Centre for
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Understanding the needs and what works for girls in the Children and Young People's Secure Estate: Literature Review

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Executive summary

Girls in the Children and Young People Secure Estate

This is a review of academic evidence about the needs of girls in the Children and Young People Secure Estate (CYPSE) in England. CYPSE includes children placed in secure residential care through youth justice legislation and through child protection legislation.

This literature review is the first part of a broader review of the current pathway in England and how it might be changed to improve outcomes for girls in the CYPSE.

Girls' needs are under explored in the literature with most studies taking a gender-neutral approach (treating boys and girls as a homogenous group) and with most studies focusing on women as opposed to girls' needs.

Girls are a highly vulnerable group both in custodial and secure care placements. Their pathways into these settings are closely linked with histories of exposure to multiple traumatic events – particularly physical and sexual abuse and ongoing victimisation in interpersonal relationships.

They have very high levels of a wide range of mental health difficulties – often experiencing more than one condition at a time. They also have a higher risk of physical health problems and a history of risky behaviours including early and risky sexual activity frequently linked to romantic and abusive relationships with older partners. They are much more likely to have higher levels of neurodevelopmental conditions and unmet related needs, such as ADHD, compared with girls in the community.

Research suggests that girls facing such high levels of childhood adversity, trauma and multiple needs require support that is gender-responsive and trauma-informed. Strong authentic and trusting relationships with workers and strength-based approaches are at the heart of these ways of working. There are concerns that secure settings (and particularly those with a justice, controlling and punitive approach) are inherently harmful and re-traumatising for girls who have experienced multiple traumatic events in their lives. An intersectional trauma-based approach is also advocated recognising that girls often have intersecting identities and experiences of discrimination (e.g. based on ethnicity, class, sexual and gender identity) which may amplify trauma and oppression. It is therefore essential that priority is given to creating a sense of safety for girls and that every effort if made to avoid retraumatising all girls in secure settings.

Unfortunately, gender and trauma responsive approaches have not been tested robustly and at scale for girls – or in secure settings. Some question the extent to which these approaches can successfully be adapted to secure institutions which can default to organisational and controlling procedures rather than person centred approaches. Therapeutic residential approaches appear to outperform justice-based approaches in highly quality reviews of the available evidence. Emerging evidence suggests that for maltreated children, stabilising the developmental disruption that children face following this legacy of maltreatment, is a priority before broader work on offending becomes feasible. High quality community wraparound approaches such as Treatment Oregon Fostering and Multi Systemic Therapy show consistently

good evidence for girls as an alternative to placement in secure settings and could be adapted further to reflect gender responsive and trauma informed approaches.

Introduction

In 2019, Ministry of Justice (MoJ) data (2019) indicated that girls represent very much a minority (3%) in secure justice placements for under 18-year olds (e.g. in Secure Children's Homes and Secure Training Centres) in England and Wales. Over the last decade, there has been an 86% reduction in girls entering youth justice placements (compared with a 69% reduction in boys entering these settings). Yet, according to MoJ data, girls were significantly more likely than boys to experience restrictive physical interventions and to self-harm in these settings. There are also concerns that static snapshots of data may not provide a clear view of the true number of females moving in and out of the estate - particularly if there are high numbers of girls being dealt with via shorter sentences or on remand (Goodfellow, 2019). Furthermore, there have been longstanding concerns about the lack of a strategic approach for under 18 year old girls in secure justice settings with disquiet about the extent to which it is possible to adequately meet the distinctive needs of girls in environments and in regimes which may gravitate towards the needs of the majority of boys.

On the other hand, data on those entering secure children's homes, as a result of child protection legislation, suggest that there are more girls entering these settings compared to entrants into justice settings – perhaps confirming O'Neill's theory (2005) that girls are more likely to be labelled 'at risk' rather than ' a risk'. Data in the public domain in England on girls residing in secure children's homes solely on welfare grounds are not routinely broken down and analysed by legislative route in *and* by gender. For example, 39% of girls were in welfare *and* justice beds in secure children's homes in 2019 (DfE, 2019). Although there have been recent reductions in the number of girls in the justice system, there have been questions about the extent to which this reduction has come at the expense of potential increases in the numbers of girls being detained for welfare reasons over time (Goldson, 2004).

This literature review was commissioned by NHS England and NHS Improvement and has been supported by the Youth Custody Service (YCS). It seeks to understand what international evidence tells us about the needs of girls in the CYPSE (specifically those who end up in custody through criminal justice legislation or alternatively in secure welfare placements under Children Act legislation in the CYPSE in England). It also seeks to understand their likely pathways to these settings, their needs and what might work best to support their progress forward and reduction of risky behaviours, offending and other broader poor outcomes. The review aims to create an overview of what we know about girls' trajectories into serious crime or vulnerability, summarise knowledge on the likely needs of those in secure settings and explore up to date evidence on what works. It will provide a benchmark for the development of a more strategic and evidence-informed approach to supporting the outcomes of girls in these settings.

Next steps will include a review, with policy makers and key stakeholders (including girls), of strengths and areas of development in the current CYPSE pathway for girls. Data on the needs

and characteristics of girls currently in welfare and custodial placements will also be analysed during the second stage of this work.

CYPSE placements considered as part of this literature review

Youth Justice system: In the youth justice system, girls aged 10 to 17 years of age can be placed in a Secure Training Centre (housing up to 76 children in mixed gender settings) or in a smaller mixed gender Secure Children's Homes placement (housing 6 to 40 beds and with higher staff to child ratios) through:

- being placed on a Detention and Training Order (DTO) in the Youth Court or Crown Court. This is a custodial sentence lasting between four months and two years. (This sentence is only available for 12-17-year olds).
- the Crown Court under Section 91 of the Powers of Criminal Courts (Sentencing) Act 2000 which provides for longer term detention for specified serious offences (other than murder). This sentence can apply to 10 to 17-year olds.
- the Crown Court under Section 90 of the Powers of the Criminal Courts (Sentencing) Act 2000 which is a mandatory life sentence for those convicted of murder, with a minimum term to be served in custody. This sentence can apply to 10 to 17-year olds.
- a sentence of detention for life or an extended sentence of detention under of the Criminal Justice Act 2005. This sentence is used more rarely where the Crown Court considers there is a significant risk of serious harm to members of the public from further specified offences. This sentence can apply to 10 to 17-year olds.

Remand: girls aged 12-17 can also end up in the youth custody estate on remand based on type of offending or of history of absconding and offending together - where there is a real prospect of a custodial sentence.

According to Article 37 of the United Nations Convention on the Rights of the Child (1990) penal custody for children should only be used "as a measure of last resort and for the shortest appropriate period of time" (Goodfellow, 2019). The Bangkok Rules (United Nations General Assembly, 2010) further requires priority to be given to females in conflict with the law with particular attention being paid to their gender-specific needs.

Secure welfare placement

Secure welfare placements involve girls being placed in thirteen Secure Children's Homes across England with these places being available for children that meet the criteria set out in Section 25 of the 1989 Children's Act (for placements in a SCH in England). For 13-17-year olds, this Act stipulates that a child being looked after by the local authority can only be placed (and if placed may not be kept) in secure accommodation where he/she has a history of absconding and is likely to abscond from anything other than secure accommodation; and:

- If he/she absconds he/she is likely to suffer significant harm or
- If he/she is kept in anything other than secure accommodation he/she is likely to injure him/herself or other persons.

Where a child is placed in these settings on this basis, no finite timescale is placed on the length of residence although legislation states that children should not be 'kept' in secure accommodation on this basis. Local authorities also have additional options of placing a child aged 13 to 17 years in secure welfare placements on a 72-hour emergency basis. Furthermore, a child under the age of 13 can also be placed in secure welfare placements but this requires approval from the Secretary of State (local authorities in England) or the Welsh Ministers (local authorities in Wales).

Methodology

A comprehensive initial search was completed of the following electronic databases for literature published between 2000 and June 2020: Ovid, Embase, Medline, PsycINFO, HeinOnline and PubMed. Search results were limited to papers published in English. Search terms included girls, young women, custody, detention, residential care, trauma, gender-specific, risk, recidivism, self-harm, health, neurodevelopment, mental health, transitions, resettlement, restraint, interventions. Search terms used were identical for all databases. In total, search terms identified 1565 potential articles. Titles and abstracts were filtered for duplication and relevance creating 303 relevant academic articles and resources. A further 31 were identified through manual searching of references in sourced articles. Another search was completed using Google Scholar and Google search for any relevant grey literature sourcing 63 articles. Additional articles were also forwarded on by the Project Management Team and (6). In total, this review considered findings from 403 articles (NB: some subsequent searches were completed after the initial search to answer specific questions raised by commentators on the draft version of this report). The majority of sources were peer reviewed articles.

Research questions

This literature review specifically seeks to assist policy makers to understand more about girls' complex presentations in these settings and explore the following evaluation questions:

1. What do we know about girls' likely pathways into crime, vulnerability and into CYPSE settings?
2. What do we know about the needs of girls in the CYPSE?
3. What does academic literature tell us about what works to reduce offending, improve safeguarding and improve outcomes for girls in contact with the CYPSE?
4. To what extent do girls' needs differ to those of boys?

Chapter one: girls' pathways into offending and broader vulnerability

This chapter draws together what we know from a wealth of longitudinal studies tracking girls' pathways both into antisocial behaviour, crime and into broader vulnerability. It also summarises findings from gendered pathway literature which focuses on the ways in which girls face:

- shared risks with boys but respond in broadly different ways associated with gender differences, gendered expectations or due to broad life disadvantages and social circumstances that put them at risk.
- shared risks with boys but with greater frequency compared with boys
- unique risks across their life course predisposing them towards offending and vulnerability.

(e.g., Belknap & Holsinger, 2006; Chesney-Lind & Shelden, 2004; Gavazzi, Yarcheck, & Chesney-Lind, 2006; Holtfreter & Morash, 2003; Reisig, Holtfreter, & Morash, 2006;).

There is still significantly less knowledge regarding girls' offending in comparison to boy's offending and there is a need for more high quality research focusing on the longer term outcomes of girls in secure settings (Broidy & Thompson, 2018).

Early and enduring exposure to multiple adverse risks

Both boys and girls who are exposed at an early age to multiple and cumulative adverse life experiences and traumas have a higher risk of vulnerability and of developing and persisting with anti-social behaviour (Broidy & Thompson, 2018). Key risks in terms of children's pathways to crime include:

- exposure to early and prolonged poverty and socio-economic disadvantage – particularly where exposure starts early and is ongoing
- experiences of maltreatment and abusive, harsh or inconsistent parenting
- exposure to violence, family conflict and instability in their relationships.
- boys and girls in households where:
    - parents have lower than average educational achievement
    - children are exposed to parental substance misuse, criminality, and parental mental health difficulties

(Broidy & Thompson, 2018; Gutman et al, 2018; Loeber & Farrington, 2000; Moffit, 2003; Schuck & Widom, 2005)

Studies, tracking the impact of exposure to multiple risks, and particularly to childhood maltreatment, have also noted increased probability of experiencing a range of other negative health, educational and social outcomes across children's life course including greater chance of:

- early school drop-out
- risky sexual behaviour
- mental health problems and comorbidity of problems
- premature mortality
- early pregnancy
- substance abuse
- involvement in violent behaviour
- social isolation
- lower socio-economic status
- as well as involvement in, and exposure to, intimate partner violence

- poor adult physical health (including cancer, chronic lung disease, heart disease, skeletal fractures, and liver disease, immune function difficulties etc)

(Felitti et al., 1998; Danese, Pariante, Caspi, Taylor, & Poulton, 2007; Humphreys et al., 2015; Ludtke et al., 2018).

Many studies noted particularly higher risk of girls exposed to maltreatment developing multiple co-existing mental health difficulties as they matured (Widom and White 1997; Leve et al, 2012).

The underlying thesis of these studies is that certain stressful and persistent childhood experiences (particularly physical, sexual or emotional abuse, neglect, exposure to family violence) are highly damaging to an infant's developing emotional architecture leading to complex developmental trauma and overwhelming children's ability to cope with adversity increasing likelihood of a variety of health and social problems (Felitti et al., 1998; Gutman et al, 2018; Shonkoff & Garner, 2012). Constant adaptation to a stressful, highly threatening and conflict-ridden home environment can also over-activate children's stress response system with prolonged effects on cognitive development, learning, physical health and on a child's ability to soothe themselves and regulate emotions and behaviour. (Shonkoff & Garner, 2012; Zeanah, 2012; Gunnar & Quevedo, 2007).

Physical and sexual abuse

Physical and particularly sexual abuse have been strongly associated with trajectories of persistent and serious offending among girls (Broidy & Thompson, 2018). Childhood sexual and physical abuse are 3.5 to 10 times higher for girls in the justice system than for boys (Johansson & Kempf-Leonard, 2009; Leve & Chamberlain, 2005). Girls with a history of sexual abuse tend to have more serious patterns of criminal activity than those without a history of sexual abuse (Goodkind et al, 2006; Wareham & Dembo, 2007; Leve et al, 2015).

A longitudinal study tracking outcomes for women with substantiated victimisation through child sexual abuse over 23 years highlights the toxic and comprehensive developmental impact of such experiences and noted that abused girls, on average, experienced a wider range of negative outcomes across a host of different areas of their lives compared to a matched sample of women including:

- earlier onset of puberty (which may increase the chance of ongoing sexual victimisation and which has also been associated with higher risk of adult justice involvement)
- cognitive difficulties
- increased likelihood of presenting with at least one diagnosable mental health condition including depression, Post Traumatic Stress Disorder (PTSD)
- self-harming
- major physical health problems and obesity
- physical and sexual revictimization
- school dropout
- substance and alcohol reliance
- teenage pregnancy and premature birth
- domestic violence.

Follow-up studies also found increased use of public services and intergenerational impacts – noting an increased risk of these women's children experiencing repeating cycles of maltreatment (Trickets, Noll Putnam, 2011).

Childhood physical and sexual abuse is thought to have long lasting impacts on girls' self-esteem, their belief in their ability to succeed in their lives (self-efficacy), their sense of control over their lives and on feelings of helplessness (Gross and Keller, 1992; Broidy & Thompson, 2018). Maltreatment can also result in increased anger (Broidy & Thompson, 2018).

Childhood behavioural problems

Early starting severe and persistent behavioural problems have been shown to be strongly associated both with exposure to enduring and multiple risk factors (Gutman et al, 2018) and with higher likelihood of future serious offending and other poor outcomes (Mofitt and Caspi 2001; Lahey et al. 2006; Odgers et al. 2008; Blokland and van Os 2010). Findings on this cohort of children are important as adolescents with a history of persistent problematic behavioural problems have the highest likelihood of ending up in secure settings and with multiple presenting problems (Odgers et al, 2008).

Early starting problems are our most common childhood mental health difficulty (NHS Digital, 2018) and can be seen as an early marker of complex trauma. Children appear to process, adapt to and communicate experiences of developmental adversity and trauma through their behaviour. Generally, outcomes for these children contrast with outcomes of children who present for the first-time with behavioural difficulties during adolescence (Parsonage et al, 2014).

Girls with early starting behavioural difficulties are rarer than boys (Broidy & Thompson, 2018). For example, 80% of 47 studies reviewing girl's longitudinal trajectories only identified persistent patterns of early problematic behaviour in around 1 percent of girls (Broidy & Thompson, 2018). Other studies showed that for every girl in this early starting high-risk group for behavioural difficulties and crime, there were nine to twelve boys who went on to persistently offend later (Broidy & Thompson, 2018). Furthermore, girls in this high risk group had higher chance of desisting from crime than boys, their frequency of prolific crime was lower, and offences were overall less serious and less violent than those committed by boys (Broidy & Thompson, 2018).

There is nevertheless growing agreement that there is a very small group of girls with early patterns of severe behavioural difficulties and who, like boys, account for a disproportionate amount of later crime (e.g., Moffitt and Caspi 2001; Fergusson and Horwood 2002; Lahey et al. 2006; Odgers et al. 2008; Block et al. 2010; Broidy et al. 2015; Joliffe et al. 2017). A Swedish birth cohort study noted that roughly 1.5% of girls with early starting behavioural problems were responsible for 45% of all official youth crimes and 54% of official adult crimes (Estrada and Nilsson 2012).

Parenting

There is promising evidence from UK birth cohort studies that when parental risk factors diminish over time (e.g. maltreatment, parental mental health difficulties, family conflict) there

is a positive knock-on effect on both boys' and girls' likelihood of persisting with severe behavioural problems (Gutman et al, 2018). Improvements in positive parenting skills (warm, authoritative parenting) have also been noted to be somewhat protective for children even when families face socio-economic hardship (Brown et al, 2012).
The parent-child relationship, and particularly caregiver warmth during middle childhood, have been identified as protective factors with potential to help at-risk girls avoid involvement in crime (van der Molen et al, 2011). Similar protective associations were found between parental warmth and reductions in delinquency over time in a group of girls in the justice system (Williams & Steinberg, 2011). Father warmth may also play a protective role for girls; a study of justice-involved girls indicated that the lowest levels of self-reported offending were present in girls who received both high levels of paternal warmth combined with low amounts of encouragement for involvement in antisocial behaviour from their romantic partner (Cauffman et al, 2008). Finally, effective parental monitoring, particularly during adolescent years has been linked with longitudinal declines in offending among girls (Williams & Steinberg, 2011).

Conversely, harsh parenting/punishment is associated with multiple mental health problems (including problematic behaviour) in at-risk girls, both as children and as they mature (Hipwell et al., 2008; Miller et al, 2009). It is also associated with criminal activity in samples of justice involved girls (Williams & Steinberg, 2011).

Differences in the way that girls process and respond to multiple adversity and trauma
Many studies have speculated on the reasons why girls exposed to multiple adversities have lower risk of presenting with early behavioural problems compared to boys. Findings may reflect the different ways in which boys and girls process psychological distress and developmental trauma - with girls being more likely to suppress, mask and internalise distress (resulting in a higher likelihood of experiencing self-blame, emotional and relational difficulties, mental health problems, self-harming and suicidality and other complex vulnerabilities later on) and boys being more likely to externalise distress (Leadbeater et al. 1999; Broidy & Thompson, 2018). Some girls are also thought to delay behavioural expressions of distress until adolescent years (Broidy & Thompson, 2018). Some academics suggest that differences may be explained by more rigid social controls placed on girls' behaviour - leading girls to hide visible expressions of externalised anger and distress. They may also face more restricted freedoms and opportunities as children (Broidy & Thompson, 2018).

There is, therefore, more variation in girls' pathways to involvement in serious crime compared to boys (Bright, Kohl, & Jonson-Reid, 2014; Henneberger et al., 2014; Odgers et al., 2007) with some girls presenting with early persistent behavioural difficulties (Mofitt and Caspi 2001; White and Piquero 2004; Lahey et al. 2006; Odgers et al. 2008; Blokland and van Os 2010; Miller et al. 2010) and with others internalising distress and becoming involved in anti-social behaviour and offending for the first time during adolescence and sometimes young adult years (Silverthorn, Frick, and Reynolds 2001; DeLisi 2002; Andersson et al. 2012).

Early peer relationships
Many studies found that both boys and girls with trauma histories, who struggle to control their emotions and behaviour, have a higher likelihood of problems with their peers (Broidy & Thompson, 2018). As children's behaviour worsens, they face higher risk of peer rejection and retreat into 'deviant peer networks' (Pope & Bierman, 1999).

Positive peer relationships in school, have been noted as a protective factor for girls. For example, a study of foster girls transitioning to middle school found that positive peer relationships were associated with later reduced behavioural and emotional problems (Broidy & Thompson, 2018). More investigation is required to understand what this looks like in practice for girls.

Ongoing abuse, polyvictimisation and sexual exploitation
A significant body of evidence finds that girls' pathways into offending, vulnerability and contact with secure settings, are closely linked with, and related to, ongoing abusive experiences within their interpersonal relationships including violence, victimisation and trauma (Broidy & Thompson, 2018). These ongoing experiences of victimisation often appear to be a trigger for later risk taking and anti-social behaviour.

Lopez (2011) sees girls' relationships and engagement in sexual relationships as a key means by which they cope with feelings of depression and enhance self-worth. A further body of evidence suggests associations between internalised coping mechanisms (more common among girls exposed to maltreatment) and subsequent increased risky sexual activity (Smith et al, 2006; MacDonald & Martineau, 2002). Furthermore, whereas boys join negative peer groups for protection and financial gain, girls join for protection and social support (Maxson & Whitlock, 2002). Multiple experiences of victimisation are also linked to later risk of substance misuse, found to be higher in girls and women who end up in the justice system (Gaarder et al, 2002; Cernkovich et al, 2008; Salisbury & VanVoohris 2009; Topitzes et al. 2011; DeHart et al. 2014).

The role of romantic relationships and associations with older males
Whereas romantic relationships and adult responsibilities often act as turning points helping boys desist from crime, studies suggest that the opposite may be true for girls. Many studies identify relationships as being criminogenic for girls (Sampson et al, 2006; Steffensmeier & Allan, 1998; Bright et al, 2011; Haynie et al. 2005; Rebellon & Manasse 2006). Moffit's longitudinal analysis (2001) found that partnering with a mate involved in anti-social activity could increase and sustain girls' antisocial behaviour throughout adult years. These relationships were often characterised by conflict and violence (Leve et al, 2015). In a literature review on girls involved in both justice and care systems, Fitzpatrick and colleagues (2019) observe that the 'choice' to engage in sexual activity is often not a choice at all, and entails a complex processes of coercion, repetition of earlier experiences victimisation and exploitation for these girls (Berelowitz et al., 2012; Coy, 2009; Fitzpatrick et al, 2019). However, Batchelor (2005) notes that children do not always see themselves as vulnerable nor do they simplistically fit the stereotype of passive/dependent victims when in these situations. For some academics, girls' risk taking is seen as an attempt to exercise control within the context of abusive experiences and limited gendered opportunities (Hine & Welford, 2012).

It is suggested that higher risk girls often become familiar with anti-social behaviour and criminal activity as part of a search for identity in the transition from adolescence to adulthood (McIvor, 1998) and as they widen their social network during teenage years and particularly through association with older males (Broidy & Thompson, 2018; Caufman,2008). Intimate relationships are generally accessed early during adolescence (Caspi et al. 1993; Moffitt et al. 2001; Leve and Chamberlain 2004).

Runaway status

Runaway behaviour is particularly significant as part of a chain of interlinking events that increases girls' chances of having contact with justice, care and secure care settings. Girls tend to run away from home or from care more often than boys (Johansson & Kempf-Leonard, 2009; Leve & Chamberlain, 2005). Childhood victimisation and abuse (particularly sexual abuse) increase girls' likelihood of running away from abusive home environments often as a survival strategy (De La Rue, 2018; Lederman et al., 2004). This then leads to additional adversity and risk (Broidy & Thompson, 2018). Johansson and Kempf-Leonard (2009) found these girls were almost five times more likely to be involved in serious, violent, and chronic offending compared with other justice-involved girls who had not runaway. Rates of risky sexual activity were also higher (Ford et al, 2012). Running or staying away from home also increased girls' chances of repeat victimisation, exposure to violence and risks of sexual exploitation outside the home (Whitbeck et al, 2000). Because girls were more likely to push down and internalise distress related to childhood trauma, substances also became a way of numbing and self-medicating to escape from trauma symptoms and manage poor mental health (De La Rue, 2018)

Educational difficulties

Behavioural and attentional difficulties are higher among children exposed to early, enduring and multiple risks. These difficulties can then compromise educational achievement (Schofield et al, 2015;). A systematic review of evidence on educational outcomes for girls in the care system confirms that adverse childhood experiences and parental characteristics were highly associated with poor educational outcomes for children in care (O'Higgins et al., 2017). Educational difficulties are well documented among girls simultaneously involved in both justice and care systems. Children in the justice system have higher levels of special educational needs, exclusion and histories of persistent non-attendance (HMI Probation, 2014; Summerfield, 2011; Schofield and colleagues; 2015).

