

**Age 2 to 18 –
Systems to protect children from severe disadvantage**

A report in 3 parts:

1. Review of systemic and methodological approaches to protect children from later life severe, multiple disadvantage
2. Case studies contributing to the findings
3. Transitions throughout childhood years – a resource to improve outcomes for children

'There can be no keener revelation of a society's soul than the way it treats its children'

Nelson Mandela (Nobel Peace Prize, 1993)

'There are many reasons why investing in disadvantaged young children has a high economic return. Early interventions for disadvantaged children promote schooling, raise the quality of the work force, enhance the productivity of schools, and reduce crime, teenage pregnancy and welfare dependency. They raise earnings and promote social attachment.'

James Heckman (Nobel Prize for Economic Sciences, 2000)

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Ita Walsh, June 2018

Key terms

Adverse Childhood Experiences (ACEs): the term developed by researchers Vincent Felitti and Robert Anda to describe specific experiences of childhood trauma, defined as ‘*intra-familial events or conditions causing chronic stress responses in the child’s immediate environment. These include notions of maltreatment and deviation from societal norms*’¹. These damaging traumatic experiences include: physical abuse; sexual abuse; emotional abuse; physical neglect; emotional neglect; witnessing domestic violence; substance abuse in the home; separation or divorce of parents; household member suffering mental illness; household member (usually parent) being incarcerated.

Trauma-informed care (TiC): a ‘*strengths-based service delivery approach grounded in an understanding of/responsiveness to the impact of trauma that: Emphasises physical, psychological and emotional safety for both providers and survivors; Creates opportunities for survivors to rebuild a sense of control and empowerment*’².

[Hopper, Bassuk, & Olivet, 2010, p.82]

Empathy: what we feel only when we can step outside ourselves and enter the internal world of another. There, without abandoning or losing our own perspective, we can experience the other’s emotions, conflicts or aspirations, from within the vantage point of their world. It is not telepathy but a ‘hard-wired’ capacity in all of us operating through what are called mirror neurons. Functional magnetic resonance imagery (fMRI) shows that regions of the brain involving both emotions and physical sensations light up when someone observes or becomes aware of another person’s pain or distress. Literally, we do feel another’s pain or other emotions³.

[Paraphrased extract from Douglas LaBier (US psychotherapist)]

FASD (Foetal Alcohol Spectrum Disorder): a lifelong, irreversible disability caused to the foetus by maternal alcohol consumption in pregnancy. It is likely to affect,

undiagnosed and untreated, 3+% of UK children, and severely compromises their outcomes, leading to elevated risks of later SMD.

Social Pedagogy: holistic, 'whole child', personal approach to working with children and young people. People, whatever their job titles, who work this way are described as pedagogues. Our European neighbours often apply it to a much broader set of services covering, for example, childcare and early years, youth work, parenting and family support services, secure units for young offenders, residential care and play work. In pedagogy, care and education meet. It is about raising children, and is 'education' in the broadest sense of that word, and also a foundational concept that informs many sorts of services, providing a distinctive approach to practice, training and policy. Crucially, the child is seen as a social being, connected to others and at the same time with their own distinctive experiences and knowledge.

[Paraphrased from the briefing paper 'Pedagogy – a holistic, personal approach to work with children and young people, across services' (Petrie et al, 2009)]⁴

Report structure

Executive summary, including top line legislative recommendations

Part 1: (main body of the report) structured around seven Key Messages relating to sets of separate conclusions, the first six of which appear sequentially as the background that formed the steps leading to our fundamental conclusions; the seventh summarises systems, approaches or methodologies identified as likely to bring about significant improvements in services to children and young people.

Part 2: Case Studies relevant to issues raised or covered in the report.

Part 3: Universal change in risk profiles pre- and post-age 11, followed by some of the most common (non-Universal), unpredictable transitions (e.g. into Care or being school-excluded) that, left unmitigated, can increase the risk of later life severe, multiple disadvantage and social exclusion.

Note about the research

Statistics underpinning many of our early conclusions were updated at least once and sometimes as many as three times in the course of this work. Further statistical updates were published after our report had been peer-reviewed. Therefore, while some of the detailed (e.g. UNICEF and PISA) statistics might be slightly out of date at the time of publication, there were no significant differences in trend that would alter our overall findings and recommendations.

The ground-breaking, sufficiently significant new information to delay publication were not so much in the routine updates but in, e.g.:

Recent studies and developments in ACE-awareness and quantification of mediating factors (2017), and growing interest in this around the UK, Ireland and the US, and Trauma-informed Care (TiC) (Key Messages IV and V); the section of the 2016 Commons Select Committee on Education focused on the parlous state of the UK Care system; the evidence on early education and care given to the House of Commons Science and Technology Committee on 20 March 2018 (selected extracts from the evidence of Professor Edward Melhuish are given in Key Message VI); and a May 2018 NHS report on alcohol consumption in England, including statistics on drinking habits of 11-15-year-old children.

Foreword

I embarked on the groundwork for this report following WAVE's 2014/15 global research project, funded by the LankellyChase Foundation, to identify (a) whole life course transitions and transits likely to increase the risk of severe and multiple disadvantage (SMD) and (b) systemic approaches to reduce such blights on lives. In this context, SMD is defined as the co-occurrence of two or more of: serious mental health problems; substance dependency; chronic unemployment; homelessness; anti-social behaviour; criminality.

Our initial 'broad brush' trawl for information spanned birth to 'older old age' and covered (inter alia) ethnic minorities, addiction/alcoholism, the mentally ill, asylum seekers, sex workers, street-dwelling former members of armed forces (likely to be suffering post-traumatic stress disorder (PTSD)), homelessness, and bereavement, especially suffered when elderly. Early research also included a formal Delphi Process (described below) and interviews with 40 adults already living in conditions of SMD. Any one of these groups and topics could warrant deeper research to underpin a specific report recommending improvements (or alternatives) to current UK systems.

Overwhelmingly, the evidence from our first two rounds of research pointed to SMD being rooted in adverse experiences in childhood. The Delphi Process identified two prime 'Adverse Childhood Experiences' (ACEs) as (i) maltreatment and (ii) family breakdown. We therefore agreed with LankellyChase that the most useful report would be one focusing on systems to protect children from the threat SMD, and identifying systems to equip them to fulfil their inherent promise. Although the grant had been exhausted in a combination of the initial global research and over a year of new, age 2 to 18 focused research, in mid-2016 I undertook to continue the research to enable me to write a childhood/systems-focused report. I did not expect it to take me until spring 2018 – or that so many exciting research findings and practice developments would occur over the ensuing 18+ months.

While c.60% of children cope well within the current education system, another 40% (and especially the most disadvantaged 15-20%) do not. This report is aimed at impacting policies for that significant 15-20% minority. Focused research into the 2-18 age group made it clear the key threats to human ability to thrive are *unmitigated* adverse experiences in childhood; happily, in March 2017, evidence was published to demonstrate that mental wellbeing from the impact of these experiences can be mitigated to the extent of reducing damage **by more than 50%**⁵ (Key Message IV).

