedrock of a sound Criminal Justice System? How can we work well with people who move from one of our agencies to another - Courts to Prisons to Probation - if we are not talking to one another - formally and informally.

Only last week I was in Probation Headquarters in Haymarket, launching the Probation Services and Irish Prison Services respective annual reports, their Joint Strategic Plan and The Probation Service Strategic Plan for the next three years. In launching these, I noted many of the initiatives that both Services are working on together and with other agencies. I noted in particular, the very successful Joint Agency Response to Crime initiative which involves intensive joined up working by The Probation Service, the Irish Prison Service and An Garda Síochána. This initiative wasn't thought up out of thin air. JARC was developed

based on national and international research which demonstrated that this way of working - intensive, joint monitoring, supervision and support of high risk offenders works. This is how research becomes policy and policy becomes practice. This is exactly why this conference is so important. It provides you with the material - the research findings - which will help you in your jobs and ultimately will help keep our streets - our communities - our families and friends safer.

This year - 2018 - sees the Irish Prison Service take lead partner status at the 5th Annual Irish Criminal Justice Agencies Conference. Year to year, this is shared with colleagues in the Irish Youth Justice Service, the Department of Justice and Equality, An Garda Síochána, and The Probation Service. This year's topic - Working toward a trauma informed Criminal Justice System - is not only a very interesting, but a very worthwhile topic.

What is important about this conference is that it is opening a conversation about the impact of trauma on people who come into contact with the Criminal Justice System, the traumatic impact of crime on victims AND the impact of trauma on staff who work in the Criminal Justice System. I'd like to say something about all three by way of introducing this conference.

We are here today, as in similar years, to hear from expert colleagues who will share with us the most up-to-date theory,

research and practice which will allow us to talk about, consider and implement where appropriate. The Conference rightly recognises the impact of trauma on those in contact with the Criminal Justice System, victims of crime and those working within the Criminal Justice System.

Far too many people cycle through Ireland's Criminal Justice System, wrestling with chronic mental health and personality difficulties, addictions, relationship difficulties, unemployment, poor use of leisure time, poor life skills, homelessness and isolation from the broader community. Many have experienced significant trauma in their lives.

Trauma is not an 'excuse' for criminal behaviour but an experience common to many men, women and children who have come into contact with the Irish Criminal Justice System. In fact, research would highlight that ninety-five percent of men and eighty-eight percent of women involved with the Criminal Justice System report a history of significant traumatic experiences prior to imprisonment. This is an extraordinary statistic.

You will hear from our experts today that as adverse childhood experiences or 'ACEs' build in number over the course of a child's development, the detrimental impact this has on their ability to think clearly and rationally, make decisions, problem solve effectively and act without impulse. These thinking difficulties are now recognised biologically. These

recognised thinking difficulties often lead to difficulties in the face of every day and significant stressful life events, such as addiction, complex mental health and personality difficulties, isolation, homelessness and crime.

You might ask, what makes one person who faces adverse childhood experiences lead a life free of crime and another turn to crime. It seems to depend, in part, on who and what that child learns – remember, if a father goes to prison their sons have a 59% chance of spending some time in prison over the course of their lives. It also depends on whether the person has many strengths or protective factors to help keep them from crime.

We provide people in the Criminal Justice System who have addictions or mental health difficulties with addiction and mental health services as a way of supporting them, meeting their needs and reducing their risk of reoffending. It makes sense therefore, that having acknowledged the role of trauma in people's lives, that we would now look to recognise, acknowledge and use every opportunity to intervene in trauma to reduce offending, reduce victims and create a safer Ireland.

The people you work with require a broad range of support and assistance in custody and in the community if they are to make better choices for themselves and their communities. The Probation Service, in its Strategic Plan 2018-20, recognises this exceptional need and that addressing it requires multi-disciplinary and multi-

agency co-operation and interventions with people in custody and, also, in the community to respond to the many complex challenges service-users experience and present with, including mental distress, domestic violence, homelessness, trauma and alcohol and drug misuse. I know the Irish Prison Service Strategy 2019 - 2022 will have an equal focus on the need for trauma informed approaches to meet its mission of providing safe and secure custody, dignity of care and rehabilitation of prisoners for safer communities.

Unfortunately, some people's experiences within the Criminal Justice System can often contribute to new or repeat traumas, from arrest, through to sentencing, incarceration and release. Contact with the Criminal Justice System can itself become a cyclical relationship – hence the importance of working toward a trauma informed Criminal Justice System.

The very experience of having a crime committed against you or your loved one is traumatic. We know the operation of the Criminal Justice System can also, in certain circumstances, re-traumatise victims - known as secondary victimisation. I was heartened to see that victims - too often left behind - have a voice at this Conference also. The new EU Victims' Directive, which is being implemented by my Department, considerably strengthens the rights of victims and their family members to information, support and protection. It further strengthens the victims'

procedural rights in criminal proceedings. The directive also requires that EU countries ensure appropriate training on victims' needs for those staff who are likely to come into contact with victims.

Recognition and understanding of the role that trauma plays in contributing to an individual's journey toward involvement in the Criminal Justice System and the potential for repeated exposure to trauma can become a recipe for disaster for both users of, and Criminal Justice Agency staff. Too often staff experience direct and vicarious trauma within the context of their work - all those with responsibility for the safe custody, sentencing, management, care, support, rehabilitation and supervision of people in contact with the Criminal Justice System. Staff aren't robots. They experience trauma too and it's important that they are supported to recover so that they can continue to work and support themselves, their families and their communities. Consider the Judge, Prison Psychologist, member of An Garda Síochána or Probation Officer who hears or sees the most graphic aftermath of harm committed by one person to another, or the Prison Officer who is assaulted in the course of their duty. As I said at the beginning of this address - you face some of the most challenging situations within any working environment - often times - too often - under-acknowledged, as you work toward safer Ireland. I am heartened that many of our Criminal Justice Agencies have and are continuing to acknowledge the impact of your work on you and are working toward meeting this significant need. I

note the introduction of Critical Incident Stress Management by the Irish Prison Service to meet the needs of staff who face traumatic incidents, including the introduction of free, independent counselling and psychological support where needed.

Public safety and preventing future victims are fundamental to the Department of Justice and Equality - indeed as I've mentioned - it is fundamental to the whole of Government. This point is in fact reflected in the variety of organisations and agencies represented in the speakers to this conference - we have the HSE, Tusla, Charities, Universities representatives - all working toward prevention of and intervention with trauma for a safer, but also more compassionate and humane Ireland. Indeed, what this tells me is that it is not only agencies within the Criminal Justice System that need to keep talking to each other, but whole of Government agencies.

In order for the Department of Justice and Equality to fulfil its responsibilities, it is time for us to focus on *trauma* for a safer, fairer, more equal Ireland. I challenge you today to really listen and hear what our experts have to say, think critically about not only how you could change one or two simple things you do to become more aware of and responsive to trauma, but also think big: How does the study and research you hear about today impact your policies and procedures? See this as the start of a very worthwhile journey for everyone who has contact with and works within the Criminal Justice System.

Again, I thank you for the opportunity to speak with you today and I wish you all a successful and informative conference.



Pictured (L-R): **Maura Butler**, Chair, ACJRD, **Charles Flanagan**, TD, Minister for Justice and Equality, and **Michael Donnellan**, Director General, Irish Prison Service

Better the Devil you Know? Alternatives to the Adversarial System

Mary Rose Gearty, SC

Picture a court scene. Justice – what do you see when I say that? Our first experiences of most things come from our parents, our home and our TV – or perhaps now, a home computer or smart phone.

From the very earliest days in our lives, we experience the courtroom setting as the place in which disputes are resolved, justice is done (or not?), and decisions are made that affect our lives. You may have seen Angry Birds, for instance? Red Bird is sentenced by a short bird in a long, purple gown to attend Anger Management Classes, courtroom scenes are commonplace in The Simpsons. Whether it is Angry Birds or Airplane!, The Simpsons or Judge Judy, even as children this setting is **reinforcing the traditional model of justice**. Can we defend it? Does it best suit our purposes?

Challenge perspectives

This image of a man (and it is still the most common image of a judge) who sits on a high chair and decides and punishes, is one that we imbibe as small children. It may be very hard to question this as a process, given how deeply it has been sown into our idea of justice. We have little cultural remnant of the early Brehon or First Nations' practices of community resolutions – where the people of the village collect, as a group, including parties to the dispute, to discuss the potential resolution of serious wrongs inflicted by one person on another in the society.

It is always worth examining our assumptions and looking at the options if we were to improve our current system. Can we, should we, challenge our perspectives? There is no doubt that society needs some kind of system which helps citizens to resolve disputes and

there is no reason why more than one type of system cannot co-exist. Perhaps it is as well to set out very clearly at the outset that no system run by human beings will ever be perfect but that this is no reason not to aim at perfection.

The type of dispute most relevant to this audience is the criminal wrong, serious or otherwise. In Brehon times, such wrongdoing was dealt with by assessing the damage to the *status* of the individual wronged and appropriate compensation was decided by a community judge or mediator, the Brehon.

Argument

The aim of our system is to seek truth and do so through disputation. We contrast this with the civil law system in place in most of Europe which is an investigative system. Common to both systems, however, is the view that if a serious offence is alleged and denied, the account given by the complainant should be challenged.

One of the most famous defenders of the system was **Wigmore**:

"Not even the abuses, the mishandlings and the puerilities which are so often found associated with cross-examination have availed to nullify its value. It may be that in more than one sense it takes the place in our system which torture occupied in the mediaeval system of the civilians. Nevertheless, it is beyond any doubt the greatest legal engine ever invented for the discovery of truth."

It is the last line that is most often quoted, yet the preceding words compare the effect of cross-examination to torture! *...it is beyond any doubt the greatest legal engine ever invented for the discovery of truth.*

Is that so? It is certainly effective. While my professional experience has been in the adversarial system, I have also been involved in more investigative processes. The danger of bias developing in the investigative system is well-known. But what I found more interesting was the information that emerged when an adversarial approach was taken, which was more comprehensive than that gleaned from investigative questions.

Whichever of these two systems one prefers, there is one principle that must be adhered to - **if a serious allegation is made, it must be challenged and proven.** If it is simply accepted by our society without any rigorous test of its veracity, our security as a group is deeply damaged. We thereby hand any person the means to destroy another on an allegation only.

Is there a gentler way? If the system seeks the truth and any essential facts are disputed, it seems that some form of hearing involving a challenge must take place. There is certainly room for a more informal process involving children - anyone under the age of 18. If different types of hearing are suggested for different types of crime, there is a danger that certain offences might be seen as inherently less serious, for instance. But if the distinction is made due to age and vulnerability, for instance, that would be an entirely defensible and a sensible policy choice.

If the parties agree on the facts, the search for truth becomes secondary. This typically happens with a guilty plea. It is here, quintessentially, that ideas of alternative dispute resolution could be nurtured and developed.

The current system is one that is adversarial. One side argues against the other. The system involves accusation, rights being

afforded to both sides in the process, punishment, deterrence and rehabilitation. This is a very formal system. It depends on the use of logic. It comes back to the principle of justice and fairness: hear both sides of an argument. Make sure a criminal wrongdoing is proven before any punishment is inflicted. **If a serious allegation is made, it must be challenged and proven.**

This presupposes that we act logically or at least that we use reasons in decision making. The system also allows for extensive mitigation in how certain matters are dealt with and, in particular, the single most powerful factor in mitigation is a plea of guilty.

Is this civilised? In ancient times, there were other methods, some better than others. Most impressively, and as already mentioned, in ancient Ireland there were systems of community dialogue, led by the Brehon who was both judge and poet, though the role was more akin to a mediator. There was no written record, no paper, no method of recording proceedings or decisions, so the judge had to have oratorical abilities including the ability to recall and re-tell events. Hence, I suggest, the importance of his poetic skill. Some of the Brehon Laws survived all over the country right up until the early 1600s. While some of its methods appear highly evolved, and the treatment of women at the time is generally acknowledged to have been far more egalitarian than most other countries, nonetheless the importance of status means that it is not a model that could be adapted in its entirety. As is always the case, of course, we can examine those measures that might best suit a modern system.

In Brehon Law, the real purpose of criminal hearings was compensation based on the status of the victim. In a much larger world - is this a sufficient deterrent? Is it realistic to

expect circles of reconciliation in such cases? And even while it may be an aim, it is far from being realised at the moment.

There are other systems that place emphasis on dialogue, participation and reconciliation. The language of such alternative methods is one of individual forgiveness or resolution, community sanction and reprieve. These tend to be far less formal.

The nearest comparator in use in Ireland today is the **Restorative Justice Scheme** (and its cousin, the Victim Offender Mediation) - a large step towards a less adversarial model.

The European Forum, Restorative Justice and Victim Offender Mediation and section 78

"78.—(1) Where, in any proceedings in which a child is charged with an offence—

*(a) **the child accepts responsibility** for his or her criminal behaviour, having had a reasonable opportunity to consult with his or her ... guardian and obtained any legal advice,*

(b) it appears to the Court that it is desirable that an action plan for the child should be formulated at a family conference, and

(c) the child and child's parent or guardian, or family or relatives of the child, agree to attend such a conference, the Court may direct the probation and welfare service to arrange for the convening of a family conference and adjourn until the conference has been held..."

While Restorative Justice models are not included in any other legislation, the Court may request that the Probation Service make contact with the victim, if the victim agrees to this, with a view to mediation.

The purpose behind the two alternatives that have formal recognition here in Ireland is very similar - the clue is in the title: restoration, not retribution. Restoration of dignity, insofar as that is possible, restoration of peace between

the two - wrongdoer and victim - restoration of the status quo if that is possible, and restoration of the wrongdoer to their society.

Will this work for very serious crime? Will this work for cases with multiple victims? How to introduce it in such a way that it can be tested as a system? If ever there was a case for a pilot programme, this is surely it – there is simply no appetite for the whole system to change to a community based restorative system with no room for punishment in appropriate cases. Who will be the first complainant to agree to that?

This brings us to the single biggest obstacle to more widespread use of the system; that it can only happen and can only be effective, by the consent of all parties. If the wrongdoer does not admit wrongdoing, it is doomed from the beginning. If the victim will not meet him/her, there is no benefit to the process.

Stalemate

Imagine a game of chess where it is obvious from an early stage that it is going to result in a stalemate, where neither party wins.

Restorative Justice is very rarely used. What is the point in my extolling its virtues or in us recommending it if it has been there since 2001 and is not a realistic option or is an under-used provision? It is not even named!!

Going back to the traditional model – the victim must come into court and effectively denounce their attacker if the accused denies responsibility. These models do not assist in that instance and there can be no effective system whereby an account of a serious crime is not tested. If an accused accepts responsibility, the benefits of these approaches are perfectly clear – they are less corrosive for the victim, they are potentially

very rewarding but the co-likelihood of both sides being willing and able to avail of the process is slim. So why are they not used more often?

The main obstacles in the cases in which it may have a benefit – **few people know about this and it is insufficiently resourced.**

My own experience suggests, although this can only be anecdotal even if it is based on over 20 years of practice in the criminal courts, that this kind of approach will work best, or is best-suited to, a case involving children. Again, consent is key.

Though limited in application perhaps, this is an approach which could be strongly recommended, even in serious cases, and could have far-reaching consequences if the parties involved consent to it. At the moment, there is no incentive and not much public awareness around the issue. There is much that can be done to change public approaches to Restorative Justice. The first is to make it available and, arguably, that has been done. It is an option and The Probation Service offers this option. **It is not recognised formally in any legislation, however, although section 78 of the Children Act is used to facilitate such meetings.**

The fact that the process is not named as such in that Act leads to the second change that should be considered: Raising **awareness**. How to do this?

Norway!

The process should be **named** as such in legislation, **awareness** should be raised by advertising the process and this leads to the third remedy – **resources**.

No process can survive and thrive unless it is properly resourced. Research carried out for

the **European Forum for Restorative Justice** shows that members of the public do not have a clear understanding of what Restorative Justice is. The European Forum for Restorative Justice published research in 2010 which includes an interesting summary of the Norwegian programme. They hired a dedicated media agent, Gro Jørgensen, who was a journalist and a mediator. With her team, she maintains a list of media contacts, enjoys excellent relations with the media and ensures that Restorative Justice stories are written in an accessible and interesting way so as to ensure maximum coverage. With this in mind, the forum published a toolkit on how to harness the power of the Media generally in order to make Restorative Justice a more realistic and, therefore, a more attractive option.

This toolkit and other reports on Restorative Justice projects generally, are available at the website hosted by the forum.¹

It is difficult for me to say whether, in any of the cases in which I have been involved or have followed in my professional life, Restorative Justice would ever have been chosen by any of the victims or by the accused whom I have represented. But this is largely because it was not a realistic option - it was not even considered in cases in which it may well have had an effect. But there is little point in lawyers suggesting it if it is an entirely foreign idea to clients.

Lawyers ...

In most depictions of lawyers, we are not popular. I feel that this is most unfair, given the large body of lawyers who act entirely for the rights of others, and are often underpaid

¹ See: <http://www.euforumrj.org/publications/research-reports>

particularly when engaged in that kind of work. We are frequently victims of secondary trauma ourselves, hence the reliance on jokes to comfort ourselves and to make light of information that might otherwise be overwhelming. The effects of reading and presenting traumatic material day after day, and managing the emotional trauma of others, are cumulative and can be devastating. I do not compare this with the trauma suffered by victims or by those in the front-line, such as social and care workers, but it is a mistake not to recognise how corrosive its effects can be even at the remove of the lawyer who deals routinely with harrowing cases. In order to remain professional, we must be aware of the risks to ourselves and guard against the effects of secondary trauma. In a conference which focuses on trauma, this must be acknowledged.