School is another potentially protective environment for children affected by maltreatment (Smart et al. 2003; Bryan, 2015). For girls from less supportive families, strong school engagement and commitment has been noted to protect against non-violent offending and cannabis misuse (even when their peers were users) (Belenko et al, 2004).

Neighbourhood risks

Several studies highlight the part played by neighbourhood context in increasing girls' risk of anti-social and criminal activity. Having a family member involved in gangs as well as neighbourhood criminality were identified as risk factors for girls' subsequent involvement with gangs (Khan et al, 2013). Girls' aggression has also been linked both with experiences of violent victimization (such as being attacked with a weapon, beaten up, chased, threatened with

serious harm in the past year, as well as reports of past year sexual assault) and concentrated poverty in girls' neighbourhoods (Molnar, Browne, Cerda, & Buka, 2005).

Contact with the care system

Entry into care was noted to make a unique contribution to risk of criminal justice involvement in a largescale (n = 99,602) study of youth in the justice system (Barrett et al, 2014). Residential placements were noted to increase that risk compared to those on child protection orders at home (Strijbosch et al., 2015).

In a recent overview of evidence on girls involved simultaneously in care and justice systems, Fitzpatrick and colleagues (2019) concluded that a very high proportion of girls in UK custody have previously been subject to intervention from children's services and many have been 'looked after' (e.g. Douglas & Plugge, 2006; Jacobson et al, 2010). Girls were four times as likely to be justice involved if they were living in a children's home compared with other girls in care (DfE, 2018; Fitzpatrick et al, 2019). Girls' own stories of their experiences in care note how they were often criminalised in these settings for incidents which in other circumstances would be dealt with within the confines of a family home (e.g refusing to go to bed).

> "It started out from simple things, like when I was in my first care homes refusing to go to bed, they'll call the police, then you'll be in a cell overnight… Everything that I ever was locked up for was through the care system," (Sheena, 19).

(Plan-UK, 2020)

Other international studies document associations between placement in residential care and girls' justice involvement (DeGue et al, 2009; Goodkind et al., 2013; Malvaso et al., 2017; Ryan & Testa, 2005; Ryan et al., 2010).

Evidence reviews have also noted how underuse of restorative justice in children's homes can result in girls being charged with many more minor offences leading them to escalate up the sentencing tariff (Fitzpatrick et al, 2019). An inspectorate report concluded that a substantial minority of children (30%) who were prosecuted in residential care placements had no previous youth justice system contact and had probably not offended before (HM Inspectorate of Probation, Ofsted & Estyn, 2012). The Howard League also found evidence of children having justice contact when residential home staff felt overwhelmed or when police concluded that a child needed to be detained in custody for their own safety (Fitztpatrick et al, 2019).

Justice system risks

A large body of studies suggest that girls may be judged differently to boys in the justice system. On the one hand, they can be judged more leniently because they are perceived as being more vulnerable. In the United Kingdom, one review found that 'at each key point in the system, girls are less likely to receive the more serious of the options available' (Penal Reform International, 2014). Compared to boys, they were more likely to receive a police warning, less likely to be prosecuted, and less likely to be referred to court (Penal Reform International 2014). Similarly, Conger & Ross (2001) noted a greater bias towards placing girls in care when justice contact occurred than is the case with boys.

Conversely, girls could also be treated more harshly if they were not behaving in ways that were consistent with gender, sexual or cultural expectations (Chesney-Lind, 2010). In a US study, Tam and colleagues (2016) noted a greater chance of girls being placed in youth custody than a matched sample of boys. This study also noted that girls with child protection histories were often at greater risk of being placed in more restrictive settings than boys regardless of the charge – which authors attributed to a 'misguided' desire to protect girls (Tam et al, 2016).

When gender intersects with race, sexuality and a child's conformity to gender stereotypes, these biases can become even more profound leading to over representation (Parrish, 2020).

Difficulties shedding anti-social identities

Antisocial behaviour can also lead to an entrenched antisocial identity that is difficult to shed, regardless of intentions (Belknap and Holsinger 2006; Cernkovich et al, 2008; Broidy &Thompson, 2018). This is thought particularly to be the case during adolescence when adult identity remains malleable and is still forming. Petrosino's study (2010) of the impact of justice and wider services system contact on both boys' and girls' offending noted that system contact in itself appeared to be criminogenic – reinforcing the importance of diverting girls away from the justice system wherever possible.

Neural development and adolescent girls.

Increases in girls' and boys' emotional vulnerability, risk taking and linked offending are associated with changes that take place in the brain during critical adolescent years which largely resolve by the mid-twenties and which are seen to be closely linked to young adults tendency to 'mature out' of offending and risk taking. This section seeks to understand emerging evidence on the extent of any differences in the experiences of girls as opposed to boys during this critical period of neural change.

Dramatic neural pruning, together with changes to the structure and function of the brain during adolescence and young adult years, appear to be an important part of the process of developing an efficient well-functioning adult brain. Based on neural imaging studies, neuroscientists suggest that these structural changes affect shifts in the volume of white versus grey matter in the brain with changes continuing up until 25 years of age (Steinberg, 2012). The net effect of these changes is thought to be a mismatch in timing between the maturation of subcortical areas of the brain which begin 'signalling' and changing earlier and which govern emotional responses, sensitivity to rewards, sensation seeking, ability to regulate emotion and anger etc and the later maturing pre frontal areas which broadly speaking act as a brake on impulsiveness, emotional responses, and sensation-, danger- and pleasure-seeking responses. This later maturing prefrontal cortex also affects many other aspects of children's functioning including promoting ability to plan ahead and moderating social behaviour. (Steinberg, 2012).

Research exploring gender-based differences in neural development between those assigned female versus male gender is at an early stage. But studies note: some structural differences between male and female brains at this time; some gendered differences in the nature and timing of changes; and differences in the way that children's brains respond to dominant sex hormones – changes which broadly are thought to affect girls' and boys' responses in different ways (Sisk & Zehr, 2005).

For example, studies suggest that structural differences in girls' and boys' brains during infancy and childhood form the basis of girl's well-documented greater communication skills compared to boys (Lenroot, 2010).

During teenage years, early evidence generally suggests that slightly different areas of the brain dominate for boys compared with girls (Lenroot, 2010). For example, both the hippocampus and the amygdala form part of the limbic system which governs feelings and emotions and fight or flight reactions.

Studies have noted that the hippocampus has more receptors for, and experiences more neural 'signalling' during adolescent years activated by, female oestrogen (Lenroot, 2010). It is also larger and develops more rapidly during adolescence in girls whereas the amygdala is more pronounced and experiences more changes in boys (Suzuki et al., 2005; Wilke et al., 2007).

The hippocampus governs the way humans process memories and also plays a part in how we manage stress. Sustained high levels of stress have been noted to cause adverse structural changes to areas of the hippocampus and this damage has been linked both to PTSD and to higher likelihood of schizophrenia (Stark, 2007). Such experiences have also been noted to affect attention and short term verbal memory (Elzinga and Bremner, 2002; Sala et al., 2004). Finally, structural changes of areas of the hippocampus in the womb can also re-programme responses to stress in the foetus and the extent to which infants can react in a regulated way to stress and self soothe - the impact of which has been noted to continue into adulthood (Lenroot, 2014).

On the other hand, the amygdala is broadly noted as larger and as having more mass in boys during adolescent years than in girls (Goldstein et al., 2001) as well as having more receptors responsive to higher levels of testosterone. This area of the brain also plays a primary role in processing memory and emotional responses but also governs how we respond to and process fear, anxiety and aggression (Amunts et al., 2005). There is some evidence that the amygdala works differently in terms of its structure and in how it functions in boys and girls. For example, because of the way that fear is processed in the amygdala, one study noted that girls retain more vivid and longer standing memory of emotional events than is the case for boys (Hammann, 2005). Another study of neural responses to fear noted that although boys and girls had similar responses to angry faces in childhood, during puberty, females' sensitivity to angry faces increased compared with males (Lenroot et al., 2007).

Other studies have also noted broader differences in the HPA stress management Axis in the brain comparing boys and girls as they reach puberty, with girls being observed to experience heightened activity in this area of the brain and boys being noted to experience decreased reactivity to stress possibly associated with higher testosterone levels (McCormick & Mathews, 2007).

Finally, there is an indication that neural functioning varies across the menstrual cycle – although research remains at an early stage. For example, tests of learning, memory and spatial ability show fluctuations across this cycle, suggesting that temporary changes in exposure to sex steroids can affect brain plasticity and consequent performance across a range of tasks (Farage, Osborn, & Maclean, 2008).

At this stage neuroimaging findings should only be taken as clues pointing us towards different evolutionary processes potentially affecting male and female brain development rather than definitive statements about the capabilities of girls and boys. However, these findings do provide some insight into neural differences, influenced by changing sex hormones, that may provide some explanation of things such as girls higher susceptibility to anxiety and depression during teenage years compared with boys (as noted in prevalence studies over many years) and gendered differences in response to stress, trauma and risk.

Chapter two: what we know about the needs of girls in secure and justice settings

This chapter focuses on the needs of girls in secure settings. Studies confirm some similarities in their needs, compared to boys as well as some very unique and important differences.

Trauma exposure and sexual abuse

Experience of trauma—especially cumulative exposure over time—is associated with increased risk not only of post-traumatic stress disorder (PTSD) symptoms but also complex trauma. Complex trauma describes children's exposure to persistent and pervasive traumatic events (often of an interpersonal nature) and the developmental, immunological, psychological and neural damage and long-standing effects associated with attempting to survive these experiences (National Children Traumatic Stress Network, 2020). Children with complex trauma history, can experience reminders of various traumatic events everywhere in their environment. Such a child may react often, react powerfully, and have difficulty calming down when upset. Many of the responses associated with children experiencing complex trauma have been noted to overlap with those present in children who offend (e.g. impulsivity, emotional and behavioural under or over arousal, explosive responses, models of a hostile and threatening world, low interpersonal trust etc) (Vitopolous et al, 2019). Both PTSD and complex trauma have been linked to a variety of other problems such as anxiety, depression, substance misuse, behavioural problems and suicidal thinking (e.g., Copeland, Keeler, Angold, & Costello, 2007; Kerig et al, 2009; Rosenberg et al., 2014; Wasserman & Mcreynolds, 2011).

In the US justice system, one study identified 80% of those in custodial settings having been identified with histories of childhood maltreatment (Smith et al, 2006). Many studies also note that girls who offend generally show higher rates of interpersonal trauma and PTSD symptoms than boys (Kerig et al, 2009; Vitopoulos et al, 2018). In one other study of boys and girls (n = 658), Dierkhising and colleagues (2013) analysed trauma histories and found relatively similar rates of exposure to nineteen different types of trauma between boys and girls. One notable difference, however, was that girls had significantly higher rates of sexual abuse and sexual assault. Caufman and colleagues (1998) also confirmed that girls were more likely to report higher levels of exposure to sexual assault and interpersonal victimization whilst boys reported higher rates of witnessing violence.

In 2017, Baglivio used the Adverse Childhood Experiences (ACE) framework (focused on emotional abuse, physical abuse, sexual abuse, emotional neglect, physical neglect, violent treatment towards mother, household substance abuse, household mental illness, parental

separation or divorce, and having an incarcerated household member) to improve understanding of the risk profiles of 64,329 children in custody (aged 18) in Florida. Overall risk profiles for both girls and boys were four times higher than risk profiles found in those in the original community ACE study (with a college background) (Felitti et al., 1998). Girls in Baglivio's study had the very highest ACE risk profiles, with significantly higher chance of having multiple adverse childhood experiences and with higher prevalence than boys on every single ACE indicator (See Table 1):

Table 1: Comparison of Adverse Childhood Experience risk profiles comparing girls and boys

	Boys (n= 48,844)	Girls (n= 13,692)
Reporting at least 2 ACES	89%	92%
Reporting at least 3 ACES	71%	80%
Reporting at least 4 ACES	48%	63%
Reporting at least 5 ACES	28%	46%

Findings from Baglivio's study also noted other gender specific-risk differences among this sample:

- Sexual abuse was reported 4.4 times more frequently by girls than by boys (31% and 7%, respectively)
- The average composite ACE score for girls was 4.29, while the average for boys was 3.48
- the average girl in this sample reported at least 4 ACE indicators while the average boy reported 3-4 ACE indicators.

Baglivio (2017) also explored associations between adverse experiences and risk of re-offending rates (although results were not disaggregated by gender). Findings suggested that some ACEs were more associated than others with risk of reoffending estimates. These included physical neglect, family violence, household substance abuse, and household member incarceration.

A large body of additional empirical evidence demonstrates connections between girls' involvement in the justice system and past victimisation and adversity with a greater likelihood of girls experiencing sexual abuse, relational aggression, domestic violence, poor parental mental health, poor mental health than boys who offend (Belknap & Hoslinger, 2006; Bloom et al, 2002; Bloom & Covington, 2001; Hodge et al., 2015; Covington et al., 2008; Garcia & Lane, 2012; Vitopoulos et al.,2019). In their study of a more vulnerable community sample of children who had offended (n=100), Vitopolous and colleagues (2019) also found that girls were more likely to have been separated from a caregiver, twice as likely to have a parent with mental illness, more likely to be exposed to victimization by a peer or to have witnessed death. Studies also found that sexual abuse, trauma and depression were the most commonly identified predictors of suicidal thinking and behavioural problems among those in the justice system (Development Services Group, 2019).

Trauma histories of those in residential care settings

Studies analysing adverse childhood experiences in children in residential child protection placements identify similar findings including:

- 80% of children in over 60 residential care settings reporting exposure to traumatic experiences
- multiple traumatic childhood adversities being associated with mental health symptoms (over and above PTSD symptoms) – including greater risk of diagnosable anxiety and mood disorders and severe and persistent behavioural problems
- a greater likelihood of children presenting with more than one mental illness (ranging from 3 to 5).
- About a fifth of children and adolescents reporting occasional and repetitive non-suicidal self-injury (linked with depressive symptoms, conduct problems and substance misuse.
- A higher likelihood, among these children, of experiencing repeat victimisation during their time spent in institutional care.
- Girls with multiple traumas being more likely to engage in rule breaking, to present with attentional problems, hyperactivity and severe and persistent behavioural problems compared with girls with no such history of interpersonal trauma).

(Fischer et al, 2016; Lüdtke et al., 2017; Lueger-Schuster et al., 2018; Euler et al. 2015)

In the US, no differences were identified in lifetime prevalence rates of exposure to traumatic events between adolescents involved in the justice system and those admitted under 'care and protection' legislation (who are similar to children entering secure settings via child protection legislation here).

The mental health and neuro disabilities in girls in secure settings

Girls in the justice system

A large body of international and UK research also confirms higher likelihood of mental health need among girls compared with boys in youth custody. Beaudy's (2020) recent metanalysis of 47 studies covering 32,787 adolescents aged between 10 to 19 years in nineteen countries (including six from the UK) confirmed that:

- Approximately 1 in 4 girls met criteria for diagnosis with major depression compared with 1 in 10 boys. Rates of depression for girls in these settings were noted to be twice as high as those found in girls in the general population.
- 59% of girls, compared with 62% of boys in youth custodial settings presented with a lifetime diagnosis of any conduct disorder – a roughly equal proportion of girls and boys. This finding is important because it runs counter to patterns found in community populations which consistently suggest that boys are roughly twice as likely to meet criteria for conduct problems at this age. Girls in these custodial settings are also eleven times more likely to have conduct problems than girls out in the community (compared to boys who are 7 times more likely to have conduct disorder than boys in the general population).
- 18.2% of girls met criteria for diagnosis with PTSD in youth custodial units compared with 8.6% of boys. Girls were therefore twice as likely to present with these difficulties

than boys in these settings and nearly 10 times more likely than girls of the same age in the general population to meet criteria for PTSD (NHS Digital 2018). A previous UK study (Chitsabesan et al, 2006) also identified higher rates of such symptoms among Black, Asian and Minority Ethnic children in custody (although findings were not disaggregated by gender). In one community study of girls and boys in the justice system (n= 100), post traumatic symptoms were significantly associated with the number of maltreatment types experienced by females. However, this was not the case for boys (Vitopolous, 2019).

- 2.9% of these girls met criteria for a psychotic illness compared with 2.7% of boys. This is a 10-fold increase in prevalence compared with age equivalent children in the general population

Overall, findings pointed to much greater likelihood of children in these settings meeting criteria for mental health diagnosis. Many of the types of difficulties we see in this study are consistent with what we know about the impact of exposure to multiple and persistent adversity and victimisation during childhood and over time. For example, behavioural difficulties are more commonly found among children exposed to maltreatment and developmental trauma (although rarer among girls who are as likely to develop depressive and other illnesses following experiences) (Broidy & Thompson, 2018). High levels of PTSD among this cohort (and particularly among girls) tends to mirror wider research pointing to girls' greater likelihood of exposure to trauma and victimisation as part of their pathway into these settings (Baglivio et al, 2017).

A condition not covered in this meta-analysis was emerging borderline personality difficulties. Borderline personality disorder (BPD) is a debilitating condition that occurs in approximately 1–3 % of the general population (Leichsenring, Leibing, Kruse, New, & Leweke, 2011; Lenzenweger, 2008) but which is noted to be more prevalent among those in custodial and in psychiatric settings (Fossati, 2014). Eppright's (1998) small-scale study of boys and girls in custody (n=100) in the US noted associations between children presenting with conduct problems and their likelihood of later developing personality disorders (more commonly diagnosed after the age of 18 years). Eppright found that girls had higher likelihood of presenting with borderline personality difficulties in this study.

This is a controversial condition when discussing under 18-year olds - since there are concerns that personality is highly dynamic during adolescence and that symptoms in many ways mirror common adolescent developmental characteristics (Bleiberg et al., 2011). There is concern that children might receive what is a weighty and potentially heavyweight and life-changing diagnostic label when presenting features might be nothing more than a normal part of adolescent development. However, clinicians and academics also raise concerns about an overly tentative and cautious approach which 'watches and waits' and ignores constellations of symptoms that might be significantly impairing a child's day to day functioning and safety (Fossati, 2014). Many clinicians and academics question the plausibility that such symptoms 'jump out of the blue' post 18 years of age (Bleiberg, Rossouw, & Fonagy, 2011; Chanen et al., 2004; Winograd, Cohen, & Chen, 2008). Furthermore, Fossati (2014) points to promising

evidence for intervening early to mitigate the impact of this condition on children's social and emotional functioning and life chances.

Mental health of children in residential care settings

Studies have shown that children in residential care settings also have some of the highest rates of poor mental health compared with children in the general population with approximately three quarters meeting criteria for psychiatric diagnosis (Ford, et al., 2007). However, few studies have analysed differences in detail by gender. One recent Norwegian study of children in residential care (Greger et al, 2015) identified that:

- Nearly three quarters of girls reported maltreatment histories compared to just under two thirds of boys. Girls also reported high rates of poly victimisation.
- 70% of maltreated girls met criteria for any mental health diagnosis compared with 68% of maltreated boys.
- Two thirds of girls met criteria for a diagnosis with emotional difficulties compared to 37.4% of boys.
- Boys in state care were twice as likely to meet the criteria for conduct disorder than girls (29.5% v 14.8%)
- 40.8% of girls had experienced sexual abuse, and 46.4% reported having been a victim of family violence (compared to 6.5% of boys who had experienced sexual abuse, and 27.3% were victims of family violence.) This study found that prevalence rates for mental health difficulties increased the more exposure a child had to different forms of maltreatment.
- Depressive conditions and suicidal thinking were more commonly associated with types of maltreatment in which the child was the direct victim of violence (in family or community) or of sexual abuse (rather than witnessing abuse and maltreatment).
- Conversely, the odds for conduct disorder were significantly increased in youths exposed to community violence, both as witnesses and victims.

Multiple co-existing mental health difficulties

Girls in justice or secure care settings have higher likelihood of experiencing more than one diagnosable mental health difficulty. For example, a study of female admissions to a US youth custody setting indicated that 78% of girls met diagnostic criteria for at least one diagnosable mental health condition and that the overall sample average was three different co-existing disorders (Lederman et al., 2004). Studies also indicate that girls' rates of comorbidity in custody (as is the case with their experiences of adverse childhood experiences) are higher than among boys. Abram and colleagues' findings (2003) indicated that over half (57%) of girls met criteria for two or more disorders compared with 46% of boys (Abram et al,2003).

These results mirrored those in other studies of children in residential child protection placements (Ford, et al., 2007; Greger, 2015). In Greger's analysis (2015) of co-morbidity in residential care placements, girls had a higher mean number of mental health diagnoses (2.4 mean diagnoses as opposed to 1.7 found for boys) and also had a higher mean number of different types of maltreatment experienced. In one Australian study, number of psychiatric

disorders was the most significant factor associated with likelihood of offending (Dixon et al, 2004).

Self-harming and suicidal ideation

Although self-harm can be a means of emotional release and a way of coping with psychological distress (and often lacks suicidal intent) there are strong associations between self-harming and greater likelihood of suicidal thinking and completed suicide (Laporte, 2017). This correlation has been noted to be higher in girls than boys in largescale community studies.

The number of children self-harming in the custodial secure estate has increased by 3% in the latest year, to over 1,800 incidents and represents the highest number of incidents seen over the previous five years (MoJ, 2020). In the latest year, there was an average of 13.7 self-harm incidents per 100 children in custody per month (MoJ, 2020).

Recent Ministry of Justice data indicates that the average monthly rate of self-harm per 100 children in custody was higher for:

- Girls (at a rate of 72.3 per 100 girls compared to a rate of 11.8 for boys) (although the average monthly rate of self-harm by girls had decreased compared to the previous year's statistics).
- Those aged 15-18 (at a rate of 13.7 per 100 children compared to 13.3 for 10-14-year olds). The rates between the age groups are now also more comparable.
- White children (at a rate of 19.8 per 100 children compared to 7.2 for ethnic minority children). However, recent statistics do show that the rate for ethnic minority children has more than doubled in the last year (MoJ, 2020).

However, caution must be applied to drawing robust conclusions from this annual data since the population of girls is now small and can fluctuate significantly as different girls move in an out of the estate.

In the youth justice system, Wasserman and colleagues (2010) identified girls being twice as likely as boys to disclose a previous suicide attempt, and three times more likely to have made a suicide attempt. Putnins' Australian study (2005), focusing on 900 boys and girls aged 11 to 20 in custody, also found higher risk of suicide in girls with 46.5% of girls having made previous suicidal attempts and 48.2% disclosing recent suicidal thinking. Rates for suicide attempts and ideation were almost double for girls compared with boys. Past suicide attempts were associated with greater likelihood of future suicide attempts. In Greger's (2015) study of children in residential care settings, girls were also identified as being more likely to have attempted suicide than boys with nearly half presenting with this history compared with just under a quarter of boys.

A largescale study of children who self-harmed in the general population found that childhood sexual abuse was the strongest predictor of subsequent self-harm among girls (Gratz et al, 2002).

Girls themselves talk about how upsetting it was to witness the distress of other girls in secure settings which they saw affecting their own mental health and coping skills (Plan-UK, 2020).

Neurodisabilities, neurodevelopmental difficulties, learning disabilities and speech, language and communication needs

ADD and ADHD

In Beaudy and colleagues' recent meta-analysis of children in custody (2020), just under 1 in 6 girls (a similar proportion as with boys) met criteria for diagnosis with Attention Deficit and Hyperactivity Disorder (ADHD). This finding is surprising as ADHD symptoms are significantly rarer in girls compared with boys in community samples (being at least 4 times more likely to be diagnosed in boys) (see NHS digital, 2018). Although still impairing, studies also note that this condition is more likely to be subtler in its manifestation in girls (being less likely to be expressed through behavioural difficulties and hyperactivity and more likely to be associated with attentional problems). It is therefore more likely to get missed in school settings (McGee and Feehan, 1991). Beaudy's findings indicate that girls with these difficulties are disproportionately ending up in custodial settings. Putnin (2005) also found that substance misuse histories, having a 'bad temper' and ADHD symptoms were also associated with lower and more distressed mood among children.