Of identified mitigating factors, the one that best fosters successful development, despite even the worst circumstances, is resilience – the ability to bounce back from reversals, to find 'silver linings' in the darkest clouds of adversity, and successfully navigate the ups and downs of life. Resilience is an outcome built at the individual level in a trusting one-to-one relationship between a child and an available, accepting adult. This is also a key component of 'Trauma-informed Care' (TiC). It became clear that understanding ACEs, however enlightening, is of little more than academic value without the healing counter-balance of Trauma-informed Care (Key Message V). If we take note of this plus the opportunities inherent in Trauma-informed care, we might be able to reduce our current social problems (and costs) by as much as half.

New research also showed that the risk of poor outcomes for children lies less in the negative effects of being in any minority group than in being deprived of acceptance and

support for their individuality. The American Journal of Community Psychology reports that the key difference in outcomes for sound mental health (including sound levels of both self-acceptance and self-esteem) lies not in the circumstance of being ‘privileged’, ‘normal’ or ‘average’ but in the level of support and unconditional acceptance received from family (and friends, in the case of gender issues)⁶. When we receive nurturing love, support and acceptance as children, our opportunities to thrive happily and succeed are boundless. The obvious inference is that significant focus on educating and supporting parents plays a major role in improving outcomes for children (see especially Key Messages I, IV and V).

Our calculations show that the incidence of FASD (Foetal Alcohol Spectrum Disorder) endured by an estimated 3+% of the UK population has been an under-reported, insidious threat to normal development and, consequently, to social inclusion. Yet neither perinatal professionals nor Education and Health professionals are trained to detect this either at birth or in the most challenged/challenging 3 to 12-year-olds (the age range when it is most obvious and diagnosable).

Systems identified: the Executive Summary gives a brief overview of some promising approaches found within and outside the UK; Case Studies in Part 2, and Key Messages V and VII expand on these.

Reality check: We are aware many of the recommendations in this report appear to add to short-term costs, and that they are being proposed in an era of swingeing cost-cutting. In our direct and recent experience, the reality is that when public agencies within a local area agree to take transformative action, because it is simply the ‘right’ way to go, they collaborate across multiple agencies to unlock the funds for most or all of the necessary actions without adding to their existing combined budgets. Reallocation of funds can produce both payback on investment (as quantified by Public Health England’s ‘A Better Start for London’), and better future financial security for us all from vastly improved social outcomes and decreasing social dependency. We heard of one local area where 50% of their health and care budget was used up on 50 families, with the remainder spread over the other almost 20,000 families.

So the problem is not that we cannot afford better care for our children; rather those bearing the responsibility for this need to be convinced of the urgent need to depart from ‘silo’ working and embrace the opportunities of multi-agency collaboration, delivery-friendly structures, and sound methods – all set within a highly functional, evidence- or science-based, user-focused system. A multi-agency approach⁷ has the best chance of working in practice when local areas adopt an overarching, inter-agency budgetary framework (e.g. as practised in Highland Region) to ensure smooth implementation of policies, without pressure for delivery practitioners to choose between their ‘own’ jobs and collaborating with colleagues in other agencies to achieve optimal overall outcomes for service users (Key Message VII).

Neighbouring countries equally affected by current economic conditions have better child outcomes than we do in the UK, although some spend less on welfare⁸ (Case Study F: Netherlands). With public spending increasingly devolved to local areas, the most successful UK local authorities will be the open-minded ones willing to learn from the few who are already reducing social problems by effective, enlightened and economically viable practices – not by spending more, but by spending more wisely.

Ita Walsh

EXECUTIVE SUMMARY

Core conclusion: A national shift to a user-focused, trauma-informed care system characterised by ACE-awareness, followed by adoption of a pedagogical approach across all aspects of children and family services, would protect against severe, multiple disadvantage.

KEY MESSAGE I: Adverse Childhood Experiences are major causes of later life severe and multiple disadvantage

1. Childhood abuse, neglect and other ACEs are precursors of over 80 negative life outcomes. Unmitigated ACEs manifest as measurably increased risks for physical, mental and lifestyle disadvantages, including increased risks for addiction, cancer and degenerative organ disease (even after allowing for lifestyle-related effects⁹). Compared to those with no ACEs, those with 4+ are:

2 times more likely (currently) to binge drink and have a poor diet

3 times more likely to be a current smoker

5 times more likely to have had sex before they were 16

6 times more likely to have had, or caused, an unplanned teenage pregnancy

7 times more likely to have been involved in violence in the previous year

10 times more likely to have felt suicidal or self-harmed

11 times more likely to have used heroin/crack, or been incarcerated

6 ACEs increased ...

by 46 times: the risk of becoming an IV drug user, and

by 35 times: the risk of suicide

2. High-risk group: Foetal Alcohol Spectrum Disorder (FASD): 3+% of the population suffer lifelong disadvantage from the irreversible neurological damage of foetal alcohol spectrum disorder (Appendix I¹⁰ and Case Study A).
3. The vast majority of the prime root causes of mental illness are strongly associated with adverse experiences in childhood, e.g. almost 10 times more likely to have felt suicidal or self-harmed (Wales ACE report¹¹).
4. The Government Green Paper: *Transforming children and young people's mental health provision* fails to address its root causes.
5. ACEs are not the only contributory factors to later life SMD: school exclusion, bereavement and (outside 2 to 18 age range) end of employment were seen by the Delphi Process academics as significant contributors.

KEY MESSAGE II: Early symptoms of being on a pathway to severe, multiple disadvantage are visible in children who 'externalise' problems in e.g. social, emotional and behavioural disorder (SEBD), but less detectable in those who 'internalise' (including the disabled or neglected)

1. Both externalising and internalising children risk being unable to concentrate on school work.
2. A significant co-occurrence of social, emotional and behavioural disorder (SEBD) and Special Educational Needs (SEN) can be seen both in children who bully (externalising style) and those who endure it (internalising style).
3. Professor Richard Tremblay showed that by age 2-3, 17% of children are already 10 times more aggressive than the most peaceable 33%.
4. Practitioners agree most misbehaviour in school has its roots in the home.

5. 52% of young, and 40% of all, offenders had been permanently excluded from school; 32% had both truanted and been excluded¹².
6. Anecdotal reports suggest UK SEN statement reductions from 21% to 15.4% since 2010 could reflect the raising of 'need thresholds'.
7. High levels of UK school bullying can be significantly reduced (Case Study C).

KEY MESSAGE III: Parental dysfunction is a major cause of childhood ACEs; levels of youth and adult dysfunction are higher in the UK than other western European countries

Summary of UK dysfunction:

Our research shows:

1. Alcohol and drug consumption is very high among females.
2. Cocaine use is high among all age groups, including young parents.
3. A significant proportion of young parents are serving custodial sentences.
4. Violence conviction rates of 'non-adult' females are proportionally higher than for males.
5. A current dangerous cultural trend of combining alcohol and cocaine.
6. Under-age sex widely considered 'a normal part of growing up'.
7. Overall: we have very high levels of live births to teens:
 - a. c.4 x Netherlands and Denmark and more than double Germany's level;
 - b. births to 15-17 year-olds are c.6 x the level of Denmark and Netherlands;
 - c. births to teenagers in the most disadvantaged 10% of wards are 10 times higher than in the least disadvantaged.
8. Teenage mothers suffer high levels of postnatal depression, persisting for 3+ years, and there is also increased risk of accidental harm to their children.
9. OECD (2016) found England's youth had the lowest literacy levels and 2nd lowest (after the US) numeracy.
10. Levels of NEETs increased at a time when general unemployment was decreasing.
11. High levels of youth homelessness, including the 'hidden' homeless escaping adverse or toxic home environments.
12. UK inter-partner violence statistics are higher than any others available.