Shakespeare is responsible for this particular old gag: *"first thing we do, let's kill all the lawyers"*. Allow me to change this perspective, if I may?

Most scholarly discussions of this line recognise that it is open to many interpretations. Is this a socially wry comment set in the mouth of an ignorant thug? It is "Dick The Butcher" who suggests how to improve the country by killing all the lawyers as part of an attempted coup.

Shakespeare knows which body of men, and nowadays women, is likely to stand in the way of the strong men, like himself, who seek to subdue the weak.

Back to Changing Perspectives

Just as we try to reframe or question the value of the adversarial system, and my own assessment is that, while it is difficult and fraught with other problems that we should address – delay, archaic language and lack of

diversity at various levels (communities should feel invested in their legal system) – the unthinking hatred or mockery of lawyers should be revised also. We serve a function which is when trauma affects the judgment of those intimately affected by the allegation of a crime. Either they are the victim or they are the accused. Each party needs a friend in court and what I want is a friend who is not emotionally invested in the case, who is not traumatised by it, but who is a professional and who can represent my interests. What good is a system which serves only those who are contrite, or apparently so? Our system does at least enable all, even the poorest, to defend themselves against the most serious allegations. And it enables all those who are injured by crime to have their case professionally presented to a judge or jury. This is not a small privilege; it is not something we should ever take for granted.

Swipe Right if you liked your lawyer? Am not sure this will catch on.

Most lawyers are young, female and they first studied law because they wanted to help people. As such, they did not grab any headlines as good news is not news. Just as the Restorative Justice projects suffer from being too beneficial and not exciting enough to make the news, so the well-intentioned lawyer does not get much attention. Those who got a good service in a criminal case or in a family law dispute do not write up their review on social media.

How to use alternatives?

Wrongdoer apologises... How is this news??

I'm being deliberately mischievous here. Of course I'm not suggesting that you spread fake news but you do need to **think very seriously about public awareness across all**

the different media now available. As members of the public, not just stakeholders, we do have a bigger influence than we used to have - we just don't tend to use it...

Summary

Restorative Justice models are not included by name in legislation, the Court may request that the Probation Service make contact with the victim, if the victim agrees to this, with a view to mediation. This is a vastly underused service that could be of great worth, particularly in cases involving children.

The minimal use of Restorative Justice in Ireland means that our experience of it is inadequate to fully explore its value as an

alternative. Hence the name of this paper. Without a serious attempt to test the benefits of Restorative Justice or Victim Offender Mediation, few will avail of these services and we will stick with the devil we know. While the value of Restorative Justice may be limited, if it can be enhanced, and becomes a more visible option, it may well replace the court case, even in criminal offences, wherever consent is obtained. This can only benefit children and vulnerable parties in particular.

I formally record my sincere thanks to Nina Paley for her instructive cartoons (included in the slide show at the conference).

What Happened to You? Understanding the Impact of Chronic Early Adversity and Neglect in Infancy and Early Childhood

Ciara McCarthy, Senior Clinical Psychologist, Primary Care Psychology Service, Health Service Executive

Introduction: Going Back to the Beginning

It is increasingly understood that the impact of early adversity and unresolved trauma is becoming one of the greatest public health concerns of our time (Van Der Kolk 2014; Harris 2014). The lifelong significance of early childhood experiences has interested developmental researchers, clinicians, neuroscientists, social scientists, psychoanalysts, economists, policy makers, artists and writers and many more, for decades. Questions such as: "Why do we have unresolved and left over issues from our childhoods? Why do events from the past influence the present? Why do past events continue to influence our present perceptions?" (Siegel, 2012)

These kinds of questions have a significant role when we begin to explore the long term impact of chronic early trauma and adversity. Like many practitioners working across various services and agencies with adults who present with complex trauma, I often felt overwhelmed and powerless to intervene meaningfully. I remember speaking about this with a clinical supervisor and describing how "I don't know where to start!!" His reply was short and simple, he simply stated "well.... start at the beginning". While there is now widespread agreement that early experiences matter, the challenge faced by services and agencies is to

identify and intervene as early as possible with at-risk infants and parents.

The following paper is an introduction to the beginning, that is to say that it is a brief overview of the emerging discipline of Infant Mental Health (IMH). As an early intervention and prevention framework, IMH holds the antenatal to three years as being the optimal time period to intervene and ameliorate trauma and adversity. When faced with complex trauma, well-meaning services often approach the assessment and intervention with the question "what is wrong with you?" IMH is an approach that adopts a more curious stance, asking the question "what is your story?"

The paper describes the main content of the presentation at the 5th Irish Criminal Justice Agencies Conference in Dublin Castle on 4th July, 2018. There were two video clips used during the presentation which are recommended viewing while reading the paper. They both last approximately two minutes and are available on YouTube: "Serve and Return Interaction Shapes Brain Circuitry" (Center on the Developing Child at Harvard University) and the "Still Face Experiment: Dr. Edward Tronick".

The Beginning- "Keeping the Baby in Mind"

"There is no such thing as a baby, there is only a baby & someone" (Donald Winnicott)

While the chances for a baby's survival have improved significantly, it is not easy being born into the 21st century world. Babies are not designed for noisy, fast moving and over stimulating environments. (Barlow & Svanberg 2010) They are however driven to connect with their caregiver(s) who can help them make sense of the chaotic world that they find themselves in. (Powell, Cooper, Hooper, & Benton, 2014) While this connection is deemed essential for the baby's survival, the presence of a sensitive and responsive carer has more significant meaning than just meeting basic needs of hunger and shelter. The presence of the carer(s) is recognised as the most important ingredient for the baby's social and emotional development, which in turn is central to their emotional well-being across the life span.

Imagine a baby who has been born in Ireland today and for a moment consider how the next three years will determine: her mental health over the rest of her life, shape the brain she will live with for the rest of her life and determine how much her mental health will cost the state for the remainder of her life. (Maguire, Carolan, 2017)

Decades of research has concluded that this baby came into the world hard wired to connect to a trusted attachment figure,

ideally her parent(s). She will leave the hospital with her mother who has been given no DIY book or parenting manual. However, the mother does have a highly influential "working model" or blueprint of relationships that has been embedded since she was a baby. This will go on to influence how she responds and cares for this new baby.

The Beginning - Infant Mental Health

"Babies don't develop relationships with caregivers. Relationships with caregivers develop babies." (Powell et al 2014)

Starting with the "beginning" has interested researchers for decades and has led to compelling evidence that early childhood experiences and relationships matter for lifelong mental and physical health. (Cusick, Georgieff, 2018, Harris, 2014; Barrandon et al, 2005) Internationally renowned child development experts now recognise that the first 1000 days, approximately from conception to the second year of life mark a *sensitive* or unique period of development when the foundations for optimum physical and emotional well-being across the lifespan are established. (Cusick, Georgieff, 2018, Stern, 1998, Schore, 1994, 2001, Shonkoff et al 2010) It is equally recognised and acknowledged that the main ingredient of optimal development is the parent-child relationship.

Early parent-child relationships, which occur within multiple cultural and social contexts, shape and support the development of social competence in

young children, which is associated with long term adaptive behavioural, emotional and cognitive outcomes. (Zeannah & Zeannah, 2009) When children experience abusive and neglectful care their development is significantly compromised and the need for services significantly increases. Adverse and traumatic experiences in childhood are significantly exacerbated when they occur in the context of poor infant-parent relationships.

The long term impact of positive and negative experiences during infancy and early childhood has strongly influenced the growing field of Infant Mental Health (IMH) and the need to place it centre stage in the broader context of public health and prevention. (O'Connor & Parfit, 2009) IMH is a relational model that places central importance on the relational experiences of the infant and views the parent-infant relationship as the key ingredient for the baby's optimal social and emotional development, with far reaching influences.

The theory and clinical applications associated with IMH are informed by normative childhood developmental and trajectories that occur within contexts at risk. The goal of IMH interventions is to support infants and their families in establishing, maintaining, returning to or developing a developmental pathway of social emotional competence and well-being. (Rosenblum, Dayton & Muzik, 2009) Developmental psychologist Shonkoff states that meaningful promotion of optimal health and

prevention of disease begins in the first years of life. The absence of a consistent, sensitive and responsive care can have lifelong effects in two critical ways: the accumulation of damage over time and or the biological embedding of trauma and adversity that can last a lifetime. (Shonkoff et al 2010)

What is Infant Mental Health?

A well-documented definition of Infant Mental Health was created by a steering group in the USA. (Zeannah & Zeannah, 2009) The definition holds the infant central from antenatal to three years and describes IMH as:

"The young child's capacity to experience, regulate, and express emotions, form close and secure relationships, and explore the environment and learn. All of these capacities will be best accomplished within the context of the caregiving environment that includes family, community, and cultural expectations for young children. Developing these capacities is synonymous with healthy social and emotional development." (Zero to Three, 2001)

The discipline of IMH is thought to have emerged in the post second world war years when Selma Fraiberg's clinical work in Michigan in the USA fuelled her interest in the influences on deviations from normal infant development. She became increasingly interested about the importance of the parent-child relationship. She explored the role of unresolved trauma in the parent's history and how this went on to present in the current relationship with the baby.

Fraiberg et al's (1975) seminal paper "Ghosts in the Nursery", illustrated how *"the visitors from the unremembered pasts of the parents"* continued to influence how the parent(s) cared for and interacted with the baby. (Fraiberg et al, 1975) Fraiberg punctuated how the presenting past in the current parent-child relationship could compel the mother to repeat the unresolved trauma with her baby "in terrible and exacting detail". Fraiberg went on to establish Parent Infant Psychotherapy which essentially held the mother **and** baby as being central to the intervention.

Alongside Fraiberg, John Bowlby who was based in London was exploring his theory of attachment and the central role of the primary care giver in ensuring the baby's survival. Bowlby highlighted the way parents cared and responded to the needs of their children, and the way they in turn make sense of these experiences, plays a pivotal role in child development. His pioneering work explored the devastating impact of separating children from their primary carers during wartime evacuations in the UK and the long term effect of childhood experiences of deprivation and family dysfunction in relation to "delinquent behaviour" (Bowlby 1989).

Bowlby emphasised the central importance of attachment relationships with regard to the baby's emotional and physical vulnerability, dependency, need for protection, support and loving comfort from a reliable, consistent and stable adult(s). Similar to Fraiberg, Bowlby also

highlighted the need for services to intervene with mother and baby. He emphasised this point when he stated *"if we want to look after our children, we must cherish their parents"*.

Why is Infant Mental Health Important?

Infant mental health as a discipline recognises the significance of the antenatal to age 3 years period of development in relation to laying the foundations for optimum emotional and physical health throughout the lifespan. Central to this period are the interactional experiences of the infant with their caregiver. The parent-child relationship plays a key role in:

- **Attachment**

John Bowlby (1969) was a key figure in identifying infancy as a sensitive period based on the baby's need to develop a "secure base" from which to seek comfort and protection and explore their environment. In essence, this is the baby's experience of having a predictable, trusted and reliable caregiver who influences the formation of an "internal working model" that in turn enables the child to form expectations or predictions of all future relationships. (Bowlby, 1969; 1989) Bowlby viewed attachment as essentially an evolutionary process to maximise survival. Since then, attachment researchers have highlighted how attachment has more significant and far reaching functions. Decades of research have led to widespread agreement and acknowledgment that one of the most important aspects of a baby's

development is her attachment to the adult or adults who care for her.

A major finding from the attachment research over the past number of decades is that the greatest predictor of an infant's attachment security is the sensitivity and responsiveness of the parent. Mary Ainsworth and her colleagues (1978) described the importance of the parent being attuned to the infant's cues and needs, and responding in a meaningful, predictable and consistent way. Within this relational context the child is most likely to develop a secure attachment that leads to the development of an internal working model of the 'self' that is lovable, accepted and of interest to others, and of adults as caring, protective and available.

In the context of the parent-child relationship, the baby develops a range of attachment behaviours that are aimed at keeping the parent close in order to act as a "secure base". Attachment behaviours are activated at times of real or threatened separation, physical rejection or frightening conditions within the environment. Over time, these attachment behaviours emerge as habitual ways of relating to parents that have become known as "patterns of attachment" which may be considered "secure" or "insecure". While most babies develop a secure attachment to their parent(s), there are a significant number who develop an insecure attachment. This group of children are considered to be at an increased risk of significant mental health difficulties in later child and adulthood. Insecure

attachment is described throughout the literature as being indicative of patterns known as insecure avoidant; insecure ambivalent and insecure disorganised.

Ainsworth (et al 1978) described how insecure attachment patterns of relating emerge in the context of the parent's inability to provide consistent, sensitive and responsive care. Insecure avoidant strategies emerge as an infant experiences the emotional unavailability or withdrawal of the parent at times when they need them the most. In essence the infant "under regulates" their behaviour when faced with overwhelming emotions for fear that they will drive the parent away. The child soon develops a relational pattern that appears physically and emotionally independent as he or she learns that the expression of needs has no meaningful influence on the parent. (Ainsworth et al 1978)

The pattern of insecure ambivalent emerges within the context of a parent who provides an inconsistent level of responsiveness and sensitivity to the infant. Given that the infant experiences the parent as being unreliable or unpredictable with regard to care, the child over regulates their behaviour by appearing overly clingy and dependent on the parent. The infant or toddler fails to develop the capacity to use the relationship as a reliable secure base. This manifests in what may appear as aggressive, disruptive and inconsolable behaviour as the infant or child amplifies their emotional needs in an attempt to

gain much needed connection. (Ainsworth et al 1978)

The third pattern of insecure attachment was described by Main & Solomon (1990). Repeated experiences of being with a mother, who is frightened or frightening, leave the infant with what is known as "disorganised attachment", and is particularly relevant to infants and children who experience prolonged abuse and/or neglect. For some children the parent is the source of trauma when repeated experiences of abuse and neglect become central to their interactions. Attachment as a relational system serves to motivate the infant to seek proximity to the parent at times of distress. It follows then that a child is left with a huge dilemma when the very source of comfort is in fact the same source of fear. The terror experienced by the child can be in numerous forms such as verbal, emotional, sexual, physical abuse, parental intoxication, and exposure to domestic violence. Disorganised and chaotic behaviours manifest as the child attempts to manage overwhelming distress. Attachment strategies and behaviours may appear as being ambivalent or confused such as the infant seeking the proximity to the parent only to aggressively pull away at the last minute or hit out at the parent at times of reunification. Other observable behaviours are zoning out or dissociating at times of distress. It is estimated that over 80 per cent of infants and toddlers who experience adversity and trauma in their early years develop a disorganised attachment. (Siegel & Hartzel, 2014)

A growing body of research highlights that while early relational patterns or "working models" can be modified, they are resistant to change as they begin at a preverbal stage of development. (Crittendan, 1990) A significant association between the parent's "working model" and the infant's suggests that insecurely attached adults are more likely to foster insecurely attached children. (Fonaghy et al, 1991) Attachment researcher Mary Main placed a strong emphasis on the role of unresolved trauma and/or loss in the parent's early life. She stated that the enduring effects of these negative experiences impact on parenting because of the chronic lack of opportunities for the parent to make sense of their early trauma experiences.

- **Brain development**

"Human connections make neural connections" (Siegel, 2012)

The foundations of brain architecture begin before birth and continue into adulthood. The antenatal to three years represents a "sensitive period" of development. This essentially refers to "biological time points" during which the effects of experiences on the brain are particularly strong and when certain types of experience need to be present. (Cusick et al 2018; Shonkoff et al 2010) Essentially they are time periods of development when infants are most receptive and expectant of specific stimuli, experiences and interactions that are the essential ingredients for optimal development.

The quality and nature of these experiences affect the development of the brain which provides the foundation for all future learning, behaviour and health. (Siegal, 2014) Similar to how the weak foundations of a house impacts the strength and quality, experiences in early life can impair brain architecture, with negative effects that can last a life time. (Shonkoff et al, 2010)

The interactions of genes and early experiences are an essential process for shaping the developing brain. While genes effectively provide the genetic blueprint for the formation of brain circuits, it is through repeated interactional experiences that lead to them being reinforced. Developmental psychologist Edward Tronick began to take a closer look at the specific interactions between mothers and infants that were thought to influence learning, cognitive, social and emotional development. He began to explore and observe "protoconversational turn taking" also known as "Serve and Return", between mothers and preverbal infants as young as two months. Tronick's observations helped to illustrate the baby's instinctive skills and strategies to engage in face to face social experiences and the key presence of a sensitive adult to respond and make sense of the interaction. The baby actively uses social skills such as babbling, facial expressions and or gestures to engage the adult who in turn responds to the communication in a meaningful way. (Murray, 2014) "Serve and Return" interactions are considered to be the main ingredient for optimal

brain architecture. (Shonkoff 2010, Tronick 1989)

In the "Serve and Return" video clip we can observe serve and return interactions between a mother and young baby. The interactions illustrate the reciprocal nature of the communication through facial expressions and gestures. These daily back and forth communications are deemed essential in forming neural connections in the brain, which are the building blocks for more complex connections that emerge later. The early interactions, in the context of a sensitive and responsive parent-child relationship, support the social and emotional well-being of the infant and the emerging cognitive and linguistic capacities that are deemed essential for meaningful participation in the school, workplace and community. (Shonkoff et al 2000)

In the absence of consistent sensitive and responsive caregiving the brain's architecture cannot develop as it is biologically expected or intended, leading to disparities in later learning and behaviour. A developmental psychologist from Harvard University emphasises the unique opportunity in the early years as he describes how optimal interactions allow the brain to develop in a way that is similar to pushing open a door with a light touch. In the absence of optimal care during the early years *"this is more like trying to push open a heavy door that weighs about 1000 pounds"*.

