CHILDREN AND YOUNG PEOPLE IN CONFLICT WITH THE LAW: POLICY, PRACTICE AND LEGISLATION

Section 5: Trauma and Adversity

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1. Introduction

Adversity (*n*) a difficult or unpleasant situation

The dictionary definition of adversity reminds us that it is a broad term, which encapsulates a wide range of events, circumstances or experiences that might have an impact on an individual's physical, psychological, social or emotional wellbeing. Examples include: poverty; abuse; discrimination; bereavement; bullying; serious injuries or accidents; disability; violence and parental separation. Exposure to adversity can cause short-term distress, as well as longer-term harm to everyday functioning. However, as will be seen throughout this section, adversity is widespread, and it is neither practical nor possible to protect children from all potentially adverse events in their lives. Also, experiencing adversity need not always lead to negative outcomes and, in some circumstances, brief exposure to low level stressors may build resilience, promote growth and prepare individuals for stressful experiences throughout the life course (Cicchetti & Rogosch, 2009). However, in order to recover and grow from stress and adversity children need to have access to stable, caring and supportive environments and relationships (Bellis et al., 2017; Meyerson et al., 2011). It is therefore imperative that as practitioners in Scotland we take a two-pronged approach, in which steps are taken to prevent and reduce the adversity and inequality that children face wherever possible, but also, to ensure that our society, systems and services are set up to promote optimal recovery and resilience in the face of adversity.

It is important to note that this section does not aim to systematically review all evidence on the subject of childhood adversity; it does not cover all possible forms of adversity, nor is it intended to provide the reader with a comprehensive guide to practice with children affected by adversity. Rather its purpose is to provide a general introduction to the most common types of childhood adversity and to draw upon the key messages from research to raise awareness about the impact of adversity and its relevance for youth justice practice.

2. Key Findings from Research

2.1 Adverse Childhood Experiences

While the concept of adversity is broad, the term 'Adverse Childhood Experiences' (ACEs) has come to refer to a well-known study (Felitti et al., 1998) in which the long-term relationship between exposure to seven different adverse experiences in childhood and an increased risk of poor health outcomes in later life was documented.

This large-scale study, partnered with the Center for Disease Control and involving more than 8,000 adults attending a Health Appraisal Clinic in San Diego for a routine medical examination, asked participants to document their childhood experience of seven categories of adverse experiences. Three of these categories related to abuse (sexual, physical and emotional); the remaining four were indicators of household dysfunction (familial substance abuse, familial mental illness, domestic violence in the home and the incarceration of a household member). A composite ACE 'score' was calculated which was a simple summation of the presence of each ACE, producing a 'score' of between zero and seven. The prevalence of ACEs ranged from 3.4% (incarceration of a household member) to 25.6%

(substance abuse within the household). Around half of participants (50.5%) had experienced at least one ACE and 6.2% had experienced four or more.

More strikingly, the authors found a strong dose-response relationship between the number of ACEs encountered and the presence of health risk factors and diseases implicated in the leading causes of death in adults. For example, respondents with exposure to four or more ACEs were more than twice as likely to be a smoker than respondents with no exposure to the measured ACEs; the odds of experiencing depression in the past year were almost fivefold; alcohol addiction sevenfold; and suicide attempts were 12 times more likely. In relation to non-communicable diseases, the odds of ischemic heart disease, cancer and stroke were roughly twice as likely in those participants exposed to four or more ACEs and chronic lung disease occurred four times more frequently.

Since the original study, the ACEs research has been expanded to cover ten core experiences, with physical and emotional neglect and parental separation added to the original seven. The study has also been replicated in different countries and cultures, and a strong and graded association with a range of physical health, mental health and social outcomes has been consistently documented including: early onset of alcohol use (Dube et al., 2006); binge-drinking (Bellis, Hughes, Leckenby, Jones, et al., 2014); alcohol addiction; illicit drug use (Dube et al., 2003); depression (Anda et al., 2002; Chapman et al., 2004; Fang et al., 2016; Schilling et al., 2007); low life satisfaction (Bellis, Lowey, et al., 2014); and unintended teenage pregnancy (Bellis et al., 2015; Bellis, Hughes, Leckenby, Jones, et al., 2014; Hillis et al., 2004).

ACEs are understood to have a negative effect on social, health and other wellbeing outcomes through three key mechanisms (UCL Institute of Health Equity, 2015):

- Through the adoption of **health-harming behaviours** to help regulate or manage the distress associated with adverse experiences. Such behaviours include smoking; over-eating; use of legal and illegal substances; risk-taking behaviours; violence etc. These behaviours can directly harm health through disease, accidents or violence, or can do so indirectly by affecting the circumstances in which people live.
- These circumstances are known as the **social determinants of health** and include factors such as education, employment and income. These social factors can affect exposure to ACEs and also the ability of people to be resilient to ACEs.
- There may also be a direct impact of ACEs on **neurobiological and genetic pathways**. Changes to stress hormones and the stress-response system as a result of experiencing ACEs can affect brain development, including areas of the brain that have a role in emotional regulation, somatic signal processing, substance abuse, sexuality, memory, arousal and aggression etc.

Within the UK, there have been studies conducted on nationally representative samples that have documented a widespread prevalence of ACEs. Around half (47%) of individuals in England and Wales had experienced at least one of the ACEs (Bellis et al., 2015; Bellis, Hughes, Leckenby, Perkins, et al., 2014). There has not been a population study of ACEs in Scotland, although it has been hypothesised that the prevalence of adversity is likely to be higher in Scotland than in the rest of the UK, given Scotland's specific social, cultural and economic characteristics (Couper & Mackie, 2016; Smith et al., 2016). The limited population data that does exist, in a study drawing upon a nationally representative sample of 3,119

eight year-old children, bears this out (Marryat & Frank, 2019). Although the study only looked at seven of the ten ACEs (or 'proxies' for ACEs), it found that two-thirds of eight year-olds had experienced at least one ACE.