Also, a May 2018 NHS study of children's alcohol use in England¹³ showed that:

- 43% of boys and 46% of girls age 11 to 15 have drunk alcohol;
- 70% of children who drink are supplied by parents or guardians;
- 23% of 15-year-olds get drunk, sometimes 3 or 4 times in a 4-week period.

Parental dysfunction: (Table 1): In a 6-country comparison of 33 relevant measures, Netherlands had 11 'best' outcomes and no 'worsts'; the UK 12 'worsts' and no 'best'.

Portugal's drug law reform: Table 2 and Case study B, part 1, show:

- a. This led to better treatment of drug problems, reduced prison over-crowding, and increased arrests of traffickers and major dealers¹⁴.
- b. Decriminalisation produced dramatic reductions in drug-related health problems, and a decrease in drug-use uptake by 15-17-year-olds (the 'starting' age Portugal identified as predictive of future addiction). [A CASA study found 9 out of 10 adult addicts started using drugs before age 18, compared to 1 in 25 who started using at age 21+¹⁵.]

- c. Table 2 (drug consumption) scores the UK 8 'worsts' (highest of 7 countries) and no 'best'; Portugal scores 13 'bests' (including 2 equal) and no 'worst'.

KEY MESSAGE IV: Early damage from trauma can be significantly mitigated when a child is accepted unconditionally by a reliable, available adult. The 2017 Bellis study¹⁶ broke new ground by **quantifying** how effects of ACEs can be mitigated to reduce later life, health-harming behaviours and low mental wellbeing:

1. The effects of both ACEs and consistent adult support (AAA) far outweighed that of poverty in the development of harmful behaviour.
2. Presence of an AAA in childhood reduced by 50+% adverse effects on the mental wellbeing of those who had suffered 4 or more ACEs, i.e. an AAA has the highest impact among the most vulnerable group.

KEY MESSAGE V: Resilience is a key protective factor (or 'antidote') to ACEs that can be developed by adopting social pedagogical and trauma-informed approaches in social services, schools, criminal justice and other public services

1. Resilience definition: *Children need adults who believe in them unconditionally and hold them to the high expectations of being compassionate, generous, and creative; Children and young people live up or down to our expectations; [modelling] healthy resilience strategies for our children is more important than anything we say on the matter. Dr Ginsburg (author of the 7 Cs of resilience)¹⁷:*
2. An ACE-aware, Trauma-informed pedagogical approach to educating and caring for vulnerable children is widely recommended.
3. Effectiveness of Trauma-informed care: evidence includes initiatives across the United States and an (unnamed) UK 'special' school (Case Study A).
4. Senior police officers from Ayrshire, Derry/Londonderry and South Wales who attended WAVE workshops reported changes in their own behaviour and better job satisfaction, after adopting trauma-informed approaches.
5. Trauma-informed prison: Norway's prison officers are high status professionals, trained for 3 years (including in psychology) vs the UK's 12 weeks (and 7 days for some in charge of young offenders). Benefits accrue in reduced recidivism (Table 5).
6. Trauma-informed Communities are now thriving in many locations, yielding dramatic, measurable improvements in outcomes (Key Message V). Approaches vary with local resources, cultures and circumstances, yet all benefit from:
 - a. Networking and Cross-agency/cross-sector collaboration being the norm.
 - b. Initiatives building on strengths while addressing challenges.
 - c. The essential element of addressing trauma in the workforce.
 - d. Communities seamlessly combining education about trauma and resilience with prevention, treatment, support services and social justice.
7. Government advocates the necessity of physical activity for childhood wellbeing¹⁸, but a Unison study of 168 local authorities showed youth activity club numbers, staff and available hours are reducing radically.

KEY MESSAGE VI: With few exceptions, UK systems have not promoted good educational outcomes or resilience, or provided pedagogical or trauma-informed care

Absence of consistency across UK services: The level of variations between policies for systems, methods and structures across the UK appears to be making consistency of delivery very challenging for our local authorities, whereas the Netherlands, with far

more local bodies (408) quite autonomous Municipalities, seem able to follow consistent policies in e.g. children's social worker caseloads (16-17 vs UK 14.6-45).

Education in England: 2016 GCSE results were the worst since 2008; the OECD review placed England at the bottom of the 24 OECD countries measured; lacking educational qualifications is a common factor among the socially excluded; children at highest risk of educational failure are the school-excluded, those who have SEN statements, or are/have been, in Care, or are NEET.

These very disappointing results arise from earlier educational policies:

School-readiness: Public Health England's school-readiness study 'A Better Start for London' concluded that:

1. 2 in 5 lower SES children are not 'well parented'; support programmes impact positively mental wellbeing of parents as well as children; and that major benefits would accrue from investing in pre-school care and education.
2. A child's communication environment is a more dominant predictor of early language development than social background and, in turn, language proficiency is a key predictor of school success: *'Parenting in the early years has a greater influence on a child's life chances than education, wealth or class'*.
3. Professor Edward Melhuish (Oxford University) agreed with the PHE conclusions; adding that early year' education needs to focus on the softer rather than academic skills; and that government has 'missed a trick' in not specifying the exact type of support it funds to educate the most disadvantaged 2-4-year-olds (which he recommends would be best spent on programmes to help parents create a suitable 'home learning environment' for their children).
4. Save the Children estimates that if all children were reading well by age 11, GDP in England in 2020 could be an extra £23 billion¹⁹.
5. Countries where children begin *academic* education at a later age have very good outcomes. This might, in part, be impacted by monitoring from an early age – the EU ECEC recommendation is to monitor all children from birth.
6. Systemic failure of UK Corporate parenting:
 - a. The Eurochild National Surveys On Children In Alternative Care²⁰ found the statistics *'...provide clear evidence that children who have been in care – and in particular in residential care – are more likely to end up homeless; to commit crimes; to have children before the age of 20 themselves; and to have their own children taken into care'*.
 - b. A 2016 Commons Select Education Committee found (on mental health and wellbeing of looked-after children²¹) a plethora of adverse outcomes, including being: 4 times more likely than their non-looked-after peers to have a mental health condition and 5 times more likely to attempt suicide ... and to face significant 'bureaucratic' challenges in getting access to mental health support.
 - c. These findings echo Janet Boddy's *'Understanding permanence for looked-after children – a Review of research for the Care Inquiry' (2013)*²² and the 2012 'TACT' report, *'Looked After Children and Offending: Reducing Risk and Promoting Resilience'*²³.
 - d. **Shortage of social workers?** One major need for social workers arises from high levels of teen births.
 - e. Numerous studies point to two other key UK distinguishing features: (i) absence of training and ability in pedagogy in our Teaching, Care and Social Work professions; (ii) extreme nationwide variations in social worker case loads (ranging from 14.6 to 45).