- **Self-Regulation**

Self-regulation is widely recognised as playing a pivotal role in promoting social and emotional wellbeing throughout the lifespan including mental and physical health, relationships, educational and vocational achievements. It may be defined as the ability to manage thoughts and feelings in order to enable goal directed actions and achievements. Self-regulation involves sets of behaviours that are deemed essential for positive outcomes in relationships, school, and the workplace and throughout life. (Gallinsky, 2010) While the term "self" implies that it is an individual or internal process, emotional regulation is essentially a gradual, developmental process that begins at birth and continues throughout the lifespan. It is widely accepted and understood that babies cannot regulate their emotional world and therefore need the presence of a parent to help them manage and make sense of their feelings through the dyadic process of "co-regulation". Sensitive and responsive care ensures that a baby is not overwhelmed by distressing experiences as the presence of the parent essentially supports the infant to be calm and make sense of the distress. In turn, the baby learns "*my feelings are manageable*"; "*my feelings won't push other people away*", "*my feelings won't kill me*". (Lyons et al, 2018) While the capacity for self-regulation may grow, the relational process of co-regulation is deemed an essential resource throughout development and indeed life.

- **Adverse Childhood Experiences (ACES)**

There is mounting evidence that traumatic Adverse Childhood Experiences (ACES) have long term consequences for physical, mental health and social problems. ACES include: physical, sexual and emotional abuse; neglect; exposure to domestic violence; household substance misuse; parental separation/divorce; and incarceration of close family member. Consistent findings from the research reveal that while ACES are common among the population, they have a dose-response relationship with numerous negative outcomes across the lifespan including physical health and diseases, social/emotional and behavioural difficulties, risk behaviours and substance misuse. (Felitti et al 1998) In the context of poor family functioning and the absence of early sensitive and responsive care the infant has no "buffer" or person to help make sense of and mitigate the trauma. Therefore, the trauma of ACES is exacerbated with far reaching consequences throughout physical and mental health well-being. While poverty is associated with multiple risk factors for physical and emotional health, it is thought to exert its strongest influence on the outcomes for infants through its effects on parenting. ACES are thought to affect physical and emotional health in adults in a number of ways such as the accumulative damage over time and the biological embedding of adversity and trauma during sensitive periods of development. (Shonkoff, 2000) As one of the researchers stated "*time does not heal all wounds, since humans convert*

traumatic experiences in childhood into organic disease in later life". (Felitti et al 1998)

- ***"An ounce of prevention is worth a pound of cure"***

The economic benefits of early intervention in the antenatal to age three years period are well documented by child development, mental health, social science, and economic researchers alike. While a large portion of studies have originated in the USA, they are still relevant to service providers and policy makers closer to home.

A UK study in 2014 found that public health spending surrounding Perinatal Depression cost £8.5 billion a year. Almost two thirds of these costs related to the adverse impact on the child. (Bauer et al 2014) In the USA longitudinal evaluations of early interventions tailored to support the parent and child to foster the optimal emotional and social development of infants have consistently revealed positive results. Crucially in terms of physical and mental health outcomes, the net benefits are shown to increase over time and with the age of the individual, far into the future. (Moffit et al, 2008) Professor of Economics Cunha (2017) describes how several programmes in the USA that targeted parent/infant interventions aimed at improving the emotional and social development, showed positive returns that were in line and above some of the most attractive investments on the current stock market.

- **Interdisciplinary and Interagency**

IMH is recognised to be a multi-disciplinary and interagency field. It is not just of interest to any individual service, agency or discipline such as nursing, paediatric medicine, psychology, psychiatry or social work, but requires a comprehensive approach with regard to investment and commitment. There is mounting recognition that the implementation of an IMH framework requires additional education, training and reflective supervision to build workforce capacity and competencies in order to respond and meet the needs of infants and their parents/carers. (Svanberg & Barlow, 2010)

The Still Face Experiment - Dr. Edward Tronick - *"The Good, the Bad & the Ugly"*

In the brief "Serve and Return" video clip we observed the serve and return interactions that are described as being essential in the early years for optimal brain development. We also observe these interactions in the video clip "Still Face Experiment"

(https://www.umb.edu/Why_UMass/Ed_Tronic). We see a mother and baby aged one year engage in this developmental game of attunement. The baby serves using babbling, smiling, pointing, and other gestures to engage the mother who in turn returns the serve with meaningful responses. Initially the mother is attuned to the baby as she shares the emotional experience and responds to her needs in a sensitive and regulating manner. The mother uses warm, amplified facial expressions, a soft tone of voice, smiles and touch throughout the serve and

return interaction. The baby responds and appears to experience the mother as "being with" her throughout the initial interaction. It is clear in the video clip that this baby is used to the attuned serve and return experiences with her mother as she clearly serves with the expectation that her mother will return.

Tronick describes the interaction as "the good" meaning the everyday attuned moments when both mother and infant are engaged in playful, coordinated, co-regulated and meaningful interaction. Attuned parents can engage in this dance or developmental game as they regulate the interaction to meet the baby's needs and repair disruptions with relative ease. It is widely recognised that attunement is an essential ingredient in fostering a secure attachment.

We go on to observe the mother disengaging from the interaction with the baby as she adopts a still face and non-responsive stance. Tronick refers to this as "the bad", as from the baby's perspective the mother is now emotionally unavailable and unresponsive to her emotional needs. We painfully observe how the infant "feels the stress" of her mother's withdrawal and uses "all of her abilities to get the mother back". (Tronick) In a brief period, she attempts to engage her mother through gestures, screeching, pointing, and eventually crying. The emotional unavailability or absence of her mother activates negative emotions and the baby's stress response. Physiologically her body and brain are now on alert "fight or flight", with a rush

of adrenalin, release of stress hormones and increased heart rate.

Thankfully the mother does come back and empathically co-regulates the infant's distress using facial expressions, a soft tone of voice, touch, and affection to repair the disruption. The baby and mother return to the attuned dance of "serve and return" with relative ease. The baby appears to recover and overcome the distress with the return and emotional availability of the mother. While the "bad" illustrates distress from the infant's perspective, experiences of disruption and repair with the parent are considered essential developmental processes. Opportunities to repair and "reconnect" are associated with enhanced relationships, security and building resilience. (Rosenblum, Dayton & Muzik, 2009; Hoffman et al 2017)

The "ugly" which we don't fully observe in this clip, is the baby's prolonged experience of distress in the context of the emotional unavailability or absence of the mother. As Tronick describes, it is when the infant has no opportunity "to get the mother back" and therefore no opportunity to regulate and make sense of or repair this experience. From the baby's perspective, this is terrifying and over time can foster detrimental consequences.

Hoffman et al (2017) urge us to imagine an acrobat free falling from a trapeze. He lets go of his bar and reaches out his hands expecting the support of his fellow acrobat to catch him, only to discover

there is no one there. Expecting and needing someone to be there is experienced as a very real threat to survival. This frightening, prolonged sensation of abandonment for a preverbal infant activates the stress response of "fight, flight or freeze" and becomes embedded in "sensory" or implicit memory. Chronic or toxic stress for an infant who has no capacity to understand or make sense of the frightening sensations has detrimental effects that will endure for a life time. (Shonkoff et al 2012)

As a preverbal, sensitive developmental period, toxic stress can lead to the biological embedding of adversity. Chronic exposure leads to structural and functional abnormalities in sensitive regions of the brain: the amygdala, hippocampus and prefrontal cortex. During the second year of life the infant's brain is developing to incorporate more complex cognitive functions involving merging capacities for language, reasoning and problem solving. At the very time cognitive skills are optimally unfolding to help and support a child to make sense of their experiences, toxic stress derails the neural connections needed for this developmental process. (Shonkoff & Garner, 2012)

It was assumed that babies would not remember or recall the past because they lack the language skills to speak about experiences. However, it is now understood that while a baby may not be able to speak about memories, the experiences are stored in the body and

sensory system as "implicit" or sensory memories. (Siegal 2012) Implicit memory is present from birth and continues throughout the lifespan. It involves the lower part of the brain, the amygdala, which is responsible for basic biological functions that are essential for survival such as heart rate and temperature. While implicit memory is non-verbal, it involves the sensory systems of sight, sounds, smells, touch and images and is responsible for generating emotions, behavioural responses, perceptions and bodily sensations. It requires no cognitive thought or awareness. It shows up in behaviour and actions without any conscious awareness that the memory or "sensation" is being recalled from a past experience.

Additional trauma in the environment such as loud noises or screams, banging, aggressive handling, and neglect to meet basic needs such as hunger are exacerbated in the context of the poor infant-parent relationships. The baby faces the impossible dilemma of needing the very person or buffer who is playing a central role in the traumatic experiences. Implicit memory means that the body and brain are compelled to a state of high alert even when there is no apparent harm. In the absence of a sensitive and responsive adult the trauma and adversity become embedded within the sensory system with far reaching consequences. Implicit memories are vulnerable to reactivate frightening sensations in the present when the child or adult *perceives* a facial expression, door slamming, touch, smell, scream, feeling of hunger as being a

threat to their survival without having any awareness that the original trauma actually occurred in the past.

While going "back to the beginning" may be the ideal in an attempt to ameliorate early trauma and adversity, staying with the beginning often proves challenging. Bearing witness to an infant or young child experiencing emotional distress can be an evocative and painful experience for the observer who may be a frontline practitioner, researcher, service manager, developer or policy maker. Despite the wide range of experience and expertise in the room on the day of the ICJA conference, there was a notable sigh of relief when the baby's distress in the video came to an end. It is almost unthinkable to imagine that for some infants this distress is experienced on an ongoing chronic basis with minimal or no opportunity to experience the sensitive presence of a reliable carer.

It is challenging to think about or feel the distress of an infant. To do so can stir up issues that may resonate on a personal level in relation to one's own childhood experiences and parent(s) and or one's own children and parenting. It is understandable why we would use a range of defensive manoeuvres to keep the infant's distress at a distance that can often manifest as "them" and "us". As noted earlier, it is difficult being born into today's modern society for all infants. It is also difficult and at times overwhelming being a parent in today's increasingly challenging and complex society. The discipline of IMH illustrates how the

responsibility of nurturing the optimal emotional development of a baby and child goes way beyond the parent and family to broader society. (Sroufe et al 2005) In order to improve outcomes for infants and children it is vital that services are willing and supported to establish approaches or frameworks that address the complex factors that influence the early parent-child relationship. (Svanberg & Barlow, 2010)

IMH in Practice in an Irish Context

A major challenge in terms of service delivery and provision is translating the compelling evidence into practice. As a relatively new discipline, it is recognised internationally that there is a need to build workforce capacity and competencies among all services and disciplines working with young children and their parents. The Irish Association of Infant Mental Health (I-AIMH) was established in 2009 to advance the social and emotional health and well-being of infants, children and their families. Since then I-AIMH has provided training and networking opportunities to advance the skills and competencies across all disciplines working with children under five years. As an affiliate of the World Association of Infant Mental Health, I-AIMH launched their publication of competency guidelines, *I-AIMH Endorsement for Culturally Sensitive Relationship Focused Practice Promoting Mental Health* (McSweeney, Lovett & Maguire, 2018) earlier this year. Building on similar guidelines that were developed by the Michigan Association of IMH, they provide a framework that outlines the

core knowledge, skills, capacities and abilities for the early years' entire workforce. (McSweeney et al 2018)

The emergence of the Area Based Childhood Programmes (ABC's) across Ireland has provided a meaningful platform to facilitate the implementation of an Infant Mental Health framework. As an early intervention and prevention programme, the ABC's help to identify infants, children and families living in areas of disadvantage and considered to be at risk of a wide range of adverse experiences. The most established programmes are currently Young Ballymun (YB) in Dublin and Young Knocknaheeny (YK) in Cork. At the time of writing YK are about to launch their "Learning Together" Young Knocknaheeny Process Evaluation which documents the establishment and implementation of their programme from January 2015 to December 2017. This programme is underpinned by an infant mental health framework and is currently available on their website

www.youngknocknaheeny.ie.

A considerable number of other ABC's are also implementing an IMH framework and are at different stages of the process. These include Tallaght West, Finglas, Ballyfermot, Clondalkin, Bray and Limerick. There is no doubt that other ABC's around the country will continue to benefit from the YK guidance and support. It is hoped that other services, agencies and policy makers will make a similar investment and commitment to

implement a meaningful infant mental health framework.

The widely quoted proverb "*it takes a village to raise a child*" has a particular relevance when we consider young babies born in Ireland today. The responsibility of nurturing the baby's optimal emotional well-being belongs to all services, agencies, developers, and policy makers working with children and families. Meaningful investment and commitment to keep the baby in mind and support early child/carer relationships has far reaching benefits for the individual, family, community and society. Decades of compelling evidence support the need for early intervention and prevention of adverse and traumatic experiences in infancy and childhood. As Frederick Douglass stated as far back as the 1800s "*it is easier to build strong children than to repair broken men*". As a relational model, IMH not only helps us to understand "*what has happened to you?*" but also how services and agencies can intervene meaningfully with infants, children and their carers. While early adversity and trauma may originate in the context of key infant/parent relationships, IMH provides a vital framework that nurtures those relationships to heal, repair and improve the outcomes for infants, children, families and society.

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Vicarious Trauma: The Impact of Working with Survivors of Trauma

Dr. Sharon Lambert, School of Applied Psychology, University College Cork

Practitioners who work in the criminal justice services, both statutory and voluntary, have long known that a huge number of the people they come into contact with have long histories of challenging life circumstances. While in Ireland we have limited data regarding the breadth and depth of traumatic experiences in the lives of people who are incarcerated, we are aware that most emerge from situations of marginalisation, poverty, mental health and addiction¹, (Kennedy et al., 2005). There is growing recognition that early life experiences, particularly adverse childhood experiences, have a direct role in the development of later negative events and behaviours (Taylor et al., 2008; Fellitti et al 1998). The public often lacks empathy for those who commit crime (Schissel, 2016) as too can professionals (Kjelsberg et al., 2007). However, the client blameworthy perspective is being challenged by advances in research, particularly public health, neuroscience and developmental psychology. This new evidence indicates that people who have been exposed to chronic stress and trauma in childhood are not engaged in 'bad behaviour' but 'adaptive behaviour' (Lambert & Gill-Emerson, 2017). Adverse structural changes occur in the developing brain due to exposure to adverse

childhood experiences (Teicher & Samson, 2013). This conference paper will discuss the impact on front line staff of working with vulnerable people and ways in which organisations can respond to improve outcomes for service users, staff and the whole organisation. In order to understand the impact on staff we must first understand the types of trauma presenting.

Psychological trauma can be understood as exposure to primary trauma (i.e. directly exposed to a traumatic event) and secondary trauma (indirect exposure to traumatic events from exposure to others stories). It is important to not assume that all clients present with primary trauma and that all staff are impacted by secondary trauma. However, to act as if there is a trauma history maximises the safety of the worker and client by reducing the likelihood of further re-traumatisation (SAMSHA, 2014). There are many variables at play in human services organisations. As workers we bring with us our own life experiences and some of us will have been exposed to our own personal trauma histories. Additionally workers can face primary trauma experiences through their work, such as exposure to threats and violence, finding a person deceased etc. (McGinley & Lambert, 2018). It is important to be cognisant of our own stories and how this may make us more vulnerable to hearing the stories of others.

¹ Oberstown Children's Detention Campus (2018). Key characteristics of young people in detention. <https://www.oberstown.com/wp-content/uploads/2018/06/Key-Characteristics-2018.pdf>

Trauma can be classified and includes developmental trauma, intergenerational trauma, and one off trauma events such as illness or accident. The last ten years has seen an increased interest in Adverse Childhood Experiences (ACEs) and their impact on later life outcomes. The original ACE study conducted by Felitti et al. (1998) utilised a ten item scale recording a range of traumatic events in childhood such as abuse, neglect and household dysfunction (e.g. loss of a parent, exposure to addiction, mental health and domestic violence). This study had been replicated many times and the findings indicate that exposure to early life adversity increases the risk for poor physical and mental health and poor social functioning (Lambert & Gill-Emerson, 2017; Bethell et al., 2014), even in the absence of health risk behaviours (Felitti et al., 1998). The original study revealed that exposure to adverse childhood experiences is common with almost 40% of the general population experiencing two ACEs. However this decreases to 12.5% for four or more ACEs. It has been argued that four ACEs are clinically significant and that each additional ACE has a dose response for increasing the likelihood of illness and dysfunction (SAMSHA, 2018). For example a score of 4 increases the risk for attempted suicide 23.2 times (WHO, 2014).