Autistic spectrum conditions

International studies have noted mixed and very varied findings concerning the extent to which children with core features of autism (specifically pervasive developmental disorders and Aspergers) are overrepresented in justice and secure settings (Rutten et al, 2017). Such neuro-disabilities are more rarely identified among girls compared with boys in community samples (NHS digital, 2018). However, there is concern that girls' lower chances of being identified with autistic conditions may be related to poorer clinical and professional skills in detecting the presence of the condition and any impairment in girls. Girls are thought to be better at masking key features of the condition through their generally superior social skills during childhood and adolescence. Knowledge is virtually non-existent concerning prevalence among girls in justice and care systems (King et al, 2014).

In Rutten and colleagues' systematic review (2017), prevalence rates among a sub sample of boys and young men who had offended aged 15 to 22 and who were referred for further assessment (so not the general youth offending population) was 15% for those presenting with a pervasive developmental disorder and 3% for those identified with Aspergers.

Intellectual/learning disability

Studies indicate that a high number of children in secure settings meet the criteria for diagnosis with a learning disability. However, findings have often been complicated by variations in definitions of intellectual disabilities based on different tools and classification systems used. Few studies have focused on comparisons between girls and boys presenting with these difficulties in these settings.

The most comprehensive study into the mental health and neurodisability needs of children in UK secure custodial settings oversampled girls. It used the ICD-10 definition of intellectual disability characterised by significant limitations in conceptual, social and practical adaptive skills (with a standard IQ score of 70 usually being accepted as cut-off for intellectual disability) (Chitsabesan et al, 2007). It looked at data on 301 children in secure settings of whom 23%

were girls and around 16% of the sample were from Black Asian and Minority Ethnic communities. It found that:

- Boys had significantly lower verbal IQ scores and full-scale IQ scores across all intellectual disability measurement domains than girls - although scores for girls remained just below the average score for the general population.
- Girls had an average reading age of 12.3 years (compared with an average age of 11.1 years for boys). Once again, both reading ages were significantly lower than aggregate male and female reading ages of a matched age group not in custody (15.1 years).
- Girls had better average reading comprehension age than boys in the sample (11.6 years versus 9.6 years) – but in both cases below national norms.

Chitsabesan and colleagues (2007) concluded that many of these intellectual disabilities and learning difficulties were mild to moderate and were highly likely to be missed in mainstream and community based educational provision because:

- children might appear to be able to read but may lack comprehension skills
- difficulties were overshadowed and masked by behavioural problems.

The study found high levels of school exclusions among these children – affecting three quarters of those in custodial settings and poor post 16 educational support (Chitsabesan, 2007). There was evidence to suggest that the needs of these children were better met in secure settings than was the case in community educational provision (Chitsabesan, 2007).

Traumatic brain injury

A traumatic brain injury (TBI) is defined as 'a disruption to normal function of the brain resulting from a direct blow to the head, penetration of the skull, or a force that causes the brain to move around inside the skull' (Hughes et al, 2015). Common causes for such injuries include falls, road traffic accidents and assaults.

Childhood TBI can result in a number of potential neurocognitive and developmental difficulties that subsequently have a knock-on effect on social, educational and behavioural functioning often involving cognitive and communication difficulties, problems managing frustration and aggression, difficulties with impulse control and with responding appropriately to other people's emotions and (Hughes et al, 2015).

There are more studies of TBIs in boys in custody than in girls (Hughes et al, 2015). In analysis of US administrative data, Chesney-Lind and Morash (2008) noted prevalence of TBIs in girls as being lower than in boys at roughly 15% in girls in custody. However, findings are mixed on gender differences with two US studies of adults showing roughly equivalent rates by gender (50% for males and 49% for females and 32.1% for males and 33.3% for females) but most showing significantly higher prevalence in males ranging from being around two to seven times more likely to present with such histories than females (Hughes et al, 2015).

Foetal alcohol syndrome disorder (FASD)

Foetal alcohol spectrum disorders (FASDs) are a group of conditions across a spectrum that can occur in a person whose mother drank alcohol during pregnancy. Symptoms can include an

abnormal appearance, short height, low body weight, small head size, poor coordination, lower intellectual ability, behaviour problems, learning difficulties and problems with hearing or sight.

There is a high prevalence of FASD within the youth justice system (36 percent of boys and girls in a recent estimate in Australia based on a full assessment). Children with FASD are nineteen times more likely to be incarcerated than those without FASD, which may have to do with high vulnerability for negative peer influence and arrest (Popova et al, 2011.) Parrish (2020) found a greater risk of substance exposed pregnancies among girls on community orders and Bower and colleagues (2018) noted that it is very possible that substance-exposed pregnancy is multigenerational for some justice-involved families.

Speech, language and communication needs (SLCN)
Difficulty in developing speech and language skills is one of the most common developmental problems affecting children (Black et al, 2015). SLC needs can be linked to a range of different conditions including developmental language and processing disorders, autism, hearing impairments, speech and stammering difficulties. In Bercow's updated review (2018) around 10% of children in the general population were identified with SLC needs. Rates were five times higher in deprived communities (ICan and RCSLT, 2018).

In one other English School-aged study, 0.4% of children overall aged 5-16 years presented with needs warranting formal Special Educational Needs' intervention. A further 0.6% (in year 7) and 2.7% (in year 1) were noted to have SLC needs requiring additional school adjustments by schools to support learning (Dockerell et al, 2012). SLC needs were noted to be transient and temporary for most children reducing with age (Dockerell et al, 2012). However, evidence also suggests educational needs continue for some children throughout their lifespan (Durkin et al. 2009). Findings are largely not disaggregated by gender but boys in Dockerall's study were noted to be 2.5 times as likely to present with these needs than girls in this school-aged population study (Dockerell et al, 2012).

SLCN are over-represented among vulnerable child populations (e.g. looked-after children and children at risk of exclusion from school) (McCool and Stevens 2011; Clegg et al. 2009). Boys are more likely to present with these difficulties in the custodial estate than girls. UK studies of boys in youth custody found around two thirds of boys in these settings with some form of speech, language and communication impairment with around a third having more severe speech impairment (Bryan et al, 2007; 2015). One US study of girls aged 13 to 17 years noted that more than 20% in custody were identified as language impaired (Sanger et al, 2001). In the UK we lack studies on girls in residential care and justice systems (Bryan et al, 2015).

In a study of boys entering secure care and custody settings (Bryan et al, 2015), there was evidence of low identification of these needs before entry despite high rates of prevalence. Bryan and colleagues (2015) found that many of these children's needs also continued to be overlooked after entering these settings.

Educational background

International studies tracking experiences and outcomes of girls in custody and in residential care showed that roughly 8 out of 10 girls who had been detained experienced at least one school problem, including expulsion, suspension or being held back a year (Acoca 2000; Lederman et al. 2004). Girls were also found to have more additional educational needs (Bright & Jonson-Reid, 2010). Some of these studies suggested that girls in custody experienced more school-related problems than boys - particularly being more likely to drop-out of school and completing fewer years in school (Hoyt & Scherer, 1998; Bloom et al., 2002; Molidor et al., 2002; Gould & Payne, 2004; Chitsabesan et al., 2006).

A UK study of the educational background of children in custody showed that:

- 74% of girls and 88% of boys had been excluded from school.
- 41% of girls and 36% of boys said they were 14 years or younger when they were last in education
- 90% of boys and girls sentenced to custody had a previous record of being persistently absent from school (missing 10% of sessions within a school year)

(Murray, 2012).

On a positive note, Lederman and colleagues (2004) found that more than 8 out of 10 girls in custody liked school despite histories of disengagement.

Physical health difficulties

There are well documented associations between exposure to persistent maltreatment and trauma, childhood behavioural problems and co-existing physical health problems (Pajer et al, 2006; Piqero et al, 2007; Shepherd & Farrington, 2003).

Neuroscientific evidence is also mounting indicating that as children survive and adapt to threatening environments and to continuing stressors, neurobiological systems suffer wear and tear (called increased allostatic load) and can be altered increasing the likelihood of vulnerability to physical disease and mental health problems (Gunnar & Quevedo, 2007 Odgers et al, 2008). During adolescence, health risks can further increase due to children's higher risk of involvement in many health-risk behaviours (e.g. substance misuse, risky sexual activity and self-harm). Some of these risky behaviours are neurotypical and relate to structural changes taking place in the brain (see page XXX). Some are a means of coping with, compensating for, escaping or numbing prolonged emotional distress linked to repeated exposure to stressors and risky family and environmental contexts (Repetti et al., 2002; Odgers, 2015).

Birth cohort studies tracking children into adulthood found that girls with histories of maltreatment have greater likelihood, than other girls, of:

- cardiovascular disease
- obesity
- diabetes

(Knox et al, 2004; Miller et al, 2004; Whooley, 2006).

Other physical health problems of relevance to girls on high-risk offending trajectories and more likely to end up in secure care settings included:

- poorer reports of overall health
- greater reports of health discomfort
- higher rates of longstanding physical complaints
- an earlier onset of adult reproductive problems (even when controlling for demographic factors and pre-existing health history)
- higher risk of presenting with respiratory illness and with chronic bronchitis
- higher likelihood of gum disease and decayed tooth surfaces.

(Odgers et al., 2008; Pajer et al., 2006; Gould & Payne, 2004)

A small number of studies noted greater likelihood of under 18-year-old girls presenting with Hepatitis B and C (compared with boys) in studies of children in custody. In one study, tests carried out during this study showed that a significant number of girls were unaware of their positive Hepatitis B status) (Butler et al, 2008; Murray et al, 2003).

In Williams' study (1999), girls who offended aged 12 to 18 reported double the number of symptoms of sleeping problems, forgetfulness, dizziness and headaches compared with a matched community sample. These girls also found these symptoms more impairing than community peers. Butler and colleagues (2008) observed that all these symptoms, although presented as physical health problems, were associated with minor psychiatric difficulties potentially reflecting underlying mental illnesses.

Profound social and economic disadvantage has been associated with health inequalities among those in custody (Social Exclusion Unit, 2002; Goldson, 2005; Harris, Hek, & Condon, 2007). However, some of the difficulties found among girls existed even after controlling for social and economic deprivation. A significant body of research has also emerged linking experiences of maltreatment and anti-social behaviour with early biological alterations increasing later susceptibility for disease. (De Genna et al, 2006; Pajer et al, 2006; Piquero et al, 2007; Shepherd & Farrington, 2003).

Disadvantaged populations are much less likely to seek medical advice for health issues. (Butler et al, 2008; Australian Institute of Health and Welfare, 2004). Girls in custody were more likely than boys to access GPs about health concerns. However, 31% of girls, compared with 19% of boys, believed they had put up with a medical problem in the last 12 months and had not sought medical treatment. A third of girls and boys believed that a health problem had worsened due to a lack of medical treatment. Reasons for not seeking medical advice included a fear of what the doctor would say or do, logistical issues to do with payment or transport, not knowing who to see, and having no family member or friend to accompany them (Butler et al, 2008).

Risky health behaviours

Greater risk of physical health problems linked to disadvantage, exposure to maltreatment and experience of other multiple risk factors during childhood were found to be subsequently exacerbated during adolescence by riskier health behaviours.

Sexual health issues and early sexual activity
Several international studies and reviews found that girls in secure settings had greater risk of a range of sexual health risks and problems:

a) 76% of girls in custody (aged 12-17) reported being sexually active. On average their first sexual experience was at 14 years of age.
b) Between a quarter and a half of girls in custody described having three or more sexual partners in the preceding year.
c) Only 15% of girls reported always using condoms. Sexual risk taking (intercourse without a condom, serial partnerships, intercourse with partners who inject drugs) was prevalent and associated with involvement in offending, gang involvement, being a victim of sexual abuse and with depressive symptoms.
d) Between 20% (in a 2004 study) and 42% (in a 2010 study) of girls had been diagnosed with an sexually transmitted disease (STI)- with girls being twice as likely as boys to have STIs and four times more likely than girls in community samples.
e) 10% of girls in custody said they had been paid for sex during adolescence and nearly 14% reported forced sex.
f) Girls in custody were identified with higher rates of pelvic inflammatory disease – with few having sought treatment before entering custody.

(Douglas and Plugge, 2006; Cromwell et al, 2002; Kelly et al, 2000; Odgers et al., 2010; Berelowitz et al, 2010; Becket et al, 2012; Leve et al, 2015; Lederman et al, 2004; Leslie et al., 2010; Noll, Haralson, Bulter, & Shenk, 2011).

One study, following outcomes of girls who were in custody into young adult years also found that their sexual health outcomes worsened further as they matured suggesting that secure settings present not only a golden opportunity to treat girls sexual health needs but also a significant public health opportunity going forward (Leve et al. , 2015).

Substance misuse
There has been an overall downturn in smoking and e cigarette use, drinking, and drug use in the UK among children in recent years, although risky use is still thought to be higher among vulnerable children (e.g. in families who support use, where children are disengaged from school and, in the case of drug use, where children have low mood). (Young Addaction, 2015; NHS Digital, 2018).

Eight percent (amounting to just over a 100) of those accessing treatment in secure settings in the last year were girls. Girls in treatment tended to be slightly younger than boys (16 versus 17 years). Nearly two thirds (61%) were recorded as white British; children from White and Black Caribbean communities represented the next largest ethnic group in treatment (9%). Cannabis was the most common substance used by children accessing help (91% of all in treatment cases). Just under half disclosed problematic alcohol use (47%), followed by nicotine (22%), and powder cocaine (16%) (PHE, 2019).

In a small 2018 survey of children's use of New Psychoactive Substances (NPS) (n =300) in Youth Offending Institutions, STCs and SCHs, 9 out of 10 children in custodial and secure

settings (data not disaggregated by gender) said they had taken drugs and around a third used drugs to cope with feelings of anger or grief. There was minimal evidence of NPS use across the CYPSE (User Voice, 2018).

Wider studies have found that although boys were more frequently referred for substance misuse support, girls tended to report more vulnerabilities than boys, particularly self-harming behaviour (29% compared with 10%) and sexual exploitation (11% compared with 1%). Teplin and colleagues (2005) found intertwining risks between substance misuse, sexual exploitation and sexual risk taking with 96% of girls reliant on substances in custody being sexually active, 62% having had multiple sex partners in the past 3 months, and nearly two thirds having had unprotected sex in the past month. Substance misuse among girls was also associated with self-medicating to address psychological distress and to manage co-morbidity of multiple mental health difficulties (Douglas & Plugge, 2006).

Substance misuse was associated both with girls' relationships with (often older) romantic partners and with generally poorer sexual, physical and mental health (Odgers et al, 2010; Leve et al, 2015). Some studies found greater links between PTSD symptoms among girls using substances than among boys – with these girls being over 3 times more likely to meet criteria for a current diagnosis of PTSD compared with substance misusing boys (Belenko et al, 2004). Another study identified higher risk of subsequent substance exposed pregnancies for girls in the justice system who were substance reliant, (Parrish, 2020).

International research confirms that substance misuse starts earlier for children in custody – finding that around 20% began using substances before nine years of age (Morris et al, 1995). Early substance experimentation is a major marker for girls' and boys' exposure to childhood trauma and for chances of later prolific patterns of offending.

A review of the evidence for girls involved in both care and justice systems (see WSIPP, 2019) noted that girls involved simultaneously in both systems had even higher risk of substance misuse and higher risk of suicidal ideation than other girls in custody. Girls with these histories were also noted to have higher chances of having accessed substance misuse treatment before the age of 18 years. (WSIPP, 2019).

Aggression

Alitola (2014) identifies significant interconnectivity among children in the justice system between experiences of repeated maltreatment and trauma, developmental problems during childhood and unprovoked aggression and subsequent contact with the justice system.

Levels of assaults by girls in youth custody settings in 2018 were noted to be roughly comparable to (although marginally less than) those for boys – although sample sizes are low and these findings must be approached with caution (MoJ, 2020). Longitudinal research on male and female trajectories of offending suggest that girls are generally much less likely than boys to commit violent offences and acts (Broidy &Thompson, 2018). However, there is evidence that girls' particular experiences of childhood maltreatment and exposure to multiple forms of trauma, sexual abuse and exploitation in wider interpersonal relationships can compromise their ability to effectively regulate fear, anger and frustration – particularly when in survival

mode and fight or flight mechanisms are activated (Graves, 2007). Experiences of victimisation have also been associated with a significant increase in girls' chances of offending (Burnette and Repucci, 2009).

Wider factors associated in the literature with higher levels of aggression in girls include:

- poorer caregiver support
- feeling unsafe
- difficulties regulating anger – which is a key feature of several psychological conditions commonly noted affecting girls in secure settings including depression, PTSD, and borderline personality disorder
- higher levels of impulsivity - again linked to conditions such as conduct problems and ADHD
- concentrated poverty in girls' neighbourhoods and normalisation of violent victimisation.

(Molnar et al, 2005; Pears et al., 2012; Leve et al, 2015)

One qualitative study of girls' explanations for girl-to-girl aggression (both bullying and physical aggression) and violence in secure settings found that girls with greater likelihood of aggression were strongly invested in identities which involved expressing themselves through fighting. They also saw aggression as a means of self-protection. One surprising finding was that girl to girl aggression was also described as a form of connection, attachment and friendship – something which may be linked to confusing experiences of violence and caregiver bonding within households characterised by family conflict (Zenz Adamshick, 2010). Finally, girls who viewed themselves negatively and believed that peers also held negative views of them were also most likely to feel threatened by peers, and thus retaliate with aggressive behaviours (Zenz Adamshick, 2010).

Further studies suggest that negative attitudes toward school, lack of academic success, low self-esteem and negative perceptions of self, perceived lack of opportunities, narrow beliefs about women's roles and girls' desire to gain power and control in an unstable social context might all play a part in girls' increased use of physical aggression (Zenz Adamshick, 2010; Chesney-Lind & Shelden, 1998; Moretti et al, 2001; Artz, 1998).

A study of older boys and girls in foster care in the USA, found that positive relationships, whether they be with biological parents, foster parents, and/or peers, can protect girls from developing aggressive behaviours (Farruggia & Germo, 2014).

Broader safeguarding and mortality risks

Setting aside these girls' greater likelihood of experiencing sexual and physical victimisation, other worrying safeguarding concerns emerged from studies on the health needs and experiences of girls in custody. For example, some US studies found that:

- 56.2% of girls said they were the victim of physical violence by romantic partner during adolescence (rising to 61.6 in young adult years)
- 60% reported an injury with a third saying they had experienced a fracture

- three quarters of girls aged 13- 22 in custody had been badly hurt or had been in danger
- over half had been involved in a road traffic accident
- 83.8% had witnessed violence, as an adolescence in one or more contexts – mostly in their local neighbourhood
- 56.4% said they were afraid of violence in one or more contexts in their lives
- between two thirds and three quarters of girls aged 10-22 had witnessed another person getting injured/killed
- 60% of these girls had either been raped or felt at risk of this outcome.
- 49% thought 'someone close' was going to be badly hurt or die

(Odgers et al 201; Cauffman et al, 1998; Abram et al, 2004)

An Australian study investigating mortality outcomes for children leaving custody found worryingly higher likelihood of reduced mortality. Mortality levels were much higher than those for the general population and even for those with psychiatric diagnoses (who themselves face well-documented higher risks of premature death) although levels were comparable to those found for children in substance misuse treatment. Although the sample included a very small proportion of girls (making findings very much less reliable), levels of mortality were higher among girls compared with boys (40 versus 9 per 100,000). This finding requires greater international investigation following up and pooling samples of girls' outcomes. Most deaths were recorded as unintentional and were associated with substance misuse (Coffey et al, 2003).

There has been little research on fears, experiences and such outcomes in UK custodial contexts.

Risk of Serious Harm, safety and wellbeing

The Youth Justice System uses two measures to assess risk of harm and safeguarding risks. Risk of Serious Harm data describes an assessment of the likely imminence and likelihood of death or serious personal injury whether physical or psychological among children in custody in England and Wales. Safety and Wellbeing assessments evaluate whether a child's safety and well-being is now, or in the future, potentially compromised through his or her own behaviour, personal circumstances due to acts or omissions of others.

2018 figures show greater risk of 'high' or 'very high' risk of harm for boys compared with girls (31% versus 12%). Conversely, 'high' or 'very high' safety and wellbeing risks were roughly equal but slightly elevated for girls (42% for boys versus 47% for girls) (MoJ, 2020).

All findings involve a very small cohort of girls which mean that caution must be applied when drawing conclusions from these figures.

Pregnancy and girls in secure settings

In June 2020, the Ministry of Justice published its review of operational policy on pregnancy, Mother and Baby Units and maternal separation and announced the imminent implementation of a new Pregnancy, Mother and Baby Units and Mothers in Prison Policy Framework and operational policy for adult women in the custodial estate (MoJ, 2020). This framework and the Female Offenders Strategy reinforce the importance of custodial sentences being very much a

last resort for women who are pregnant. No bespoke strategy or framework currently exists for girls under the age of 18 years.

Given the well-documented and specific risks faced by, and needs of, girls who give birth during teenage years, it is important to consider the bespoke implications of girls who are pregnant and give birth in secure settings. At the current time there is one Mother and Baby unit in a Secure training Centre in England.

Few studies have been completed on under 18-year-old girls and pregnancy in secure settings. Those that do exist reinforce the importance of the following considerations.

- Adolescent pregnancy carries particular well-documented health and social risks. Girls who become pregnant within two years of menarche have higher risk of preterm births (with associated rates of preterm birth known to impact on infant and child development). Long term studies have also noted that children of adolescent mothers have higher risk of a range of health and social adverse life experiences compared with other children (Corcoran, 1998; Maynard & Garry, 1997). Effective support at this time therefore provides a significant opportunity.
- Girls who enter secure settings have significantly higher levels of psychological distress, trauma symptoms and mental health difficulties both before entering secure settings and after entering these settings. This increases their chances of experiencing perinatal mental health difficulties (Nielsen-Forman et al., 2000). Some studies suggest that perinatal difficulties are under identified in such settings (Beck & Gable, 2001).
- Being in a secure setting can be an inherently stressful experience (in terms of the loss of control that accompanies entry, separation from support networks). Prenatal exposure to prolonged and elevated levels of stress during pregnancy have been noted to be counterproductive to foetal development and to good infant mental health and development (Zeanah, 2018).
- An inherent tension has been noted between core values of community healthcare during pregnancy (which revolve around a mother's right to choice) and the contextual realities, principles and organisational goals that often drive secure settings (which are often about limitation of choice and control) (Hufft, 2004). This can lead to challenges in delivery.
- Girls in secure settings often have chaotic lives before entry and can also have higher than average rates of substance misuse. These factors may impact on foetal developmental and increase the chances of birth complications. Substances used during pregnancy are also related to increased incidences of low birthweight, preterm labour and bleeding disorders (Gaziano, 1997)
- As outlined earlier, girls who enter secure settings have higher likelihood of being victims of sexual abuse and sexual victimisation before admission (Baglavio et al., 2014). This not only impacts on their mental health but can also affect the extent to which they can feel good about, and feel motivated to care for, their bodies during pregnancy and childbirth. These experiences may also increase the chances of self-destructive behaviours (which may impact on the foetus), affect trust in healthcare and

wider staff and can undermine motivation to sustain healthy behavioural changes (Siefert & Pimlott, 2001).