Adverse Childhood Experiences and Justice

Research has shown a relationship between exposure to ACEs and future violence, whether as a victim, a perpetrator, or often both. However, it should be noted that the majority of people who are exposed to adversity in childhood are not involved in violence, and that the association is retrospective and not necessarily predictive. For example, an English study found that respondents with four or more ACEs were seven times more likely to have been a victim of violence in the past year. They were also eight times more likely to have committed a violent act than those with no ACEs (Bellis, Hughes, Leckenby, Perkins, et al., 2014). In Wales these figures were more pronounced, as those who had experienced four or more ACEs were 14 times more likely to have been a victim of violence in the past year, and 15 times more likely to have been the perpetrator of a violent incident (Bellis et al., 2015). In a study of people in prison in Wales, those with a higher number of adverse experiences were more likely to be involved in prolific or violent offending than those how had experienced fewer ACEs (Ford et al., 2019).

Young people in conflict with the law are also found to have a higher rate of exposure to ACEs than the general population. Analysis of pre-existing risk assessments for around 64,000 young people involved in offending behaviours in Florida (Baglivio et al., 2014) found that this group of young people were four times more likely to report four or more ACEs. A study of almost 12,000 young people involved in offending (Fox et al., 2015) found that, on average, exposure to each additional Adverse Childhood Experience increased the risk of serious, violent or chronic involvement in offending by 35%, although some ACEs were found to have more impact on future behaviours (for example, physical abuse, or having an incarcerated family member).

In Scotland, a case file review of 130 young people, deemed to be at risk of serious harm to themselves and others (Vaswani, 2018a), found that the level of ACE exposure in this vulnerable population was much higher than in the wider population studies of ACEs. Whereas between 9 and 14% of adults in the UK population studies had experienced four or more ACEs (Bellis et al., 2015; Bellis, Hughes, Leckenby, Perkins, et al., 2014), in this sample 59% had been exposed to four or more. Further Scottish studies of children in secure care found that between 64- 74% had experienced four or more ACES (Gibson, 2020, 2021). A summary document outlining the relevance of ACEs for crime and justice has also been prepared by the Scottish Government (2018). Recent research (Gray et al., 2021) with youth justice workers in England observed that exposure to ACEs can cause a child or young person to be constantly alert to signs of danger, heightening their fight, flight or freeze reactions. This response may increase the likelihood of children coming into conflict with authority (such as teachers or the justice system). The same study concluded that children with exposure to ACEs may display an increased need for belonging and acceptance, which can leave them vulnerable to both peer pressure and Child Criminal Exploitation (CCE).

Viewing ACEs Through a Critical Lens

There has been growing awareness and discourse about ACEs in Scotland over the past few years, with training events, film screenings, conferences and published works discussing the importance of ACEs. The ACEs research has been hugely important for stimulating this discussion, but there are important differences in the way our conceptualisation of ACEs has been, and should be, applied in research versus real world practice contexts. Thus, it is important that, as with any new research or practice developments, practitioners, academics and citizens critically engage with the topic before applying the learning into their own specific context.

Firstly, it is important to note that the relationship between these ACEs and poor outcomes is not necessarily causal, and the majority of individuals who experience these events in childhood do not grow up to experience poor health outcomes, persist in offending or violent behaviours, or end up in prison. However, there is an increased *risk* of poor outcomes and there may be some mechanisms and mediating factors that contribute to outcomes (for better or worse) in later life. Similarly, just because an event has been experienced, it does not automatically mean that it has been experienced as an adverse event or has a long-term impact (for example, a parent with mental ill-health may often still provide warm, sensitive and nurturing caregiving; a parental separation may provide relief and safety to a child who has experienced significant family conflict or abuse). There are also limitations with the conceptualisation of adversity as specifically defined in the ACEs studies, which typically look at around ten potentially adverse experiences. While other experiences (for example, being in care, bereavement, bullying) have not been included in the research framework; this does not mean that they are not adverse experiences. Importantly, ACEs research has also hitherto made scant reference to structural inequalities as a form of adversity or considered the intersection between these inequalities and ACEs (Walsh et al., 2019). More recently Jahanshahi et al. (2021) confirm a relationship between ACEs and offending behaviours, but that the structural context, and the type of adversity experienced also matters. Lastly, the framework does not distinguish between events in relation to their nature, frequency, intensity, impact, available support etc. and as such exposure to the ACEs in this framework, or an ACE 'score', is only a proxy measure of adversity (Anda et al., 2020). While this may be sufficient for research purposes, and for public health policy, the ACEs methodology has limited use for organisational decision-making or individual practice. This position has recently been reiterated by some of the authors of the original ACE study (Anda et al., 2020).

Practice Implications

In 2016, the Scottish Public Health Network (ScotPHN) published a report Polishing the Diamonds which summarised the current public health thinking around ACEs (Couper & Mackie, 2016). An update to Polishing the Diamonds was published in 2020, setting out a public health approach to preventing adversity and highlighting case examples from across Scotland (Hetherington, 2020). In short, the approach to ACEs in Scotland needs to be multi-dimensional and should include:

- raising awareness of the long-term impact of adversity in childhood,
- preventing exposure to ACEs in the first place
- encouraging the development of resilience in children
- supporting families

- ameliorating the health and social effects of ACEs in adults and preventing intergenerational transmission of ACEs

The Scottish ACEs Hub (hosted by Public Health Scotland) has more information about the background of ACEs, and the use and limitations of the ACE questionnaire and routine enquiry (where patients and other groups are asked about their childhood experiences of adversity). The Hub also produced a set of updated principles in August 2019, that could underpin cross-sectoral work in preventing and responding to ACEs (NHS Health Scotland, 2019). These include:

- ACEs inform our approach, but do not define it
- ACEs questions are a limited proxy indicator of wider experience
- ACEs need to be understood in the context of poverty, inequality and discrimination
- ACEs are about relationships
- Our understanding of childhood adversity is improved by multiple perspectives