Is this then simply a case that having a bad childhood means you engage in bad behaviour? Not necessarily, and the research reveals that it is much more complicated than that. Research is

emerging and on-going but it is argued that epigenetic changes occur in the presence of consistent toxic stress (Meaney, 2010). Advances in neuroscience have revealed that exposure to toxic stress or trauma in childhood impacts on the ways in which the developing brain hard wires with very serious consequences for later life functioning (Shonkoff et al., 2009; Danese et al., 2012). The adult brain is not fully formed until the 25th year of life and undergoes many changes throughout childhood and adolescence (Johnson, Blum & Giedd, 2009). Experiences of a warm responsive caregiver and exposure to a range of educational experiences facilitate healthy brain development (Gunner, 1998). However, exposure to toxic stress or developmental trauma can cause synaptic pruning or the death of neural connections at just the time when the brain should be forming and growing (Schoore, 2001)². Individuals exposed to high levels of stress have highly responsive fight or flight systems (Danese & McEwen, 2012). Arousal of the sympathetic nervous system has consequences for thinking and behaviour (Perry et al., 1995); individuals whose systems are set on flight or fight experience both their internal and external world as threatening (Janoff-Bullman, 1989). The behavioural manifestation of this stress response can range from aggression to withdrawal (Kisiel et al., 2014). Often these behaviours are viewed as challenging

²

<https://developingchild.harvard.edu/resources/toxic-stress-derails-healthy-development/>

when in fact the impacted individual has little control over these automatic systems. The 'challenging' behaviours presenting may well have once been required for survival in childhood.

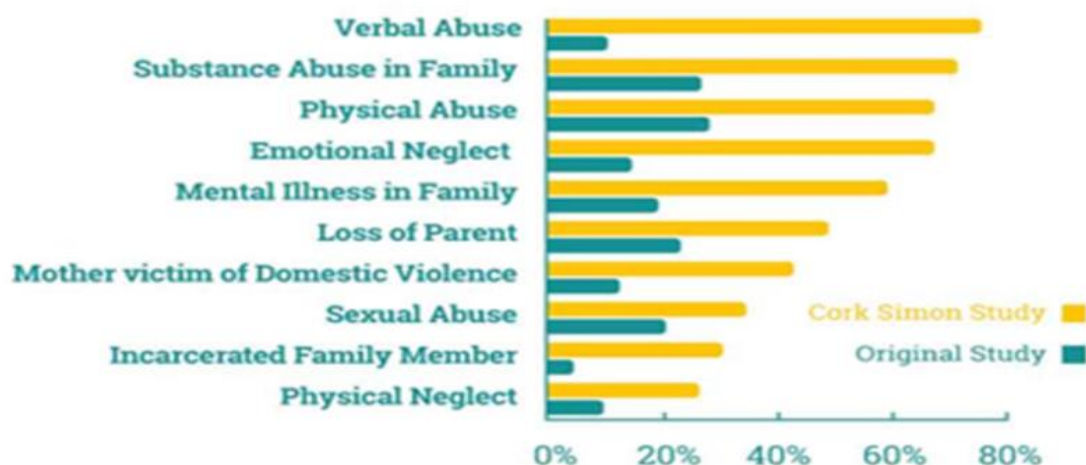
Research advancements have improved our understanding of the impact of trauma. In terms of understanding the implications of this for a criminal justice context one must consider the profile of those passing through the systems. Within the criminal justice system there are a disproportionately higher number of former care leavers, mental health sufferers, and people experiencing homelessness, people from impoverished and deprived backgrounds and those who are socially excluded. High levels of childhood trauma have been identified in all of these cohorts. There can be no dispute but that the most vulnerable and marginalised amongst our community are those who end up incarcerated. Exposure to childhood adversity with limited or no intervention leads directly to the adoption

of high risk behaviours, social dysfunction and risk of early death (Fellitti et al., 1998; Lambert & Gill-Emerson, 2017)

An ACE study was conducted in a Cork based homelessness organisation. A collaboration between Applied Psychology, UCC, the HSE Adult Homeless Integrated Team and Cork Simon Community, the study collected ACE and other data from fifty service users. The results indicated very high levels of exposure to early childhood adversity and demonstrated the stark differences between the childhoods of those experiencing homelessness and those from the general public (See figure below: courtesy of Cork Simon Community).

The evidence suggests that many people transitioning through the criminal justice system have high levels of trauma and researchers would argue that there is a potential for trauma contagion (Gill-Emerson, 2015). Trauma contagion refers to the concept that working with trauma

ACEs among Cork Simon service users compared to the general public in the original ACE study:



survivors may increase the risk for vicarious trauma, secondary traumatic stress and burnout for some. The terms are at times used interchangeably in the literature. According to Pearlman & Mac Ian (1995) vicarious trauma occurs following long-term exposure to the stories of traumatised service users and may cause decreased motivation and empathy. An additional feature of this is a risk of a 'distorted world view' (McCann & Pearlman, 1990). The experiences of workers in front line services represent a small minority of the general population as a whole. However if a worker develops vicarious trauma they may perceive their world as more unsafe than the actual statistical risk. Staff may isolate themselves from others who do not work in front line services as they no longer hold similar views of risk, danger and trauma and may tend to gravitate more towards others who share similar occupational experiences. Secondary trauma stress differs to vicarious trauma in that it does not change a person's world view. It has instead been described as a syndrome among staff working with trauma survivors that mimics post-traumatic stress disorder (Figley, 1995). This can be as a result of exposure to service users' trauma stories or it can occur suddenly as a direct result of exposure to a stressful incident such as violence or finding a service user dead (Baird & Kracen, 2006; McGinley & Lambert, 2018). It must be noted that not all staff in front line services are impacted by secondary or vicarious trauma and many report feeling satisfaction with their ability to offer care and develop a

connection with service users (Jacobson, 2006). Burnout occurs when the demands outweigh the resources and results in physical and emotional fatigue that may also result in disengagement from work and the depersonalisation of service users. This is an adaptive response where the stress becomes so overwhelming that, in order to continue to function, the worker needs to disengage from empathising with service users in order to protect one's own mental health; this usually occurs over a period of time and may be an unconscious process for the worker. Other symptoms of burnout may include feelings of helplessness and despair, insomnia, health risk behaviours (e.g. over eating, misuse of substances), difficulties within personal relationships etc. (Baker et al., 2007; McGinley & Lambert, 2018). It can become systemic in that a whole organisation can be impacted. Vicarious and secondary trauma have been described as 'occupational hazards' for those who work in front line services, therefore the organisations have a "practical and ethical responsibility to address this risk" (Bell, Kulkarni, & Dalton, 2003, p. 465). There are a number of ways that an organisation can respond to their staff needs; regular and effective supervision that is separate and distinct from line management, the focus is on the impact of the work. Reflective practice in supervision is an effective way to reduce the impact of the work on staff (O'Sullivan, 2018). A work environment that demonstrates good practice in relation to self-care is vital.

Addressing the trauma needs of both service users and staff results in a range of benefits for the organisation such as decreased incidents, increased morale and staff retention to name but a few. Many organisations that provide services to vulnerable and marginalised groups now recognise the importance of adopting a trauma informed work environment. A trauma informed environment is one that understands the impact of trauma on both service users and staff and makes changes to policies, procedures and practices (SAMSHA, 2014). A trauma informed service does not necessarily treat trauma using clinical interventions. It does however recognise the levels of trauma within its organisation and responds to these (Lambert & Gill-Emerson, 2017). Workspaces have become increasingly focused on output, risk management and paperwork. Taking the focus away from the people, both staff and service users, increases the risk for all involved including the organisation itself. Workplaces need to invest in understanding trauma and its impact in order to maximise the safety of all within that organisation.

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Homeless Men with Mental Illness in Irish Prisons

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Psychiatric bed numbers have reduced sharply in recent decades from around 20,000 in 1963 to under 2,500 today as part of the community policy of replacing institution-based care with treatment and support in the person's own home where possible. This process has been very effective for many people.

Certain sections of the population may be unable to benefit from this approach. It is argued that this applies particularly to homeless, impoverished young men with psychotic illnesses like schizophrenia, at times when they are acutely ill and most in need. It has been suggested that some of these are people who would previously have been admitted to hospital when there were more beds. The number of prison places has increased as the number of psychiatric hospital beds has reduced in recent decades.

Among the most severe forms of mental illness are conditions related to schizophrenia. When people are acutely unwell with these conditions, they may be unable to think clearly, experience frightening hallucinations (such as hearing voices, often menacing or frightening which seem real to the person experiencing them), and delusions (believing things which are bizarre and untrue, for example paranoid beliefs about those close to them).

Minor mental illnesses are unlikely to be associated with behaviours that lead to

people being arrested, but people who are acutely psychotic are over-represented in Irish prisons.

Homeless, psychotic young men are less likely to qualify for bail, even when charged with relatively trivial offences, compared with similar offenders who do not suffer from mental illness. This is because they tend to be unable to provide an address or a small sum of money.

Young psychotic men may paradoxically have the greatest difficulty accessing psychiatric services at times when they are most in need. Homelessness may lead to rejection by local services on the basis that they are "not from the catchment area" - this may occur even when people have been born and reared in a given area, later becoming homeless in the context of psychotic illness. Admissions, when they do occur, are much shorter than in the past.

Psychiatric Hostels, developed to enable certain "long stay" patients from previous decades to return to the community, are not equipped to deal with young men with recurrent psychotic conditions. Night shelters whereby these young men wander the streets during the day are unlikely to provide the stable base envisaged in "Housing First" ⁽¹⁾ for these young men to manage their mental illness or avoid drug use. Frequent relapses are to be expected in such circumstances and meaningful recovery is highly unlikely. Young single men are unlikely to be

prioritised on a waiting list for housing. Services such as the Father Peter McVerry Trust do provide supports for these young people at such times of greatest need.

This presentation argues, with evidence over twelve years from Ireland's main remand prison, that the current systematic failure to fully implement the components of community care for younger men with psychotic illness, largely from deprived areas, constitutes a "cycle of rejection" and echoes previous examples in Irish history when our more vulnerable young people have been ill-served at times of their greatest need.

The National Forensic Mental Health Service delivers a structured approach to mental health care to the majority of prisons in the state, involving screening, assessment and treatment, liaison and pre-release planning. There is a validated and structured approach to making decisions regarding location of treatment and prioritising need for treatment ⁽²⁾. The DUNDRUM Toolkit has been adopted in jurisdictions in Europe, America, Australia and New Zealand.

Inpatient forensic psychiatry beds in Ireland are only available at the Central Mental Hospital, which has 97 beds. Capacity to admit patients from prison has reduced to a very small number each year, in recent years. This is mainly because the number of people found not guilty by reason of insanity has increased from one or two a year to over ten a year since the implementation of the Criminal Law (Insanity) Act in 2006. Per capita forensic

bed numbers in Ireland are less than one-quarter of those in equivalent western jurisdictions such as the UK or Sweden. Ireland is also towards the lower end of countries in terms of per capita general beds and mental health spend.

There were 2,408 psychiatric inpatients in Ireland on a census date on 31st March, 2016 ⁽³⁾. Of these, approximately half were female. Over a quarter were in private hospitals, and unlikely to be accessible to young psychotic men from deprived areas. Over one third were occupied by persons over 65 years and over one third were occupied by persons who had been in hospital for over one year. Again, such beds are unlikely to be available to young, psychotic men. Possibly 400-450 acute beds are available nationally to young men from deprived areas with all psychiatric conditions. A system of psychiatric intensive care units planned in the mental health blueprint "A Vision for Change" ⁽⁴⁾ has not been delivered.

The large and continuing reduction in Irish psychiatric beds in recent decades has been associated with a similar increase in prisoner numbers. Typically, general psychiatric inpatients are approximately 50% male, while prison populations and "forensic" psychiatric inpatients are mostly men. Rates of the most severe forms of mental illness, particularly psychotic illnesses, are much higher in prison populations than in the community, for both genders. Predicted forensic admission rates increase exponentially in deprived urban areas ^(5,6). Men die by suicide at over five times the

rate of women. The difference is even greater for men under 54 years.

Numbers of young men with psychotic illness have increased sharply in Ireland's main male remand prison at Cloverhill. The presentation describes, for the nine years 2006 to 2014, a subgroup of "revolving door" patients who repeatedly present to remand prisons, usually after minor offences, at times when they are homeless and actively psychotic.

Proactive screening, coupled with diversion to appropriate healthcare (as recommended in "A Vision for Change") has helped to mitigate the time such people spend in toxic prison environments where they cannot benefit from treatment ⁽⁷⁻¹⁰⁾. However, as the small number of acute inpatient beds continues to shrink year on year, psychotic young men accumulate in larger numbers and spend longer in prison before they can access treatment which cannot be delivered in prison.

Conclusions:

There are a large number of young men suffering from very severe mental illness in Irish prisons. A number present repeatedly at times when they are homeless, actively psychotic and charged with minor offences. As the number of psychiatric beds accessible to young men continues to reduce year on year, and in the absence of non-forensic Intensive Care Rehabilitation Beds in most parts of the country, these severely ill young men accumulate in toxic prison environments where they cannot be appropriately

treated. Involuntary treatment when required cannot be given in prison under current legislation, as a result severely ill young men can spend long periods untreated awaiting admission beds which are increasingly unavailable. Most of those receiving inpatient treatment in recent years from remand settings have had this arranged in general psychiatric hospitals, rather than the Central Mental Hospital.

There is a need for a coherent approach for delivering care for mentally ill men, particularly those who are poor, homeless and suffer from the most severe conditions. It is argued that the catchment area approach leads to discrimination against young men with psychotic illnesses, so that at times of greatest need it is most difficult for them to access community inpatient services.

There is a need for increased funding for, and access to, beds for Homeless Psychiatry services. There is a need for more access to psychiatric intensive care facilities. There is a particular need for Intensive Care Rehabilitation Units (ICRU) as identified in the policy document "A Vision for Change". In order for these young men to achieve meaningful recovery, quality of life and dignity, they require access to longer term structured, supported, secure care. There is a need for more forensic inpatient places for those who could not be managed in such ICRU facilities. Ireland lacks certain legislative options for diversion, community treatment orders and hospital orders as exist in other jurisdictions.

While some people charged with serious offences will need forensic care, many of those charged with less serious offences can and should be managed by local general mental health services. Being homeless should not act as an obstacle to this. There needs to be an identified person or position at national level to resolve issues of catchment area responsibility for such individuals.

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Delegate Recommendations Towards Action Plans

Delegates answered questionnaires at the conclusion of each Workshop session and made the following recommendations which were presented during the final plenary session of the conference.

Workshop 1 - The Potential for Applying the Tusla-led Meitheal Practice Model in a Trauma-Responsive Criminal Justice System

Delegate recommended actions for implementation immediately:

- Further development of inter-agency work, particularly between Tusla and Criminal Justice agencies.
- Tusla should deliver family and parenting programs.
- Increased supports for parents.
- Introduction of Trauma-Responsive training across all agencies.

Delegate recommended actions for implementation in the near future:

- Mandatory training in the Meitheal process, similar to mandatory reporting.
- Training for as many professionals as possible in the Meitheal model and Trauma-Responsive care.

Workshop 2 - Towards Trauma-Responsive Addiction Treatment Service at Tabor Group in Cork

Delegate recommended actions for implementation immediately:

- Trauma-Responsive training for frontline staff across all services.

Delegate recommended actions for implementation in the near future:

- A professional qualification.
- A national strategy.

Workshop 3 - Poverty, Homelessness, then Prison - and back to Poverty, Homelessness again

Delegate recommended actions for implementation immediately:

- Mental Health - Improving psychiatric services for the homeless, including residential services.
- Addiction- (a) Improving access to addiction services through collaboration with HSE services in prison and (b) establish a custodial drug treatment centre for courts to refer or divert to.
- Release - (a) Advance planning of release and (b) Develop a different style room for homeless prisoner access upon release.

Workshop 4 - Prisons: Trauma Informed Interventions - Them and Us?

Delegate recommended actions for implementation immediately:

- Training of staff in Comprehensive Resource Model (CRM).

- Development of research in CRM and complex Post Traumatic Stress Disorder (PTSD).
- Better Public Awareness.
- Feedback to Governors on the outcome of the CRM group.

Delegate recommended actions for implementation in the near future:

- Continued resourcing.
- Shared research and learning.
- A national roll-out.
- More understanding surrounding this area.

Workshop 5 - From Exclusion, through Muddle, to Rights: The Place of Victims in Sexual Offences Trials

Delegate recommended actions for implementation immediately:

- Devise strategies on how best to understand trauma in the courtroom setting.
- Consider how to develop legal representation for victims of sexual offence cases.
- Conduct further research into the experiences of victims in the CJS to understand the trauma they encounter and to seek their views on how to improve the system.
- Training for lawyers and legal professionals on the best practice responses to trauma and to be cognizant of trauma when carrying out their work.

Delegate recommended actions for implementation in the near future:

- Simple changes, like ensuring victims do not need to sit across from the accused at the trial.
- Raise awareness and promote discussion about sexual violence and its effects to ensure public consciousness of trauma.
- Adequate resourcing for supporting victims within the CJS.
- Make sure existing rights for victims are implemented and realized.

Workshop 6 - Every Woman Every Story: Trauma, Criminality and Women in Prison

Delegate recommended actions for implementation in the near future:

- Learn from the approach taken with women to see what can be applied to men.
- Train staff to deal more effectively with trauma of women in the prison service.
- Encourage and implement a peer-to-peer structure.
- Reduce unnecessary committals to prison.