- Pregnant adolescents with a history of violence in their lives are twice as likely to exhibit severe patterns of substance abuse as compared to nonvictims (Martin et al., 1999).
- Girls who enter these settings also are more likely to lack parents who have modelled nurturing and authoritative parenting and may be less likely to have imbibed these skills (Hufft, 2008).
- Diagnoses of conduct disorders, neurodisabilities and high rates of attention deficit hyperactivity disorders and low educational achievement may complicate the ability of adolescents to adapt to pregnancy and manage health promotion activities. (Hufft, 2004)
- Anticipatory grief at any planned separation from the baby (and the ongoing impact of this on girls' wellbeing) is identified as a significant issue for girls in this context Hufft, 2004).
- Studies demonstrate that pregnant women and adolescents need more sleep, especially during the first and third trimester of pregnancy (Larkin & Butler, 2000). However, secure environments and their day to day institutional routines may not be sufficiently flexible in allowing girls to get the additional sleep they need. This will require some whole system problem solving.
- For most girls, an unplanned pregnancy would be difficult to cope with; thus, being pregnant, alone, and incarcerated, is perceived as a challenge of particular significance (Hufft, 2008).
- Many custodial settings housing adolescent girls are ill equipped to provide healthcare in general, let alone prenatal services, postpartum care, or parenting classes.
- Studies suggest that girls can often believe having a baby will help them form connections with others, such as bringing them closer to their romantic partner, creating a family etc; others may believe a baby will help them grow up, achieve status, gain positive attention and admiration, and in the face of limited opportunities provide a platform to be 'successful'. Some think their baby will be their "friend" and comfort. The reality of having and caring for a baby can often not live up to these hopes (Hufft, 2008).

In terms of what best practice care looks like studies recommend the following best practice principles for effective care.

- As far as possible, perinatal care should be equivalent to community perinatal care albeit with some necessary creative adaptations to the secure environment. Achieving this will require whole system commitment to scrutinising policies to assure they allow flexibility and are meeting the specific needs of pregnant girls. If everyone agrees on the importance of perinatal care, then finding space for health promotion activities such as prenatal exercise and prenatal classes, as well as flexible scheduling of work details, can be addressed. Healthcare staff should be proactive in advocating for the girls' bespoke needs whilst pregnant to address any tensions between her rights and institutional and secure systems and processes.

- Secure settings as a whole should consider the important role that engagement with healthcare makes during pregnancy as a general protective factor for teenage parents as they move forward (Koniak-Griffin & Truner-Pluta, 2001).
- A strength-based psychosocial model should be employed which focuses on risks associated with adolescent pregnancy, recognises pregnancy as a key motivational opportunity to develop and build on girls' strengths, that understands the demographics of girls who come into these settings, and which works creatively with the whole institution and with girls to problem solve ways around the physical and social limitations and expectations presented by the secure environment (Hufft, 2004).
- Nurses supporting girls' pregnancy in secure settings need to incorporate knowledge of obstetric, child development and forensic nursing in order to develop interventions most likely to produce positive pregnancy outcomes and long-term infant and maternal health.
- Screening at admission for pregnancy is critical together with immediate and comprehensive prenatal care upon confirmation of pregnancy including healthcare screening and assessment, monitoring of pregnancy milestones, perinatal education and counselling, establishment of social support systems, and medical and psychological care.
- There should also be routine screening of, and early treatment for, girls' mental health and wellbeing during pregnancy with whole system hypervigilance for any deterioration. Qualitative data that elicits information about feelings contributing to fatigue, how girls see themselves, anxiety, or frustrations are also important. Attention should also be given to depression or psychosis in the immediate family, the disruption of social support or breaks in family ties, low self-esteem, adverse life events, and ambivalence toward the pregnancy.
- Nurses supporting pregnant girls need to work proactively and with undaunted persistence to engage and build trust with girls as well as working proactivity with mental health practitioners and with the wider unit to ensure a whole system coordinated approach promoting the wellbeing and best outcomes for mother and baby.
- Collaboration between the girl, the nurse, and the extended family and support systems is critical. This may also, where requested, include involvement of the father.
- Pregnancy is often a golden motivational opportunity to support positive health behaviour changes and to build critical skills associated with responsive and positive parenting skills.
- Nursing activity should attempt to help the pregnant teen negotiate an altered activity and rest schedule, and modifications in work or school scheduling if these are required. (Hufft)
- Girls may also need nutritional supplements, including vitamins, nutritious snacks, and nutritional supplements, with more protein and less fat than is normally present in correctional meals.
- In addition to teaching the usual topics in prenatal health education, the focus of education for pregnancy in secure settings should include particular pregnancy risks for girls in custody, how they can be helped to adapt pregnancy to the secure environment and stress management in what is an inherently stressful situation, alternative comfort

measures, anticipatory grieving and loss, maternal role alteration, development of alternative support systems.
- Nurses providing perinatal support require skilling up in effective communication strategies and skills to ensure girls' active involvement and empowerment in their care and to avoid paternalistic decision-making.
- More evidence is required to make informed decisions regarding nursing interventions with this high-risk group.

(Hufft, 2004; Cohen, 2006; Hufft, 2008)

Specific groups of girls in secure settings

Gang-involved girls

There is not clear and accurate data on the number of girls involved in gang and county line activity (Brown and Mutebi, 2020). However, rates are thought to be higher than suggested by official figures and a recent UK parliamentary debate reinforced the importance of greater awareness for girls affected by, and involved in, county lines activity (Brown & Mutebi, 2020).

Based on an analysis of 2013 UK point of arrest data across 37 sites nationwide (n = 8565), girls who disclosed gang involvement had many more and more severe health, family and social difficulties than boys who were gang involved and than other girls who offended – confirming that these girls are a particularly high risk group (Khan et al, 2013).

Chesney-Lind (2008) noted that gang involvement was associated with having a family member or boyfriend who was a member of a gang. Other studies note associations between gang involvement, sexual exploitation, and a range of other risky health-compromising behaviours (e.g. earlier sexual activity, unprotected sex, sex with multiple partners, higher rates of sexually transmitted infections and lower knowledge about these health problems, sex with multiple partners, witnessing violence, increased likelihood of early pregnancy etc) (Wingood et al., 2002; Minnis et al., 2008; King et al, 2015). A US study of African American gang-involved girls noted that gang involvement was associated with having a boyfriend who was a member of a gang, having one or more casual sexual partnerships, lower levels of STD prevention knowledge, high levels of drug and alcohol abuse and condom misuse (Voisin et al, 2014).

The Office for the Children's Commissioner in England (2017) reported similar patterns of high-risk sexual activity and exploitation among girls within the context of relationships characterised by grooming, disrespect, manipulation and physical and sexual violence towards girls and women. However, sources also note that girls rarely saw themselves as victims seeing themselves instead in romantic relationships with those grooming them (Brown & Mutebi, 2020).

Low disclosure of gang involvement and generally low access to help were also noted among girls. Girls who became gang involved were also noted to have low levels of self-esteem and difficulties in processing emotions. Voisin and colleagues (2014) conclude that they may be drawn to gangs due to the status conferred by membership. Thornberry (2002) saw girls' gang identity being associated with histories of family and wider victimisation, poor self-esteem and

peer rejection who sought protection and belonging from gang involvement (Thornberry et al., 2003; Dukes et al, 1997).

Girls dually involved in care and justice systems

Youth Justice data on children in custody identified a higher proportion of girls assessed with the following care statuses compared to boys:

- Child in Need (22% compared to 18%)
- on a Child Protection Plan (13% compared to 8%)
- an Eligible Child (18% compared to 15%)[1]
- having siblings in Care (37% compared to 27%).

(Fitzpatrick, et al, 2019)

Girls in care have been identified as being four times as likely to be youth justice involved if living in a children's home than girls in care more generally (Howard League, 2019).

Studies comparing long-term outcomes for those involved both in care and criminal justice systems, with those of children only involved in juvenile justice, noted that dually involved children were more likely to:

- be arrested as adults
- receive welfare benefits
- have unstable accommodation
- enter inpatient hospitals
- be in contact with outpatient mental health and substance abuse services
- access health services in an emergency.

(Culhane et al 2011; Baetz, 2015)

Specifically, in the case of girls, Butler and colleagues (2008) found childhood care placement to be associated with unintended pregnancies, increased number of sexual partners, increased risk of sexually transmitted infections and poorer mental health (Carpenter et al, 2001).

LGBTQ+ identities and girls

Although data remains poor for children, there are indications of a rise in recent years in the number of children identifying themselves as transgender or as having a gender other than male or female - commonly referred to as 'non binary' or 'gender fluid' (but encompassing a very wide range of self-identified expressions of identity (de Graaf & Carmichael, 2018; de Graaf, Giovanardi, Zitz & Carmichael, 2018; Richards et al., 2016). For these non-binary children, thinking in very binary male/female ways feels out of keeping with their experience of the world.

In a German study of 940 children aged 10-16 years the following patterns of self-identification were noted in relation to gender (Becker et al., 2017) .

[1] An Eligible Child refers to those in care aged 16 and 17 who have been looked after for a period to be prescribed. The age at which spells in care start to count towards eligibility will also be prescribed.

Table 2: patterns of self-identification of gender in a German study (n=940)

	Assigned male at birth	**Assigned female at birth**
Gender incongruent[2]	0.7%	2.4%
Gender ambivalent[3]	0.7%	1.4%
No gender	0.9%	2.0%

Categories used were quite narrow and may result in under identification of children's actual experiences of their gender identification. Although girls are more likely to self-identify in all of these categories during adolescence, conversely those assigned male gender at birth self-identify more often as gender incongruent and ambivalent compared to those assigned female at birth during adult studies suggesting that the process of self-identification can be dynamic and may be different for those assigned different genders at birth (Twist, 2019). Another key message from studies completed so far is that categorisations in this area do not capture the full complexity of children's experiences and that gender identity can be fluid. In a Scottish study of under 25-year olds associated with the Scottish Trans Alliance (2016):

- 65% considered themselves to be transgender *and* non-binary
- 54% described themselves as fluid
- 31% described themselves as fixed in their identity
- 15% were unsure

Stonewall's surveys of school children (2017) (n = 3713) indicates higher levels of bullying compared with non-LGBT peers (a risk factor for long term poor mental health and other poor social and economic outcomes). Furthermore,

- more than 4 out of 5 children identifying as transgender self-harmed; 3 out of 5 lesbian, gay and bi children said they self-harmed.
- 2 out of 5 transgender children have attempted to take their own life; one in five lesbian, gay and bi children said they had attempted to take their own life

It is important to also note that studies focusing on the experiences of non-binary children note that they are as likely as transgender children to experience higher rates of mental health difficulties but they are also less likely to access trans-specific healthcare (Chew et al, 2020).

Gender and sexual identity in secure settings

Very few studies have been completed either into the experiences of children who identify as transgender or lesbian, gay and bi in secure settings. Those that have been completed (and mainly in the US) suggest that those identifying themselves as LGBTQ+ may be more likely to:

- be expelled from school, to runaway, to be homeless and to be overrepresented in secure settings
- be rejected by family
- have experienced child abuse
- have faced intersecting experiences of discrimination (with higher number of ethnic minority girls being identified in custody from LGBTQ+ communities)

[2] Individuals who identify with the 'other sex' more than their assigned sex

[3] Individuals who identify equally with 'both sexes' – one kind of non binary identity

- face bullying and victimisation (and, although the literature is scant on this issue, more likely potentially to experience victimisation and exploitation on transition to adult secure settings)
- keep their identity and concerns private for fear of victimisation
- self-harm than non-sexually minority girls.
- be seen as ‘agressors’ and ‘predatory’ in custodial settings
- ask for and seek, counselling than non-sexual minority peers. In a study of 404 children in custody Belknapp (2012) found that counselling was more commonly requested for sexual and physical abuse counselling, family and mental health issues by LGBTQ+ children.

(D’Augelli, 2002; Garofalo et al., 2006; Irvine, 2010; Walls et al., 2010; Pardue, Arrigo, and Murphy (2011; Belknap et al., 2012) Holsinger & Hodge, 2016;

Holsinger and Hodge also noted a lack of knowledge about LGBTQ+ issues and low confidence in staff about how to support and manage girls presenting with LGBTQ identities.

Gender dysphoria study in secure impatient settings
Gender dysphoria is the description used for the discomfort experienced by someone whose gender does not match the one they were given at birth. Feeling gender typical and content with one’s gender is generally thought to positively influence well-being, whereas feeling pressure to conform to gender stereotypes is generally a negative influence (Carver, Yunger, & Perry, 2003).

Around 12 to 27% of children are more likely to experience long term discomfort about their assigned gender and children identifying these feelings from the age of 10 to 13 are most likely to experience ongoing discomfort with greater likelihood of presenting for support with gender re-assignment (Steensma et al., 2013; Fuss et al., 2015; (Byne et al., 2012).

There are mixed research findings on the extent to which those suffering from gender dysphoria are more likely to present with higher likelihood of diagnosable mental health difficulties. This requires more research. But self-harming behaviours, as noted above, appear consistently much higher across studies amongst children with these needs. Self-harming behaviours are seen as a means of coping with the discomfort and stigma experienced as a result of their discomfort at the mismatch between their assigned gender and their self-identified gender, the lack of affirmation and acceptance for who they are and also potentially linked to higher levels of bullying.(Hill et al, 2020).

Hardly any studies have explored experiences of dysphoria in secure settings. One very small-scale UK study of children in medium and low secure inpatient psychiatric settings (Hill et al., 2020), identified with gender dysphoria (n = 13), noted that:

- these children represented 6.22% of medium secure admissions and 37.5% of low secure admissions between 2008 and 2019
- they were all assigned female gender at birth
- half this small sample were looked after children before entry.

Ten of the sample consistently reported gender dysphoria and changed the expression of their gender to a varying extent. Six children consistently identified as male asking to be addressed

by a male name with male pronouns and adopting a masculine appearance. Others were less consistent in identifying as male.

Compared with a small, matched sample of other girls in the unit, those with gender dysphoria, were identified with higher rates of confusion about who they were, stronger negative views of themselves and higher body disapproval. However, samples sizes were very small and these differences may not be associated with their gender incongruence.

In many other ways, these children shared similarities with other girls entering the setting (in terms of their background, experiences of complex trauma, prevalence and type of mental health conditions etc).

LGBTQ+ girls in custodial settings

Generally poor UK data exists on any distinct differences and needs of LGBTQ+ girls in secure settings in the UK. In the US, studies of youth justice populations suggest an over representation of LGBTQ+ girls including those who do not identify with assigned gender identities in custodial settings.

The number of children in the youth female estate in the US who identified as lesbian or gay or identified as 'gender non-conforming' was found to be between five (for LGB+) and thirteen times higher (for gender non-typical) compared with those in the male youth custody population (Irvine-Baker et al, 2019). One recent US study also found nearly 50% of those assigned female identity in one youth custodial setting identifying as either LGB+ or gender non-typical. Himmelstein and Bruckner (2011) found that these children faced greater risk of justice involvement than non-LGB+ and gender conforming peers. They also faced higher risk of being suspended and expelled from school.

LGBTQ+ children have been identified as particularly vulnerable in custody where they were seven times more likely to experience peer victimization compared with peers (Beck et al, 2013). Many from these communities were also from Black, Asian and Minority Ethnic communities reinforcing the need to consider the impact of the intersecting and amplified nature of these children's experiences of discrimination and oppression. They also had histories of homelessness, substance misuse, family and school problems. (Schaffner, 1998; Irvine-Baker et al, 2019). Irvine-Baker and colleagues raised concerns that the needs of LGBTQ+ children, were neglected in justice delivery which was rooted in binary and more normative understandings of gender and sexuality.

We do not know if such disproportionality is mirrored in UK secure settings as current data on LGBTQ+ children is poor and research underdeveloped. Given high levels of victimisation being reported in custodial settings elsewhere in the world, issues affecting LGBTQ+ children in secure settings merit further exploration.

The needs of girls from Black, Asian and Minority Ethnic communities

Little research has been completed on the needs and experiences of girls from Black, Asian and Minority Ethnic communities involved in care and justice systems and routine data, disaggregating gender by ethnicity, is poor (Fitzpatrick et al, 2019; Goodfellow, 2019.).

In 2017, the Sentencing Council for England and Wales published a new guideline for sentencing children placing an increased focus on the background, circumstances and vulnerability of children. It concentrated attention on welfare considerations, giving a stronger emphasis to children's rights, the issues facing looked after children and inserting a new requirement to consider the over-representation affecting some Black, Asian and Minority Ethnic children (Sentencing Guidelines Council, 2017; Goodfellow, 2019)

In the youth justice system, the proportion of children from Black, Asian and Minority Ethnic communities arrested, cautioned, sentenced, remanded and in custody over the last 10 years has been increasing. Disproportionality primarily affects children from Black and Mixed Ethnic backgrounds as opposed to other ethnic groups. The number of children in youth custody, identifying as being from a 'Black' background, has increased by 6% in the last year, and now accounts for 28% of the youth custody population which is almost double the proportion of children in these settings compared with 10 years ago. The proportion of children from Asian and Mixed Ethnic backgrounds has also increased in the last decade (MoJ, 2020).

Data on girls in secure settings (in care, on remand and serving a custodial sentence) is not routinely available disaggregated by gender and ethnic background. In 2017, based on an analysis of data supplied by the YJB, Goodfellow (2019) noted that girls from Black, Asian and Minority Ethnic backgrounds represented 37% of girls in custody. She also noted greater disproportionality of girls from such communities on remand compared with sentenced girls. This is important because studies have found that large numbers of those on remand do not ultimately go on to receive a custodial sentence (Goodfellow, 2019) yet separation from family, from community resources and routines can often seriously affect the progress and stability of girls lives as well as causing distress (Goodfellow, 2019; Gibbs & Hickson, 2009). Goodfellow also noted that a higher proportion of girls from Black, Asian and Minority Ethnic groups (67%) were placed in a Secure Training Centre (rather than a smaller Children's Home) compared to White girls (58%), 'potentially indicating that they are being assessed as less vulnerable'. Goodfellow (2019) also suggested that routine MoJ data "disguises the true picture of the number of girls detained over a longer period, caused by a frequent flow of girls through custody for brief periods on short custodial sentences and periods of remand".

Goodfellow (2019) observed that children from some Black, Asian and Minority Ethnic communities were similarly over-represented in Looked After cohorts in England and Wales.

Broader international research suggests that girls in the justice and care system from some Black, Asian and Minority Ethnic communities:

- had higher chance of being involved simultaneously in both care and justice systems
- had higher chance of being dealt with more punitively in the justice system than white girls
- presented with higher rates of sexual health difficulties and physical health inequalities
- had an additional trauma-related burden which impacted on resilience – that of the collective trauma or historic community trauma
- were at higher risk of having been in unstable accommodation
- may be more affected by cumulative adverse childhood experiences than white girls

- needed to manage the 'weathering' effect of racism and persistent cultural misinterpretations (particularly in relation to aggression and threat) during day to day communications and interactions. De La Rue and colleagues (2018) noted that chronic exposure to everyday micro aggressions (such as managing other people's disapproving and negative cultural misinterpretations, stereotypes and characterisations) and discrimination had a confounding effect on feelings both of belonging and of safety.

(Cox & Sacks-Jones, 2017; Feilzer & Hood, 2004; Fitzpatrick et al, 2019; De la Rue, 2018)

In one US study, Bright and colleagues (2014) noted that despite presenting with some of the highest risks and needs, girls from Minority Ethnic backgrounds were least likely to get the support they needed. Epstein and colleagues (2017) focussed on the concept of 'adultification' of Black girls demonstrating how, in a survey of 325 mostly White adults there was evidence that these adults held different attitudes to Black girls, which led to different responses to their needs from the age of 5 to 14 years. This US study found that adults generally perceived Black girls, to be developmentally older, less vulnerable, less in need of protection, to need less support and comfort and as they mature, to know more about adult issues and sex, to be louder and more aggressive than their white peers and to be more culpable for their actions. This is seen to translate into girls being treated more harshly than their white peers and receiving lower support. These attitudes and beliefs are also seen to underpin patterns of higher school exclusions and elevated rates of contact with the justice system (Wilson, 2017). The most significant differences were found in middle childhood and early adolescence (e.g. ages 5–9 and 10–14) but with trends continuing to a lesser degree in the 15- to 19-year-old age bracket.

There is a lack of current research into any potential over representation, and into the needs of, girls from Gypsy and Traveller communities in secure settings.

Young carers

In Australia , Butler and colleagues (2008) found that two-thirds (n=28) of children who offended lived with someone prior to custody suffering from a "…physical, mental, or emotional problem/limitation affecting that person's daily life" and identified themselves as the primary care-giver prior to custody. Mental illness and substance abuse accounted for 56% of the conditions affecting those cared for by these children (Butler et al, 2008).

Chapter three: supporting the strengths and needs of girls in CYPSE – what works?

Academic evidence indicates that girls entering secure settings are significantly more vulnerable than boys (who themselves have higher risks of multiple vulnerabilities than the general population). These girls experience greater histories of polyvictimisation and present with higher risk of longstanding developmental trauma, co-existing mental health, neurodevelopmental problems and substance misuse difficulties as well as a wide range of other intertwined and clustering health, social and safeguarding risks.

Due to their minority status in custodial units, concerns have been raised that justice environments, regimes, responses and programmes have all been developed to meet the needs of boys – particularly in justice settings (Goodfellow, 2019). There has been a longstanding call to adopt gender-responsive theoretical approaches and establish gender-transformational environments and care and interventions to better address and meet the unique needs of girls (Mallicoat, 2007).

Gender responsive approaches

Gender-specific or responsive approaches refer to a whole-system, strength-based and trauma-informed response to girls' needs (Kerig and Schindler). The approach aims to work with girls' unique psychological, developmental and social needs taking into account their particular pathways into vulnerability and involvement in crime (Garcia & Lane, 2010; Bloom et al, 2005; Corston, 2007). It recognises the 'realities of female lives in a social and structural context' acknowledging that these girls are subject to gender-based inequalities , violence and dynamics within society that increase chances of female dis-empowerment, victimisation and social exclusion.

Chesney-Lind (2001) asserts that effective gender responsive approaches (GRA) recognise and understand the interconnected nature of women's victimisation experiences, their survival strategies and the trauma-driven issues affecting their lives. GRA adopts a holistic, comprehensive, relationship-driven and empowerment-based approach to addressing girls' needs (Watson & Edelman, 2012).

Key areas of focus include:

- a clear emphasis on proactively building trust and on promoting girls' feelings of safety
- placing girls' voices at the heart of how they move forward
- having in place a 'wrapround facilitator' who builds a strong relationship with girls and who seamlessly glues planning and activity together, ensuring linkages, resources and effective connections across all the complex intertwined areas of a girls' life
- promoting, restoring, sustaining and supporting healthy relationships (e.g., romantic, peer, family
- building on girls' assets, aspirations and promoting wellbeing as well as strengthening coping and life skills
- focusing on girls' goals, aspirations (and also on parenthood)
- providing practical and material support with housing as well as facilitating educational, recreational, vocational and employment goals and resources
- mobilising concrete and safe opportunities for moving forward
- developing female empowerment and self-efficacy as a means of promoting positive self-esteem and growth
- encouraging critical awareness and appraisal of gender roles and norms.

(Baines & Alder, 1996; Belknap et al., 2010; Bloom et al., 2002; Bond-Maupin et al., 2002; Chesney-Lind et al., 2008; Covington, 2000; Gaarder et al., 2004;Watson & Edelman, 2012; Javdani and Allen, 2016; Bateman and Hazel, 2014; Goodfellow, 2019; Bloom et al., 2003; Garcia & Lane, 2010; Centre for Mental Health, 2019; Bloom et al., 2003;)

Most gender-responsive approaches have been tested in community-based contexts (some of which involve very small residential and therapeutic groups homes for girls). This may suggest limitations in the extent to which GRA operational principles can be adapted, and maintain fidelity, when implemented in secure care settings. (Bloom et al., 2003; Smith & Smith, 2005).