2.2 Loss, Bereavement and Separation

One key childhood experience that is missing from the ACEs framework is that of childhood bereavement. Bereavement is a common childhood experience, with studies indicating that between 43% (Highet & Jamieson, 2007) and 78% (Harrison & Harrington, 2001) of school children have experienced a bereavement. In Scotland, around half of all children have experienced the death of a close family member by the age of eight, and 62% by age 10 (Paul & Vaswani, 2020). Children who are in conflict with the law have been found to have experienced a higher rate of childhood bereavement than the general adolescent population (Vaswani, 2008; Vaswani, 2014), and importantly, to have experienced multiple and traumatic deaths (Dierkhising et al., 2019; Finlay & Jones, 2000; Vaswani, 2008; Vaswani, 2014). A study of young men in HMP&YOI Polmont found that 91% had been bereaved, and more than three-quarters (77%) had experienced at least one traumatic death (Vaswani, 2014).

Bereavement is often seen as the ultimate loss, because of its irreversibility and the pain associated with such a permanent loss. However, in his seminal work on attachment, John Bowlby (1998) acknowledged that the majority of losses in society arise from reasons other than death. Certainly this is true of children who are caught up in the care or justice systems, who have experienced a multitude of losses in childhood. These losses can be tangible (loss of family relationships, loss of home; loss of friends; loss of belongings) or less tangible (loss of identity; loss of culture; loss of family roles etc). Having contact with the justice or care system also often creates additional losses, such as separation from family, friends and social support. Young males in custody described four key categories of loss that had been experienced on their journey to, through and beyond custody (Vaswani, 2015), which were:

- Loss of relationships: separation from family, friends, professionals and other forms of social support etc.
- Loss of stability: disrupted and chaotic childhoods, school changes and exclusions; placement moves; the revolving door of custody etc.
- Loss of status: the shame and stigma of being care or justice experienced; the loss of autonomy to make decisions in restricted settings etc.

- Loss of future: the loss of hope and ambition for the future, often as a result of facing real barriers posed by a disrupted education and a criminal record, and perceptual barriers related to self-esteem and self-worth. This is often experienced as a bereavement for oneself (Markus & Nurius, 1986).

Some of these losses may seem trivial, but their cumulative effect can have a lasting impact. Also, some of these losses experienced by children may be more ambiguous than others. Pauline Boss, a family therapist, first coined the term ‘ambiguous loss’ in the 1970s. Boss (2009) distinguishes between two types of ambiguous loss: where the person is *psychologically* present but *physically* absent, most clearly exemplified by missing persons; and where the person is *physically* present but *psychologically* absent, such as with people suffering from dementia or severe brain injuries. More commonplace examples that are of relevance to children in conflict with the law, and that align clearly with the ACEs research, include: psychologically absent parents, such as those who are emotionally unavailable due to substance misuse; mental ill-health or neglect; or physically absent relatives, for example, estranged parents or siblings, or parents who have been imprisoned, where the child is not fully aware of their whereabouts (Vaswani, 2018b).

The importance of ambiguous loss is that, unlike bereavement, it is not as straightforward to recognise and is therefore not associated with the same level of societal understanding, social support or important social and cultural rituals. To give an example, while bereaved individuals can attend funerals, wakes, gravesides or memorials, there are rarely such markers for losses caused by family breakdown, or adoption (Courtney, 2000). As ambiguous loss often goes unsupported, or by its nature is difficult to process, Boss (2006:4) argues that “the inability to resolve the situation causes pain, shock, distress, and often immobilisation. Without closure, the trauma of this unique kind of loss becomes chronic.”

Ambiguous loss, or losses that are simply less tangible and understood, can therefore result in disenfranchised grief. Disenfranchised grief is where losses are not openly acknowledged, publicly mourned or socially supported (Doka, 2002). Doka describes a number of scenarios where grief is more likely to be disenfranchised, including: where the loss is not recognised (e.g. miscarriage or pet loss); where the relationship is not recognised (e.g. ex-spouses or friends); where the griever is not recognised (e.g. young children or people with learning disabilities); in certain disenfranchising deaths (e.g. suicide or overdose); and where the griever does not conform to societal norms and expectations about grieving. Children and young people, and especially young males or those in conflict with the law, are at increased risk of disenfranchised grief due to: their age and status in society; cultural and societal norms about masculinity and grief; the high levels of stigmatising deaths such as murder, drug overdose and suicide among children in contact with the justice system; and attitudes towards those who have caused harm to others as being undeserving of their grief.

Practice Implications

It is important to remember that grief (however it presents) is both individual and normal, although symptoms can be physical, emotional, psychological and behavioural. Symptoms can include, but are not limited to: crying; anxiety; rumination; sadness; numbness; anger; irritability; withdrawal; difficulty concentrating; sleep problems; stomach problems; shock; denial etc. It is important for parents, carers, teachers and professionals to recognise these appropriately as grief and not just poor behaviour. Symptoms should subside over time, but may resurface multiple times, especially at major life events or anniversaries. Luckily most

children will not require specialist support to adjust to the death of a friend or family member, but rather comfort, support and a listening ear from a trusted family member, friend, or professional.

However, if bereavement is not seen solely as a 'specialist' issue this means that a wide range of people need to be equipped with the confidence and skills to talk about death, and have an awareness of what services are available should further support be needed, as well as their own supports to lean on when helping a young person through a difficult time. More information and resources on talking to children and young people about death, dying and bereavement are available in this CYCJ Information Sheet.