- f. **Foster care:** As shown in the Bucharest study²⁴, even the most damaged children in family Foster care do much better than those in institutions, making extra support for institutionalised children vital²⁵.
- g. **Shortage of Trauma-informed care (TiC)** Trauma-informed care helps looked-after children; it also helps keep children from needing to enter Care²⁶. TiC is playing no major part in the current UK Care environment.
- h. **Social pedagogy** ('where education and care meet') is still a relatively unfamiliar term in the UK, despite being repeatedly recommended (especially for the Care system) for more than a decade²⁷.
- i. **Homelessness:** The estimated one million 'hidden homeless' will invariably also suffer other severe disadvantage (Part 3, homelessness).
- j. **Structural issues in local authorities:** Benefits of a flat organisation structure are described in Key Message VII and Case Study E.
- k. Services to the public are blighted by a flawed approach that counts transactions and outputs instead of outcomes, and compounds the error by measuring speed of transaction-response rather than successful incidences of meeting the needs of service users²⁸.

In this context, Key Message V describes **Trauma Systems Therapy (TST):** A 2017 US evaluation study of this²⁹ found: *'As children's care teams implement TST, children demonstrate greater improvements in functioning, emotional regulation, and behavioral regulation and... increased placement stability...'*

KEY MESSAGE VII: A national shift to a user-focused, trauma-informed care system characterised by ACE-awareness, followed by adoption of a pedagogical approach across all aspects of children and family services, would protect against severe, multiple disadvantage.

Recent advances in ACE-aware, Trauma-informed Care

ACEs are of growing interest to senior civil servants, policy-makers and academics in Scotland, Wales and Northern Ireland, and in some local areas in England:

1. **The Welsh Government** has committed to prioritise attention to ACEs³⁰.
2. **NHS services in both Scotland and Northern Ireland** have organised major conferences to publicise recognising and tackling ACEs as a public health priority; NHS Scotland's summary paper³¹ after their November 2016 conference 'Polishing the Diamonds', included the conclusion: *'... Moving from a culture of blame, shame and punishment to one of understanding, nurturing and healing is fundamental for supporting individuals and families...'*
3. **The Scottish Government** has set up a high-level ACEs Community of Interest group, comprising Directorates of Health and Social Care, Learning, Population, Safer Communities and the Chief Medical Officer. Their 2017-18 Programme for Government committed to embedding a focus on preventing ACEs and, where they occur, addressing their negative impacts by supporting the resilience of children and adults in overcoming early life adversity.
4. **Both Scottish and Welsh NHS** promoted community understanding of ACEs by showing the ACE documentary 'Resilience' to local areas around their countries³².
5. **Northern Ireland NHS** has set up, jointly with the **Republic of Ireland**, a 4-year Multiple ACE (MACE) project³³ to *'transform the lives of vulnerable children and families at risk from multiple adversities in their lives, by identifying ACEs, intervening early and providing nurturing support within their own homes and communities.'*

6. Although **England** was the last of the 4 UK countries to develop strong interest in ACEs, Public Health England is now engaged³⁴, and the Borough of Blackburn with Darwen has led in establishing a vision to reduce the number of ACEs experienced by local people, and build the resilience of those who already have³⁵.
7. **Social pedagogy**: BAs and MAs are now offered in a number of UK universities, and UCL has a Centre for Understanding Social Pedagogy (CUSP)³⁶. The Centre plans to develop national occupational standards, professional qualifications and a Social Pedagogy Professional Association (SPPA), and will develop and disseminate high quality social pedagogy training across the UK (Key Message VII).
8. **'Putting Children First' (PCF)**³⁷: This 2016 government major restructuring initiative, based on 3 pillars of social work reform (People and leadership; Practice and systems; Governance and accountability), is intended to replace the unpopular ICS and is being trialled in 8 local authorities (Key Message VI).

SPECIFIC LEGISLATIVE RECOMMENDATIONS

1. **Make pedagogic, ACE-aware, Trauma-informed Care** a national priority.
2. **Age 2-4**: Specify exact nature of support Government is paying for in targeting the 40% most disadvantaged families; this support will yield 'high quality' results if focused on helping parents create a suitable home learning environment for teaching their 2-4 year-old children (Key Message VI).
3. **Age 3**: The significant link between 'externalising' problems (e.g. temper tantrums; daytime enuresis; soiling) and adult criminality³⁸ points to a clear need to deliver prevention programmes during pre-school³⁹, when behaviour is predictive of later criminality (Key Message II).
4. **Care**: Overhaul present system to become a more professionally qualified, ACE-aware and Trauma-informed service for traumatised children; and also:
5. Overhaul CAMHS so it cannot use a looked-after child's lack of permanence of place as a reason to deny support for mental health (Key Message VI).
6. **Education (general)**: See above and Case Studies on Finland and Netherlands for recommendations.
7. **School exclusion**: Replace both the stigmatising term and the practice with a trauma-informed approach to support schools with all children.
8. **All age groups**: Assess for ACEs children exhibiting learning or behavioural problems, and ensure support systems are in place (e.g. Nurture Groups or suitable alternative education provision). (Key Messages IV and VII).
9. **Births to teens**: focus efforts on the disadvantaged wards that have 10x the levels found in the non-disadvantaged.
10. **Age of criminalisation**: Increase from age 10 to the more general age 14 (Part 3, Transitions into Gangs and Youth justice).
11. **Youth justice**: Transform custody to places equipped to enable young people to reintegrate into society – including vastly improved staff training (currently can be as little as 7 days). Youth reoffending is 72% one year after release.
12. **Homelessness** (Key Message VII and Part 3, Transition into homelessness):
 - a. Adopt the proposition in Homelessness Reduction bill to introduce to England the (2014) Welsh-type homelessness reduction framework (the first UK *preventive* programme for homelessness).
 - b. Prioritise identifying and helping 'hidden' homeless teenagers, afraid either to return home or to feel at the mercy of adult hostel residents.
 - c. Heed the informed advice provided by Centrepoin.
 - d. Study Finland's experience of Housing First and the UK trials of it.

- e. Compare outcomes of Housing First and Social Bite for ideas on ways to help homeless children and young people, especially runaways.
13. **Local authority organisation structures:** Guarantee inter-agency collaborative working by rewarding it at individual levels (Case Study E).
14. End local authority 'silo' culture by adopting the transformative whole Council approach of **Bridgend** (Case Study D).
15. **UK police forces:** Provide senior officers with training in understanding trauma-informed approaches, to pass on and ensure all officers in contact with the young can identify when care rather than being criminalised is appropriate.
16. **Problem substance use among the young:**⁴⁰ Work with parents, police, schools and youth organisations to end the appalling levels of childhood drunkenness recently reported by the NHS; see Case Study H for how **Iceland** reduced this dangerous problem by 90+% in 17 years, including significant, measurable reductions in the first 2-3 years.