Trauma informed environment and culture
A trauma-informed environment is considered a key and active ingredient for effectively supporting, improving and changing the outcomes of girls with histories of polyvictimisation (Lanctot et al, 2018). A core starting point for trauma-informed approaches includes focusing on the trauma that is driving responses and behaviour and moving from asking "what is wrong with you?" to "what has happened to you?" (Centre for Mental Health, 2019). Interventions and approaches should also do no harm (International Working Group on Therapeutic Residential Care, 2016). Staff should manage the physical environment so as to minimise triggering events, should be sensitive to the effects of trauma on attachment issues and should focus on support rather than control (Zelechoski et al., 2018).

Other key components of trauma-informed environments include:

- whole system ownership of this way of working by leadership, staff, girls and families
- creating and sustaining a safe, nurturing, transparent, accepting, compassionate and respectful environment where girls' needs are put first
- Finding ways to make sure girls have a voice even when their behaviour might be challenging – e.g. by creating advance agreements or safety plans in which girls can let staff know how they would like staff to treat them if they disengage from the service or if they are acting aggressively
- putting trust and building relationships (rather than procedures) at the heart of activity
- emphasising girls' strengths and resilience and understanding their multiple problems in the context of how they have learnt to survive (rather than in terms of a set of problems or symptoms)
- offering girls genuine choices
- creating a listening and empowering culture that minimises power imbalances – this involves seeking systematic feedback and working proactively with girls to learn reflectively, thoughtfully and flexibly about how support might adapt and be re-designed to better meet their needs
- focusing as much on therapeutic alliance and on *how* support is provided (not just on what is delivered (e.g. evidence-based interventions being delivered in the context of strong relationships)
- a unique and tailored approach to each individual
- embracing the extent to which women face multiple layers and experiences of victimisation based on intersecting identities of race, sexuality, disability and gender nonconformity.

(Elliot et al., 2005; SAMHSA, 2014; Centre for Mental Health, 2019; Wilton and Williams, 2019)

Wraparound care

Because of their interconnected needs, most girls need contact with a range of other services such as the (health, mental health, substance misuse, etc). Further important elements of GRA and TIC include the role of integrative interventions or wraparound approaches. Effective care involves co-production (with girls, professionals, kin and family etc) of an integrated plan driven by girls' goals and mobilised by a wraparound facilitator who fosters a strong relationship with each girl as well as ensuring linkages and effective connections across all the intertwined areas of a girls' life (Walker et al., 2012).

The importance of authentic and nurturing relationships

A further critical ingredient is developing strong relationships with girls. Farruggia & Germo (2014) reinforce that good quality relationships (e.g. with biological parents, foster parents, and/or peers) can protect older girls from developing aggressive behaviours. Baines & Alder, (1996) also suggest that girls respond best to interventions when sustained, consistent, nurturing and trusting relationships are established between the girl and the adults with whom she is working. GRA approaches place a strong emphasis on developing a strong therapeutic alliance and using these relationships as a facilitator for building trust, exploring life experiences, building empowerment, modelling positive coping skills and setting the foundations for more enabling and healthier relationships (Jordan, 2013; Anderson, 2019).

An approach led by girls' voices

A keystone of gender-responsive approaches includes girls having a voice in and determining the nature of the help they receive (Belknap et al., 2011; Javdani & Allen, 2016; Raviora et al., 2012; Lanctot and colleagues (2016) noted that this was particularly important to overcome feelings of dis-empowerment and victimization.

An approach that recognises that girls have intersecting identities and experiences of discrimination

Finally, Bright and colleagues (2014) argue that while gender responsive services are important, being gender-responsive is not enough. Programmes must also be flexible enough to accommodate diverse groups and must consider the complexity of intersecting identities (e.g. race, disability, LGBTQ+) and how these identities and experiences may amplify experiences of day-to-day marginalisation and layers of trauma.

Evidence for the effectiveness of gender responsive approaches

The principles of this way of working are widely accepted and considered highly relevant to the histories of trauma and interconnected needs of girls in custody. However, there is as yet inconsistent and insufficient high-quality evidence to establish what difference implementing gender responsive approaches makes to girls' outcomes (Chesney Lind, 2008; Zahn et al, 2009; Anderson et al, 2019). For example, Zahn and colleagues (2009) looked at nine gender-responsive programmes which demonstrated mixed results in reducing re-offending. Most gender responsive programmes were community based; two were alternative educational units, one was a small group-based residential home (where girls had some freedom in their local community). Only two gender-responsive programmes had a rigorous evaluation design with

randomisation and use of control groups. Zahn's review (2009) found some evidence of an overall pattern of improvement in relationships and in school success. There was also some evidence of improvements in support systems, employment, self-esteem, and empowerment). However, there was less evidence for long-term effects of reduction in recidivism (e.g. for more than 6 months) although both Chesney -Lind's and Zahn's evidence reviews found that comprehensive programmes that target multiple risk factors are the most effective in reducing involvement in crime, regardless of gender (Chesney-Lind et al., 2008; Zahn et al., 2009). Since then, one Group Home approach has demonstrated reductions in offending for girls placed in these settings using a high-quality research design (Anderson, 2019) (see page XXX).

A range of reasons have been given for mixed evaluation results in the literature. Findings have been hampered by:

- a lack of investment in rigorous research in gender responsive approaches and also to a lack of studies disaggregating effectiveness of programmes by gender.
- a lack of comprehensiveness in what was being offered which failed to address the interconnected factors associated with girls' vulnerability. Studies have particularly noted a general lack of services such as counselling for abuse, health education, sex education, career guidance and anger management for at-risk girls.
- the heterogeneity of delivery and a lack of operational clarity regarding the implementation of gender-specific services. For example, Walker and colleagues (2015) identified at least 35 distinct gender-responsive principles across empirical and practice publications. The volume of principles outlined in gender-responsive literature was considered likely to create difficulties for practitioners in translating these into practice and/or identifying which principles are most important to prioritise to meet intended goals.
- linked to this, a lack of attention in practice to whole system workforce fidelity to gender responsive models. More effective programmes are those which pay close attention to delivering support in a way that is faithful to the core elements associated with successful outcomes. This is important as even when projects were described as gender responsive, some frontline practitioners did not consistently demonstrate good knowledge of principles. To date, there are no validated tools that measure whether an intervention is gender responsive. Furthermore, trauma informed responses advise against allowing processes and procedures to dominate responsivity to women's support needs (Wilton & Williams, 2019).
- conflicting goals in organisational cultures: both gender responsive and trauma informed approaches require a significant cultural shift in workforce attitudes, working practices, balances of power and in environmental culture – which may not be easy to achieve and practice consistently, particularly in settings where staff are dealing with a majority of boys and where controlling procedures dominate therapeutic and caring approaches.
- lack of a consistent methodological approach to tracking any shifts in outcomes (particularly recidivism) across studies.

- too narrow a focus on recidivism as an outcome and a lack of activity tracking wider factors underpinning women's pathways into vulnerability.

(Kerig & Schindler, 2013; Anderson et al, 2019; Hubbard & Matthews, 2008 Chesney-Lind et al., 2008; Holsinger et al., 1999)

Furthermore, gender responsive principles are yet to be broadly implemented and evaluated in custodial settings (Salisbury, 2015; Walker et al., 2015; Zajac, 2015).

Future research and evaluation endeavours should focus on developing a clear theory of change, operational model and empirical standards for defining, operationalizing, and measuring gender-responsive services – particularly in terms of broader outcomes beyond offending and following girls up over time (Anderson, 2019).

Evidence of effectiveness for trauma-informed (ITC) care in secure settings
Once again, although there is growing consensus on the logic and value of using trauma informed principles and approaches with girls in secure settings (with the case also being made for boys), research findings on trauma-focused secure environments remains at an early stage - especially when translating TIC into custodial units and when piloting these with girls (Ford et al., 2012). More investment in high quality evaluation and replication is required (see Benedict 2014; Elwyn, 2015). Some approaches piloting TIC principles which have been delivered and evaluated in custody are described below:

Trauma and Grief component therapy for adolescents
For example, in the US, Trauma and Grief Component Therapy for Adolescents (TGCTA), which had previously been evaluated as promising with war-torn youth populations and with high risk gang involved youth (Grassetti et al., 2014; Saltzman et al., 2006), was implemented with a mixed cohort of boys (n = 58) and a very small sample of girls (n=11). This intervention, involved 23-25 sessions across 4 modules and focused on developing core knowledge and skills to enhance posttraumatic emotional, cognitive, and behavioural control (b) group sharing and processing of trauma experiences; (c) group sharing and processing of grief/loss experiences; and (d) moving toward improved skills in self-management, progress and future orientation. The approach was adapted for custodial settings. A shortened version was also tested. It was delivered hand in hand with a 'Think Trauma' training programme for staff (Layne et al., 2008).

Despite histories of polyvictimisation and loss among these children, there was a significant decrease in trauma-related symptoms. Decreases in these symptoms were greater for those housed in settings that were able to implement the longer intervention. Settings with high rates of behavioural incidents before the pilot experienced large reductions in these events when both TGCTA and staff training were fully implemented. The quality of the methodology did not allow evaluators to confidently attribute changes to the intervention (Olafson, 2018). Furthermore, a big limitation of this initiative was the low number of girls involved in the intervention.

Sanctuary Therapeutic Community model
A further example of systematically implementing a trauma-based approach in US custodial settings is the Sanctuary Therapeutic Community model (a therapeutic community approach

mirroring many of the trauma-informed principles and programme elements outlined earlier). Elwyn and colleagues describe this approach as:

> "a consciously designed social environment and program in which social and group processes is harnessed with therapeutic intent" and where "therapy" constitutes the learning which occurs through involvement, participation, problem solving, personal and social responsibility, and interpersonal feedback, which are all structured components of TCs (Elwyn et al, 2015; Shuker, 2010).

Elwyn's (2015) evaluation of this intervention in a small custodial setting holding girls aged 13-20 (n = 26) found statistically significant pre and post reductions between 2008 and 2012 in:

- rates of youth misconduct resulting in injury, confinement, or restraint assaults (with assault rates per 100 person days dropping from 6.6 to 1)
- in room confinement rates (with rates per 100 person days dropping from 0.5 to 0.05)
- in physical restraints (with physical restraints per 100 person days dropping from 7.6 to 1.11)
- youth on youth assaults (with youth assault rates per 100 person days dropping from 0.3 to 0)
- assaults on staff (with staff assault rates per 100 person days dropping from 1.4 to 0.4)
- youth complaints
- staff complaints

Improvements were also noted in girls' perceptions of feeling unsafe which dropped from 44% to 11%.

Reductions were not only tracked pre and post over time but also compared outcomes with data on the performance of the wider youth estate of 100 settings. In almost all instances, these improvements did not appear to be driven by trends found in the wider estate. In fact, incidents in the wider estate continued to increase whilst incidents in the smaller girls' unit decreased. It should also be noted that the girls' unit had had some of the very worst rates of challenging behaviours across all domains before this pilot started.

The research acknowledged limitations, one being that it was not possible, because of the way that wider data was provided for the youth custody control population, to create a matched comparison out of wider estate data. Another limitation, once again, was that Elwyn's methodology had not enabled researchers to confidently attribute change directly to the trauma-informed intervention. This was also a small establishment, with a small sample of girls involved in the intervention – yet despite this there were statistically significant improvements in behaviours, safety and management challenges noted. It is unclear how easy it might be to implement this approach in larger institutional settings. (Anderson et al, 2019). The approach also requires replication.

Whole system trauma-informed approaches trialled in residential psychiatric settings for children

Stanley and Boelstadt (2019) evaluated the impact of a whole system trauma-informed approach with boys *and* girls (n = 206) with complex trauma in a psychiatric residential setting

in the US comparing outcomes with those in similar settings which did not employ these approaches. Girls made up roughly 40% of the sample in intervention and control sites (n = 86).

Using the CAFAS (which measures shifts in general functioning, behaviour toward self/others, moods/self-harm, thinking, and substance use (Bates et al. 2006)), this study found that both boys and girls with complex trauma in settings employing whole system trauma-informed approaches (e.g. Individual Trauma Focused Cognitive Behavioural Therapy (CBT), trauma-trained staff, and a trauma recovery group curriculum) made more improvements by the time they were discharged than those in standard psychiatric residential settings. Also consistent with the literature (Chow et al. 2014; Farmer et al. 2017) was a positive association between length of stay in this trauma informed setting for girls and improvement in how they were able to function and overcome impairment. Longer participation in a therapeutic setting resulted in more change and this was particularly the case for girls. Girls also made slower improvement over time than boys but with benefits increasing more as time passed whereas for boys, after initial improvements, progress tended to plateau. Children who experienced six or more crisis intervention responses during their time in these secure settings (e.g. restraint and other punitive management techniques) benefited less in their overall functional impairment at discharge, suggesting that restraint and seclusion is counterproductive to progress undermining children's treatment outcomes (Fox 2004; Sunseri 2001, 2004). Alternatively, findings could suggest that youth who require more crisis intervention experience fewer benefits.

Trauma based cognitive behaviour therapy

There is other early-stage evidence that trauma-based CBT (which has a good evidence base in the community for reducing PTSD symptoms) has potential to reduce post-traumatic stress related symptoms in residential settings. Trauma-based CBT includes appropriate identification and engagement of traumatized youth and caregivers and the delivery of nine treatment elements: psychoeducation, relaxation skills, affective modulation skills, cognitive coping skills, trauma narration and processing, in vivo mastery of trauma reminders, joint youth–parent sessions, and a focus on enhancing safety and future development.

The introduction of the intervention in a children's custodial setting went hand in hand with a structured rating used by staff to ensure faithful replication to make sure the intervention had the best chance of working effectively. It was piloted with a small sample of girls (n = 42) and boys (n = 39) aged up to 17 years (average age 15 years) in US secure settings. Using this intervention resulted in a positive reduction in PTSD and in depressive symptoms (commonly linked to self-harming behaviours) (Cohen et al, 2016).

Dialectical behavioural therapy in custodial settings

Dialectical Behaviour Therapy (DBT) is a cognitive behavioural treatment for adolescents with complex mental health conditions. DBT for children in custodial settings is one of the few custodial programmes evaluated as effective in current Washington State Institute of Public Policy leagues tables for effective interventions reducing re-offending in custody (see WSIPP, 2020). In this instance, DBT was delivered to both boys and girls (n = 50) serving sentences in a US custodial institution. Participants received DBT over a period of 1 to 12 months (see WSIPP; 2020; Drake & Barnoski, 2006).

DBT was originally developed to treat chronically suicidal individuals but has been adapted for those who have difficulty regulating their emotions. It has shown promise for adolescents with emerging borderline personality disorder (Fossati, 2017) and for those who self-harm (both more common among girls in the CYPSE) (Hawton et al, 2015). It has also been used as an intervention to reduce substance misuse, and bulimia (Fossati, 2014; Chapman et al, 2020). DBT focuses on the following four objectives:

1) enhancing children's behavioural skills in dealing with difficult situations
2) motivating children to change unhelpful behaviours
3) ensuring new skills are used in daily life
4) training and consultation to improve practitioner skills

Other approaches tested in secure settings

The Good Lives Model

The Good Lives Model is a strength-based (rather than simply being a risk and problem orientated approach) which has primarily been tested as a rehabilitative framework with adult populations. This framework sees behaviour in the context of a common human drive to satisfy basic quality of life (QoL) needs (e.g. connections with others, purpose etc). GLM sees some people experiencing various obstacles to achieving basic QoL needs with the result that a few offend directly to achieve those needs (e.g., stealing instead of working to obtain material well-being). Sometimes, obstacles to achieving those needs (e.g. mental health problems, substance reliance etc) also undermine people's QoL leading indirectly to offending. Often these indirect obstacles can trigger a chain reaction of further challenges which increase the likelihood of further offending (Purvis, Ward, & Willis, 2011; Ward, Mann, & Gannon, 2007).

In terms of intervention, GLM's starting point has human rights at its core. It also begins with the assumption that while those who offend have obligations to respect other peoples' rights to wellbeing and freedom, they are also entitled to similar respect and considerations. According to GLM, the best way of reducing re-offending is to improve wellbeing, to focus on strengths and empowerment and to enhance people's legitimate access to a more fulfilling and a more socially integrated quality of life (Good Lives Model, 2020). In doing this the approach focuses both on supporting strengths and removing obstacles that prevent access to a better QoL (Ward, Yates and Willis, 2012).

A model that starts by exploring children's own perception of QoL, instead of immediately focusing on specific problems, has been identified as a less threatening and more engaging and motivating approach (Fisher et al., 2010). However, the model has so far been predominantly tested with adults rather than with children with a small number of adult studies finding associations between QoL and offending (Bouman et al., 2009; Willis & Grace, 2008; Willis & Ward, 2011).

Because some principles of GLM overlap with those identified in gender responsive literature, Van Damme and colleagues tested this model with girls detained in custody (n = 95) in Belgium following them up for 6 months after release. The study aimed to identify the impact on:

- reincarceration
- mental health problems

- offending

Van Damme and colleagues (2016) did not find support for a direct negative pathway from poor QoL to offending. However, findings did provide support for a pathway of low QoL scores rendering girls more susceptible to poor mental health which then subsequently placed them at risk of re-offending (see Figure 2). Indeed, girls' QoL and mental health problems, together with selected sociodemographic factors, explained the majority of the differences found in offending after discharge from custody (i.e., explaining 77%).

Figure 1: Van Damme's model of indirect link between QoL and offending in detained girls

Van Damme and colleagues concluded that 'rather than an exclusive focus on strengths and empowerment' it was also essential with girls in custody to have robust mechanisms in place to detect, support and improve mental health problems in this vulnerable group if re-offending was to be reduced.

One surprising finding from this study was that girls' high satisfaction with the quality of their relationships after release was associated with a *higher* chance of re-offending. Van Damme suggested that this finding might be linked to a greater susceptibility for girls with backgrounds of family disharmony and abuse to seek high status identity, connectivity and a sense of belonging by fitting back into anti-social groups – associations which then increase chances of involvement in more anti-social behaviour (Vanne Damme, 2016). However, this finding may also be linked to another risk factor – a higher risk of involvement in romantic partnerships with older males. It reinforces the importance of a focus on promoting greater awareness among girls about healthy peer and romantic relationships.

<u>The six core strategies to preventing and reducing separation, restraint and violence</u>

Several research studies have highlighted both the harms of, and associations between, activities such as restraint and separation and elevated levels of institutional trauma and violence both between patients and to staff (Smith et al, 2015). There has also been increasing concern at the extent to which these practices seek to pathologise and blame

patients/children's behaviour rather than reflecting on the extent to which the environment and systemic practice increases the chances of such behaviours occurring – particularly among vulnerable and traumatised people (Huckshorn, 2015).

In response to these concerns, an approach founded on the Six Core Strategies (developed in the US) has been implemented in many countries including Finland, the US, the UK and Australia – informed by a growing body of early stage but promising research. The Six Core Strategies include:

1. **Leadership:** both organisational and practice leadership are needed
2. **Data collection and analysis:** using data reflectively to understand when risks occur, to make decisions and to monitor progress
3. **Whole workforce development:** staff are trained in preventative rather than reactive approaches
4. **Using reduction tools and strategies:** using evidence based, trauma informed and preventative approaches
5. **Involving people with lived experience:** using lived experience to inform reduction strategies at all levels
6. **Post incident support and post incident review:** providing emotional support after incidents to all (including children) and non-blaming opportunities to reflect and learn later on.

(Huckshorn, 2005, Duxbury et al., 2017; University of South Wales, 2020)

Although high quality research is still emerging and most higher quality studies have been trialled with adults and males, some countries and settings have adopted the approach with children with positive results.

A randomised control trial in Finland with a very high-risk cohort of predominantly adult male patients with schizophrenia (n = 286), including a small group of children in a 20 bedded ward (mostly boys), and with 800 staff, noted overall statistically significant reductions in restraint, separation and observation time in these settings without any attendant increase in violence. As part of this process, in consumer specialist meetings, service users routinely discussed personal experiences with violence and coercion, triggers of violence, and effective calming activities. They also suggested new ways and practices to decrease fear, violence, and coercion and problem solved ward rules and practices in community meetings with staff and doctors. Some patients and staff improved the courtyard to enhance the environment of care. (Putkonen et al, 2013)

In less robust studies, similar patterns of reductions in restraint and separation were noted in a review of the evidence for the implementation of these Six Core Strategies in the US (in mixed gender child and adolescent psychiatric hospital and units) (Lebel et al, 2014 and see Azeem, Aujla, Rammerth, Binsfeld, & Jones, 2011; LeBel, Huckshorn, & Caldwell, 2014) and in New South Wales with mixed gender children in 83 specialist acute CAMHS inpatient beds across nine units in metropolitan and regional cities. In all these pre and post evaluations, significant

and notable reductions were noted over time in restraints and separation. This approach appears to hold some promise but needs specifically to be trialled more robustly with girls.

Implementing trauma informed approaches in custody
The interventions detailed above are all of interest as they provide early stage indications of specific interventions that have been tested in secure settings showing some evidence of reducing trauma-related triggers, worrying and concerning behaviours, mental health symptoms and in one instance also showing promise in reducing later chances of re-offending. Most have been tested with mixed samples of girls and boys or with very small numbers of girls and most evidence is at an early stage requiring more robust methodologies, bigger samples, replication and more development.

Some of the approaches seek to help girls process and manage trauma responses; others focus as much on trying to influence the leadership and the institutional environment to simultaneously reduce practices that trigger trauma reactions and linked behavioural distress and problems. The literature on best practice gender responsive and trauma informed approaches would suggest that isolated implementation of 'interventions' (e.g. DBT approaches) is unlikely to be conducive for change for girls without also creating a whole institutional environment founded on a trusting and empowering relationships, that minimises trauma triggers, that promotes girls voices in the shaping of that environment and that fosters broader gender responsive and trauma informed principles (as set out in Wilton and Williams, 2019).

Challenges of implementing gender responsive and trauma informed approaches in secure settings

Therapeutic approaches versus traditional justice approaches: Some challenges have been noted in the literature linked to delivering gender responsive and trauma informed approaches in secure or custodial settings. Such challenges primarily are associated with the need for gender and trauma responsive environments to have a flat hierarchy to promote girls' empowerment, to have a strong commitment to enhancing girls' voices and feelings of safety, to be person-centred and relational rather than based on procedures and contain and control models and to be therapeutic and committed to minimising experiences of re-traumatisation. Existing studies also largely suggest that therapeutic techniques focused on promoting changes in behaviour such as restorative programs, skill building, counselling, and integrated working have, for example, larger impacts on re-offending than external control techniques and punitive models where discipline, punishment, deterrence, and surveillance predominate (Knorth et al, 2008; Evans-Chase and Zhou, 2014; Lipsey et al., 2010). There is also some evidence that trauma can be highly challenging to treat in secure, compared with community, settings (Dierkhising et al, 2013; Powel, 2014).

In a metanalysis of 27 international studies, Knorth and colleagues (2008) noted that when looking at outcomes for a mixed cohort of children (12-18 years and n = 2345) with externalising and internalising difficulties in a range of secure residential placements (mostly psychiatric, treatment-focused, therapeutic communities but a small minority of whom were in justice placements), externalising and internalising outcomes were significantly better in therapeutic settings (compared to justice settings). Stronger impact was noted for improvements in

behaviour than for internalising conditions (measured via a short follow up of 3-6 months after discharge). Justice settings performed worst in terms of improving behavioural outcomes. Results were not broken down by gender. Outcomes for children in therapeutic (rather than justice) residential treatment generally compared favourably with MST.