It should not be assumed that just because a bereavement was in the past, it is not still affecting the child now. Children may not need or want support initially or when offered, although they often find it difficult to ask for help later, especially if the bereavement was a long time ago. It is therefore important to remember to offer children help and support at multiple points along their bereavement journey. It is also important to consider the child's developmental stage and offer age-appropriate support and information. It is now well understood that children can grieve at any age, with even infants aware of, and deeply affected by, separation and disruption in routines (Adams, 2011). A basic understanding of death, and therefore more tangible mourning, begins to emerge around age three (Worden, 1996), although it is not until about age seven or eight that children understand that death is final (although they may still harbour fantasies about reunification). Children may revisit the loss as they progress through the developmental stages, and it is essential to continue to check in and continue to update children with age-appropriate information about the death or the situation, as their needs and understanding develop throughout childhood and into adolescence and young adulthood.

Some children may require support from outside of the family, or access to specialist support to help them learn to live with their losses and bereavements. This may be because symptoms of grief are impairing the child's functioning over a prolonged period of time, or because the parent or caregiver is struggling with their own grief (or other issues) and cannot provide the consistency and stability needed. More complicated experiences, such as traumatic or ambiguous losses, may be more likely to require specialist support. Some children have also indicated that they would prefer an outside source of help, in order that they can express their worries freely without fear of upsetting a grieving caregiver (Dyregrov & Dyregrov, 2008). The school can be an important place of support that provides sanctuary, routine and direct support. Interventions commonly used in schools include the Seasons for Growth programme for change and loss. There is also guidance available on a Whole School Approach to bereavement and loss, developed by Glasgow City Council and NHS Greater Glasgow & Clyde. Schools also have an important role to play in educating all children (not just those who have been bereaved) about death, dying and bereavement as part of the curriculum, and schools should look to incorporate this wherever possible.

Not all children will be attending school, and some children may require more specialist support. Other resources and sources of information include, national and local bereavement organisations, such as Child Bereavement UK, Winston's Wish, and Cruse Bereavement Care Scotland. A comic anthology, 'When People Die: Stories from Young People' which was developed by bereaved young people from CHAS, Richmond's Hope and HMP&YOI Polmont (via Barnardo's Scotland) for other bereaved young people is available as a free

download. Free hard copies of the comic may be available; children, parents, carers or professionals can contact cycj@strath.ac.uk to enquire about availability.

2.3 Bullying

Being the victim of bullying is another common childhood experience that can have both a short- and long-term impact on health and wellbeing, that has not been incorporated into the ACEs research framework. However, as our understanding of the effects of bullying has developed, it has been argued that bullying is an adverse and stressful experience that "...should be considered as another form of childhood abuse alongside physical maltreatment and neglect" (Arseneault, 2018:416).

The definition of bullying requires: a repeated pattern of behaviour; the knowledge that the behaviour is likely to cause harm or distress; and a power imbalance between victim and perpetrator (Olweus, 1997). Behaviours such as arguing or fighting with peers are therefore not included within this definition, unless the behaviours are targeted and sustained over time. The power imbalance between bully and victim could be actual or perceived, and may result from a difference in strength, status, numbers or other factors (Arseneault, 2018; Olweus, 1997) - for example anonymous bullying online. More recent research recognises that the dichotomy between bullying and victimisation is not always a useful distinction (Kelly et al., 2015), much as is the case with the blurred boundaries between the perpetrator and victim of offending. Thus, while the terms bully, victim and bully-victim are used for clarity here, it is acknowledged that such labels can be stigmatising, disempowering and unhelpful in supporting behavioural change or recovery (Respect Me, 2019).

Bullying can cause lasting harm to individuals. Being a victim has been associated with suicide, self-harm, poor school attendance and achievement, anxiety, depression, low self-esteem, as well as other mental and physical health outcomes - often lasting into adulthood (Arseneault, 2018; Bainbridge et al., 2017; Fullchange & Furlong, 2016; Troop-Gordon, 2017). Children involved in carrying out bullying behaviours (bullies) are at risk of later suicide, offending, violence, and substance misuse (Farrington & Ttofi, 2011; Gibb et al., 2011; Sourander et al., 2007; Ttofi et al., 2012). Those who are involved in bullying at both ends of the spectrum (bully-victims) tend to have the poorest outcomes of all (Barker et al., 2008; Kelly et al., 2015). The effects of bullying can extend beyond those immediately involved, with witnesses and bystanders also experiencing a detrimental impact on their health and wellbeing (Bainbridge et al., 2017; Equalities and Human Rights Committee, 2017).

There is no legal definition of bullying in Scotland, hence bullying in itself is not a crime (Scottish Government, 2017), although some bullying behaviours may constitute a crime (for example, assault). It should be noted that the vast majority of children who bully or who are bullied do not become involved in offending behaviours in later life. However, understanding and addressing bullying behaviours is especially pertinent for practitioners working in youth justice and related fields, as there is growing evidence that suggests a small but significant association between bullying behaviours in childhood and later involvement in offending. For example, children who were identified as being involved in bullying other children between the ages of seven and 12, were found to be significantly more likely to have been arrested by age 30, than children who did not bully at those ages (Gibb et al., 2011). In Finland, carrying out bullying behaviours was also associated with a higher frequency of offending at age 26 (Sourander et al., 2011). These findings appear to hold fairly true across

time and place, with a systematic review and meta-analysis of 29 studies concluding that bullying was highly significantly associated with offending behaviours six years later (Farrington et al., 2012).

Bullying perpetration in childhood is also more strongly associated with violence in later life. A Finnish cohort study found that 20% of those identified as frequent bullies at age eight had committed a violent offence in early adulthood, compared to 3% of those who were not involved in bullying at all (Sourander et al., 2011). Similar findings were reported in the Edinburgh Study of Youth Transitions and Crime (McVie, 2014). A meta-analysis of 15 studies concluded that bullying perpetration was a significant risk factor in later violence (Ttofi et al., 2012). This association has led to debates about whether bullying, aggression, offending and violence are simply expressions of the same underlying construct (e.g. antisocial tendencies) but are interpreted differently depending upon age and situational context (Farrington & Ttofi, 2011). However, Ttofi et al. (2012) conclude from their meta-analysis that bullying is a specific risk factor for later offending.