Recommended systems from other countries

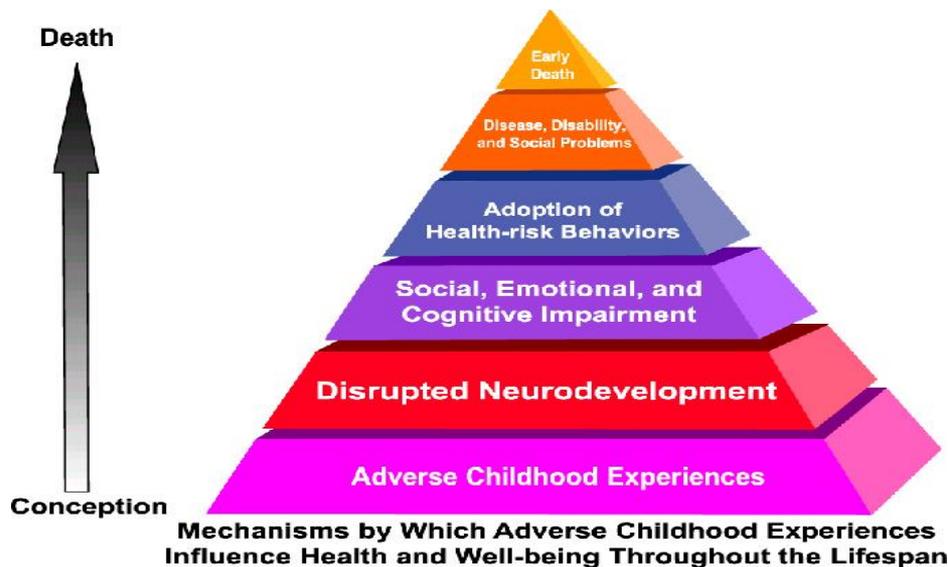
- a. Case studies B and F-H summarise major features of systems from Portugal, Netherlands, Finland and Iceland, all of which are recommended for close attention. Although without a Case Study, **Norway** is also included, to explain and recommend a prison system that leads to low recidivism.
- b. The **Portuguese** system relates solely to drug use and how decriminalising it not only reduced its uptake among the young but also reduced prison overcrowding (from 140% to 101% of capacity). The adoption of a policy that so significantly reduces the 'parental incarceration' ACE must be worthy of consideration in a system designed to reduce SMD (Case Study B).
- c. **The Netherlands**, while not perfect, does model a very promising 'whole country' system, in education, work ethic, social care (including for mothers of new-borns and looked-after children) and integration of immigrant populations. It is characterised by the same mixture of national and local policy-making as the UK, yet its outcomes in child happiness, youth behaviour, teen pregnancy and education are far better (Case Study F).
- d. **Finland's** holistic approach to education and health resulted in educational outcomes that became famed as 'the envy of the world'. Although a relatively poor country, Finland also claims to have eradicated begging and (street) homelessness (Case Study G).
- e. **Norway:** Potential benefits of adopting their 'integrative punishment' style: reducing 2 and 4-year recidivism from 51.4% and 74.2% respectively to 22.6% and 39.2% (Key Message VII). Here again, a move away from 'segregation, punitive' that reduces recidivism would also reduce the ACE of a 'parent incarcerated'.
- f. In under 2 decades, **Iceland** transformed its unruly youth from some of the hardest drinking European teenagers to top of the 'cleanest living teenagers' league table: smoking, alcohol and drug use was reduced by 90+% in the 17 years from 1998 to 2015 (Case Study H).

PART I – KEY MESSAGES

KEY MESSAGE I: Adverse Childhood Experiences (ACEs) are major causes of later life severe and multiple disadvantage

Childhood abuse, neglect and other ACEs (defined in Terms section above) are precursors of more than 80 negative life outcomes. Over 50 academic studies identify a dose-responsive relationship⁴¹, at group level, between numbers of ACEs and adverse outcomes. Unmitigated ACEs start a relentless progression of lifetime disadvantages. These manifest as measurably increased risks for physical, mental and lifestyle disadvantages, including increased risks for addiction, cancer and heart, lung and liver disease (after allowing for lifestyle-related effects⁴²). They form key threats for lifelong dysfunction, including inter-generational cycles of Low self-esteem, resilience and empathy; providing fertile ground for:

- Childhood antisocial behaviour, including bullying (perpetrated or suffered);
- Substance dependency and mental/emotional health problems;
- Low educational and employment achievements, and later
- Poor parenting practices, and consequent:
 - Absence of childhood resilience, leading to:
 - Social dependency, exclusion and repeated cycles of:
 - Adverse Childhood Experiences.

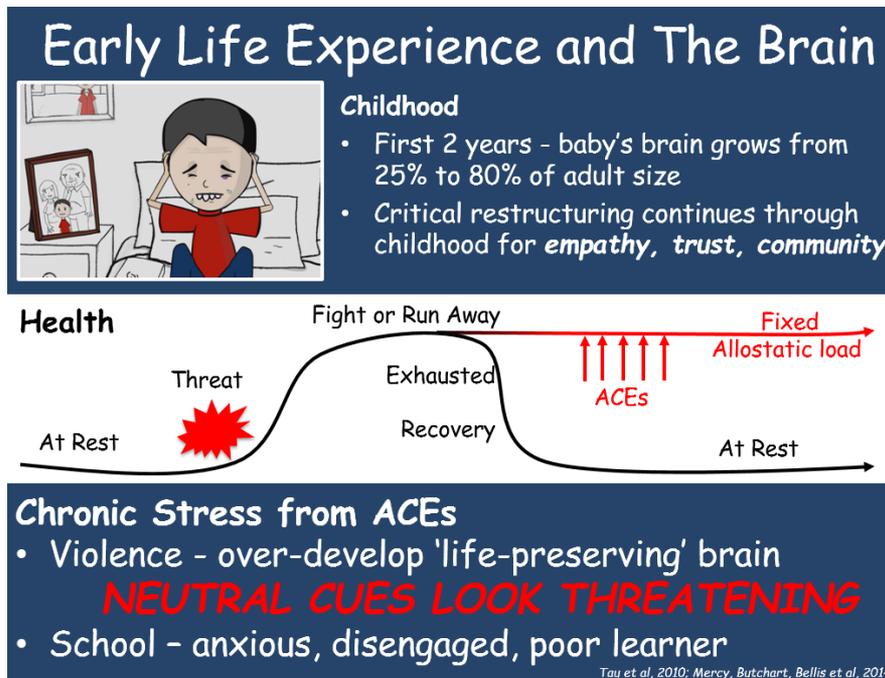


ACEs are also of concern because they can:

- Alter the structure of a developing brain by the impact of chronic traumatic stress.
- Increase the body's 'allostatic load' – wear and tear through fluctuating or heightened neural or neuroendocrine responses.
- Directly impact a child's health e.g. through inflicted physical injury.
- Normalise such behaviours as violence, assault and abuse.
- Result in behaviours offering short-term relief at the expense of longer-term health (e.g. smoking, harmful alcohol or drug consumption, poor diets and early sexual activity).
- Increase risk of transmission to the next generation – the intergenerational cycle.

Outcomes of Adverse Childhood Experiences

The point about allostatic load is demonstrated in the diagram below (with thanks to Professor Mark Bellis):



The higher the number of (unmitigated) ACEs, the worse the later life outcomes. The latest research of Bellis⁴³ shows how these effects can be mitigated by the consistent support of a trusted Always Available Adult (what he terms an 'AAA'). This and the key protective factor of resilience are covered in Key Message IV below.

The Bellis findings are supported by the 'experts by experience' interviewed: when asked what might be the single thing to have helped them deal better with harrowing early experiences, the consistent answer was: 'Someone who believed in me.'