Workshop 7- Pathways to Prison - The Experience of the Traveller Community

Delegate recommended actions for implementation in the near future:

- Study into the over representation of the Traveller population in prisons.
- Awareness of the issues faced by the travelling community, i.e. racism and discrimination.

- Awareness of the positive aspects of the travelling community.
- Discussion on the wider societal issues facing the Traveller community and the impact of these on their mental health.

Workshop 8 - Vulnerable Migrants and the Criminal Justice System

Delegate recommended actions for implementation near future:

- Training and accreditation for translator services.
- Translate essential legal documents.
- Trauma/Culturally-Responsive training for Criminal Justice Agencies interacting with vulnerable migrant groups and translators.
- Changes in legislation for the temporary release of non-nationals.
- Encouraging minority groups to get involved in public life.
- Look at best practices in other countries.

Workshop 9 – Trauma in Probation Practice

Delegate recommended actions for implementation immediately:

- Interagency approach.

- Incorporate ACEs model risk assessment and practice.
- Inform clients of the benefits of doing ACEs assessment.

Delegate recommended actions for implementation in the near future:

- Additional Research.
- Pilot Scheme ACEs.
- Massive investment in early intervention is needed.
- Another conference on ACEs interventions.

Workshop 10 - Addressing Psychiatric and Psychosocial Morbidity in Irish Prisons

Delegate recommended actions for implementation in the near future:

- Implementation of A Vision for Change recommendations.
- Psychiatric nurses in Garda stations for early diversion.
- Additional communication and coordination between the services.
- Better multi-disciplinary working and fewer barriers to patient entry.
- Increased numbers of low security beds for community diversion.
- Customized treatment programs to meet low IQ needs.

WORKSHOP SUMMARIES

1. The Potential for Applying the Tusla-led Meitheal Practice Model in a Trauma-Responsive Criminal Justice System

Presenters: Fergal Landy, Regional Implementation Manager for Prevention, Partnership and Family Support, Tusla, and Eimear Ryan, Senior Speech and Language Therapist, Assessment Consultation and Therapy Service (ACTS)

Chairperson: Enda Kelly

Rapporteur: Kate Daniels

Introduction (Fergal Landy)

Tusla is the statutory state agency responsible for improving wellbeing and outcomes for children and families. Adverse childhood experiences and trauma-responsive care are among the broad range of services offered by Tusla. The Child and Family Agency's services include a range of universal and targeted services:

- Child protection and welfare services
- Educational welfare services
- Psychological services (ACTS Scheme)
- Alternative care (foster and residential care)
- Family and locally-based community services

The Prevention, Partnership and Family Support Programme (PPFS)

This programme aims to make all Tusla services and partnerships with other

agencies centred on being preventative, evidence-based, integrated and outcome-focused. Central to this programme are five distinct but complementary and interwoven work packages: parental support, public awareness, participation, commissioning (which focuses on the use of resources to achieve outcomes) and the development of Child and Family Support Networks and the Meitheal model. The development of cohesive Child and Family Support Networks and the Meitheal Model at the front line alongside the development of strategic responses at Children and Young People's Committees together represent an opportunity to prevent and mitigate Adverse Childhood Experiences (ACEs) through the development of trauma-informed services.

What is Meitheal?

Tusla has a preventative resource structure in all of its seventeen areas implementing the Meitheal model. Meitheal is a national early intervention practice model to ensure that the needs and strengths of children and their families are effectively identified, understood and responded to in a timely way so that children and families get the help and support needed to improve children's outcomes and to realise their rights. It places an importance not only on the child but also on the parent to facilitate an open conversation with families. The Meitheal process facilitates

the early identification of need; the co-production of a support plan to meet that need and the ongoing coordination and review of that support until the desired outcome is achieved. In using Meitheal to coordinate supports to children in youth justice projects, Tusla has had direct involvement from An Garda Síochána, as Lead Practitioners as both Juvenile Liaison Officers and Community Gardaí, and the Irish Youth Justice Service.

How does it work?

Meitheal is a voluntary process in which the relationship between the Lead Practitioner and the families is critical. All aspects are led by the parent/guardian and child/young person, from the decision to enter the process, to the nature of information to be shared, the outcomes desired and the agencies to be involved. The Lead Practitioner acts as a source of ongoing support in the families' engagement with services and provides practical assistance to parents and children.

A number of other strengths associated with Meitheal are also outlined. These include its multi-agency approach, less duplication of services provided to families, improvements in communication between practitioners and between practitioners and parents and the development of more tailored plans to support families in reaching their outcomes. Tusla recognises that all elements within Meitheal can be looked at with an ACE aware and trauma informed lens in order to achieve better outcomes for families and children. The

strengths based and participatory nature of Meitheal may help to offset concerns that ACE awareness and trauma-informed practice can be deficit oriented.

Pathways to Meitheal

- Direct - as a result of a discussion between a parent and Lead Practitioner
- Diverted - this occurs when the situation does not reach the threshold for social work intervention so the family can be diverted
- Step down pathway - this occurs following social work intervention when further support would be beneficial due to an outstanding unmet need

Future Steps

- ACE aware and Trauma-informed Child and Family Support Networks – all services working together locally with a common understanding of the impact of adversity and trauma on children and young people's lifelong developmental trajectory.
- Meitheal as a multi-agency trauma-informed process – training of Lead Practitioners in ACE aware and trauma informed practice.
- Whole system approach (inclusive of the Criminal Justice System, the HSE, the Education System etc.) – wider uptake and application of Meitheal to ensure a whole system response to adversity and trauma.

A Trauma Responsive Clinical Service: What, Why, How & What Next? (Eimear Ryan)

The Assessment Consultation & Therapy Service (ACTS) provides a multidisciplinary in-reach clinical service to special care units and Oberstown Children Detention Campus. ACTS consists of five disciplines: social work, social care, speech and language therapy, addiction counselling and clinical psychology. All clinicians share common skills around engaging and working therapeutically with young people and their families. Young people in secure settings generally present with high risk behaviour and complex clinical needs.

What?

As described by van der Kolk (2005), developmental trauma disorder refers to:

- Multiple exposure to developmentally adverse interpersonal trauma and subjective experience
- Triggered pattern of repeated dysregulation in response to trauma cues
- Persistently altered attributions and expectations
- Functional impairment: educational, familial and peer, legal and vocational

Young people with a history of developmental trauma tend to be 'on alert' and hyper-vigilant in their daily routines. Responses in everyday interactions can be over- or under- what would be expected. Young people may re-enact their earlier traumatic experiences without it being apparent that they are doing so e.g. a cup of tea

that is too hot can be a trigger for the general experience and feeling of not having their needs met. When someone has experienced trauma, they see the world through a trauma lens. Difficulties also present in the formation and maintenance of trusting relationships with others. A trauma-responsive clinical service is therefore fundamental to engaging young people in secure settings.

Why?

Findings from a number of international studies such as the Adverse Childhood Experiences (Feletti et al. 1998) consistently demonstrate the long term effects of childhood neglect and abuse. Closer to home, research exploring the views of young people and professionals on the mental health needs of children and young people with experience of the care and youth justice systems in Ireland emphasised the requirement for services to focus on engagement, significant relationships and trust (McElvaney et al. 2013). Furthermore, a quantitative study based on an audit of mental health screening profiles of young people in detention in Ireland highlighted high levels of traumatic experiences and a range of emotional/behavioural difficulties (McInerney et al. 2018).

How?

The therapeutic relationship between the young person and their key clinician is a priority in a trauma-responsive clinical service. Young people may already have met a large number of professionals in their life and they may often have done so under duress. It is therefore crucial that

clinicians take time to get to know the young person and to be flexible in how they try engage with them. Following the young person's lead provides the young person with a sense of agency and a 'say' in how they work with the clinician. What this looks like in practice includes changing the time of an appointment at the young person's request or engaging in a therapeutic session while the young person is shooting some basketball hoops. A trauma-responsive clinical service is one that is creative and readily adapts to suit each young person's needs and preferences. Relational repair through reliability and consistency are also vital; do as you say and don't let the young person down unexpectedly. A balance also needs to be struck between assessment and intervention; the system around young people is often keen for repeat formal assessments and finding out 'what is wrong?' so that it can be 'fixed'. Instead, a trauma-responsive clinical service emphasises working *with* the young person and developing a shared understanding of their strengths and weaknesses in a way that makes sense to them and is helpful. Young people are then better able to think of goals in a therapeutic intervention and to monitor their own progress. Supporting the young person to notice their gains and achievement, however small, can lead to a development of a sense of mastery and competence.

What next?

- Increased systemic working with other services

- More careful transition planning for young people as they return to the community
- Continued focus on activities based modalities
- Development of specific evidence based trauma interventions (e.g. EMDR, neuro-feedback)

Discussion

Participants were curious about the Meitheal model and recognized its potential use in their own agencies and organizations. Some participants highlighted that the Meitheal model has already been implemented in their agencies and workers are being trained in trauma-responsive care. The challenge of multi-agency work was also discussed. It was noted by delegates that all stakeholders need to be brought together to create a whole system approach.

Concerns were also raised in relation to how the parents of children in care can get more involved when their child is in custody. It was noted that ACTS has services if a child wants more support in transitioning back into the community. It was acknowledged that it is difficult to get parents of children in care into Oberstown due to practical problems and logistics. However, the service has plans to develop a wider network in the future, subject to government funding.

Delegates were delighted to hear and learn about the Meitheal practice model and were enthusiastic about implementing the process in their own agencies. A strong emphasis was placed

on the need for multi-agency training. It was also recommended that a public awareness and communications strategy should be implemented to raise awareness among professionals and practitioners who could lead a Meitheal, and also among the wider population.

2. Towards Trauma-Responsive Addiction Treatment Service at Tabor Group in Cork

Presenter: Mick Devine, Clinical Director, Tabor Group, Cork

Chairperson: Assistant Governor Constantin Cazac

Rapporteur: Rory Penny

Tabor Group is a leading provider of residential addiction treatment services in Ireland. Tabor Lodge is their primary residential treatment centre. It is located 15 miles southwest of Cork City and is surrounded by woodlands and rolling pastures. Tabor Group was awarded 'Rehabilitation Clinic of the Year' at the 2016 Irish Health Centre Awards.

When a traumatic state is triggered there is a tendency to seek sedation through alcohol or drugs. The aims of Tabor Group include teaching coping skills and to restore people to the window of tolerance. The 28-day programme consists of one-to-one counselling, group therapy, education, meditation and nature walks. Step-down facilities are utilised to create a safe environment.

Treatment Pathway

- Initial Contact
- Initial Assessment
- Stabilisation Period
- Admission to Residential Programme at Tabor Lodge
- Admission to Residential Extended Care Treatment At Renewal (Women) and Fellowship House (Men) - 12 weeks
- Sheltered Accommodation - 12 weeks
- Community Continuing Care Programme - 52 weeks
- Community Family Programme - 4 Weeks, 12 Weeks and 52 weeks

In 2017 there were 316 initial assessments completed, 213 admissions to Tabor Lodge's 28 Day treatment programme, and 183 who completed the residential programme. The age profile of those admitted is generally between 25-45 years, with the number of men admitted twice that of women. The highest rates of referral to the lodge are self-referral and those from concerned families.

What is Trauma?

The Substance Abuse and Mental Health Services Administration (SAMHSA) Trauma and Justice Strategic Initiative states that: *"Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being"*.

Symptoms of trauma include depression, panic attacks, and self-destructive

behaviour. A substance dependency may develop in an effort to be well and solve the underlying issue.

After Trauma, the nervous systems remain prepared for danger (Ogden, Minton & Pain, 2006). The Window of Tolerance is a term used to understand and describe normal brain and body reactions, especially following adversity. The concept suggests that humans have an optimal level within the Window that allows for the ups and downs of emotions. It is crucial to remain within the Window of Tolerance. Here, feelings and reactions remain tolerable. An individual can think and feel simultaneously, and reactions adapt to fit the situation. Outside the Window of Tolerance the polar sensations of chronic hyperarousal (emotional overwhelm, panic, impulsivity, hypervigilance, defensiveness, feeling unsafe, reactive, angry, racing thoughts) and chronic hypoarousal (numb, "dead", passive, no feelings, no energy, can't think, disconnected, shut down, "not there", ashamed, can't say No) may occur. Hyperarousal was previously mistaken as aggressiveness and a danger. Tabor Group now works to return patients to the Window of Tolerance.

Tabor Group Training Programme 2017: Seeking Safety

Treatment Topics include:

- Safety
- PTSD: Taking Back your Power
- Detaching From Emotional Pain
- Taking Good Care of Yourself
- Integrating the Split Self
- Asking for Help

Knowledge, skills and attitude are three fundamental attributes imparted to staff at Tabor Lodge. Tabor Lodge Staff possess the skills to assess the nature, severity and impact of trauma of an individual's capacity to engage with addiction treatment. These skills help facilitate clients to develop capacities to cope with complex trauma while learning to manage addiction.

The attitudes that are cultivated are focussed on working respectfully and emphatically with clients. It is essential to develop awareness of the pace at which clients develop resilience and capacity to manage addiction and complex trauma.

Integrating Trauma Informed Dimension to Treatment Delivery at Tabor Group

The central findings of this recent integration of a trauma informed dimension are of staff feeling better prepared to deal with trauma. Clinical staff have witnessed that the acute needs of residents are now being addressed with the development of a competence to respond to the dysregulation of a client with significant trauma history.

From the perspective of residents, they feel safer in the knowledge that clinical staff can communicate understanding of this dimension of their lived experience and can respond to this need with skill so that distress is alleviated. This has resulted in everybody in Tabor Lodge feeling safer. Staff report significant professional development and stronger

team ethos as a result of the training programme.

The commitment to implement a trauma informed approach to treatment is high among staff participating in this training project. The structures put in place to facilitate delivery of this training project are now being embedded into the treatment delivery in Tabor Lodge. These include physical activities (such as yoga) which assist with emotional regulation and a follow through to treatment delivered post Tabor Lodge treatment episodes. An attitude of sensitivity to the pace the client can engage with treatment implied that extended care and continuing care programmes need to become trauma informed.

The challenges of implementation include maintaining the primacy of the focus on addiction treatment be maintained in the face of continued integration of trauma informed approach. There are also resource implications to extending this new capacity to all clinical staff of Tabor Group. It is essential that the element of review and evaluation be maintained in the implementation phase.

Discussion

The discussion section of the workshop presented some important aspects that still need development, as well as proposals offered for future success. How Tabor Group has become more trauma-responsive was initially discussed. Those with aggression used to be discharged. However, they now try to alter care plans to avoid certain triggers. An example of

this would be for non-literate individuals who may be ashamed of this. When a traumatic state is triggered for an individual, showing compassion can help calm them down. It is easy to invoke an intolerant response, but this ultimately just contributes to extended trauma. Help with bills and home life is also provided for. Even the interior design of the Lodge is now aimed at trauma responsiveness.

How Tabor Group is seeking to better help the families of those with addiction issues was then discussed. Family members of individuals in treatment often experience a form of trauma and there is a recognition that they need help too. There have now been workshops set up for families, to help become more trauma informed. As well as this, there is a 12-24 month rollout for a family programme which will involve assessments and care plans. The role of children, in the treatment of parents with addiction issues, was also mentioned. However, this may be done at the risk of traumatising the child.

The issue of how best to help children affected by parental addiction issues was highlighted. Examples of the 'Silent Voices' report by the Children's Commissioner for England and the children's programme run by the Betty Ford Centre in America were given to highlight successful initiatives enacted abroad.

Another major concern for those present was the critical issue of homelessness, which can result in the perpetuation of

trauma. There is no trauma informed care found in hostels, and it can be extremely difficult to break the cycle of addiction living on the streets.

The mentality of trauma victims was then considered. Many present who had previously encountered an addict had witnessed how they would refer to themselves as a 'scumbag'. They would use this phrase due to their lack of self-esteem and thoughts on how society viewed them. It is therefore essential to avoid pre-conceived notions when seeking to help them.

A criminal defence solicitor then broached the issue of training and referrals to trauma services. In his experience with clients he had found it very difficult sometimes to find help for them. As he put it, 'there is no training in dealing with traumatised clients in Blackhall'. He stated it would be helpful to be able to refer clients to trauma services, although the issue of time waiting for the service is still present.

When the discussion finished a feedback questionnaire was distributed. It was found that trauma informed training for front-line staff (such as social welfare officers, Gardaí etc.) was an immediate concern. In the near future it would be ideal to have a cohesive national strategy, as well as potentially implementing a professional qualification to entice individuals to undertake trauma informed training.

3. Poverty, Homelessness, then Prison - and back to Poverty, Homelessness again

Presenter: Fr Peter McVerry, Peter McVerry Trust

Chairperson: Fergal Black

Rapporteur: Beth Duane

Introduction

The Peter McVerry Trust is a charity established by Fr. Peter McVerry with the aim to reduce homelessness and the harm caused by drug misuse and social disadvantage. The charity provides low-threshold entry services, primarily to younger people and vulnerable adults who have complex needs, by offering pathways out of homelessness based on the principles of the Housing First model. Housing First is an approach that offers permanent, affordable housing as quickly as possible for individuals and families experiencing homelessness, and then provides the supportive services and connections to the community-based supports people need to keep their housing and avoid returning to homelessness. The Peter McVerry Trust has developed a range of services such as prevention services, homelessness services, drug treatment services, and under 18s residential services. In addition to these services, the Trust is committed to developing and maintaining links with other relevant agencies to provide an effective wrap around service. This interagency model is designed to ensure efficient service delivery, and to eliminate gaps in services, and to assist in client

progression. The Peter McVerry Trust's Vision statement reads

"An Ireland that supports all those on the margins and upholds their rights to full inclusion in society"

Prisons are full of people who are poor, not just in Ireland but in every jurisdiction, but not just poor economically, but socially, psychologically, educationally, and with people who have very limited opportunities in life. It is an unfortunate fact of life that within the prison service the issues of mental health and addiction are huge challenges for everybody. There are a large number of people in prisons who suffer from serious mental health illnesses in custody. Despite efforts by staff and others, drugs are readily available in prisons and have become a huge scourge for everybody in custody.