There is also an association between bullying victimisation and later offending, although the relationship tends to be less strong than it is for bullying perpetration. Farrington et al. (2012) found that the odds of a victim of bullying being involved in later offending was around 1.1, which was not quite significant after controlling for other factors. They conclude that victimisation might increase the risk of later offending by around 10%. A moderate association between being bullied in childhood and adult crime was also found by Sourander et al. (2011), although when adjusted for factors such as mental ill health or psychological impairment in childhood, this association ceased to be statistically significant. The nature of this relationship is not fully understood, and there are debates as to whether offending, and other externalising problems, are a reason for victimisation (Troop-Gordon, 2017) rather than a symptom of victimisation.

However, there is a stronger link between bullying victimisation and later violence, with the odds of violence increasing by 1.4 - which was highly significant (Ttofi et al., 2012). The meta-analysis also found that the younger a person was when they were victimised, the greater the likelihood of later violence (Ttofi et al., 2012). This may help to explain the finding that being bullied in school is the most common ACE reported by people across the Scottish prison estate, reported by 61% of those in custody (Scottish Prison Service, 2018). Furthermore, the custodial environment is often a setting for bullying behaviours, especially in youth establishments, as young people use bullying to develop or maintain social status.

The link between victimisation and later offending and violence is often attributed, at least in part, to the role of bully-victims (those who are both victims of, and perpetrate, bullying). The trajectory of victim to bully has been observed in different samples (Bettencourt & Farrell, 2013; Toblin et al., 2005). The hypothesis is that some victims try to regain power and control after being victimised, which can lead to involvement in offending and violence, in order to attain this position (Wong & Schonlau, 2013). These victims were found to display behaviours that were more impulsive and emotionally driven than children who were ‘typical’ bullies (Bettencourt & Farrell, 2013; Toblin et al., 2005), and as a result can be more unpredictable, with a tendency to lash out or retaliate when provoked. In the most extreme example of this, Wong and Schonlau (2013) observe that the majority of perpetrators in US high school killings had been, or perceived themselves to be, victims of bullying by others in the school environment.

Importantly, it should be noted that those involved in bullying (whether as victims or perpetrators) often have a range of other needs and risks that may contribute to, or arise from, their bullying behaviours. For example, a study of the case files of 128 children who were deemed to be at a high risk of harm to others (Vaswani, 2019) found that experiences of bullying (either as a victim or perpetrator) were higher than in the general population; with only one-third having had no encounter with bullying. However, the study also found that children who have experienced adversity or other challenges were often bullied because of these experiences. Furthermore, social exclusion and rejection was significantly higher, with those who were victimised (victims or bully-victims) significantly more likely to be rejected by peers, and those who were actively involved in bullying (bullies or bully-victims) significantly more likely to be excluded from school. On a combined measure of social exclusion (peer, school, other isolation etc) 100% of bully-victims, 96% of bullies and 83% of victims had experienced social exclusion. Also of relevance to justice, is that 'system' exclusion was a common feature, with exclusion arising from the sometimes highly restrictive conditions imposed to manage potential risk. Examples include: children who were not officially excluded from school, but educated in isolation; conditions of bail or other orders, making social contact almost impossible; and restrictions imposed by concerned parents, carers or professionals.

Practice Implications

Respect for All is the Scottish Government's national approach to preventing and dealing with bullying behaviour in children. It provides a holistic framework for all adults working with children and young people to address all aspects of bullying, including prejudice-based bullying. Respect for All reflects Getting it Right for Every Child (GIRFEC) and recognises that bullying impacts on wellbeing.

The framework sets out the values and principles that local and organisational policies should include. It is important to ensure that the ethos of anti-bullying is embedded in day-to-day practices that are in step with Respect for All. The message that bullying is never acceptable is always prevalent and continuously and consistently reinforced in all organisational policies and practices. Policies should also: include a definition of what bullying is; provide a clear statement that bullying is a breach of a child's rights under the United Nations Convention on the Rights of the Child (UNCRC); outline expectations and codes of behaviour; and outline strategies for addressing bullying behaviour, including listening to the views of children and parents/carers.

The framework also provides information about the key principles to guide a response to individual instances of bullying and sources of training to support professionals. Respect for All notes that bullying takes place in the context of relationships. Promoting respectful relationships, repairing relationships where appropriate, and ensuring we respond to all forms of prejudice, will help create an environment where bullying cannot thrive. There are a range of strategies and programmes being used throughout Scotland that can improve relationships and behaviour, promote equality and challenge inequality, and develop emotional wellbeing to help prevent and address bullying. These focus on:

- Anti-bullying professional learning
- Recognising and realising children's rights
- Restorative approaches
- Creating inclusive and supportive learning environments

- Solution oriented approaches
- Nurturing approaches
- Mentoring and peer support (including Mentors in Violence Prevention [MVP])

More guidance and resources for responding to bullying behaviour and anti-bullying practices are available on the respect:*me* website.

2.4 Poverty and Inequality

The UN Special Rapporteur on extreme poverty and human rights visited the UK in November 2018, and observed that despite having the fifth biggest economy in the world, political and ideological decisions and policies in the past ten years have led to an increase in child poverty. Despite acknowledging the attempts of the devolved governments to mitigate austerity policies, and that Scotland has the lowest levels of child poverty in the UK (Rogers, 2019) child poverty still remains a widespread problem in Scotland. Despite a slight reduction in child poverty in the most recent statistics, around one-quarter of all children (23%) are living in relative poverty and one-fifth (19%) are living in absolute poverty (Scottish Government, 2023); around one-in-nine children (11%) are deemed to be living in severe poverty.