ACEs increase risk of developing health-harming behaviours

Compared to those with no ACEs, those with 4+ ACEs are:

- 2 times more likely (currently) to binge drink and have a poor diet
- 3 times more likely to be a current smoker
- 5 times more likely to have had sex before they were 16
- 6 times more likely to have had, or caused, an unplanned teenage pregnancy
- 7 times more likely to have been involved in violence in the previous year
- 10 times more likely to have felt suicidal or self-harmed
- 11 times more likely to have used heroin/crack, or been incarcerated

6 ACEs increased ...

- by 46 times: the risk of becoming an IV drug user, and
- by 35 times: the risk of suicide

There is also an impact on criminal offending, homelessness and parenting (having suffered ACEs contributes to the intergenerational cycle of disadvantage):

- 68%⁴⁴ of prisoners were abused in childhood.
- Of incarcerated 15-21-year olds, 39% of females are estimated to be mothers. 25% of males are estimated to be fathers⁴⁵.
- A high proportion of young homeless are fleeing family violence or conflict.

The most recent and reliable (in terms of ethnic spread) assessment by Professor Mark Bellis et al of the impact of ACEs was in Wales in 2016⁴⁶, showing 14% of the population had suffered 4 or more ACEs. These figures are based on data collected only from households, and exclude those in prison, the military services, the homeless or those with no fixed address, and are, by definition, an understatement.

US studies⁴⁷ found people with 6 or more ACEs die 20 years younger than those with none.

Meta-analysis findings published in the Lancet (August 2017)⁴⁸, based on 2016 data and funded by the Welsh Government, concluded multiple ACEs to be a major risk factor for many health conditions. Effects were:

- Strong: for sexual risk-taking, mental ill health, and problematic alcohol use;
- Strongest: for problematic drug use and interpersonal and self-directed violence.
- The outcomes most strongly associated with multiple [4 or more] ACEs also represent ACE risks for the next generation (e.g. violence, mental illness, and substance use).
- *'Improvements in public health requires a shift in focus to include prevention of ACEs, resilience building, and ACE-informed service provision.'*

ACEs by another name and youth drug dependency issues

The *Young people's statistics from the National Drug Treatment Monitoring System (NDTMS) 1st April 2015 to 31st March 2016* provides evidence from a perspective other than ACEs, that it calls '**problems or vulnerabilities**', e.g.:

*'The majority of young people presenting to specialist substance misuse services have other problems or vulnerabilities related to their substance use (such as having mental health problems, being 'looked after' [or not being NEET])...'*⁴⁹

Academic experts: As mentioned above, we were advised in a Delphi Process by a panel of 14 academic experts¹ on severe and multiple disadvantage.

¹The Delphi Process (and its 14 participating academic experts)

The Delphi Process is an, iterative exercise to arrive at consensus on issues involving no peer-to-peer consultation. It was carried out in the first round of research when we conducted a broad sweep to explore the causes of SMD over the whole life course. The participants were:

Child & Adolescent Psychiatrist, Glasgow University; Scottish Centre for Crime and Justice Research (Former R&D Director, Revolving Doors); Sociologist/Researcher, City University London; Leader within BIG Scotland on Life Transitions; Chair of Mental Health Forum, Scottish Association of Social Workers (specialist in adult transitions); Chief Executive, Mental Health Foundation; Editor, International Journal of Housing Policy (co-author Multiple exclusion homelessness in UK); Policy Evidence Branch, Australian Department of Social Service; Deputy Director, Social Futures Institute, Teeside University; Director of Policy, Homeless Link (London); Throughcare and Aftercare Lead, CELCIS, Strathclyde University; Consultant Psychiatrist and NHS England Specialist Mental Health Clinical Reference Group; Professor of Sociology and Social Policy, Leeds University; Parents Project Manager, The Elfrida Society (London).

The closest Consensus among the Delphi experts was that ACEs (especially child maltreatment and family breakdown) were the most powerful triggers leading to SMD, with the most powerful influences those that most deeply undermine the sense of self-worth, resilience, personal efficacy and connectedness to others.

‘Experts by experience’: Intensive confidential interviews with 40 adults living with severe, multiple disadvantages, in the form of addiction, chronic unemployment, imprisonment and social dependency, all identified their present problems as being rooted in childhood, with multiple ACEs playing a major role along their pathways. Their significant childhood experiences had included severe physical, sexual or emotional (including all three) maltreatment, feeling unloved, unresolved trauma (including parental death or divorce), being in Care or abandoned, domestic violence, anger at learning they had been adopted, and feeling abandoned when foster/adoptive parents were violent.

One factor could encompass most (if not all) ACEs: the absence of a safe, secure and loving home, which so often makes the transition into youth homelessness (Key Message III and Part 3, Transition into homelessness) the final or confirmatory negative transition into severe, multiple disadvantage and social exclusion.

Non-ACE significant social factors: the formally listed ACEs were not the only factors Delphi Process academics identified as significant contributors to pathways leading to later life SMD. They included school exclusion (for any reason), bereavement and (outside the 2 to 18 age range) end of employment. They also drew a distinction between those who experience an intergenerational set of disadvantages from birth and those for whom SMD is a result of cumulative and multiple negative triggers and transitions later in life.

Other significant social factors: There are sound sources of support that can operate at both individual and national policy level to reduce the impact of ACEs:

Individual: adults who suffered extreme maltreatment in childhood later feeling fulfilled by supporting/mentoring others who are still suffering;

National: policy for health-based education (Case Study G); or to improve youth culture by diversion from substance abuse to wholesome activities (Case Study H).

High-risk group: Foetal Alcohol Spectrum Disorder (FASD): 3+% of the UK population suffer lifelong disadvantage from the irreversible neurological damage of foetal alcohol spectrum disorder (FASD) – an umbrella term for several diagnoses related to prenatal exposure to alcohol: Foetal Alcohol Syndrome (FAS); Partial Foetal Alcohol Syndrome (PFAS); Alcohol Related Neuro-developmental Disorder (ARND); Alcohol Related Birth Defects (ARBD); and Foetal Alcohol Effects (FAE). Any of these detailed diagnoses amounts to harm to the foetus arising solely from alcohol consumed by the mother when pregnant. Appendix I demonstrates why the oft-cited World Health Organisation figure of 1% of populations being affected by FASD is an underestimate derived, we think, from once popular, inexpensive methodological assessment methods now superseded by more comprehensive and reliable approaches.

The primary consequences of FASD include: hyperactivity; attention deficits; deficits in sustained and focused attention and cognitive flexibility; planning difficulties; learning and memory problems; new memories not consolidated; and difficulties with arithmetic, receptive language, verbal processing and social understanding⁵⁰. To keep a short

overview of a complex subject as simple as possible, Appendix I confines (or recalculates and translates) statistics to represent the FASD umbrella term. In any of its guises, this condition leads to very challenged and challenging children and teenagers.

Link between ACEs and mental health problems

Although root causes of such mental illnesses as FASD, ADD and ADHD can be physical, the majority of the prime root causes (Wales ACE report⁵¹) are strongly associated with ACEs. While the Government Green Paper on *‘Transforming children and young people’s mental health provision’* fails to address root causes as part of committing to prevention and early intervention in mental health, the April 2018 Home Office strategy on reducing serious violence⁵² does strongly acknowledge the importance of early prevention, intervention, ACEs and trauma-informed care in both policing and social justice.