Mental Health

Mental illness poses a huge problem in Irish prisons. A young man was recently released from prison after serving a five-year sentence for a serious assault on a passer-by on the street - it was a random, unprovoked assault. He spent most of his time in the Central Mental Hospital, and a few weeks before he was released there was a case conference regarding the terms of his release. It was argued that he was not fit for release, and that he should be admitted to a psychiatric hospital following his release. However, no psychiatric hospital in the country would take responsibility for him, and he was released into homelessness. He stated that the reason why he stabbed the victim was due to the fact that he had

stopped taking his medication, as he had no medical card and could not afford to pay for them. This is the way that the system has let this young man down.

Mental illness has recently been outlined as being a major problem in Oberstown Detention Centre. In the *Key Characteristics of Young People in Detention Report* (2018), it was found that over half (52%) of young people arriving in Oberstown have a mental health need, 27% of young people were prescribed medication for a mental health concern, and there were concerns about self-harm in respect of 23% of people. These figures present an interesting narrative proving that mental illness remains an increasing and difficult problem in Irish prisons.

Addiction

Prisons are one of the biggest methadone clinics in the country. People use drugs as an escape from the trauma that they have experienced in their lives. Up to 70/75% of prisoners have an addiction. They use drugs to provide a temporary escape from their incarceration. Additionally, many people cannot cope with these experiences, and have never been to therapy and have never developed coping strategies to deal with this abuse. Thus, using drugs provides an effective release from this trauma.

A young man told the Peter McVerry trust that when he was thirteen years old, he would sit at his kitchen table every night and watch his parents inject heroin. He is now in prison. Correspondingly, an eleven year old boy went to Fr. McVerry and

asked for help. It was found that his alcoholic parents were sending the young boy out every night into prostitution to collect money for them, and if he didn't he would be physically abused. He too is currently in prison. An informal questionnaire taken by Fr. McVerry at St Patrick's Institution, when it was open to children, found that out of 20 of the children, 19 of them had a parent who was addicted to alcohol and/or drugs. Therefore, negative childhood experiences have a considerable impact on how an individual responds to these life experiences.

Release

Prison is the only public service in this country to which the poor have access that has no waiting lists. Recidivism depends not so much on what goes on in the prison, but as to what happens in the six weeks following the individual's release. If you are released from prison back into homelessness, back into nothing to do, back into having no money to sustain yourself, it would be more difficult to maintain a drug and crime free lifestyle. The one thing that pushes people back into crime is being released into nothingness, with nothing to do all day long, and this drives people back into drugs and crime. It is essential to secure accommodation for prisoners on release, in conjunction with having a medical card and access to addiction or mental health services in the community.

Discussion

Participants explored possible resolutions under the headings; mental health, addiction and release planning.

Mentally ill homeless people are failed again and again by a system which is not set up to adequately meet their needs. The participants agreed that there is a need to reform homeless psychiatric services to try to solve this issue. Developing psychiatric services for homeless people, and specifically, access to residential care for homeless people is a priority.

It was suggested that access to addiction counselling in prison is insufficient. The participants outlined how a majority of the prison population (up to 70%) have issues relating to addiction. Therefore, the participants suggested that improving access to addiction services in prison, in addition to HSE support for prison services, would be an effective solution to this problem. There was a discussion regarding how a custodial drug treatment centre, in lieu of a custodial prison sentence, would be a better alternative to treat offenders who are addicted to substances. However, the participants maintained that prisoners being released from custody need a wraparound service to stop them from destabilising and becoming an addict again.

More advanced planning needs to be developed to ensure that, on release, individuals are not homeless and have an appropriate level of care. The discussion group outlined how it would be possible

to make emergency accommodation beds for prisoners on release, and how important it is that they were given their own space to feel safe and have the choice to isolate themselves from other drug users. The discussion group brought up how an extra two hundred beds are found for homeless people during the Christmas period, and remarked how renovating a building would be a logical solution to this problem. The group found the pilot schemes involving the securing of medical cards for prisoners on release to be promising. They stated that the provision of these cards was essential so that newly released prisoners could continue to receive any psychiatric or addiction-related prescriptions. However, the participants found that there were issues relating to acquiring medical cards due to the non-compliance of GPs and other related services. They suggested that this scheme should be continued and urged for greater compliance between GPs, the HSE, and the Irish Prison Service.

4. Prisons: Trauma Informed Interventions - Them and Us?

Presenters: Claire Moloney, Chartered Counselling Psychologist, IPS Psychology Service, and Aoife Rice, Assistant Psychologist, IPS Psychology Service

Chairperson: Mark Wilson

Rapporteur: Annita Harty

A small research project began as a short group intervention and was conducted in

Cork prison. This research project was the focus behind the workshop. The psychology team in Cork Prison felt it was of benefit to conduct this intervention due to the prevalence of Post-Traumatic Stress Disorder (PTSD) within the prison population. The title of the workshop relates to the fact that a given individual can be both traumatised and a traumatiser.

Understanding Post-Traumatic Stress Disorder (PTSD)

PTSD is a mental health disorder which sometimes develops in the aftermath of a terrifying or horrific life-threatening experience. It is characterised by three clusters of symptoms:

- Re-experiencing – flashbacks, nightmares, intrusive thoughts
- Avoidance – of people, places, thoughts, activities, feeling detached from others
- Increased arousal – vigilance, sleep problems, anger, poor concentration

PTSD may be diagnosed if these symptoms are still present a month after the event and cause clinically significant distress/impairment in social, occupational, or other daily functioning.

NICE (National Institute for Health and Care Excellence UK) Guidelines set out recommendations regarding when and if, trauma-focussed interventions should be provided and the guidelines also recommend specific types of psychological intervention.

However, PTSD alone does not adequately describe the full range of traumas or trauma responses. In 1992 Judith Herman

first proposed the idea of Complex PTSD as *"an attempt to bring some kind of order to the bewildering array of clinical presentations in survivors who had endured long periods of abuse"*. In 2009 the National Child Traumatic Stress Network (NCTSN) led by Bessel van der Kolk proposed the new diagnosis of *Developmental Trauma Disorder* for inclusion in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). The NCTSN asserted that Developmental Trauma results from prolonged or multiple exposure to adverse events including repeated and severe interpersonal violence and disruptions of caregiving. Such experiences typically give rise to:

- Affective and physiological dysregulation
- **Attentional and behavioural dysregulation**
- Self and relational dysregulation
- Post traumatic spectrum symptoms
- Functional Impairment

It is interesting to focus a little more closely on what is meant by "attentional and behavioural dysregulation" and more importantly, the implications of this for the child concerned. The NCTSN's description of "attentional and behavioural dysregulation" includes:

- ***Preoccupation with threat, or impaired capacity to perceive threat, including misreading of safety and danger cues***
- ***Impaired capacity for self-protection, including extreme risk-taking or thrill-seeking***

- Maladaptive attempts at self-soothing (e.g. rocking)
- Habitual (intentional or automatic) or reactive self-harm
- Inability to initiate or sustain goal-directed behaviour"

How difficult and dangerous must life be for children who have the above symptoms? It is worth considering how these symptoms can actually give rise to further trauma, for both the original patient and those he/she encounters.

While the DSM-5 subcommittee rejected the 2009 NCTSN proposal on Developmental Trauma, in 2018, the 11th revision to the World Health Organization's International Classification of Diseases (ICD-11) proposed two distinct sibling conditions: Posttraumatic Stress Disorder (PTSD) and Complex PTSD (CPTSD). ICD-11 describes Complex PTSD as a disorder that may develop following exposure to an event or series of events of an extremely threatening or horrific nature, most commonly prolonged or repetitive events from which escape is difficult or impossible (e.g., torture, slavery, genocide campaigns, prolonged domestic violence, repeated childhood sexual or physical abuse). The disorder is characterized by the core symptoms of PTSD; that is, all diagnostic requirements for PTSD have been met at some point during the course of the disorder. In addition, Complex PTSD is characterized by 1) severe and pervasive problems in affect regulation; 2) persistent beliefs about oneself as diminished, defeated or worthless, accompanied by deep and pervasive feelings of shame, guilt or

failure related to the traumatic event; and 3) persistent difficulties in sustaining relationships and in feeling close to others. The disturbance causes significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

Why is it important to treat trauma?

Trauma begets trauma. This is not to say that people who have experienced trauma intentionally set out to traumatize others, but Complex PTSD *can* leave a person vulnerable to both experiencing and perpetrating trauma in later life. There is a known association between trauma and subsequent offending behaviour (Ardino, 2011) and researchers such as Lyons-Ruth (1996) have found evidence for the intergenerational transmission of trauma.

The challenges of treating trauma in a prison setting

All psychological therapies are predicated on a trusting relationship between therapist and client, yet trauma interferes with a person's ability to trust and this is heightened in a prison setting.

Experiences in prison can trigger memories of a prior traumatic event e.g. having to remove one's clothing, being restrained, being confined, being alone and not having opportunity to connect with a loved one, feeling abandoned, or

witnessing violence. A further complicating factor is the instability which often characterises the prison setting.

As we noted earlier, the NICE Guidelines provide direction on treating PTSD in a community setting, but what of *Complex* PTSD in a prison setting?

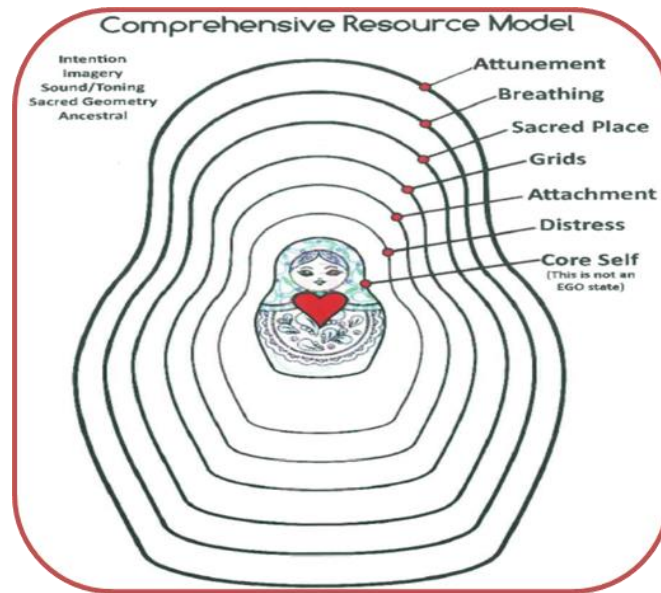
The Comprehensive Resource Model

The Comprehensive Resource Model (CRM) is a relatively new, neurobiologically-based trauma therapy. It is a nested modality which is conceptually represented by the nested Russian Dolls (Schwarz, Corrigan, Hull and Raju, 2017) - see Figure A. The client is provided with positive and internally sourced attachment resources which facilitate the client in remaining fully present while processing traumatic material.

Stabilization, processing and integration occur simultaneously while the resources utilised are anchored through eye positions in the brainstem.

As CRM is especially suited to the treatment of Complex PTSD, it was this model which was chosen for the Cork Prison Psychology Group.

Figure A



The Group

The CRM group ran for six weeks and included seven male participants ranging in age from 19-65 years, the majority of whom had convictions for violent offences. Their time in custody varied from 2.3 years to 16.3 years, all had alcohol and substance misuse issues and some had very poor literacy.

A culture of responsibility and belonging was cultivated in the group and participants were given the choice to opt in, or out, of both the exercises and group. The intervention involved teaching the participants about trauma and teaching them Attachment and Neurobiologically based CRM resourcing exercises (5 of the seven resources plus the secondary resource Intention). A quasi-experimental research design was employed and the

study utilised both qualitative and quantitative measures. The quantitative measures provided data on PTSD (PCL-5), Dissociation (MDI), Depression, Anxiety and Stress (DASS) and Alexythymia (TAS-20).

Results

A paired samples t-test was conducted to evaluate the impact of the intervention on all four measures. (Figure B) There was a statistically significant decrease in DASS scores from pre ($m=29.14$, $SD=20.84$) to post ($M=13.29$, $SD=12.50$), $t(6)=2.48$, $p=.048$ (two-tailed). The eta squared statistic (.51) indicated a large effect size. Qualitative data indicated that participants found the group both enjoyable and useful and reported finding in it, a sense of belonging.

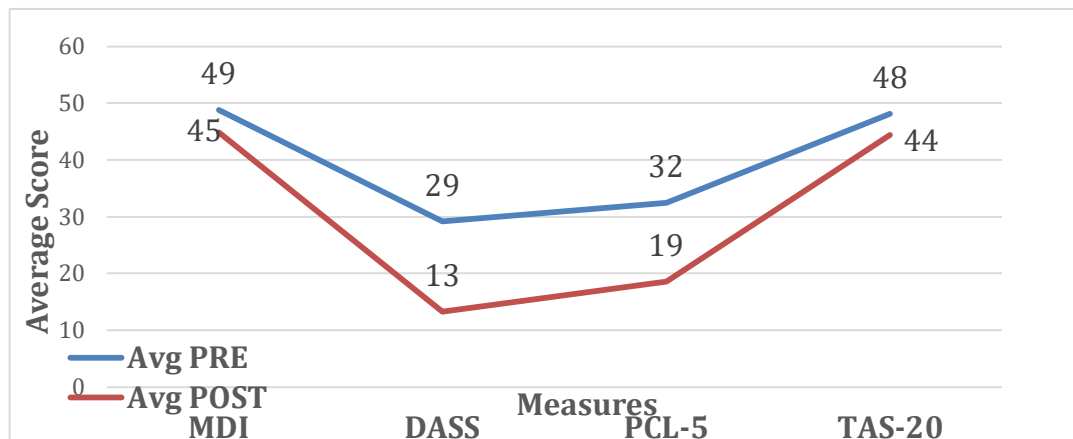


Figure B

Workshop Discussion

The following questions arose at the end of this workshop:

Q. Was it the sense of belonging to something (the group) or the actual therapy model that created the positive results?

The research group cannot exactly determine what produced the results, it could have been the psycho-educational aspect of the group, and the CRM resources or it could have been a mixture of other factors. Data was collected after one week of completion of the group. It would be beneficial for long-term data to be collected. However, this is difficult to do because there is a variance in custody times and some of the participants were due to be released from prison earlier than others.

Q. Has this model ever been used with children?

It was uncertain if CRM had been used with children. Any trauma therapy employed with children would need to be one which provided the child with sufficient resources to tolerate the therapy.

Q. Were the prison officers interviewed after the sessions were completed to ascertain dialogue coming from prisoners about the group experience?

No dialogue was obtained from prison officers before or after the group, as it would have been impossible to control.

Concluding Remarks

Structural issues in society have also been recognised as factors to trauma. Addressing issues at a micro and macro level has an effect on all in society. Clinicians are addressing one area and it is up to policy makers to address other factors, such as homelessness, in order to reduce trauma which may occur. A general consensus from the workshop was that there needs to be training for all prison staff in trauma, more public awareness on trauma and the CRM model, and to have this model rolled out nationally to all Prison environments. Moving toward a Trauma-Responsive Criminal Justice System could lead to reductions in suffering, offending and costs to all in society.

5. From Exclusion, through Muddle, to Rights: The Place of Victims in Sexual Offence Trials

Presenter: Noeline Blackwell, Chief Executive Officer, Dublin Rape Crisis Centre

Chairperson: Dr. Susan Leahy

Rapporteur: Alaina Maher

Historically within the Irish Criminal Justice System it was nearly impossible to have the victim's voice heard; the victim was seen to have no place within the system. The basis of the common law system hampers our domestic system from recognising the rights and place of victims within the Criminal Justice System.

Initially, communities meted out justice at a local level within the community. Over the centuries, as the system became more administrative and power was pulled away from the community, victims could have a place in the Criminal Justice System if they had the money to pay the State to take a case on their behalf. As time progressed, the State came to recognise that society was harmed by crime and as such, the State was entitled to prosecute, on behalf of society, and to require the citizens of the State to assist with their prosecution as jurors or witnesses. Today within our domestic system, it is up to the State to present the case on behalf of society. Over the past 100 years or so, an imbalance of power between the State and the accused was recognised, with the accused being very poorly served against the might of the State. As such, there was a movement toward striking a power

balance between the two parties to the trial in the twentieth century articulated internationally in the enactment of various instruments such as:

- The Universal Declaration of Human Rights
- The International Covenant on Civil and Political Rights
- The European Convention on Human Rights

Domestically, the right of the accused to a fair hearing was established in the Irish constitution and was elaborated by the Irish courts over time.

These developments saw the recognition and implementation of rights of the accused such as the right to Due Process and to a fair hearing.