Whole system approaches are superior: in their review of trauma informed approaches, Wilton and Williams note that 'Trauma-informed care is not a strategy that can be adopted piecemeal. Instead, it is an approach that requires a wholesale change in an organisation's ideology and approach, touching all aspects of its design and delivery' – which can make implementation in custodial institutions challenging. It requires continued vigilance and self-checking to make sure that what is offered dovetails with core trauma informed working principles and needs.

Doing no further harm and eliminating retraumatising triggers: in England, several Office for the Children's Commissioner reviews of children's experiences in custody and many HMIP inspectorate reports have raised concerns over routine occurrence of potentially re-traumatising experiences affecting children in custody which are considered to cause traumatised children more harm. These included:

- the frequency of use of restrictive physical interventions (higher among girls many of whom have identified past experiences of sexual violence and rape) and with girls reporting feelings of distress, violation and being re-traumatised by such experiences.
- searching and separation activities
- many girls feeling unsafe (especially in some larger STCs)

(Ofsted, 2019; Berelowitz et al, 2011; Prisons, 2017; Ofsted, 2018; Apland et al, 2017; Goodfellow, 2019).

Cohen and colleagues findings (2012) note that a wide range of events in secure settings can be experienced as re-traumatising - acting as reminders of past trauma and family conflict (e.g., stern adult voices, assaults, restraint, arguments, punitive separation). They note that trauma reminders can often "trigger" children 's well-developed fight or flight 'survival' mechanisms which subsequently increase chances of emotional or behavioural outbursts and trauma re-enactment responses (e.g. assaults and self-harm). Trauma re-enactment responses can also have a knock-on effect subsequently leading to other traumatised children feeling unsafe and subsequently activating their trauma-driven responses. One further small-scale study also noted increases in poor mental health

Furthermore, US studies found positive associations among adults and juveniles between feeling unsafe and institutional 'misconduct' (Gover et al, 2008; Lujan, 2017). Some studies also suggested that feeling unsafe could seriously undermine the effectiveness of trauma-based interventions and children's ability to be receptive to treatment (Development Services Group, 2019).

Another study noted how children's placement in custodial units appeared to promote broader harm. For example, a US study of 100 girls and boys entering custody noted that for one-third of incarcerated youth diagnosed with depression (n=18), the onset of the depression occurred *after* they were brought into custody – suggesting a detrimental association between being in

custody and wellbeing. This is a small study that requires further investigation and replication (Kashani et al, 1980).

Cohen and colleagues (2012) also found that if frontline care staff reacted to children 's trauma responses in a manner that was oblivious to trauma (e.g. harshly redirecting, confronting in an authoritarian manner), this was likely to serve as an additional reminder and lead to further trauma re-enactment. But if care staff reacted to children's responses in a trauma-informed manner (e.g., remaining calm, validating the child's distress, helping them mobilise trauma-informed coping skills), this was more likely help children regain effective control over their feelings instead of escalating into cycles of trauma re-enactment.

De La Roux and Ortega (2019) indicate that this systematic attention to the *consequences* of exposure to institutional trauma as well as the whole workforce actively striving to not engage in practices that re-traumatize people, for example, making all attempts to limit consequences like restricting or isolating, which can further exacerbate and worsen trauma symptoms.

Institutional processes and procedures versus flexible, relationship-based approaches: In a literature review and qualitative study focused on the views of children in a secure setting in Scotland (n = 7), Copley (2015) noted an intrinsic competing tension between the processes, procedures, rules and regulations which tend to dominate in day to day life in institutions to promote efficiency, and the extent to which activity could be, and felt, fair, flexible and child-focused (Abela and Colleagues, 2005 as reported in Copley, 2005).

Other key learning points emerging from implementation of trauma-informed and gender responsive approaches in secure and custodial settings include:

1) confirmation that whole system commitment (from leadership down and including all staff) to trauma transformative approaches, culture, learning and to implementing changes was critical
2) that careful attention was needed to organisational readiness when undertaking implementation of evidence-based trauma treatment. Not every setting may be appropriate or ready to implement such approaches. This was felt to be particularly the case when working with systems that traditionally did not focus on trauma, such as the justice system
3) that a learning collaborative approach should be adopted supporting staff knowledge including supervision and reflective practice
4) that providing ongoing training for all new staff was essential (as incident rates were noted to rise at times of high staff turnover)
5) that systems should be in place to ensure faithful replication of trauma-informed (and gender responsive) approaches.

(Markiewicz et al, 2006; Wilton & Williams, 2019).

However, given the critical nature of programme environment for gender responsive and TIC approaches (Cantora et al., 2014; Wilton & Williams, 2019) (e.g.one that promotes connectedness, respect, safety, and support) some academics have questioned the feasibility of

effectively implementing such approaches in custodial or secure settings (Bloom et al., 2003; Hubbard & Matthews, 2008; Kerig & Schindler, 2013).

Finally, there is a current lack of rigorous evidence on the effectiveness of gender responsive and trauma informed approaches for girls in secure settings. There is also a lack of evidence on the effectiveness of secure settings in being able to promote better outcomes for girls and for the communities in which they live. More investment is needed in piloting and high-quality evaluations of these approaches.

What we know about what works for girls

Custodial, residential and community-based interventions

There is a lack of research into the effectiveness of what works disaggregating outcomes by gender.

The majority of effective interventions for children, resulting in reductions in re-offending (and in improvements in other areas of children's lives), tend to be community based. For example, Washington State Institute of Public Policy has for a decade now maintained a database and has been a major international reference point for up to date information on effective and cost-effective interventions for children and children who offend. The methodology underpinning this database includes refreshed metanalyses, every 6-12 months, of any new evidence that has emerges on outcomes of interventions (mainly focused on recidivism) as well as calculation of whether interventions are likely to be cost effective. Based on the last review of this evidence in December 2019, of the thirty one programmes deemed to be cost-effective in reducing offending, only 19% were for interventions in custody; 6% related to programmes facilitating effective transitions back to the community from custody whilst nearly threequarters were community based interventions. Many of these have now built up a decent sample of girls among these analyses. However, some of these community-based interventions may be those designed for children whose problems were not as complex as those affecting children in secure settings.

On the other hand, there have also been other studies which have set out to compare outcomes for a sample of children who have matched risk factors and characteristics for re-offending (moderate to high predictors of re-offending), some of whom had been placed in custody and others of whom were on community-based interventions. These studies have not disaggregated findings by gender although samples include girls.

For example, Wiebush (1993) compared outcomes of an intensive community-based youth offending intervention with outcomes for those placed in custody and on standard youth probation (n= 244) (comparing a matched sample of children and children who had not committed highly violent offences but who were nevertheless at moderate to high risk of recidivism). Wiebush found that intensive community-based support outperformed custodial containment.

Ryon and his team also compared re-offending outcomes for a sample of children in community-based interventions (n = 2,823) with those placed in custodial settings (n= 269) tracking

outcomes for a matched sample (n = 209). The community-based sample was comprised primarily of boys (approximately 76%); and 34% of the study group was White. Most of the residential releases in the sample were male (81%) youth. More than half of the releases were non-White (78%). Comparing these matched samples, findings suggested that those in custodial settings had higher rates of recidivism compared with matched children dealt with via community-based support. The authors concluded that children with moderate to high risk of re-offending should, as far as possible, be dealt with through community-based interventions which they assessed would serve public safety more effectively (Ryon et al, 2013).

In a meta-analysis of studies comparing outcomes for matched children in community based and custodial residential placements (predominantly male and with stronger effect sizes for findings for boys because girls generally re-offended less), Black (2016) found that custody was associated with an 8% increase in recidivism whereas community based interventions were associated with a 6% decrease in recidivism. Black called for more research as a matter of urgency on the impact of community versus custodial outcomes for girls.

Finally, other studies, with samples which were predominantly boys, also showed that once detained, even when controlling for current offences, offending histories, and other variables, children remanded to or placed in custody were more likely than non-detained peers to end up escalating deeper into the youth justice system (Benda & Tollet , 1999). Indeed, one longitudinal study tracking outcomes of 37,692 children into young adult years over a ten year period in a US State noted that child custodial experiences increased the probability of adult imprisonment rates by 22 percentage points and reduced the chances of a child completing their education by 13 percentage points (Aizer & Doyle, 2015).

On the other hand, a Swedish metanalysis was completed by Knorth and colleagues (2006) of the outcomes of children (mostly boys but including some girls) in secure residential placements (mostly psychiatric or therapeutic residential placements) following children up for a short period. Overall, justice placements were the least effective of all in reducing severe and persistent behavioural problems – and justice placements generally compared less favourable than MST. However, Knorth concluded that therapeutic residential placements in themselves were not damaging to children but that a therapeutic approach and milieu (rather than a justice approach) was essential for improving behavioural outcomes (and to a lesser extent other psychological outcomes). These psychiatric and therapeutic placements performed broadly as well as MST. However, therapeutic residential placements performed less well in terms of reducing internalising difficulties, which are more commonly found in girls. Findings were not disaggregated by gender.

Community based interventions tested with positive outcomes for girls

On the other hand, many more high-quality evaluations have been completed on community-based interventions which demonstrate good outcomes for both boys and girls including improvements in recidivism (Lipsey, 2009; Leve et al, 2015). A US review of this body of evidence on justice interventions noted that girls now made up an overall sample of 800 in high

quality reviews of what works to reduce recidivism (Development Services Group, 2019). In light of current poorer evidence for gender responsive approaches, Leve (2015) suggests instead, building further on these well-tested wraparound interventions (which have good evidence in promoting girls' outcomes), modifying them to include gender responsive approaches and to simultaneously address trauma, substance use, healthy family and partner relationships, risky sexual behaviours, family and romantic partner-related issues, mental health and wellbeing and practical and aspirational needs. These modified interventions should then be tested and evaluated further to check ongoing effectiveness and salience for girls. The following section provides an outline of those overall elements considered effective for girls and outlines specific promising interventions.

Lipsey's meta-analysis (2009) identified three factors associated with programme effectiveness for both girls and boys who offend. These included:

1) targeting interventions at those involved in high-risk offending
2) approaches with a "therapeutic" intervention philosophy
3) interventions which were of high quality (Lipsey, 2009). High quality interventions have a clear operational framework and model which is delivered faithfully and consistently (Development Services Group, 2019).

An overview of current evidence relating to both girls and boys also suggests the following:

1) Bright and colleagues noted that community-based models of intensive in-home treatment have potential to adapt to children's specific needs, perhaps on a case-by-case basis, because of the flexibility of their approach. Provided in the child's home environment, these programmes might be especially well-suited to addressing unhealthy family relationships, strengthening parenting practices and supporting resilience (Barth et al., 2007; Bright et al, 2014).
2) Effective programmes focus on a wide range of risk and protective factors (Cauffman, 2008; Zahn et al., 2009). Approaches that focus on multiple systems surrounding the child and that work with children and with others to collaboratively strengthen protective factors in their lives and reduce risk factors appear particularly important (Development Services Group, 2019).
3) Family involvement and a focus on family strengths and risk factors also appear a particularly important target for support (Schwalbe et al, 2012) and are often noted to be overlooked in interventions for at-risk and justice involved girls (Roman et al, 2006).
4) Many interventions place a significant emphasis on the relationship between practitioners and girls' and boys' and families.

Interventions which have been shown to work with boys and girls outside custody

Leve and colleagues, 2015 note four approaches which have been robustly tested with both girls and boys and which show consistently positive outcomes for girls. All four interventions have been evaluated in numerous studies using "gold standard" randomized, controlled designs. All interventions focus on multiple systems around at-risk children (peers, education and employment, mental health, family, neighbourhood). Girls represented a minority of the total sample in most of these evaluated interventions but the pooled sample of girls over all studies

amounted to around 800 girls and young women. Analysis of this pooled sample suggested that interventions were associated with positive outcomes for girls - comparable to improvements noted in boys.

Functional Family Therapy (FFT)

Participants in these studies have included around 240 girls so far comprising approximately 22% of total samples. Most evaluations of FFT have demonstrated decreases in antisocial behaviour for children. During the past decade, FFT has become one of the most widely transported evidence-based family therapies, with 270 programmes worldwide treating more than 17,500 youths and their families annually (Leve et al, 2015).

Outcomes include reduced re-offending and reduced substance misuse (Early Intervention Foundation, 2020). In the UK, this approach requires further replication (Early Intervention Foundation, 2020). To be relevant to girls in justice settings, it would be useful to track the intervention's ability to improve other key areas of girls' lives including mental health, healthy relationships and engagement with education and employment.

WSIPP (2020) note significant success using FFT with children at the point of release from custody compared with usual services in reducing recidivism. In this study of post custodial functional family therapy, 35% of the sample were also from Black, Asian and Minority Ethnic communities.

Multisystemic Therapy (MST)

An estimated 440 girls have participated in the MST randomised control trials and comprised approximately 24% of study samples. MST aims to influence change in family, peer and neighbourhood dynamics as well as in other systems surrounding children. The family is seen as the most powerful agent of change. MST studies have shown that improved family functioning and decreased association with peers involved in anti-social behaviour are important processes for producing favourable outcomes for children in the justice system. MST intervention is intensive and short term, averaging 16 weeks (Leve et al, 2015).

Internationally, MST interventions have generated an impressive array of outcomes in key areas, including reduced juvenile offending, reduced hyperactivity, improved family relations, reduced substance use, reduced out-of-home placements, and reduced mental health problems, compared with youths and families in the control condition (Leve, et al, 2015; Early Intervention Foundation, 2020; WSIPP, 2020). The Department for Education have been testing an adaptation of MST-FIT (which includes DBT, mindfulness and motivational interviewing) for children transitioning back to the community following residential care (DfE, 2017) (NB see page 42 for potential limitations linked to MST in the UK).

Multidimensional family therapy (MDFT)

Multidimensional Family Therapy (MDFT) is an integrated, comprehensive, collaborative, family-centred intervention for children. MDFT addresses a range of problematic behaviours in children – substance abuse, offending, antisocial and aggressive behaviours, school and family problems, and emotional difficulties. It can be implemented in substance abuse and mental health, child welfare, and justice systems and aims to prevent placement outside the home.

Intervention has three main areas of influence – the child, parental/carer activity and other key areas of the child's environment (e.g. school, offending, peer and recreational contexts). MDFT is typically delivered 1-3 times per week over 3–6 months, depending on the treatment setting and the severity of children's problems and family functioning. MDFT studies have enrolled 122 girls (23% of the study populations). Results from outcome studies show reductions in rates of substance use and offending and improved family functioning and school outcomes (Leve et al, 2015; Early Intervention Foundation, 2020).

Treatment Foster Care Oregon (TFCO; formerly known as Multidimensional Treatment Foster Care [MTFC]).

Some girls end up in custody and in secure settings when their safety and wellbeing has been significantly compromised by family relationships – with some stating that they feel safer in these settings than outside (HMI Probation, 2014). For this reason, it will not be feasible or safe in every case to work with families to address girls' trauma and to support movement forward – suggesting a role for well supported and intensive fostering approaches.

Treatment Foster Care Oregon (TFCO) is the only evidence-based model that has been tested in randomised control trials that exclusively comprise girls (aged 13-17 years) – adapting what had been a previous intervention (previously known as Multi-Dimensional Treatment Fostering) more widely tested with boys. Girls who accessed the intervention had at least one criminal conviction and were being considered for out of home placements (e.g. foster, group home or custody). Adaptations for girls mirrored many gender responsive principles and included:

- providing reinforcement and boundaries for coping with and avoiding social/relational aggression
- working with girls to develop and practice strategies to help regulate emotions and mood (e.g. early recognition of feelings of distress and problem-solving coping strategies)
- helping girls develop skills in peer relationship–building, such as initiating conversations and managing their level of self-disclosure to fit the situation
- teaching girls strategies to avoid and deal with sexually risky and coercive situations;
- helping girls understand their personal risks for drug use, including priority setting using motivational interviewing and provision of incentives for abstinence from drug use monitored through random urinalysis
- helping girls understand personal risks for drug use, including priority setting using motivational interviewing and provision of incentives for abstinence from drug use monitored through random urinalysis.

One intervention group also piloted a trauma-focused intervention component for a subsample of girls (Smith et al, 2012). TFCO interventions were compared with outcomes for girls in group care – which in the US are small community-based residential homes (see page xxx).

Outcomes for girls participating in TFCO were superior to outcomes for those who were randomly assigned to standard group care homes in several key areas, including:

1) reoffending
2) time in custody
3) lower pregnancy rates
4) increased school engagement
5) lower illegal drug use
6) lower depressive and psychotic symptoms.

Results from the small trauma-focused pilot study also suggested improved outcomes for anxiety and depression (Smith et al., 2012). Emerging evidence suggests that this approach offers the closest fit in terms of acting as an alternative to secure placement and comprehensively meeting the needs of girls in secure settings.

In the UK, a trial of multi-dimensional fostering treatment (n = 88 of whom 44% were girls) noted mixed results for the total sample but positive and significant reductions in recidivism for higher risk participants presenting with more challenging behaviour – suggesting this type of approach is better targeted at the cohort of girls on the edges of and in secure settings (Sinclair et al, 2016). In 2 out of 5 international studies, effects did not persist after children left intensive fostering placements and there was a suggestion that the quality of follow-on placement after intensive fostering was critical to continued progress (Sinclair et al., 2016).

Other emerging community-based approaches

As well as those interventions identified above, very early stage evidence points to other approaches which may meet some of the key features of support and delivery that appear important to girls and which may merit more robust evaluation.

Evaluation of a gender responsive adaptation of the group home approach

A quasi-experimental evaluation of a community-based group home, adapted using gender responsive principles and approaches, and backed up by standard youth justice supervisory input showed positive, although early stage, results with girls. After two years, offending rates (n = 172) were significantly lower than those in a comparison group who just received standard youth justice supervision (24% versus 48%) (Anderson et al, 2019). Two thirds of girls were from Black, Asian and Ethnic Minority communities. One of the homes provided support for high-risk girls as an alternative to custody and the other supported girls with more moderate youth justice risks. In the US, small group homes are contracted by the courts and involve female workers and residents. On average, these interventions lasted 5 to 6 months with approximately 100 to 200 hours of support with the number of hours completed being dependent on the needs of individual girls.

The support model also included group CBT, individual and family interventions. It aimed to help girls develop alternative behaviours and thinking, to develop problem solving, coping, anger management, communication and self-efficacy skills. It aimed to encourage girls to build positive relationships with peers and family members and to strengthen school performance and positive leisure activities. The intervention included individualised goal development and a rewards-based system of motivation to support progress. (Anderson et al, 2019). Staff ratios were low (1:3 girls) and a trauma-informed curriculum was available as well as trauma and

substance misuse counselling. More research is required on this type of intervention to ensure that results can be replicated.

Teaching Family Model

In addition to the above-mentioned approaches identified by Leve (and confirmed as evidence based in international resources promoting evidence based practice guidance), WSIPP identifies one other approach proven effective with both boys and girls who offend and which may benefit from further investigation and adaptation to comply with gender responsive principles. Findings have so far not been disaggregated by gender. The Teaching-Family Model (TFM) provides an alternative approach to traditional residential care. Children reside in very small family-style residential placements in the community with a maximum of around 6 other children and led by TFM practitioners (who effectively act as a professional foster family). TFM practitioners receive extensive training on how to care for vulnerable children. They aim to help them:

- learn how to form healthy family relationships
- improve social skills
- identify the main triggers that cause them stress
- better manage their emotions.

In these family homes, vulnerable children learn new behaviours through TFM leads modelling new behaviours and by observing and imitating others in the family home. Support focuses on building children's strengths, problem-solving and leadership skills and aims to help children develop confidence and reach their full potential.

The intervention has been researched over 40 years and, despite some mixed results, is shown by WSIPP's systematic evidence reviews to result in reductions in crime. Mixed results have been attributed to larger numbers of children being placed in TFM placements. Of the studies included in the WSIPP analysis, approximately 23% of participants were from Ethnic Minority communities and 26% were girls. Although first developed in the US, it is now being implemented in both Australia and New Zealand. It has not yet been piloted in the UK (WSIPP, 2020).

No Wrong Door

In the UK, the No Wrong Door approach has had an early stage evaluation on its efficacy with children in care and at risk of offending with promising early stage results.

No Wrong Door provides an integrated service for children aged 12 to 25, who either are in care, 'edging to'[4] or on the edge of care[5], or have recently moved to supported or independent

[4] Edging to care is defined as when, without an intervention package being put in place, there is a strong likelihood of the case progressing to edge of care.

[5] Edge of care is defined as those children and children who are at imminent risk of becoming looked after, due to significant child protection concerns, or to prevent a long term placement; or because they have ceased to be looked after and their needs are escalating.

accommodation whilst being supported by No Wrong Door. The approach is delivered via a hub approach and includes a small residential living area as a step towards independence.

No Wrong Door workers include a speech and language therapist, a life coach (who is a clinical psychologist) and a police liaison officer. The integrated team supports the young person throughout their journey and makes sure that they are not passed from service to service.

The approach aimed to improve:

- accommodation stability
- engagement and achievements in education, employment and training (EET
- relationships with others
- planning of transitions from care to independent living
- resilience and wellbeing
- access to support in a crisis

It also aimed to reduce:

- criminal activity
- self-harm
- child sexual exploitation (CSE)
- missing from home incidents
- drug and alcohol substance misuse
- costs to society, including to a range of agencies (National Health Service (NHS) and the police).

A mixed methods early stage evaluation was completed in 2017 (Lushey et al, 2017) tracking outcome measures for 472 children. It found:

- a reduction in total Strengths and Difficulties Questionnaire scores over time (the more involvement from specialist roles, the better this outcome). This tool measures domains such as hyperactivity, behaviour, emotional wellbeing and the quality of peer relationships and is a useful proxy for behavioural and emotional wellbeing.
- a halving of incidents of children going missing, suggesting participants were happier at home or in their placement
- early stage suggestions that offending had reduced by around a third for those involved in the project with criminal convictions (n = 117).
- evidence of improvements in mental wellbeing and reductions in mental health issues
- resilience and self-esteem increased, including the use of bespoke activities which were viewed positively by the young people and raised their self-esteem
- No Wrong Door workers were a key support to the young people in time of a crisis.

To be sure that changes are associated with No Wrong Door activity (and not just a feature of say increased maturity which we know influences the likelihood of offending), a trial including a control group would be necessary before robust conclusions could be drawn on any associations between the intervention and outcomes. The approach is being piloted, or is being considered

by, a number of regions in the UK and requires more robust evaluation and replication to understand the extent to which the approach works more broadly.