Childhood abuse, neglect and other ACEs have been found to be precursors of:

- Anxiety disorders⁵³
- Behavioural problems⁵⁴
- ADHD diagnosis in middle childhood⁵⁵
- Externalising and internalising behaviours⁵⁶
- Bipolar disorder⁵⁷
- Childhood autobiographical memory disturbance (CAMD)⁵⁸
- Chronic mental health problems⁵⁹
- Depression⁶⁰,
- Lifetime and recent depressive symptoms⁶¹
- Depression in adulthood⁶²
- Dissociative amnesia⁶³
- Eating disorders⁶⁴
- Panic reactions, anxiety and hallucinations^{65,66}
- Personality disorders⁶⁷,
- Poor psychiatric outcomes in adulthood⁶⁸
- Post-traumatic stress disorder^{69,70}
- Psychoses⁷¹
- Rates of prescriptions⁷²
- Self-harm⁷³
- Suicide attempts^{74,75}
- Uncontrollable anger⁷⁶

Within the general topic of childhood root causes, there are distinct differences between the ways ‘externalising’ and ‘internalising’ children exhibit and react to early life difficulties. The following Key Message (II) explores this, and is intended to demonstrate why those charged with caring for or educating both externalising and internalising children need to understand the fundamental differences between the two behavioural styles.

KEY MESSAGE II: Early symptoms of being on a pathway to severe, multiple disadvantage are visible in children who ‘externalise’ problems in e.g. social, emotional and behavioural disorder (SEBD); less detectable in those who ‘internalise’ (including the disabled or neglected).

Externalising vs internalising children

Social, emotional and behavioural disorders manifest in various forms in mostly, but by no means always, male children who have an ‘externalising’ behaviour style (see Case Study A for a striking exception). A fairly high co-occurrence of social, emotional and behavioural disorder (SEBD) and having a Special Educational Needs (SEN) statement can be seen in both those who bully and those who endure it.

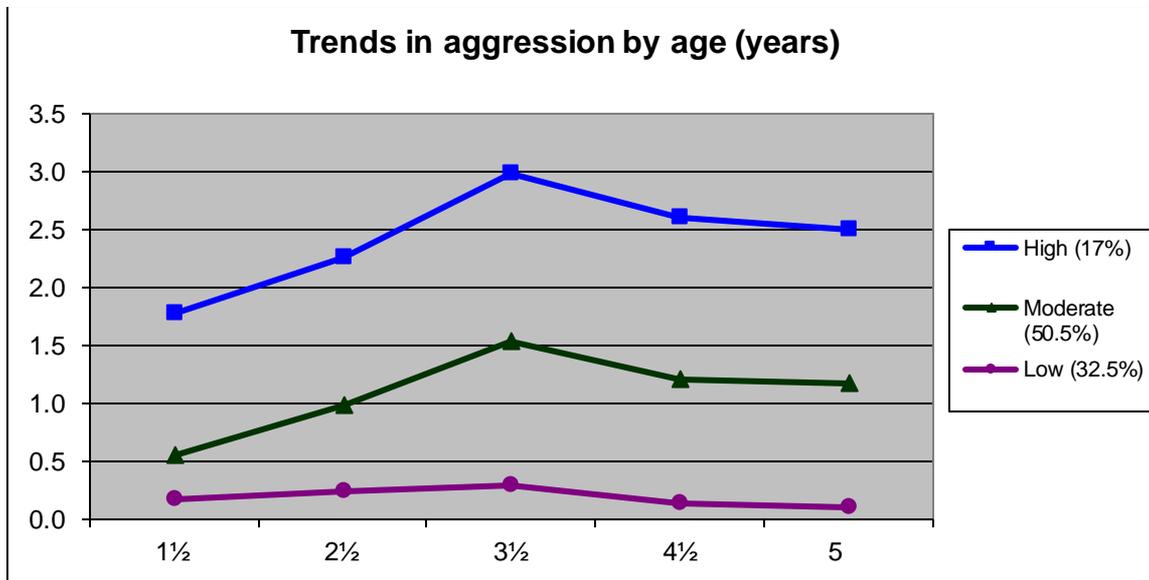
The Economics Nobel Laureate James Heckman outlines some visible ‘warning’ behavioural signals that a child might be on a dangerous life pathway: unruly /inattentive and disruptive behaviour in pre-school, lack of, or poverty in, early language ability, absence of school-readiness, lack of engagement at school, little or no interest in, or love of, learning, lack of such ‘soft’ skills as perseverance, sociability, emotional regulation or ability to defer gratification⁷⁷.

Outer signs include aggression and bullying, truancy, and a general set of very challenging behaviours that can lead to temporary or permanent school exclusion. In view of the symptoms of FASD outlined above (and in the appendix), it is reasonable to infer that a percentage of perhaps of the most aggressive and disruptive children are afflicted by the effects of some aspect of that condition. It also follows that those who are sufficiently informed to bear this risk in mind might, when faced with extremely challenging behaviour, find it more emotionally rewarding to tune into the empathy and compassion that drew them to working with children in the first place.

Misbehaviour is the prime cause of school exclusion: Teachers and social workers agree the majority of misbehaviour in school has its roots in the home. Yet, in light of this understanding and since such misbehaviour is a signal of some form of adverse childhood experience, it seems perverse for it to lead to school exclusion rather than support – especially since there are such ‘remedies’ as Nurture Groups. A Ministry of Justice survey found 52% of young offenders and 40% of all offenders had been permanently excluded from school, and 32% had both truanted and been excluded⁷⁸. It is difficult to comprehend how, in light of the knowledge of this particular root cause, society might choose to persist in penalising a child for the home environment that is the known cause, instead of taking a pragmatic and humane approach, including offering support to the parents.

Behaviour problems at age 3 and later life criminality: The British Journal of Psychiatry reported a significant link between ‘externalising’ problems at age 3 (e.g. temper tantrums; daytime enuresis; soiling) and adult criminality. *[References to studies arriving at similar conclusions are given in the BJPsych article⁷⁹]*

Another study, by Professor Richard Tremblay at the University of Montreal, shows that by age 2-3, 17% of children are already 10 times more aggressive than the most peaceable 33%. Misunderstood and unchecked, the risks of this early aggression include later life social exclusion.



Special Educational Needs and Education, Health and Care plans: UK children in receipt of SEN or EHC plans reduced from 21% to 15.4% since 2010. Anecdotal reports suggest the reductions reflect local authority spending cuts provoking the need to raise 'need thresholds' (rather than reduction in need resulting from free pre-school provision).

Finland: Until recent economic hardship forced cuts, the very 'equal' and health-focused Finnish education system enjoyed the lowest recorded gap between highest and lowest school achievers. This resulted from providing extra support for c.30% of children. Since needing to reduce that support, the educational outcomes that had made their system 'the envy of the world' have begun to slip a little, perhaps suggesting the UK's level of SEN support, at half that of Finland's, could be at least partly accountable for poor performances reported by OECD, PISA and Unicef.

It is also possible some UK children would be happier and better equipped for successful, independent lives if they received vocational rather than predominantly academic education. (Case Study F). The original Comprehensive system in England streamed children into 3 categories according to their performance on the national 11+ test, with the 'top' stream receiving Grammar school curricula, but without the vocational training option available today (just less demanding academic curricula).

The problem of school bullying

The serious problem of bullying in UK schools is covered in Part 2, Case Study C. Since it is quite often caused by conditions in the home, bullying or being bullied could qualify as an ACE under the heading of physical, mental or (sometimes) sexual abuse.