Relative poverty is a measure of whether incomes in the poorest households are keeping pace with middle income households across the UK - it is set at 60% of UK median income (after housing costs). Severe poverty is set at below 50% of UK median income, after housing costs. Absolute poverty is a measure of whether the incomes of the poorest households are keeping pace with inflation; itis based on a fixed poverty threshold - currently 60% of the (inflation-adjusted) median income in 2010/11 (the base year).
Child poverty is important not just as an indicator of immediate societal and child wellbeing, but there is also a strong association between family poverty experienced in childhood and later health, social and behavioural outcomes extending into adulthood (Chaudry & Wimer, 2016; Wickham et al., 2016). This clearly has implications for justice, although it should be noted that the majority of children growing up in deprived circumstances do not go on to develop behavioural problems or engage in criminality (Bøe et al., 2012). Indeed they are far more likely to become the victims, rather than perpetrators of crime (Webster & Kingston, 2014). However, in a study drawing on data from the 'Edinburgh Study of Youth Transitions and Crime', McAra and McVie (2016) found that violence at age 13 is strongly associated with gender and poverty at both the household and local community levels. Being male, having low socioeconomic status, and living in a poor neighbourhood were all associated with violence at age 13, and these associations held true even when other factors (positive or negative) such as previous victimisation or the relationship with school were controlled for. McAra and McVie also found that girls living in poverty were at an enhanced risk of violence and poor outcomes, although the overall risk was lower than for boys. Similarly, a snapshot of boys and young men (aged 16-21) in HMP&YOI Polmont found that 56% were from the most deprived 20% of communities in Scotland (Youth Justice Improvement Board, 2018).

There are a number of hypothesised mechanisms for this association, including that, as a result of inequality and marginalisation in society, crime can provide young people with status or material goods that would otherwise be unattainable (Kingston & Webster, 2015). Many other hypotheses stress a more indirect route between poverty and crime, one that arises from adverse factors (familial, individual, school, community etc) in childhood that are associated with poverty (Webster & Kingston, 2014). For example, health and social

inequalities mean that children born into the lowest income households in Scotland have, by the age of ten, a significantly greater risk of a parent dying than those born into the highest income households (Paul & Vaswani, 2020). However, evidence from the Growing Up in Scotland longitudinal study suggests that poverty can cause direct stress and distress to children, as well as indirectly affecting children's outcomes by increasing family stress, which in turn, can compromise parenting and family wellbeing (Sosu & Schmidt, 2017). To add to this, the Covid-19 pandemic has exacerbated these health and social inequalities and highlighted how they can cause extreme stress on more disadvantaged children and their families.

However, there are structural and potentially discriminatory factors at play here too. For example, McAra and McVie (2005) found that a factor in arrest is whether there has been police contact previously (suggesting an element of labelling based on gender and 'class'), but more importantly, that children who were from the lowest socioeconomic households were significantly more likely to be charged by the police than those who were not, for the same sorts of behaviours (McAra & McVie, 2015). They also found that children who were affected by poverty were also more likely to come into contact with formal systems and processes, even after controlling for a range of other factors. The perpetuating nature of this system contact led them to conclude that "the youth and adult criminal justice systems appear to punish the poor and reproduce the very conditions that entrench people in poverty and make violence more likely" (2015, p. 5).

Practice Implications

Addressing poverty and inequality is important for justice. Webster and Kingston (2014) report that if UK inequality was reduced to the median level seen in the developed OECD countries, a more equal UK could expect 37% fewer people being imprisoned each year (saving £1 billion), and 33% fewer murders each year (saving £678 million). An effective approach to addressing any link between poverty and offending will need to be a multi-faceted one, that combines population-level change in factors such as unemployment, family income and housing, with targeted interventions designed to meet the needs of at-risk children and their families who are disproportionately represented in poorer socioeconomic groups (Fergusson et al., 2004). However, it will be important not to label and stigmatise children and families simply because of their socioeconomic status, especially as this could lead to them being unnecessarily caught up in formal systems (Gillon, 2018; McAra & McVie, 2015). Universal approaches and interventions that focus on inclusion as a means of prevention should prove useful (Gillon, 2020). The British Association of Social Workers (BASW and CWIP, 2019) has produced a practice guide for anti-poverty practice and What Works Scotland have collated resources relating to community and local authority approaches to tackling poverty.

3. Trauma and Developmental Trauma

Trauma is defined as "… an event, series of events, or set of circumstances experienced by an individual as physically or emotionally harmful or life-threatening with lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being." (SAMHSA, 2015). 'Type 1' trauma is often a single-incident trauma which is unexpected and comes out of the blue. Examples include: a car accident; a physical or

sexual assault; a natural disaster or fire; diagnosis of a serious illness; witnessing violence; a traumatic loss. Type 2 trauma (also known as Developmental or Complex Trauma) is trauma that occurs repeatedly, often during childhood. Examples include: physical, emotional and sexual abuse; neglect; domestic violence; bullying etc.

Post-Traumatic Stress Disorder (PTSD) is a diagnostic category characterised by a collection of symptoms, including: intrusive thoughts; flashbacks; sleep disturbance; avoidance of stimuli associated with the trauma; psychological and physiological reactions to triggers; negative alterations in cognition or mood, such as dissociation, emotional numbing, fear and detachment; and alterations in arousal and activity, such as hypervigilance, anger and risky behaviour (American Psychiatric Association, 2013). There are added complications for individuals who experience developmental or complex trauma, who are at greater risk of suffering long-lasting effects of trauma, compared to those who first encounter trauma in adulthood or children who experience a one-off traumatic event in the context of an otherwise secure childhood. The inability to escape trauma by virtue of the child's powerlessness and dependency, as well as the disruption that trauma has on the child's developing brain, their subsequent world-view and template for life, love, attachment and relationships (Herman, 1992; Perry & Szalavitz, 2017), arguably leaves a lasting legacy.

It is important to note that adversity is not synonymous with trauma. Every individual will experience adversity differently, and not all adverse experiences will lead to a child becoming traumatised. However, by definition, trauma will always adversely affect a child, at least in the short-term, although this does not preclude the potential for the development of resilience and post-traumatic growth, following trauma, if the right conditions are present (Meyerson et al., 2011).