Enhanced Case Management Model – Wales

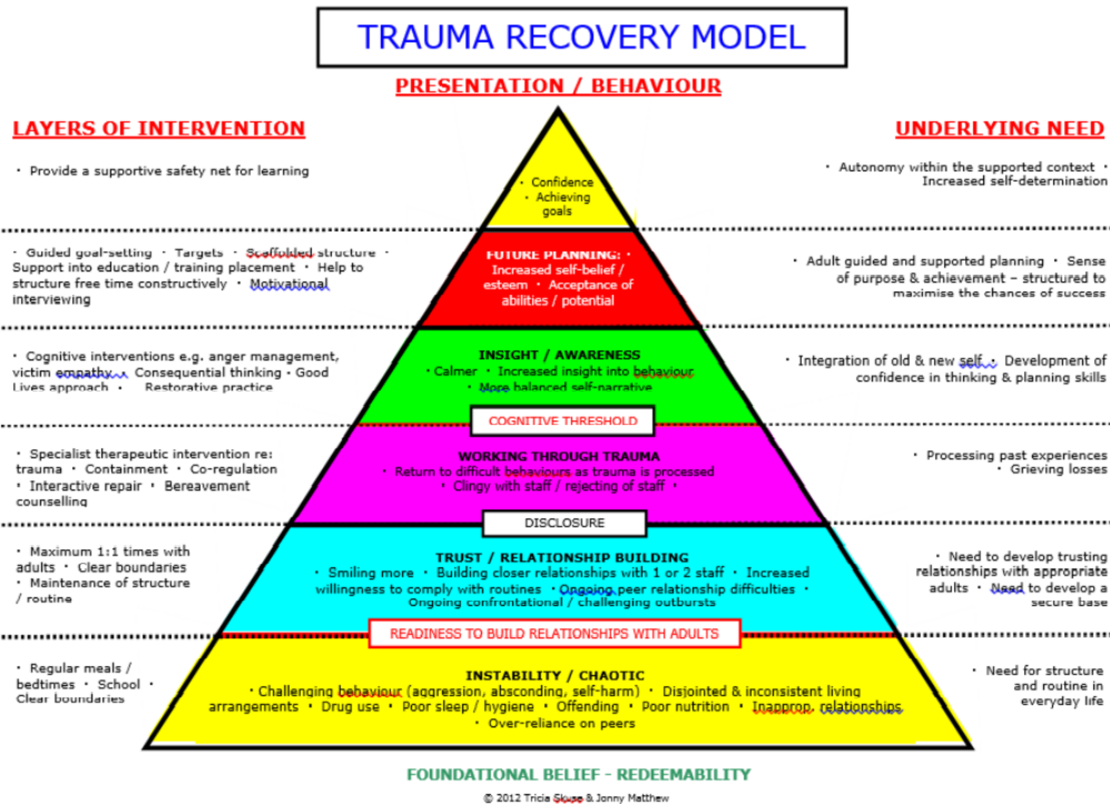
The Enhanced Case Management Model is a community-based trauma-informed approach which built on the Trauma Recovery Model developed by staff in Hillside Secure Children's Home in Wales. This approach was piloted by the Youth Justice Board (YJB) Cymru, the Welsh Government, the All Wales Forensic Adolescent Consultation and Treatment Service (FACTS) and with three YOTs focusing on 21 children involved in prolific offending in Wales. A quarter of these children were girls but sample sizes were low. The evaluation was published in 2017. On the back of findings from this early stage evaluation, the approach is being rolled out more broadly in Wales. The pilot aimed to:

- Provide YOT practitioners and managers with better knowledge and understanding in relation to how early attachment, trauma and adverse life events can impact on children's ability to engage effectively in youth justice interventions.
- Provide a psychology-led approach to multi-agency case formulation and intervention planning. It was hoped that this, in turn, would enable youth justice staff to tailor and sequence interventions more effectively according to the developmental and mental health needs of individual children.

The small-scale, very early stage evaluation found:

- Strong support for the ECM approach from all stakeholders involved in the trial and unanimous support for wider roll-out
- A high degree of fidelity and consistency in the delivery of the original ECM model across YOTs
- some improvements (particularly in relationships, higher levels of engagement and enhanced outcomes) in children's lives based on qualitative and quantitative findings.

One recommendation was that enhanced training should be made available to broader leadership and that the psychology-led trauma-informed community based approach should be extended to support broader multiagency work supporting high risk high harm children in local areas (Cordis Bright, 2017).



Contextual safeguarding

In the UK, there has been a call from some academics to broaden the systemic reach of such approaches as Multi Systemic Therapy (which largely focus on supporting children through strengthening families and supporting children away from the influence of anti-social peers). Interventions should also enhance recognition of, and interventions targeted toward, wider contextual drivers of victimisation and abuse (Letourneau and Borduin, 2008; Melrose, 2013; Pitts, 2008; Firmin, 2018). This approach is termed 'contextual safeguarding'. For example, this might mean intervening with neighbourhoods, communities or with school communities where cultures and norms promoted abusive and victimising behaviours. It also means intervening with peer groups (not just via disruption but via support, challenging harmful norms or building counter peer influence countering harmful norms). In one instance bus route data was used to improve understanding of geographically risky contexts for young people and for planning preventative interventions (Firmin & Abbott, 2018).

Contextual safeguarding has not yet been subjected to high quality evaluation as an approach.

Positive Youth Justice and Child First Offenders Second (CFOS)

The Positive Youth Justice approach challenges traditional Risk Need and Responsivity risk assessment responses to offending (see page XXX) by children which it sees as stigmatising, and which it believes excludes children, by adopting a problem focused and risk based approach rather than an asset driven and collaborative response working with children. In Wales, this approach has been taken forward through the Children First, Offenders Second (CFOS) model which promotes child-friendly, diversionary, inclusive, engaging,

promotional practice and legitimate partnership between children and adults. Many of the core principles of this approach reflect principles considered important for girls. However, so far, the approach is described in gender neutral ways. The approach has not as yet been evaluated and requires further thought to ensure gender responsivity.

A potential limitation

One note of caution concerning adoption of some of the high quality evidence based interventions outlined earlier, is that a recent evaluation of MST in the UK, which involved a 5-year follow up of children at risk of entering the justice system and on the edges of care (including mostly boys but around a third of girls), showed no significant improvements in offending outcomes over time. Neither were there improvements in cost-savings compared with management as usual. Management as usual, in this instance, included supervision by youth offending teams, child and adolescent mental health services, and social and educational services (Scott's et al, 2020). Leve (2015) speculates on whether mixed findings for these interventions in different countries might be due to the US's more punitive and less rehabilitative custodial system which encourages greater engagement and commitment from young people to avoid entering these institutions (although given children's undermined ability to plan ahead in adolescence due to brain changes, this seems unlikely). It could also be that standard community services in the UK are overall better than those in other countries where MST was implemented. Such differences in outcomes may also be linked to differences in levels of fidelity to the original model. For example, it may be that interventions were not reserved for those presenting with the very highest risks and needs as advocated by Lipsey (2009). Given that rates of re-offending for those placed in custodial units are generally consistently high (as are the costs of placement in custody) there may be an argument for reserving the use of such intensive interventions in the UK as a direct therapeutic alternative to placement in more expensive secure care and using such interventions more sparingly (rather than as an alternative for those entering care or justice systems).

Additional issues for consideration

Assessment, risk assessment and personalised care plans for moving forward

Given the multiplicity of needs faced by girls, evidence advocates for a comprehensive, trauma and exploitation-sensitive approach – an approach that is also importantly not protocol-driven, that focuses on girls' stories and that is based on girls' strengths and goals (Wilton & Williams, 2019). A strength-based model of treatment shifts the focus from targeting problems to identifying the multiple issues and challenges girls have contended with and their coping strategies (Covington & Bloom, 2006). Assessment should be underpinned by a strong relationship leading to a collaboratively developed and child-driven personalised plan for moving forward (Baird et al., 2013).

Assessment and understanding of girls' pathways should also acknowledge all aspects of girls' identity (e.g. race, culture, sexual orientation, and gender conformity) (De La Rue, 2018). For example, when a person holds multiple, intertwined identities that reside at the lower end of the social hierarchy, then discrimination, microaggressions, bigotry and trauma exposure (and related trauma) can multiply (Potter, 2015).

Risk of re-offending and girls

Much research completed on risk of offending and gender has been with women rather than girls. This limitation must be taken into account when drawing any conclusions from this summary of the largely inconclusive findings in the literature.

A significant body of literature suggests girls are generally much less likely to be persistent offenders than boys (Fontaine et al. 2009; Russell, Robins, and Odgers 2014; Joliffe et al. 2017) and some studies even deny that such a persistent offending pathway exists for females based on their findings (Goldweber, Briody, and Cauffman 2009; D'Unger, Land, and McCall 2002). In a review of multiple longitudinal studies, Broidy and colleagues (2017) identified 1-2% of women and girls thought to be on this persistent offending pathway. This same review also noted that a small number of girls (between 0.5% to 1.3%) appear responsible for a large proportion of female offences (ranging from 24% to 45%). DeLisi and Piquero (2011) note gender ratios across several studies for persistent offending as being between 9 and 12 males to every one female on a persistent offending pathway. Even when studies have focused on females who have committed violent offending, 25% of females persisted compared with 46% of males (Cauffman et al., 2017). Looking at UK data, Goldson (2005) noted that 80% of females compared with 55% of males had offending patterns lasting less than one year.

However, in their review of the literature on risk factors, Broidy and colleagues (2017) make the point that, simply focussing on offending outcomes when considering collateral damage resulting from girls' and women's vulnerability and involvement in offending, overlooks other broader problematic public health outcomes that may persist for women and girls —particularly depression and other mental health outcomes, substance abuse, poor physical health, exposure to intimate partner violence, repeat intergenerational patterns of parenting difficulties and child maltreatment, and other forms of victimisation.

Risk assessment and intervention approaches

There has been longstanding concern that established risk assessment approaches (e.g. models and assessment tools) attempting to predict recidivism for girls have adopted a gender-blind approach overlooking the different gendered experiences and pathways into and out of offending for boys and girls (Bateman & Hazell, 2014).

Evidence is still evolving in this area, is mixed in its findings, and high-quality studies remain limited in testing out differences in gender-based risk factors for girls (as opposed to women). There is also significant ongoing debate as to whether girls and boys share similar risk factors for offending (a gender neutral approach), whether girls' experience different gender specific criminogenic risk factors or whether in reality the answer lies somewhere between these two positions. This has prevented a clear strategic pathway forward on this issue.

The most established approach to assessing risk of re-offending is the Canadian cognitive behavioural Risk, Need and Responsivity model (RNR) (Andrews and Bonta, 1990; Andrews & Bonta, 2012). In this model:

- the **Risk Principle** entails matching the level of intervention to the child's risk of re-offending (so reserve the most intensive interventions for those children at highest risk)
- The **Need Principle:** assesses a set of needs which have been isolated as key to re-offending based on reviews of high-quality studies identifying drivers for offending and re-offending.
- The **Responsivity Principle:** encourages professionals to take into account and adapt what is offered to those aspects of a child's gender, culture, learning style, developmental stage, level of motivation, abilities and strengths so as to maximise impact.

This model originally developed for adults but also tested for relevance with children identified eight areas of risk for re-offending some of which are stronger (in terms of their assessed impact following statistical modelling) in their strength of association with offending than others. Some are static and some are dynamic and malleable to intervention. The central eight risk factors are composed of the "big four" and the "modest four" (with milder, but still significant, influence on children's re-offending) The big four includes:

- a history of criminal behaviour
- antisocial personality traits
- antisocial attitudes, values, beliefs and cognitive-emotional states
- and antisocial associates.

The modest four include:

- home (family/marital)
- school/ work
- and leisure/recreation
- substance abuse

The 'Canadian Model' has been supported by large samples, many studies, meta-analyses, replicated studies, and replicated meta-analyses (Vorhis et al, 2016). It has also been replicated in a few studies which have considered its salience from a gendered perspective (Andrews et al. 2012; Oliver et al. 2014). In a metanalysis of five studies (completed by the developers of the RNR model), investigating the strength of associations between RNR risk factors and women's and girls' offending and comparing effects with those found for boys and men, substance misuse emerged as having more of an association with risk of re-offending for girls/women than for boys/men. This led Andrews and colleagues (2012) to suggest that with girls we should think of the 'big five' (history of offending, anti-social personality traits, pro offending attitudes, values, beliefs, and cognitive/emotional states, anti-social associates *and* substance misuse) rather than just the big four.

Other studies have also confirmed substance abuse as having a distinct role in girls' and women's lives and an effect on their offending, noting its high co-occurrence with other problems, such as mental illness and histories of victimization (Veysey, 1997; McClellan et al., 1997; Covington & Bloom, 2007).

Finally, Andrews and his team (2012) also emphasise that although the same broad risk factors may apply to males and females, these variables, and how you intervene with them, may need to differ. For example, although peer relationships may be a risk for both genders, for girls higher risk may be associated with girls' need to seek protection and attachment and may take the form of abusive romantic relationships mostly with older men; on the other hand for boys peer-risks may be more closely associated with status and belonging connected with association with same gender peers.

Despite the impressive evidence for this framework, there has also been passionate academic debate mostly about the narrowness of the approach, the way it treats those who offend as passive recipients of behavioural interventions, its language, its apparent lack of suitability for girls and women and the extent to which it supports the rights of the child. Some academics have criticised RNR for underplaying factors linked to the quality of life of those who offend (Ward, Yates and Willis, 2012; Van Damme, 2016).

For example, some academics noted the absence in such tools, and in associated statistical modelling, of risk factors emerging as being particularly relevant to women and girls (Vorhis et al, 2010). Critics have raised concerns that RNR risks and needs are based on the needs of the male majority in the justice system and fail to take into account well-documented differences affecting women's and girls' pathways into offending (e.g. emotional distress, a history of gender-based violence and abuse, and poverty). Gender-responsive scholars also note the absence of assessment scales relating to relationships, depression, parental issues, self-esteem, self-efficacy, trauma, and victimization (Blanchette & Brown, 2006; Bloom et al., 2003; Hardyman & Van Voorhis, 2004; Reisig et al., 2006). Some have shown that only some of these RNR risks (e.g. family and personality) have salience for women and girls (Anderson et al., 2016). There are also mixed findings from largely smaller studies on how effectively RNR tools predict risk for women and girls compared with men and boys (e.g. Schwalbe, 2010 and Andrews et al., 2016; Onifade et al. 2008; Schmidt et al. 2011; Vitopoulos et al. 2012). Furthermore, RNR approaches have been noted to overestimate risk for women, both when used to determine appropriate custodial regimes and programmes, and when predicting recidivism (Hardyman, 2004).

There is, however, a much less robust focus on risk factors more salient to women – particularly girls. Findings from good quality studies providing empirical evidence for the existence and predictive effectiveness of a *different* set of factors more relevant for women and girls –– is still at an early stage (Hannah-Moffat, (2009). However, an early stage case is emerging from some high quality studies both of the broad ongoing importance of RNR domains as a target for intervention *and* for the need to adapt and refine this RNR approach, target areas and language to be more gender-responsive .

For example, in Brown and Motiuk (2008)'s analysis of a range of risk factors that appeared strongly associated with male and female re-offending (n=1530), they found that in just over half of instances (53%) there *were* differences in the risk factors driving and associated with

male versus female offending but also that there were common factors driving cross gender offending in 47% of instances. Brown and Motuik's research concluded that there was, in this study, some evidence for a gender specific pathway and for arguments associating female offending with economic marginalisation – although more primary research was recommended. The authors also made the point that they were looking for gender differences using a risk framework which had not been built from the ground up by girls and women.

Van Damme and colleagues' evaluation of the Good Lives Model and its impact on girls in custody did not provide direct evidence of a link between other Quality of Life (QoL) factors and offending in girls in custody, although it did highlight an indirect association between low QoL, poor mental health and offending (Van Damme et al, 2016). This led Van Damme to conclude that any effort to reduce offending in girls needed to work with girls' mental health directly.

Where other studies have statistically tested conventional RNR risk factors *as well as* gender specific risk factors for re-offending, these have produced mixed findings. Many have found broad commonalities between RNR risk factors for both men/boys *and* for women/girls - but some have also identified a few important differences emerging between genders. For example, Vorhis' and colleagues' study (2010), focusing on women rather than girls (n= 1626), noted that RNR risk factors were powerful predictors of: re-offending on probation; behavioural difficulties whilst in custody; and for likelihood of re-offending on release. But this study also tested other important gender specific risk factors/needs, as part of the risk modelling process, and found that some also emerged as significantly associated with women's likelihood of future involvement in anti-social behaviour. These included:

- substance abuse
- economic factors
- educational needs
- parental factors
- and mental health needs.

Additionally, trauma, unhealthy relationships, and mental health concerns were considered critical to women's ability to adjust to custody and to managing safety in these settings. Vorhis' conclusion was that these additional gender specific factors added power to the predictive capability of RNR approaches and should therefore result in adjustments to traditional risk assessment approaches with women and girls.

In a small-scale 2018 study of girls and boys with offending histories attending a mental health clinic (n=100), Vitopolous and colleagues added and tested a range of wider risk factors in statistical modelling that included and compared findings with established criminogenic needs. These new domains included:

- child maltreatment
- rates of PTSD symptomology,
- childhood adversity

which have been closely associated with girls' pathways into the justice system and some of which also feature in boys' pathways towards offending.

This study generated a few important findings:

1. that girls and boys attending the clinic had similar rates of exposure to maltreatment – although, as in other studies, girls had slightly elevated likelihood of having experienced maltreatment and of having been exposed to multiple instances of maltreatment and childhood adversity.
2. that girls were more likely to experience post traumatic symptoms as a result of their multiple experiences of maltreatment compared with boys exposed to similar levels of trauma (which may be related to gender related neurodiversity affecting brain development and responses during adolescence and described on page XXX).
3. In this modelling, maltreatment emerged as a stronger predictor of recidivism than any one of the traditional individual RNR domains for re-offending and for *both* genders. The final model explained 22% of the variance in recidivism and correctly classified 71.7% of cases in terms of their re-offending. Vitopolous and colleagues (2019) hypothesise that this may reflect findings from other emerging studies which found that while RNR youth measures were a strong predictor of re-offending in non-maltreated young people, it did not predict recidivism for this sub-group of maltreated children and young people who offend (Onifade et al. 2014; Li et al., 2015). This may help us refine what works for whom and in what circumstances with children in secure settings.
4. The number of childhood adversities was found to be more modestly associated with (and to fuel increases in) RNR scores in the areas of family, substance use and personality.
5. PTSD symptoms in themselves did not generate enough statistical power to predict offending and were seen rather as 'coinciding variables' associated with childhood maltreatment.
6. Vitopolous notes that these results suggest that the potential emotional, social and mental health impacts of maltreatment are an appropriate target for rehabilitative intervention, alongside the other criminogenic risk domains, for girls and boys alike.

Vitopolous concluded that these findings suggested a need for offending-related interventions to focus directly on: recovery from trauma; the development of enhanced self-regulation; improved coping strategies; and on interpersonal effectiveness. In this way, trauma treatment may address many of the underlying psychological, physiological, or social difficulties that fuel risks for offending. Furthermore, Vitopolous suggests that only when these legacy experiences from maltreatment are worked through, are children likely to have the ability to focus on broader offending-related risks and needs. Without focusing on and stabilising these legacy effects of maltreatment on children's attention, self-regulation, safety, trust, and coping mechanisms, activity can undermine children's ability to respond to more traditional criminogenic interventions.

This is clearly a small study with what could be considered a subgroup of children who offend (i.e. those identified with psychological difficulties that reach the threshold for attendance at a community mental health clinic). On the other hand, based on what we know from this review, on the centrality of childhood maltreatment and complex trauma to girls' (and to many boys')

pathways into secure settings, these findings may provide an important jigsaw puzzle piece in terms of what works to reduce further offending and antisocial behaviour in higher risk and trauma affected children.

Transition and resettlement

The impact of girls returning to the community should not be underestimated (Bateman et al, 2013) observed that even for girls returning to relatively stable family circumstances, experiences of returning to the community were 'disorientating and distressing' leading some girls to 'remain indoors for a week or more'.

Crucially, when girls have a background of trauma and of feeling chronically unsafe (often due to experiences of sexual abuse), finding safe and stable accommodation early on was considered critical, particularly as girls chances of offending appear more closely linked to experiences of maltreatment, repeat trauma and polyvictimisation. Fitzpatrick and colleagues (2019) found that prevailing worries over where girls would live made it difficult for many looked after children to reflect on how they might build a more positive future or take advantage of other professional support to help them move forward.

A common theme in HMIP inspectorate reports has been a lack of suitable settled and supported accommodation and planning to effectively manage release (Fitzpatrick et al, 2019; Bryan et al, 2015). Inspectorate reports also found lack of mental health and substance misuse support and an absence of education, training and employment which hampered planning and seamless care when girls transition (HMI Probation, 2015; Goodfellow, 2019). Particular challenges for girls include the distance from home as the smaller population of girls means that they are placed in settings further afield (Goodfellow, 2019).

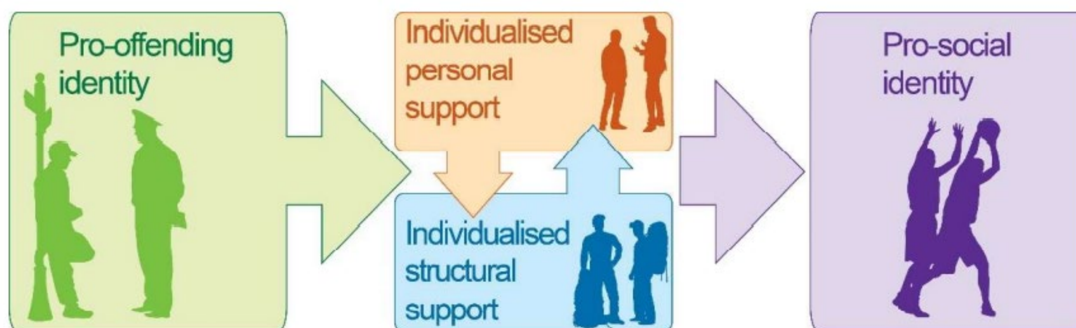


Figure 5: the shift in identity required for successful transition into the community (Hazel, 2018)

Studies also noted the critical importance of:

- seeing transition to the community as a journey for the child rather than a single transition event – and a journey that may involve relapses.
- forward planning for transition right from the very start of entry into a secure setting – this included practical aspects of planning as well as care, sentence and educational planning which should support, build on and reflect girls' aspirations and the building blocks they need in place on release.

- children being able to shift their identity from one that allows offending to one that encourages an offending-free life, social inclusion and wellbeing. When a child changes the way they see themselves and their place in the world, then their chances of successful transition back to the community are increased (see figure 5).
- collaborative working with boys and girls in custody and following release that builds upon his or her strengths and goals and facilitates this positive identity shift.
- a sense of seamlessness and purpose - girls having clear advance understanding of practical plans for their release with activity in secure units very directly feeding into concrete opportunities at the point of resettlement. This helped support optimism and hopefulness about change (which was important as many girls were noted to feel fatalistic about the extent to which life could be different).
- reliable and strong nurturing relationships both in the secure setting and outside which 'conveyed an authentic belief in girls' capabilities, agency, capacity to change and ability to circumvent obstacles' (Covington & Bloom, 2006). It was particularly important to establish an early caring relationship with the allocated worker supporting transition back to the community.
- workers who actively listened to girls and who were able to use knowledge and skills to help shape pathways forward so that plans were shaped by and relevant to girls' choices and circumstances. This practical assistance helped guard against fatalism
- support with maintaining positive personal relationships - mobilising family strengths and also navigating and managing healthy peer and family relationships. Family relationships were important to girls – even when problematic.
- providing support to address 'debilitating feelings of isolation and loneliness which can undermine determination to cease offending'
- an intensive wraparound approach focusing on the multiple risks noted to affect girls' wellbeing (underpinned by strong relationships described above) that helps draw together fragmented systems supporting girls' greater multiplicity of interconnected needs.
- greater use of mechanisms such as release on temporary licence to promote engagement with community-based services, before the end of the custodial element of the sentence, should be encouraged.

(Covington, 2006; Batemen et al, 2013; Bateman & Hazel, 2014; Hazel, 2018; De la Rue, 2018).

For many girls and women, their exposure to adverse experiences and oppressive systems has occurred across many years or even decades. De La Rue (2018) concludes that for this reason support and intervention must be available for longer periods of time and should follow girls back out into the community. If girls must enter secure settings, there may be benefit in piloting intensive through the gate evidence-based multi systemically focused approaches to help girls transitioning back out into the community which should be nested in collaborative, strong, nurturing and empowering, wraparound relationships which are established early in these settings. Functional Family Therapy has been piloted successfully in this way with a mixed sample of young people leaving custody (see WSIPP, 2020).