One crucial party to this scenario was being ignored and excluded - "the Victim". There was a general suspicion that triangulating the system by including the victim would create mess and muddle. By the 1980s, victims of sexual and domestic violence were recognised as being traumatised and in need of personal help but also as being key players in the Criminal Justice System. As such, rights for these victims began to develop and were being recognised internationally as Human Rights. In our domestic system, however, the victim was still being overlooked.

By waiving her right to anonymity following the trial of her attacker, Lavinia Kerwick spurred a movement toward recognising the need to challenge leniency

of sentencing and allowing the victim's voice to be heard. There have been developments in relation to the victim's place within the Criminal Justice System in the past twenty-five to thirty years which continue apace. Particularly with the enactment of the binding EU Victims' Directive, victims' rights are recognised, inclusive of the right to information, due process, compensation and privacy. The rights of victims are much better integrated into systems in mainland Europe than in our domestic system in that our common law structure makes the integration of these rights more difficult.

What needs to be done?

There needs to be recognition, understanding and implementation of victims' rights within the Criminal Justice System in Ireland. The system needs to recognise that implementing victims' rights will not take away from the right of the State or the accused but it will rebalance the system in a positive and fair manner. In many sexual and domestic violence cases, where the crime only occurs if the behaviour was non-consensual, a jury is looking at a "he-said/she-said" scenario where the "he-said" side of the case is being made to the jury by experienced, trained, expert advocates. On the other hand, the "she-said", who may never have been in a courtroom before and who has experienced great trauma and undergone re-traumatisation throughout the proceedings, is expected to be able to make the same case to a jury without representation or support. This is a complete imbalance of power within our

Criminal Justice System. Whilst there is provision in our legislation for limited representation for these victims there is a need to extend this further to achieve fairness.

There is a just case for trauma experts to be brought into the courts to deal with such cases because lawyers and jurors are not trained in the area of trauma and, as such, do not understand the impact of trauma on human recollection and the effect on the human mind. Within the Criminal Justice System as it currently stands, victims' rights to due process and to a fair hearing are not being effectively implemented. By failing to recognise victims in the process, our system is failing to give effect to the Victims' Directive and is also adding to the re-traumatisation of victims.

Discussion

Participants queried how the Criminal Justice System could extend the representation available to victims. The Minister for Justice and Equality has ordered a review of the treatment of victims in the Criminal Justice System and this is to be concluded by the end of the summer. The Dublin Rape Crisis Centre will be asking the Minister to review this shortfall. There is already a model in place so it is just about finding a way to carry out this change in a way that is cost-contained.

Delegates were interested in the aspect of restorative justice in terms of sexual violence. They stressed the importance of practitioners and facilitators in sexual

offence cases including the victim in the decision making process and that they must be mindful of the trauma that comes with such cases in an effort to eliminate re-traumatisation for the victim. In addition, it was acknowledged that the media and the community must be trauma-informed and be mindful of the way that their actions in reporting and commenting affect the victim in these cases.

Participants were also concerned about how the Equality of Arms is dealt with. The Irish Criminal Justice System assumes that this is solely between the State and the accused with the victim being ignored. Currently, there is a total inequality of arms which needs to be addressed going forward. It was acknowledged that total representation for the victim is not essential but that each side to the case should have an equal opportunity to tell their side of the story to the jury in the same way.

It was acknowledged that the system must become more trauma-informed and be cognisant of the fact that mental health issues are real. It was brought up in discussion that justice in sexual offence cases extends beyond trial and sentencing and that this needs to be acknowledged by the system. The Probation Service is currently running a scheme in victim-offender mediation in which Probation Officers are being trained. It is hoped that this practice will continue to grow as it has been evidenced as beneficial to the victim.

Suggestions for changes to be made included:

- Provision of trauma-specialists to accompany victims through the court process
- Moving toward specialist investigation in training front-line Gardaí in how to deal with victims in a trauma-informed way when taking statements
- Train lawyers to use appropriate sensitive language when dealing with victims of sexual offences to avoid re-traumatisation
- Offering support post-trial
- Managing the physicality of the Courtroom so as to avoid re-traumatising the victim e.g. not having the victim walk past the offender or have to sit facing the offender
- Provision of a victim liaison officer

6. Every Woman, Every Story: Trauma, Criminality and Women in Prison

Presenters: Governor Mary O'Connor and Dr. Maggie McGovern, Dóchas Centre

Chairperson: Deirdre Byrne

Rapporteur: Alaina Maher

The Dóchas Centre operates a multi-disciplinary approach which keeps women in custody at the centre of its services. The Centre aims to provide a safe environment for women and to provide each individual with services to improve their quality of life and achieve a more law-abiding future. Each woman has a

story, and often this story is challenging in its human suffering and involves many traumatic experiences. The Dóchas Centre provides one to one supports along with group programmes to offer each woman a space to address her needs and in doing so develop new skills and awareness. This work is challenged by the realities of homelessness, poverty and addiction. Many of the women committed to The Dóchas Centre, like women in custody in the UK, are better understood as troubled rather than troublesome, more a danger to themselves than to society. (Baroness Corston, 2007)

This workshop explored the experiences of women in custody and how understanding and responding to trauma related needs is helpful in working toward the goals of the Criminal Justice System. The workshop considered the role of trauma-informed practice in creating an environment that is more responsive to trauma related needs and which maximises the potential for custody to be used as an opportunity for learning.

Understanding trauma and its effects is crucial to adequately supporting women in prison and in the Criminal Justice System. Trauma within the Criminal Justice System is not a new phenomenon, but understanding its effects is crucial.

Women in custody have often experienced considerable trauma and the actions of some have caused substantial trauma in the lives of others. Whilst it is acknowledged that a history of trauma

does not excuse offences it remains relevant to understanding offending behaviour.

When women enter prison they often feel negatively about themselves, lack confidence and don't believe they have a future worth looking forward to. Staff training is accepted as essential in guiding practice that can support positive outcomes for women both while in custody and when reintegrating to the community. Training that supports officers and other prison based professionals to better understand the needs of those in custody continues to be vital. There is a necessity to continue improving training in the prison service and across the broader Criminal Justice System particularly with regard to understanding how experiences of complex trauma may be impacting on an individual's ability to engage with services aimed at supporting the offender and ensuring public safety.

What is Trauma?

Episodes of "once-off" single traumatic events which can result in post-traumatic stress disorder (PTSD) are very different to the problem of Complex PTSD. This relates to exposure to traumatic events that are repetitive, prolonged, or cumulative. Usually these events are interpersonal, involving direct harm, exploitation, and maltreatment including [neglect](#)/abandonment/hostility by primary caregivers or other, and often occur at developmentally vulnerable times in the victim's life, especially in early [childhood](#) or [adolescence](#). Such traumatic

events can also occur later in life and in conditions of adult vulnerability.

Complex trauma is a frequent feature in the presentation of women entering the Dóchas Centre; many having lived with the ever-present threat of danger. Such experiences have a profound impact on development and learning. In the absence of safety, the attention needed for other developmental tasks is required to scan for threat. Consequently, the attention required for new learning may be unavailable and this can continue in the absence of any objective danger. Women coping with complex trauma experience the world in traumatised bodies and minds. In this way, trauma experienced in the past can be more accurately understood as a description of the here and now. In the context of complex trauma, individuals often develop a deeply embedded belief that they are in some way to blame for their experiences of trauma (abuse, neglect) and this inaccurate and unhelpful belief can be very difficult to shift.

Vicarious trauma is prevalent among support staff in prison environments and across the Criminal Justice System. It is important that training and support are provided in relation to this in order to protect staff and officers from vicarious trauma and to maintain their good practice. This also serves to protect people in custody who themselves can be impacted by the well-being of officers and who can experience vicarious trauma through exposure to the traumatic

experiences of others, sometimes those of their peers in custody.

Trauma and Criminality

The more Adverse Childhood Experiences (ACES) one has, the more likely they are to enter the Criminal Justice System, as a history of childhood trauma is linked to higher rates of offending in adult life. While research has not demonstrated a causal link between trauma and criminality, there is a strong association between trauma exposure and women's offending behaviour in particular. Given that early trauma can disrupt emotional and behavioural skills development, it is important that women affected in this way are taught skills to help them experience their emotions in a more healthy way. Dóchas can present a safe environment where women can develop new skills that help them to cope more effectively. This means coping in ways that do not add needlessly to their suffering or cause needless suffering to others. Responding to trauma is the humane thing to do. The Criminal Justice System has opportunities to bring compassion into action when linking with offenders whose offending behaviours may be attributable in part to the impact of trauma.

How do we become trauma responsive?

Two strands:

- Staff and Environment
- Targeted Supports and Intervention

The impact of complex trauma can be minimised and is sometimes not recognised for its serious consequences,

not least in terms of quality of life. Understanding and responding to trauma based needs can be reparative and lead to better outcomes at an individual and societal level. In light of this, there is merit in all of our communities developing greater understanding of complex trauma and how it can impinge on human lives and behaviour as well as developing greater skill in responding to those who have been exposed to multiple traumatic events.

- **Realise** the impact of trauma and understand potential paths for recovery
- **Recognise** the signs and symptoms of trauma on clients, families, staff and others in the system
- **Respond** by integrating knowledge about trauma into policies, procedures and practices
- **Resist** re-traumatisation

Dóchas encourages positive appropriate relationships within the community, where women feel supported and challenged, and can learn from role models who encourage attachment and provide support. The ethos must start with compassion in understanding trauma and its effects on the women in custody. Dóchas strives to facilitate women in reaching their potential. At its best "Prison is an opportunity for repair"; the time in custody can benefit both the women and society more broadly. Facilitating a trauma-responsive community is down to knowledge and training. Demonstrating compassion and understanding, being open to ideas and

change and encouraging conversation are all proactive steps in becoming trauma-responsive. Trust is an important aspect to this work and fostering and offering trust upfront can be the corner stone of progress. Management are required to lead, demonstrate and challenge appropriately and understand the power of enhanced knowledge and empowers others in this way. In order for any trauma-responsive approach to succeed, consistency in day to day operations is essential. Consistency across all aspects of a prison environment is not easily achieved. However, with awareness, progress toward this can be made in increments and sometimes in strides. Also necessary is the provision of comprehensive training and support to offenders, agencies and teams.

Coping strategies

Coping strategies such as aggression and substance abuse can develop to help one deal with trauma. Whilst over time, coping strategies can become maladaptive, it is important to understand these strategies developed for a reason and served a purpose for the trauma victim at a time when survival was necessary. Understanding the origin of these strategies can support the Criminal Justice System to respond more effectively. Prison can be a safe place where victims can work through their trauma and learn new ways of coping with their traumatic experiences. In some instances, peer-to-peer counselling is an effective way for women in Dóchas to work together in overcoming issues and building healthy relationships.

Discussion

Participants queried the number of committals of women due solely to homelessness or drug abuse. Whilst there are services available for these women in Ireland, some cannot engage with the programmes because of difficulties in breaking away from their current, familiar lifestyle. Having a more trauma-informed society and an opportunity to engage with trauma specialists in the community could reduce the amount of unnecessary committals.

Participants were interested in the effectiveness of peer-to-peer mentoring amongst women in prison. Dóchas hopes to provide a safe, supportive environment for those who feel victimised. Peer support is powerful and has the capacity to be extremely helpful; confiding in others who have experienced similar trauma is very effective. Dóchas encourages a collaborative environment where offenders are encouraged to contribute ideas as how best to carry out services in an effective way.

Participants asked about services designed for specific minorities such as those with mental health issues in the Travelling Community. Psychiatric services in the Centre provide for those who were once seen as "troublesome" to be diagnosed and treated for mental health problems if these apply. This work led by the National Forensic Mental Health Team has made a substantial difference to many women in terms of their mental well-being. Travellers represent an ethnic minority within

Dóchas as do a number of other ethnic minorities at the Centre. In terms of service access, Dóchas provides equality of access to all programmes e.g. from Psychology, Probation Services, Psychiatry. Services at Dóchas endeavour to respond to each woman as an individual whilst remaining culturally conscious and informed.

Others queried the availability of services for new mothers in prison. Dóchas encourages the baby to be the mother's main focus, but new mothers are still expected to engage with the counsellors and attend classes. Often there are deep feelings of distrust between women in custody and child protective services. Dóchas cooperates with Coolmine Therapeutic Community and Tusla to ensure the provision of adequate services and to ensure that if it is reasonably possible, a mother and baby will leave prison together. There is limited availability of residential treatment for offenders who are new mothers in Ireland and it was noted that this could be expanded on. The educational programme within the Dóchas Centre provides child care classes which new mothers are encouraged to attend. There is also a level of one-to-one work available to new mothers to help in achieving attunement between mother and child.

7. Pathways to Prison - The Experience of the Traveller Community

Presenters: David Joyce, Solicitor, Mercy Law Resource Centre, and Anne Costello, Coordinator, Travellers in Prison Initiative

Chairperson: Dr. Lucy Rowell

Rapporteur: Ciara McQuillan

Introduction

The Traveller Community is a distinct ethnic minority group in Ireland. This group make up less than 1% of the population and have experienced unparalleled levels of inequality which is evidenced by the All-Ireland Traveller Health Study 2010 (AITHS). This inequality (discrimination, oppression, racism and social exclusion) has contributed to trauma within the Traveller Community. The Travellers in Prison Initiative (TPI) developed as a response to the specific requirements of Travellers in custody in prisons in the Republic of Ireland.

Trauma in the Traveller Community

There are numerous possible factors which may cause trauma in the lives of Travellers. These include:

- poor health
- poor accommodation
- poor educational experiences and unemployment
- experiences of discrimination and racism

In relation to poor health, Travellers have experienced disadvantage in accessing health services. Many Travellers have

difficulty in accessing medical cards due to changing postal address or a lack of a postal address. This leads to a difficulty in accessing a wide range of medical services including dental services, mental health services, and health screening programmes. This inequality has contributed to high rates of mortality, a higher infant mortality rate, low life expectancy and suicide rates which are seven times the national average.

The lack of Traveller specific accommodation is also a significant cause of trauma for the Traveller Community. Homelessness amongst Travellers is eleven times the national average.

In terms of education, a source of trauma may become evident when Travellers are denied access to the education system. Some Travellers experience discrimination because some schools operate a quota on accepting Traveller children. Therefore, from the very beginning of their educational journey these children experience the trauma of social exclusion, discrimination and racism. Travellers have poorer educational outcomes than the general population; the AITHS found that 55% of Travellers leave school by the age of 15 years. Recent years have seen an increase in participation in third level education. However, the barrier of discrimination still exists in relation to gaining employment. 80% of the Traveller community suffer the trauma of unemployment; in a 2017 Behaviours and Attitudes survey only 25% of people would accept a Traveller as a colleague.

These high levels of racism, discrimination and a lack of recognition and understanding of Traveller culture have led to the wholesale social exclusion of this ethnic minority. This has resulted in a community which has suffered trauma and internalised oppression. Internalised oppression manifests in minority groups whereby members of the group believe the negative stereotypes and myths attributed to the group by the majority population. This manifests itself in the following forms:

- low self-esteem, anxiety, depression and self-destruction,
- destructive behaviour towards their families and other Travellers
- high levels of addiction linked to trauma
- the over-representation of Travellers in prison
- conflict and unease with their own ethnic identity

Internalised oppression supports the position that the established majority population is superior - it is the standard; thus it undermines the self-identity of the minority ethnic community. The trauma experienced by the Traveller community provides the background reasons for over-representation of Travellers in prison.

Pathways to Prison

Membership of the Traveller community accounts for less than 1% of the overall population. The Irish Prison Service estimates that Traveller men make up 15% of the prison population, and that Traveller women constitute an estimated 22% of the prison population. A

discussion group considered the reasons why minorities are over-represented in the prison population. The following reasons emerged as possible contributory factors in the over-representation of Travellers in prison:

- socio-economic reasons, including unemployment and poverty
- educational disadvantage
- prejudice, discrimination, racism and marginalisation
- high levels of drug and alcohol addiction
- accommodation and mental health issues

The disproportionate representation of Travellers in the prison system is not unique to Ireland and comparison was drawn with the indigenous Maori people in New Zealand, who comprise 14% of the general population but 50% of prison population. Similarly, in Australia, Aboriginals account for 2% of the population yet 27% of the prison population emerges from this ethnic minority.

Other possible explanations for the over-representation of Traveller and ethnic minorities in the prison system included;

- ethnic minorities simply commit more crime than the general population
- 'over-policing' - the conscious or unconscious profiling by ethnicity. These ethnic minorities are then targeted by law enforcement.
- in general, ethnic minorities are given harsher sentences for similar offences than the dominant population.

It was concluded that there is still a void in information regarding this over-representation though with the collection of data using the ethnic identifier a stronger knowledge base will emerge.

Experience in Prison

When members of the Traveller Community are imprisoned they experience trauma which is particularly unique to their ethnic group. Travellers, many having experienced a nomadic lifestyle, now experience the restriction of prison - this is a physical environmental trauma. When a Traveller is imprisoned they are removed from their community and their only 'safe space' within society is gone. Prison has been designed for the general population, and the prison staff members are not specifically trained to work with Travellers. Much of the trauma and internal oppression experienced by the Traveller community generally now manifests and impacts on their experiences in prison.