Trauma is relevant to youth justice practice, as traumatic experiences are over-represented in the justice population (Dierkhising et al., 2013). Research from the US and Canada suggests that PTSD occurs in approximately 4% of the general public, but reaches up to 48% in prison populations (Briere et al., 2016). Not only do people enter the justice system with higher levels of trauma, contact with the justice system, loss of liberty and the custodial environment can be both re-traumatising and traumatic experiences in their own right (Gooch, 2016; Vaswani & Paul, 2019). Environmental factors include: bright lights; noise; crowded conditions (or solitary confinement); uniforms; violence (the threat of, as well as direct experience); witnessing distress and self-harm; bullying; and rapid withdrawal from substances. Trauma symptoms such as hyper-arousal, impulsivity, anger, self-regulation, withdrawal etc. may be misinterpreted as poor behaviour and, if unaddressed, may directly result in risky or offending behaviours and increase the risk of exposure to new traumatic events (Ardino, 2012; Vaswani et al., 2016).

Practice Implications

Increasing awareness of the prevalence of ACEs and trauma among the population has led to a greater emphasis on trauma-informed practice. Trauma-informed practice can be defined as: individual or organisational practice that understands the prevalence and impact of trauma; that recognises the signs and symptoms of trauma; that responds to this knowledge by revising policies, practices and procedures accordingly; and endeavours to ensure that the response from services or systems does not re-traumatise individuals (SAMHSA, 2014).

In Scotland, NHS Education for Scotland (NES) produced a knowledge and skills framework called *Transforming Psychological Trauma* (NHS Education for Scotland, 2017). Aimed at the entire Scottish workforce, the framework is split into four tiers depending upon the nature, setting and context of the role. This ranges from 'trauma-informed', which is simply the baseline awareness and skills that are required by everyone, to 'trauma specialist' for professionals who play a specialist role in providing therapies or interventions to people affected by trauma. Much of youth justice practice will take place at the middle two tiers, in particular the 'trauma enhanced' level.

The thinking behind such a blanket approach, is that widespread trauma-informed provision will acknowledge and minimise the negative effects of trauma, even when trauma is not known about, thereby reducing some of the barriers to engagement and help-seeking. At the same time, a more supportive and accessible environment will be provided to all, regardless of whether individuals have been exposed to traumatic events or not. In 2018, NES launched the Scottish Psychological Training Plan to help organisations implement *Transforming Psychological Trauma*. This framework provides guidance and planning tools to support:

- Workers, managers and organisations to identify their own trauma training needs with reference to the Trauma Framework
- Service managers and commissioners to develop or commission training to address the needs of their organisations and workers
- Training providers to develop and deliver high quality trauma training
- An understanding of key principles to bear in mind in developing and commissioning trauma training
- An understanding of organisational factors that will support and maintain the translation of training into practice.

These trauma plans and resources have been further developed into the National Trauma Transformation Programme. Trauma-informed practice rightly applies across every workplace, service and organisation. However, a note of caution is needed for justice and justice-related organisations and institutions, such as the police, prisons, courts and care systems. These are complex organisations, with specific and defined roles, and even with the best of intentions, these types of organisations may struggle to be truly trauma-informed within the confines of the current justice system and prison estate (Jewkes et al., 2019; Vaswani & Paul, 2019). Guiding principles of trauma recovery and trauma-informed practice include restoring safety, power, control, relationships, trust, intimacy, collaboration, autonomy and choice (Herman, 1992; SAMHSA, 2014). These principles are harder to achieve in certain settings, especially those with a punishment remit (Vaswani et al., 2021). For example, trauma recovery most effectively takes place within trusting and healing relationships once safety has been established (Herman, 1992) and social support has been found to be a critical success factor (Pettus-Davis, 2014; Van der Kolk, 2014). However, in many justice settings, individuals do not feel safe and are disconnected from their social support networks, or are placed in environments where establishing trust and intimacy is difficult, if not impossible.

Furthermore, individuals in justice settings (including in community-based justice) often have power and autonomy removed, with little or no control over the services they receive, the restrictions they face, or the staff they must engage with. While wider justice reform may be needed if true trauma-informed practice is to be achieved, this does not mean that significant

steps cannot be made in the meantime to better support and improve the experience of people with trauma who are caught up in these systems -even if the full criteria for trauma-informed practice is not met.

4. Resilience

While prevention of adversity is the ideal strategy, it is not realistic to remove all forms of adversity from a child's life. Furthermore, experiencing low levels of stress and adversity may help (in the right circumstances) prepare a child with the confidence, knowledge and skills to face stressful life events in the future (Cicchetti & Rogosch, 2009). Regardless of the adversity faced, resilience is a reoccurring theme in helping children deal with even very severe adversity (Masten, 2011). Resilience is defined as positive developmental outcomes in the face of adversity or stress (Luthar et al., 2003; Masten, 2011). Resilience research now recognises the importance of understanding not only the negative impact of adversity, but also the influences that promote positive adaptation or mitigate the effects of risk or adversity (Masten, 2018).

Resilience is now more frequently viewed as an outcome, rather than an individual personality trait (Chmitorz et al., 2018) - although personality type is one of the many factors that can help promote resilience. A systematic review of 30 resilience studies in children (Gartland et al., 2019) concluded that resilience is more of an ecological framework, with factors to foster resilience found within the individual, as well as within their family, school, social network, community and wider society/culture. Individual factors, included: gender; temperament; emotion regulation; cognitive skills; social skills; self-efficacy and self-esteem. Family and social support factors, included: feeling loved and cared for within the family; availability of social support outside of the family; and a positive relationship with an adult outside of the family. School factors, included: a supportive school community; school engagement; and positive relationships with teachers. Wider factors, included: high social cohesion; informal social control; and perceived community support. Research in the UK found that having an 'always available adult' during childhood, namely a trusted adult that could be relied upon to provide support, substantially mitigated the impact of ACEs (Bellis et al., 2017). Other factors relating to resilience and offending are summarised in the Scottish Government (2018) document *Understanding Childhood Adversity, Resilience and Crime*.