Transitions to adult settings

There is now general acceptance that adolescence is a time of dramatic change in terms of neural architecture and processes – changes that have significant impact on personality, judgement including inhibiting ability to plan ahead, increasing impulsivity and undermining ability to regulate emotion and anger (Steinberg, 2012). For these reasons, 18-25-year olds can have more in common developmentally with those below the age of 18 than they can with adults. In response to this evidence, strategic health planning and community services are increasingly looking at models of delivery which are 0 to 25 years recognising qualitative differences between young adults and adults.

A small number of girls transfer aged 18 years to adult settings. In 2016, Allen highlighted the lack of focus on the needs of these young women. Whereas young adult males move into specialised young adult provision, there is no equivalent and clear pathway for young women – with many transferring out of much smaller mixed children's settings into larger adult female prisons – where differences in environmental expectations may result in significant adjustment problems for girls and in increased use of controlling sanctions (Bateman & Hazell, 2014).

Allen (2016) calls for:

- more consideration, piloting and evaluation of different models of how this transition might be more effectively managed - particularly on benefits and drawbacks of mixing young adult women with adults.
- improved systematic training for staff in women's prisons for those supporting girls' transitions including a focus on:
    - young adult development
    - as well as on the unique needs of girls and on the social care and ongoing developmental role required to assist this transition.
- better staged and staggered transition into new settings to help familiarise girls with new settings
- greater flexibility in whether girls are automatically transferred at the age of 18 – basing this instead on maturity and vulnerability

Internationally there is little research on the experiences of girls as they transition to adult custodial settings or as they move back to the community as they approach eighteen after placement in secure care. Where girls must transition to adult settings, more attention is needed to develop appropriate age and gender appropriate models and approaches based on gender responsive and trauma informed principles.

Educational needs

Studies of girls who offend note that education is protective and that girls generally enjoy educational experiences (Lederman and colleagues, 2004). However, potentially high levels of ADHD noted in epidemiological studies of young women in custodial settings may significantly affect their ability to learn without proper identification of and adjustment for neurodisabilities and learning styles and needs in keeping with statutory SEND guidance.

Bateman and colleagues (2013) noted the importance to girls of purposeful and relevant education which dovetailed with aspirations and fostered optimism. Effective help was seen to help source concrete educational and employment opportunities early on for release and provide relevant learning, building skills and knowledge to help girls work towards and prepare for accessing these openings after release. In their analysis of weaknesses in the current system, they found that educational provision was not sufficiently differentiated to match girls' individual experiences, ability, needs and goals, felt repetitive to girls and did not lead to concrete qualifications.

Single gender settings

The benefits of single sex versus mixed placement in girls' secure settings is under evaluated with unclear and contradictory messages emerging from studies on advantages and disadvantages. Some commentators advocate the importance, particularly for 'adolescent girls with highly complex and challenging needs', of single sex settings (Hill, 2009; O'Neill, 2008). Some studies exploring girls' views advocate for mixed placements with girls not always seeing themselves as having distinct gender-specific needs (Copley & Johnson, 2016) - although they did recognise some advantages in having time set aside for some single sex activities (Amaro et al, 2001; Maccoby, 1998). Other reviews of girls' views suggested that placements in mixed settings for some increased their chances of sexist and unfair treatment from staff as well as exposure to inappropriate and intimidating behaviour from boys (Plan-UK, 2020). Other reviews relate how residential settings have argued in favour of mixed gender settings thought to have a 'calming effect' (Goodfellow, 2019).

Many gender responsive interventions involve female-only environments. This is primarily based on what is known about girls' and women's high histories of polyvictimisation by romantic partners and other men in their lives; single sex placement is believed to create a safer, reflective, less oppressive environment within which girls can move forward, become empowered, and maximise recovery from multiple trauma exposure (Goodfellow, 2019, Covington, 2006). Some academics, supporting the development of gender specific services, advocate the advisability of a stepped and dynamic approach concluding that single and mixed-sex groups are appropriate for girls and women at different stages of their lives and at different stages of intervention. (Fedele and Harrington, 1990). For example, Covington and Bloom note that female-only intervention groups are important and preferable for girls and women who are sexual abuse survivors or in the early stage of addiction or mental health recovery (Covington & Bloom, 2006). This is because single sex experiences can help validate common survival experiences and support girls sharing ideas and feelings helping to strengthen self-esteem, agency and empowerment - creating an alternative sense of self. Once a girl has developed 'more empathy for herself and is more empowered', Covington & Bloom see mixed intervention groups as subsequently supporting the next stage of female empowerment and recovery. However, Covington makes the point that although mixed groups may have their place in later recovery, it is important that treatment for addiction and for trauma continues to use all-female groups (with a female facilitator).

Very early stage research into a behavioural intervention for a small group of adolescent girls with ADHD (n=10) also pointed to some benefits for girls from single sex group interventions

(Babinski , 2013) (e.g. in terms of self-management, assertiveness and rule keeping, ignoring distractions and participation levels). Conversely, boys in the same study responded better to mixed sex settings where their aggression levels were lower as was their self-management, rule keeping, participation and tendency to be distracted. Findings need more exploration but may be relevant given the high number of girls being identified with ADHD in secure settings.

In terms of gender responsive staffing, there is an emphasis on programmes being delivered by relatable female role models – ideally sharing common characteristics in terms of culture, sexuality and gender conformity (Aston et al, 2017).

Conversely, there is a body of literature that has argued that single sex settings reflect highly binary and oppositional approaches to gender underpinned by 'heteronormative assumptions' that have the potential to further marginalise LGBTQ young people (Goodkind, 2013).

Workforce

A large body of literature highlights staff attitudes as being a significant barrier in effective delivery of gender responsive approaches, with workers often being more reluctant to work with girls than boys, being less tolerant of their needs and finding girls more challenging (Baines & Alder, 1996; Lanctôt et al, 2012). These attitudes were most common when staff had professional experiences primarily with boys and had developed a set of principles they unconsciously used when working with them (Baines & Alder, 1996). When these principles and skills did not work with girls, their lack of experience working with girls led them to consider girls 'difficult' (Betances, 2019).

Several studies suggest the need to recruit professional, specialist, trauma aware, supportive, respectful staff, who are enthusiastic about working with girls. All staff should be well trained and supervised in girls' pathways to vulnerability, in trauma informed approaches and in child and adolescent development. They should have good listening skills, be non-defensive, be patient, have a positive attitude, enjoy working with girls and be reliable. They should also have a commitment to getting it right for girls – checking and reflecting with girls on where things are going well and where things aren't quite working for them (Wilton & Williams, 2019).

Some studies indicate that workers should have a similar background to the girls with whom they work (Bloom et al., 2003; Garcia & Lane, 2010; Green et al., 1998; Hubbard & Matthews, 2008; Ravoira et al., 2012, Walker et al., 2012; Wilton and Williams, 2019). Others recommend using mentors from the same community and culture as the youth (Adamschik, 2011). Having relatable workers is also considered important for girls from Black, Asian and Minority Ethnic communities (Aston, 2017). Some studies also suggest matching staff and youth based on reciprocal interests and congruent personality characteristics to maximise outcomes (Bloom et al., 2003; Zahn et al., 2009).

For effective trauma-informed support, Wilton and Williams (2019) also identified other important elements which were important for supporting staff to work in a trauma informed manner. These included:

1. having access to supervision and reflective practice opportunities - as standard but also when specific incidents have been managed.
2. staff being trained in non-defensive communication approaches – where criticism was used as an opportunity for change and development
3. training in diversity and in girls' experiences of intersecting layers of discrimination and oppression.

Supporting girls from Black, Asian and Minority Ethnic communities

There is little high-quality evidence as yet on what specifically works to support girls from Black, Asian and Minority Ethnic communities to move forward whilst in, or transitioning from, secure settings. However, early stage evaluations suggest that girls are likely to need culturally and trauma-informed safe (physically *and* emotionally) and stable spaces with a relatable worker where girls can also develop affirming cultural awareness, values and beliefs and access relationships, resources and strategies to support resilience and form a positive racial identity (Belgrave et al., 2004; Aston et al, 2017). Person-centred approaches, which are strongly rooted in relationships and in understandings of the day to day impact on quality of life and on wellbeing resulting from girls' intersecting experiences of discrimination (e.g. sexism, racism, class and even potentially homophobia) are also considered important (De La Rue & Ortega, 2019; Briere & Scott, 2015).

Nanda (2012) advocates the importance of investing more effort in understanding girls' stories and pathways into the justice system. When these stories are heard, it is important that these narratives are understood in the wider context of systemic intersecting and potentially oppressive experiences of discrimination faced by some girls from Black, Asian and Minority Ethnic communities - understanding the psychologically enervating impact these experiences have on girls' day-to-day quality of life, resilience and wellbeing (De La Roue, 2016). Scholars also advise hypervigilance and positive action to address patterns whereby some girls from Black, Asian and Minority Ethnic communities are more likely to be blamed for their victimisation or not seen as an 'ideal victim' making it harder for girls to secure support, receive acknowledgment of their victimisation experiences and to access resources which help them move forward from experiences of trauma, inequality and social isolation (De La Rue & Ortega, 2019; Nanda, 2012)

In secure settings, academics recommend improved whole system awareness of the different experiences and impact of trauma on marginalised groups. Whole system activity is also encouraged to take a proactive critical race theoretical approach (e.g. one that is not blind to the way that racial identity has an effect on social and economic opportunities, on trust in the system, on equal rights and on daily experiences and on access to resources and that takes positive action to address these inequalities). In collaboration with children, there should be a focus on identifying spaces, resources systems and ways in which the secure setting can be adapted to better meet the needs of girls and women (De La Rue & Ortega). An Intersectional Trauma-Responsive system of care also requires that systems and the setting make efforts to not engage in, or prompt, additional acts of trauma or harm (e.g. via disproportionate use of isolation, restraint or through adultification etc).

From a systemic perspective, Nanda (2012) calls for proactive reflective learning to recognise unconscious bias (particularly relating to promoting negative stereotypes) and to address chains of decision making which can contribute to further discrimination and inequality in systems heightening the social vulnerability of girls from Black, Asian and Minority Ethnic communities.

Finally, in her review of over representation in the justice system, Nanda (201) recommends that steps forward can be made which include:

a) involving girls in the system as activists in system change and advocacy work.
b) working closely with public health officials to frame girls' offending as public health concerns rather than purely a 'criminal' issue.
c) being transparent, non-defensive and reflective about evidence of disproportionality in the justice system
d) creating a Girls' decision making panel or Court as part of a system of collaborative courts that focus on rehabilitation as opposed to punishment
e) strengthening an integrated multi agency approach to support girls who are at risk of or excluded, who are running away, are at risk of exploitation and abuse and other vulnerabilities.
f) calling for data-driven decision-making that includes objective and culturally relevant and validated risk/need assessments.

More high-quality research is needed into understanding optimum ways of diverting girls away from secure settings and supporting girls from Black, Asian and Minority Ethnic communities to make progress in and transitioning out of secure settings. This area requires more high-quality research as a priority co-producing improvements and solutions with children and communities.

Supporting Transgender and LGBTQ girls

There is emerging evidence that lesbian, bisexual and transgender+ girls are overrepresented in custodial settings. However, there is little evidence on how justice and secure systems have responded to this potentially overrepresented group. This area requires more high-quality research as a priority to identify the extent to which patterns being identified in US studies are mirrored in the UK. Improvements and solutions should be co-produced with children, young people and communities.

'Identity integration' is considered central to reducing psychological distress experienced by some LGBTQ+ children. Identity integration involves:

- becoming accepting of one's SMS identity (e.g., lesbian, gay, bisexual, transgender, queer),
- resolving internalized homophobia (if it is there),
- adopting positive attitudes toward sexual minority status,
- feeling comfortable with others knowing and disclosing to them
- and involvement in activities supporting sexual minority status.

Sexual identity integration is a strongly protective factor against developing a range of problems associated with SMS (e.g. suicide ideation and attempts, self-injury, depression, unprotected sex) (Rosario et al. 2001).

Other recommendations from the scant literature include:

- developing policies to prevent victimisation of and to support LGBTQ+ children and young people (co-producing improvements in practice with LGBTQ+ children and young people)
- improving knowledge and training among staff and non-judgmental awareness among peers
- responding in ways that respect and support children's identity integration (e.g enabling children to be known by their preferred name, to live as their affirmed gender, to be respected, to have their identity affirmed).
- supporting dynamic changes in children's gender expression. Some children's expression may change over time but allowing children the freedom of expression is vital to maintaining good mental health.
- providing access to specialist gender identity services and gender transition treatment as well as trauma informed counselling – potentially working in partnership with community-based groups
- building trusting adult relationships with LGBTQ+ children. One study noted that sexual minority girls who did not self-harm in custodial settings, compared with those who did, were more likely to be able to identify a trusted and safe adult in their lives (Walls et al., 2010).
- parental (e.g., Savin-Williams, 1989) and peer support (Diamond and Lucas, 2004; Swann & Spivey, 2004) provide protection against many of the negative outcomes experienced by LGBTQ+ children and young people.

Reducing self-harm in secure settings

Girls in custodial settings in England and Wales present with much higher levels of self-harm compared with boys – often linked to higher levels of mental health difficulties and linked to histories of trauma and polyvictimisation.

Self-harm has been described as a 'high intensity social signal used when less intense forms of communication such as speaking, crying and screaming fail' (Kenning, 2011). Self-harm in custodial settings has also been linked to overwhelming feelings of hopelessness, shame, anger frustration, powerlessness and frustration hopelessness, worthlessness and burdensomeness (Howard League, 2001; Hutson and Myers 2006; HMPPS, 2019).

Safe physical environments (both physically and emotionally) are important to minimise self-harm and suicide (NICE, 2013). Self-harm can increase in secure settings as children lose long-standing (sometimes unhelpful) coping strategies which manage trauma-related feelings. Evidence explored in this review also finds that self-harm may be highly related to a mismatch between the environment and girls' needs in these secure settings – where they can be exposed to an array of potentially re-traumatising institutional experiences and processes (e.g. room

confinement, restraint, searching felling unsafe etc). Risks of triggering trauma related responses may be higher when controlling approaches overshadow caring, supportive, empowering, nurturing and trauma-informed responses.

Adopting promising approaches such as the Six Core Strategies (see page XXX) which focuses on mobilising whole system activity to reduce and (most importantly) to prevent self-harm, restraint and separation and which includes transparent discussions, learning and planning around each individual child's potential triggers (working collaboratively with children and young people) and concerning what helps children self soothe effectively appears important.

A multi informant trauma-informed assessment of self-harming is recommended exploring the meaning of self-harm for each child. It should also work with girls to understand and identify protective and risk factors, personal factors or significant events which may trigger self-harm. It should also include skills, strengths and assets. (RCPCH, 2019; NICE, 2013).

Wraparound holistic care, including DBT – adolescent version, delivered in the context of good quality therapeutic relationships also shows promise as an intervention for girls in secure settings given the range of needs they present with (Hawton et al, 2015). DBT interventions need to be delivered in the context of authentic, consistent and trusting relationships and should form part of a whole organisational trauma-informed approach.

Families, carers and friends *can* help to support a young person who has suicidal thoughts or plans. They can also provide valuable input to an assessment of the person's needs to help keep them safe (Rink & Tricker, 2003)

Children in secure settings have noted how institutional practices to manage self-harm, such as increased observation and having things taken away often felt like a punishment and made them feel worse – although they acknowledge and understood workers responsibility to keep them safe (Abela et al., 2005). Solutions to these difficulties require collaborative problem solving and planning with children and young people.

Chapter four: conclusion and implications

Girls pathways to secure settings are characterised by multiple experiences of trauma – particularly sexual victimisation (and often repeat victimisation). Early distress is often missed due to their tendency to internalise trauma and to mask neurodisabilities which may nevertheless be severely impairing their progress.

Overall, this review highlights that girls generally experience different and distinct pathways into offending, risky behaviours and into secure settings compared with boys. Although both boys and girls in custody are equally likely to have been exposed to multiple and longstanding adversities and maltreatment as children, girls appear to experience particularly damaging and traumatising forms of victimisation such as childhood sexual and physical abuse - which are highly associated with later risk of care or justice involvement. These experiences lead to a chain of additional risks of ongoing exploitation during adolescence (usually within the context of relationships with older intimate partners). Girls' romantic relationships are also associated with

subsequent involvement in a range of risky behaviours which further compromise their opportunities and health and wellbeing sometimes bringing them into contact with justice and care systems. Because of the way that girls process these traumas during childhood (e.g. through internalising psychological distress or through more subtle behaviours), early psychological and neurodevelopmental difficulties are often missed and opportunities for earlier intervention overlooked.

Girls in secure settings have higher and multiple interconnected health, social and educational needs than boys – many of which are fuelled by past experiences of victimisation and associated risky behaviours.

It is also clear that those girls who enter secure settings, have more extensive and severe experiences of trauma than boys (who themselves have elevated histories of past adversity and trauma compared to community samples). They also present with more mental health difficulties such as PTSD and depression (often co-occurring) and with higher risks of self-harming - all linked to previous experiences of trauma. Finally, they also have a wide array of other interconnected physical health and sexual health needs which studies suggest can escalate further as they move into young adult years without appropriate support. Finally, although girls seem to have lower levels of conditions such as speech and language problems than boys in secure settings, unusually high numbers of girls seem to cluster in custody meeting criteria for ADHD – a condition which is rarer among girls in community settings, more subtle in the way it presents (being more likely to involve inattentiveness rather than hyperactive and impulsive behaviours) and which is yet again noted to be under identified and appropriately supported in girls in schools.

Gender responsive and trauma informed approaches appear best suited to girls needs and outcomes

Based on these multiple interconnected needs, gender responsive and trauma informed approaches are advocated as the most effective way of promoting girls' outcomes and of reducing re-offending. Essential elements of gender-responsive approaches include comprehensiveness, listening to girls stories, wraparound approaches, girls voices and choices driving how they move forward, using relationships as a tool for change, whole organisational commitment to gender and trauma informed principles, maximising feelings of safety, looking at and understanding girls' behaviour and responses through a 'trauma' lens, empowering girls as they move forward, and supporting healthy family and peer relationships (e.g. peers, romantic). Delivery should ideally be provided in the context of community-based services and must be safe-feeling. Delivery must also be underpinned by a process of checking with girls that practice consistently reflects what they need and that delivery is consistent with trauma informed principles. It requires specialist well supervised staff with good knowledge of girls' pathways into criminal activity and vulnerability. They should have a commitment to ongoing non defensive reflective practice, empowering and non-hierarchical ways of working and enthusiasm for working with girls. Given the range of interconnected and intergenerational damaging and costly challenges that girls appear to face, approaches, interventions and evaluation should focus on a wider set of outcomes than just re-offending.

Evidence on effectiveness of these approaches is still at an early stage

The evidence base for effectiveness of these approaches remains at an early stage and requires more development and investment – particularly with girls. However, these approaches are strongly advocated by women with lived experience.

There are some early signs that trauma-informed approaches in secure settings (backed up by collaborative learning) can result in reductions in rates of assaults, self-harm and physical restraints. However, interventions cannot be introduced effectively in a piecemeal way and whole system commitment to creating environments which are conducive to promoting girls' development, optimism and recovery from trauma appear particularly important to successful outcomes. Similarly, trials of gender responsive approaches with moderate and high-risk girls in community groups homes have shown some promising signs of reducing re-offending. More piloting and evaluation is required exploring the effectiveness of these interventions - ideally evaluating a wider array of outcomes which we know affect girls progress and life chances.

Community interventions generally outperform custody (when tracking outcomes for matched samples). Therapeutic residential care performs better than traditional justice secure placements. There is evidence that traditional custody may do more harm for girls and boys with histories of trauma.

High quality US studies tracking matched samples of children on community orders with those who end up in custody show that community interventions outperform outcomes for children in custody in terms or risk of re-offending.

A Swedish metanalysis of outcomes for children in residential care showed that *therapeutic* residential care (e.g. psychiatric or therapeutic placement) performed largely as well as interventions such as MST in reducing externalising behaviours; improvements were more modest for internalising difficulties (more commonly experienced by girls). Justice-based residential interventions were least likely to result improvements in behavioural outcomes and offending for boys and girls.

Many international studies and inspectorate reports air concerns about girls' detention in custodial environments. These include:

1. that custodial interventions are least effective for those with backgrounds of trauma and maltreatment
2. that to promote girls' recovery from trauma, a safe environment - which places nurturing relationships and girls' active participation at the heart (rather than institutional processes and control) - is considered an essential active ingredient for promoting change
3. that current custodial and care experiences often go hand in hand with institutional processes which act to further traumatise girls and embed criminogenic risks.
4. that custodial settings, with a control and command milieu may be limited in how far they can flex to allow trauma informed approaches to pre-dominate - particularly when staff are dividing attention between the majority of boys and a minority of girls with more intensive and different needs.

Of particular note is the recommendation that gender responsive principles are primarily designed to be therapeutic, comprehensive and community based.

Any model of secure setting moving forward should ensure robust whole system commitment to do no further harm to girls.

Wraparound approaches have proved effective for girls

Despite the current lack of rigorous research into gender responsive and trauma-informed approaches, one academic notes a large body of well-tested effective interventions for children in the justice system which have now also built up knowledge on effectiveness for a large pooled sample of girls. It is suggested that these interventions could be modified so that they more fully mirror gender-responsive and trauma informed principles and practice. Such programmes include multi systemic approaches, Functional Family Therapy and intensive foster-treatment therapy all of which include many key principles considered important for girls. Indeed, intensive fostering has already been successfully trialled with girls with proven reductions in offending. If adapted to more fully reflect gender and trauma responsive principles, such approaches could also be used as community-based wraparound alternatives to placement in secure settings for girls considered to be at high safeguarding risk, on shorter sentences or on remand. This would mirror recommendations made by Baroness Corston concerning the need for gender responsive community alternatives to custody for women and girls in her seminal review of women and girls needs in the justice system (2007).

One note of caution: a recent evaluation of MST for children on the edges of care and of the justice system in the UK did not show effective long-term reductions in re-offending. Re-conviction rates were compared with those girls attending YOTs (rather than with those in custodial settings). It may be that these programmes were not targeted in a way that is compliant with core principles of what makes justice interventions work best – namely that they are targeted at and reserved for those at the highest risk of offending. Girls were noted to have performed better in this trial with a recommendation for further evaluation on gender specific outcomes.

Maltreatment is a particular risk factor for children's re-offending

Activity to reduce vulnerability and re-offending should focus as a priority on dealing with the consequences of maltreatment (e.g. behavioural dysregulation, impulsivity, mental health problems etc). Only then can girls and boys with histories of maltreatment focus on traditional re-offending risk and needs.

Transitions for girls are particularly important

Finally, if girls enter secure settings, transition back out to the community is a particularly critical event requiring seamless management maximising a focus on girls' physical and emotional safety. It was important that they were helped to develop early, meaningful plans (shaped by their voices and choices) providing concrete opportunities for their future and that activity in secure settings provided relevant activities to move further forward in direct achievement of girls' goals maximining feelings of safety and hopefulness. In the US, some

evidence-based interventions have been used as a vehicle to offer intensive transitional support back onto the community (see WSIPP). Furthermore, in the UK, the DfE are currently testing one of these approaches (MST-FIT) for those transitioning out of residential care.

An area overlooked in studies is how the minority of girls who transfer to the adult prison estate are supported in an age appropriate way with this transition. This requires more practice-based investigation with subsequent evaluation of new models.

There is a need for an intersectional trauma-based approach

Such approaches recognise that girls can come to the justice system with many interlinking identities (e.g. ethnicity, class, sexuality, gender-identity). These interlinking identities can amplify experiences of trauma and of oppression. There is a need for whole system understanding, monitoring and positive action to adopt an intersectional trauma-based approach minimising further inequities and trauma linked to further discrimination.

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