- Travellers often experience racist name calling by other prisoners, and prison staff
- The low literacy levels impact on Travellers' ability to participate in educational opportunities in prison
- Many Travellers fear being targeted by other Traveller groups, leading to many choosing to seek protection and 23 hour lock up.
- Many experience mental health issues, depression, suicidal thoughts and many begin to use drugs as a means of coping with prison life
- Traveller women experience stigma, anxiety, and fear as they were

separated from their children, many of whom are in foster care

- Many Traveller women have post release concerns. They fear for their safety on release and fear racist and discriminatory provocation from law enforcement.

Conclusion

The discussion groups concluded that there is a need:

- To gather information through ethnic data collection about the pathways into prison of Travellers, and to further research the relationship between social exclusion, marginalisation and offending behaviour.
- To recognise and draw on the knowledge of Travellers and their experiences and expertise, particularly in relation to their experiences of prison and prison services, and their experiences with the Gardaí and the Criminal Justice System.
- It was widely accepted that there was a need for post -release strategies for prisoners, such plans need to include access to employment and education, housing and health care.
- Equality and anti-racism and intercultural training for the Gardaí and employees in the criminal justice system.
- Traveller pride – education of the general population on Traveller Culture and heritage.

8. Vulnerable Migrants and the Criminal Justice System

Presenter: Wendy Lyon, Solicitor, KOD Lyons Solicitors

Chairperson: Dr. Emma Black

Rapporteur: Annita Harty

This workshop focused on migrants' interaction with the Criminal Justice System (CJS). There are particular areas of concern which may affect migrants more so than citizens in contact with the CJS, including language barriers, potential experiences of racism and the lack of diversity in the CJS workforce.

Language barriers

It can be extremely difficult for migrants who come into contact with the Criminal Justice System, as the availability of an interpreter is not guaranteed. Further, languages have many different dialects and this can create difficulties with interpreting. The qualifications of the interpreters should be examined as there is no formal accreditation system in Ireland for general skill in interpretation. Further, an understanding of Irish law and the CJS would be helpful. This is so the interpreter would be able to relay the complex information to the migrant. However, it is not for the interpreter to advise the migrant, as there are concerns that this occurs.

The experience of racism

The experience of racism is said to exist at all levels of the CJS. It is difficult to ascertain the amount of racial abuse which has gone unreported for fear of it not being taken seriously. The European Network Against Racism (ENAR) is working to combat racism and discrimination. The ENAR breaks down structural barriers and policies that limit the opportunities for migrants to participate fully in society.

Workforce Diversity

There is a lack of diversity within the Criminal Justice System. Only 0.4% of Gardaí are from an ethnic minority background. The percentage of applicants from ethnic minority backgrounds is reportedly in decline. It is unclear as to what percentage of legal professionals come from an ethnic minority background.

Discussion

Migrants who are sex workers are particularly vulnerable within the CJS. Migrant sex workers in Ireland are mainly from Eastern European or South American backgrounds. They tend to be single mothers who send the money home to support their family. These women have been known to work in pairs for safety reasons. However, under Irish Law those who work in pairs can be subjected to brothel keeping offences. These women tend to be unaware of their rights within the CJS.

	Total number of crime incidents	Total number of crime incidents involving violence against person	Total number of crime incidents where victim reported to gardai or was intending to report to gardai	Total number of incidents where victim agreed to anonymous sharing offender data with gardai	Total number of incidents where victim specifically stated offender was threatening victim with gardai
2018*	875	227	11	718	49
2017	1317	348	8	1087	75
2016	845	204	5	687	42
2015	618	173	13	600	29
2014	516	135	8	515	25
2013	415	92	10	415	38
* 2018 is to 30 June 2018 only					

A website commonly used by sex workers for safety purposes called www.uglymugs.ie gives sex workers the opportunity to advise each other of potential areas of risk. The above (unverified) statistics have been obtained from the ugly mugs website, which have recorded a number of crime incidents amongst the sex worker community

Migrant victims of trafficking often work in cannabis cultivation, the fishing industry and domestic work. These migrants mainly come from Vietnamese or Chinese backgrounds.

There was recognition made of all the complexities that arise within the CJS with regard to migrants and victims of trafficking. Victims of trafficking who come to the attention of the CJS have sixty days to decide if they wish to assist Gardaí with their investigation. Further, those migrants serving life sentences and who do not have a permit to reside in

Ireland cannot easily be released, as they technically have no state existence outside of the prison.

It was thought that providing relevant and important criminal justice information in different languages would be extremely useful to migrants and victims of trafficking. Interpreters should be trauma and CJS informed. Ireland should develop an accredited qualification for translators in order to ensure consistency and a quality service. Finally more awareness and training should be provided to Criminal Justice Agencies on the trauma a migrant or victim of trafficking may be experiencing.

9. Trauma in Probation Practice

Presenters: Margaret Griffin, Regional Manager, The Probation Service, Elaine Kavanagh, Probation Officer, The Probation Service and Jane Mulcahy, Irish Research Council funded PhD Candidate in Law at UCC

Chairperson: Ben Ryan

Rapporteur: Tina Cronin

Findings from a small Limerick Study - Margaret Griffin

The number of women in Limerick on general probation supervision was consistently around 23% despite a protracted period of time, various judges and no reason to suggest variances in arrest practices compared to the rest of the country, where the national average is approximately 11%. This led to the question 'What's going on for these women?' It was found that 50% of those presenting for drug treatment services were women, with a higher proportion of homeless women in comparison to national patterns. At a local level, The Probation Service in Limerick was aware that they were not meeting these women's needs. The same women were coming in and out of services and never really getting off that merry go round.

As a result, research was conducted by Quality Matters with twenty-four women who were attending eight different services, to evaluate their issues, concerns and experience of the service. The semi-structured interviews were influenced by the 'Adverse Childhood Experiences (ACE) Study' which looked at seventeen thousand middle class patients of various

health services in the U.S. The three broad categories that are referred to are abuse, neglect and household dysfunction.

Adverse Childhood Experiences have a cumulative effect on our lives and behaviour. Having four or more ACEs can be devastating. That puts the women from the Limerick study at high risk. Points of note from the study found that participants were seven times more likely to have grown up in a house with an incarcerated person and six times more likely to have five ACEs than women in the general population. Additionally, trauma continued into adulthood with 91% of the women experiencing intimate partner violence in adulthood and 95% considered their substance abuse to be related to, or somewhat related to, their experiences of trauma. The participants were extremely resilient women who were generous with their knowledge and experiences in the hope of improving outcomes for other women. The study highlighted the need for services that are safe, caring, understanding, valued and are respectful and trusting of the service user. When service users and providers rated the service, gaps were highlighted, with the Criminal Justice System ranking lowest in any of the rated domains. Organisations that scored best were voluntary services, and drug and alcohol services. The disparity needs to be further investigated.

'Flip the Script' Resilience - Elaine Kavanagh

Resilience is *"more like Batman than Superman, because resilience is about*

being adaptable not invincible" (Anaut, 2009). Neuroscience has shown the malleable and flexible brain can learn to cope and adapt when experiencing toxic levels of stress. People need to know when experiencing those extreme episodes that things will improve. Part of what The Probation Service does is look at desistance - what needs to be done to desist from crime and become more resilient? Desistance occurs naturally over time, but some may need more support than others, so how can resilience be promoted?

The Irish Probation Service applies an aspect of the Risk-Need-Responsivity approach, namely, the Level of Service Inventory Revised (LSI-R) which is used to inform decisions about level of supervision intensity, rehabilitation and treatment needs and to predict recidivism. Additionally, it is important to focus on a person's strengths and abilities, and approaches such as that espoused by the Good Lives Model (GLM) could be employed to promote personal strengths and thus, promote resilience.

Both models need to be used in tandem to combine risk, resilience and desistance. Research has found that the use of positive psychological constructs, including hope and promotion of self-esteem, have resulted in more positive outcomes in areas including employment, sports performance and, crucially, for probation court mandated supervision.

Beck's negative cognitive triad (2002) correlated the negative cognitive triad,

that is, poor self-esteem, poor world view and little hope, with higher levels of depression. A study with students found Beck's negative triad could be flipped, heretofore known as the 'positive cognitive triad', with these combined aspects resulting in higher levels of resilience (Mak, Ng & Wong, 2011).

Investigations by Woldgabreal et al. (2016) on the promotion of positive psychological constructs throughout the Court mandated supervision process suggested that resilience could be promoted if the LSI-R risk assessment was paired with such constructs, for example, the positive cognitive triad. Further input on this concept would be welcomed. The presentation concluded with the acknowledgment that nature may occur via nurture. However human nature remains open to adaptation and change, which is resilient.

The Impact of toxic stress on Probation clients: learning from neuroscience and Adverse Childhood Experiences (ACE) studies - Jane Mulcahy

Those who grow up poor, in a deprived area, where there are more single parent families, greater levels of addiction and general dysfunction, will experience more community ACEs, i.e. massive levels of childhood adversity in their immediate surroundings. *'Daring to ask, "What Happened to You?" - Why Correctional Systems Must Become Trauma-Responsive'*, a paper by Jane Mulcahy, examines the need for the Criminal Justice System and Probation Services to become ACE-aware and tuned into trauma. The

LSI-R is completely un-trauma informed and un-trauma responsive. It fails to explore what happened to a client as a child and the crucial timing of adversity. Cognitive Behaviour Therapy (CBT) is the dominant response to the LSI-R which is ineffective with people who are highly traumatised, because their pre-frontal cortex goes "offline" when fearful. Body-based interventions, such as yoga and mindfulness, are likely to be more effective.

Maslow's 'Hierarchy of Needs' highlights the need to meet basic requirements if adults are to progress up the needs pyramid. ACEs impede this progression; four or more ACEs make you twenty times more likely to go through the doors of prison, according to the Welsh ACEs study (2015). Treatments like Schwartz's Comprehensive Resource Model are exciting as this looks at how trauma is held in the body and people benefit from acquiring different types of tools to calm visceral body sensations and expand their window of tolerance. Criminality, like addiction or mental illness, is a symptom of trauma. We often forget that crime is not the biggest issue for people. Homelessness or the fundamental lack of safety in their lives may be of greater personal concern. This is not to say that the conversation on offending behaviour ceases, but interactions with Probation need to be relevant and beneficial to them for offending behaviour to reduce. Without better coping strategies, despite best intentions, in times of stress they will revert straight back into addictions or antisocial peer groups, because that is

what is familiar. A Probation Officer is their own best tool; a caring attitude, ability to build a safe, respectful relationship and to see the person in their social context, is more important than a risk assessment instrument.

Discussion

Participants acknowledged the need to look beyond trauma in probation practice due to wider political and societal aspects at play. Challenges of how to address trauma was a recurring focal point. It was noted by participants that the LSI-R model was only part of the probation process and while being very aware of the need to address trauma, practitioners were aware of the risk of re-traumatising clients. Discussions highlighted that there is no need to go deep into the trauma to have benefit, but it is an area that needs to be built into practice. It was agreed CBT is not always the answer; alternatives need to be provided to address trauma. A possible solution put forward would be to run a pilot programme within a project where an ACE score calculator and a bio-psycho social history are used as an alternative to a risk assessment.

Participants were also curious to know if the Limerick Study ascertained why figures were higher, which it had not, but it was noted there is a very particular set of circumstances in Limerick with a particular criminality history warranting a systematic examination.

10. Addressing Psychiatric and Psychosocial Morbidity in Irish Prisons

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Chairperson: Gerry McNally

Rapporteur: Beth Duane

Introduction

There are 10.35 million people worldwide who are incarcerated (Walmsley, 2016). It has been found that a large number of prisoners suffer from multiple vulnerabilities such as substance misuse, mental disorders, homelessness, and intellectual disabilities. It is generally accepted that certain people who are mentally ill and have contact with the criminal justice system should be diverted to psychiatric care rather than imprisoned. Ireland is no different. With a high prevalence of mental illness, a concerning number of individuals suffering from an intellectual disability are not correctly diverted into appropriate services. "A Vision for Change", the report of the Expert Group on Mental Health Policy (Department of Children and Health 2007) states:

'The lack of appropriate services for this group of service users has had major consequences for mental health services and for the individuals themselves. In addition to the distress of illness, they are at high risk of ending up homeless, becoming involved in petty crime, being inappropriately imprisoned, or being in a state of social isolation and dereliction'.

Discussing Estimates of Morbidity in Irish Prisons

Study 1 - 'The prevalence of major mental illness, substance misuse and homelessness in Irish prisons: systematic review and meta-analyses'

This study, which was conducted to estimate the point prevalence of major mental illness, substance misuse and homelessness in Irish prisons, put together a systematic review of all the studies which have been published over the last twenty years. The results showed:

Psychotic Disorder

Eight studies with a total sample size of 28,012 reported that 3.6% were suffering from a psychotic disorder

Major Affective Disorder

Seven studies with a total sample size of 7,928 prisoners reported that 4.3% were suffering from an affective disorder

Substance Misuse

Six studies with a total sample size of 1,659 prisoners reported that 28.3% were suffering from an alcohol misuse disorder and 50.9% were suffering from a substance misuse disorders

Homelessness

Five studies with a total sample size of 1,523 prisoners reported that 17.4% of prisoners were homeless at the time of committal

Study 2 - 'Estimating the prevalence of intellectual disabilities in Irish prisons'

It is difficult to ascertain the number of people with intellectual disabilities in prisons as the definition of an intellectual disability varies across studies.

Additionally, even in the same jurisdiction there are different diagnostic systems and different cut offs. So, this is an incredibly difficult area to research.

Only one study based on research carried out in Irish prisons met the methodology's strict inclusion criteria (Murphy et al, 2000). The criteria for diagnosis used in this study included the Kaufman Brief Intelligence Test, the Wide Range Achievement Test, the Vocabulary subtest from the Wechsler Adult Intelligence Scale Revised, and the National Adult Prisoner Survey. This study found that 28.8% of the sample of prisoners had an intellectual disability. However, it is important to note that the diagnosis of an intellectual disability not only requires psychological testing, but also how someone functions in the real world. A test of functioning was not included in the methodology of this study, and therefore, the results can be interpreted as being high.

Implications from Study 1 and Study 2

The data presented by these aforementioned studies provides us with a narrative that there is significant morbidity in Irish prisons, which gives rise to humanitarian implications. Many people in the prison system have a mental illness. Effectively treating these vulnerabilities or addressing them would support people in custody who suffer from a mental illness or have an intellectual disability. Moreover, doing so clearly has greater gains for society as a whole.

Discussing Strategies to Address Vulnerabilities

Study 3 - 'Diversion: What are the key priorities for development?'

This study carried out a comparative review in relation to the provision for psychiatric diversion across the offender pathway in Ireland, England and Wales. The aim of this study was to comment on priorities relating to the development of diversion services in Ireland through comparison with developments in a neighbouring jurisdiction.

The results showed that developments in England and Wales have focussed on the broader offender pathway in comparison to diversion services in Ireland which are chiefly linked to imprisonment. Additionally, the study found that there is little or no specialist psychiatric expertise available to Gardaí in Ireland. However, Prison In-reach and Court Liaison Services (PICLS) are currently developing in Ireland but expertise and resourcing are variable geographically. The study found that there is a lack of Intensive Care Regional Units in Ireland, as compared to the availability of Intensive Care and Low Secure Units in England and Wales. There is limited scope to divert to hospital at sentencing stage in the absence of a 'hospital order' provision in Irish legislation.

Study 4 - 'Prison psychiatric in-reach in "peripheral prisons"'

This study was designed to identify who was being referred to psychiatric services in peripheral prisons such as Limerick

prison. The data showed that of the people referred to the psychiatric service by their GPs, 21% had a psychotic illness, 12% had a major affective disorder, and 40% roughly had substance misuse or alcohol related disorders. In terms of outcomes, 51% needed psychotropic medication, 40% needed referral to psychology, and over 60% needed referral to addiction counselling, and 10% needed diversion from prison to a hospital setting.

Study 5 - 'People with Intellectual Disability in Prisons need specific care and a compassionate approach'

This study was made to get a consensus on what people with a learning difficulty need. The Delphi method was used to collect a lot of views and get a coherent consensus. The study found that very few jurisdictions succeed in screening for an intellectual disability. Additionally, the study found that if someone is diagnosed with an intellectual disability, they would need specialised care while they are in prison. In particular, if they are extremely vulnerable they could be sexually or financially exploited, thus, a higher level of care is needed. If you take 100 people with an intellectual disability, about one third of them will have seizures. The study also found that it was difficult to divert people with an intellectual disability out of prison as there are very few psychiatric beds for people with an intellectual disability.

Discussion

The participants considered the practicality of having or creating a facility of low secure beds. Psychiatric hospitals

such as Dundrum have medium to high security beds for forensic patients. However, most patients here have not committed serious crimes and do not need to be treated in a high security unit. Moreover, the participants pointed out that "*A Vision for Change*" outlined the need to create one Intensive Care Regional Unit (ICRU) for every health region in Ireland, but this has not materialised due to the lack of funding. The discussion group stressed the importance of fulfilling this recommendation set forth by the 2007 document.

Additionally, it was suggested that there needs to be customised treatment programmes for individuals with an intellectual disability. Because of the difficulties associated with accessing treatment due to barriers resulting from conviction status and artificial interfaces based on arbitrary cut-offs for healthcare services, it is imperative to invest in specialised services for this group.

There was also a discussion that there must be a strict commitment to solving the issues which were outlined during the workshop. Participants agreed that to effectively solve these issues, there has to be cooperation between services and the courts system to appropriately care for people suffering from a mental illness or an intellectual disability.

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