5. Policy Context and Legislation

The Scottish Government's ambition is to make Scotland the best place in the world to grow up. The National Performance Framework includes key high-level outcomes that are all relevant to achieving this aim. This includes an outcome specific to children and young people: "We grow up loved, safe and respected so that we realise our full potential", as well as more general outcomes such as: "We live in communities that are inclusive, empowered, resilient and safe"; "We are healthy and active"; and "We respect, protect and fulfil human rights and live free from discrimination."

The Scottish Government's Programme for Government in 2019/2020 outlined specific commitments aimed at reducing and responding to childhood adversity and disadvantage. These include, but were not limited to:

- **Reducing child poverty*:*** introducing a Scottish Child Payment and delivering a new Parental Employability Support service for low-income families
- **Children and young people with Additional Support Needs*:*** investing in additional frontline staff to support children and young people with Additional Support Needs (ASN) for learning.
- **Adverse Childhood Experiences:** there were four areas for action on Adverse Childhood Experiences (ACEs), which include: supporting parents, families and children to prevent ACEs; mitigating the negative impact of ACEs for children and young people; developing adversity and trauma-informed workforce and services; raising wider awareness about ACEs and supporting action across communities.
- **Child victims*:*** developing Scottish standards for the Barnahus (Bairns' Hoose) concept, forming a framework for a child-centred approach to delivering justice, care and recovery for children who have experienced trauma.
- **Mental health and wellbeing*:*** developing 24/7 crisis support for children and young people and their families; a new community wellbeing service enabling self-referral for children and young people; 350 additional school counsellors and an additional 80 Child and Adolescent Mental Health Services (CAMHS) staff.

The most recent Programme for Government (2023-2024) outlines a commitment to Equality, Opportunity and Community. Within this Programme for Government there are measures aimed at ameliorating child poverty, including the Scottish Child Payment and free bus travel for under 22s, as well as increased access to childcare to support families into education or work. There are also specific acknowledgements of the trauma involved in contact with the justice system, including: the implementation of the 'Bairns' Hoose Pathfinder phase' for child victims and witnesses (although not, as yet, for child accused); the launch of a new trauma informed knowledge and skills framework for the justice sector (again aimed at victims and witnesses, rather than those accused); and a focus on women's trauma-informed care in prison. There are also a number of existing or planned policy and legislative instruments focused on reducing adversity and promoting resilience, as well as helping to achieve the aims set out in this, and previous, Programmes for Government. These include, but are not limited to:

Getting it Right for Every Child (GIRFEC): It has been in place since 2006 and is central to all government policies which support children, young people and their families. GIRFEC includes actions focused on prevention and early intervention which cover a wide range of policy areas, including pregnancy and parenthood, family relationships, children's services and child protection. GIRFEC includes core principles and values which are now incorporated into Scottish legislation, policy, guidance and practice in respect of children and relevant adult services through the Children & Young People (Scotland) Act 2014.

UNCRC Incorporation: In 2019 the Scottish Government committed to incorporating the United Nations Convention on the Rights of the Child (UNCRC) into law to the maximum extent possible within the powers of the Scottish Parliament. As Deputy First Minister John Swinney announced, this means that "Every devolved body, every health board, every council and the Scottish Government itself will be legally obliged to make sure they respect children's rights. And, if they don't, children and young people will be able to use the courts to enforce their rights". The United Nations Convention on the Rights of the Child (Incorporation) (Scotland) Bill was passed unanimously by the Scottish Parliament in March 16, 2021. However, the UK Government highlighted issues pertaining to specific sections

19-21 and referred the Bill to the Supreme Court, which upheld the challenge in October 2021. The revised Bill was unanimously passed by the Scottish Parliament in December 2023 and received Royal Assent in January 2024. Most aspects of the Act will come into force in July 2024. More information on UNCRC and children's rights is available in Section 3.

The Child Protection Improvement Programme: Including the development of a National Child Abuse Prevention Plan and Framework and the establishment of a National Child Protection Leadership Group.

A Rights-Respecting Approach to Justice for Children and Young People: This is Scotland's vision for justice for children and young people, which builds on the previous strategy that ended in 2020. It sets out key priorities and outcomes that must be delivered to achieve the vision.

The Children (Scotland) Act 2020: This Act was enacted in 2020 and aims to improve the experience of children in family law cases, through actions such as the regulation of child contact centres and child welfare reporters and amended justice processes for children and families affected by domestic violence.

The Child Poverty (Scotland) Act 2017: This act enshrines in legislation a commitment to reduce child poverty, by setting four key family income targets to be achieved by 2030. The 'Tackling Child Poverty Delivery Plan 2018-2022' sets out the actions required by Government, health boards and local authorities to achieve these aims, with a focus on the three key drivers of poverty.

Respect for All: This is the Scottish Government's overarching framework for tackling bullying in Scotland. The framework is aimed at all individuals and organisations that are involved in the lives of children and is designed to support the implementation of a consistent and cohesive approach to bullying in Scotland. It is intended to guide the development of local policies and strategies, to effectively tackle bullying and build resilience, skills and capacity in children and those who support them.

Children and Young People's Mental Health Task Force: This independent review was jointly commissioned by the Scottish Government and COSLA in 2018. Its purpose being to explore how to improve the way children's mental health services are organised, commissioned and provided and how to make it easier for young people to access help and support when needed. The taskforce has called for transformational change in this area, with recommendations concerned with: leadership; a whole system approach towards mental health; increased investment in mental health services, including at the prevention and early intervention levels; and the role of the third sector in strategic partnerships.

Tackling Child Poverty Delivery Plan (2022-2026): This document sets out a vision and action plan for reducing child poverty in Scotland - including: supports for parents to enter, or re-enter work; providing support for parents to meet basic needs; and actions designed to help children develop and have successful post-school transitions.

More information on the policy and legislative context of youth justice is available in Section 1.

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