Moving on to Key Message III: Having set out to explain ACEs and their impact on life outcomes, we need to understand why so many UK children are badly afflicted by such blights. Although ACEs can be experienced at any age up to 18, and can result from adverse experiences at school and among peers, the worst and most significant adversity is suffered in the home, and then either 'acted out' or reinforced by circumstances and encounters outside the home.

KEY MESSAGE III: Parental dysfunction is a major cause of ACEs – and levels of UK youth and adult dysfunction are considerably higher than in other western European countries.

Table I: Cultural factors (UK vs Denmark, France, Germany, Italy & Netherlands)

FACTOR	UK*	DEN	FRA	GER	ITAL	NETH
DRUGS & ALCOHOL (17 FACTORS)						
		Green = best; red = worst box best or worst				
Adult Cigarette smoking (M) ⁸⁰	23.2	19.9	34.4	28.0	27.3	22.6
Child Cigarette smoking (M) ⁸¹	6.0	10.0	15	3.4	19.4	10.0
Adult Cigarette smoking (F) ⁸²	20.3	17.8	27.9	22.2	22.0	20.5
Child Cigarette smoking (F) ⁸³	9.0	10.0	14.0	5.2	21.6	12.0
Alcohol per capita (litres/annum) ⁸⁴	11.6	11.4	12.2	11.8	6.7	9.9
Heavy episodic drinking (age 15+) ⁸⁵	27.1	29.1	29.8	13.3	4.7	6.3
Heavy episodic drinking (age 15-19) ⁸⁶	40.5	42.7	48.5	50.6	20.3	50.2
Cannabis (15-64) lifetime % prevalence ⁸⁷	29.2	35.6	40.9	23.1	31.9	24.1
Cannabis (15-24) lifetime % prevalence ⁸⁸	31.0	41.5	46.7	27.8	31.0	31.2
Cocaine (15-64) lifetime % prevalence ⁸⁹	9.8	5.2	5.4	3.4	7.6	5.1
Cocaine (15-24) lifetime % prevalence ⁹⁰	10.2	5.7	5.1	2.1	1.8	3.7
Amphetamine (15-64) % prevalence ⁹¹	10.3	6.6	2.2	3.1	2.8	4.4
Amphetamine (15-24) % prevalence ⁹²	6.8	5.7	2.3	3.7	0.9	4.5
Ecstasy (15-64) lifetime % prevalence ⁹³	9.2	2.3	4.2	2.7	3.1	7.4
Ecstasy (15-24) lifetime % prevalence ⁹⁴	10.2	3.2	5.6	2.5	1.9	8.8
LSD (15-64) lifetime % prevalence ⁹⁵	4.7	1.4(j)	2.5	2.2	2.2	1.4(j)
LSD (15-24) lifetime % prevalence ⁹⁶	2.3	1.0	2.6	1.0	0.8	0.9
HEALTH/WELLBEING (6)						
Ischemic heart disease deaths per 100k ⁹⁷	98.0	71.0	43.0	115.0	84.0	50.0
Liver cirrhosis deaths per 100k (M) ⁹⁸	16.0	20.2	16.4	18.8	10.9	5.7
Liver cirrhosis deaths per 100k (F) ⁹⁹	8.0	8.9	5.2	7.8	4.7	2.5
Adult obesity % of population (M) ¹⁰⁰	26.2	20.7	22.0	21.9	21.4	18.4
Adult obesity % of population (F) ¹⁰¹	28.4	17.4	21.9	20.3	21.6	18.8
Suicides per 100k (2012) ¹⁰²	7.0	11.2	15.8	13.0	6.4	10.0
OTHER SOCIAL FACTORS (10)						
% early leavers from education/training ¹⁰³	15.0	9.6	12.0	11.5	18.2	9.1
Unemployment % of total (2014) ¹⁰⁴	7.3	7.0	10.9	5.3	12.6	7.2
Low young adult literacy (age 16-24)	c.28%	c.16%	c.22%	c.18%	c.32%	c.9%
Low older adult literacy (age 24-55)	c.29%	c.29%	c.48%	c.30%	c.52%	c.27%
% 15-24 year old NEETS (2014) ¹⁰⁵	11.9	5.8	10.7	6.4	22.1	5.0
% 15-29 year old NEETS (2016) ¹⁰⁶	13.9	10.0	29.2	21.3	34.0	12.7
Live births to 15-19s per 1000 (2014) ¹⁰⁷	14	4(j)	9	6	6	4(j)
Live births to 15-17s per 1000 (2014) ¹⁰⁸	6.8	1.1	4.4	3.6	2.4	1.3
% Children Truanting in 2 week period ¹⁰⁹	25	17	11	9	5.5	5
Offenders per 100,000 inhabitants ¹¹⁰	183.3	92.5	130.2	96.4	126.0	92.0
Total 'Worsts' count	12	2	8	2	9	0 = 33
'Bests' include 2 joint scores (j)	0	8	2	6	8	11 = 35
Aggregate of 'bests' minus 'worsts	-12	+6	-6	+4	-1	+11

NB: statistics for drug use are broken down between male and female in Table 2 below.

* UK = England and Wales wherever a definition is provided. Some statistics included Scotland and/or Northern Ireland; generally just 'UK' was quoted.

Besides the exceptional rate of births to teenagers, perhaps the statistic of most concern is the level of UK cocaine use (almost double the next 'worst' of the 6 countries, especially among the 15-24 age group), often accompanying, or following, a bout of heavy drinking – the most 'combustible' and potentially violence-provoking combination among alcohol/drug imbibing populations.

Table 2 below and Case study B, part I, show Portugal's drug law reform led not to a worse drug problem but to better treatment of it, reduced prison over-crowding, and increased criminal justice time for catching traffickers and major dealers¹¹¹.

Portugal's drug law reform

Although lack of comparable non-drug data meant omitting Portugal from our comparison in Table I, we had carried out enough research to be intrigued by their very low drug usage statistics, and investigate further:

Table 2: Comparison of drug use (at age 15-24) in 7 countries

CANNABIS	Year	Sample Size	Males	Females	Total
Denmark	2013	1723	45.3	38.5	41.5
France	2014	2006	51.6	41.8	46.7
Germany	2012	2142	31.5	23.9	27.8
Italy	2014	1223	32.7	29.3	31.1
Netherlands	2014	1078	34.3	27.9	31.2
Portugal	2012	818	16.5	8.6	12.6
United Kingdom	2014	2351	36.7	25.2	31
COCAINE					
Denmark	2013	1723	8.4	3.7	5.7
France	2014	2006	6.6	3.5	5.1
Germany	2012	2142	2.9	2	2.5
Italy	2014	1223	1.8	1.7	1.8
Netherlands	2014	1078	5.2	2.2	3.7
Portugal	2012	818	0.6	1.2	0.9
United Kingdom	2014	2351	12.6	7.7	10.2
AMPHETAMINE					
Denmark	2013	1723	8.3	3.7	5.7
France	2014	2006	3	1.6	2.3
Germany	2012	2142	5.3	2.1	3.7
Italy	2014	1223	1.1	0.6	0.9
Netherlands	2014	1078	6.2	2.7	4.5
Portugal	2012	818	0	0.5	0.2
United Kingdom	2014	2351	8.1	5.4	6.8
ECSTASY					
Denmark	2013	1723	4.9	1.9	3.2
France	2014	2006	7	4.1	5.6
Germany (j)	2012	2142	3.6	1.4(j)	2.5
Italy	2014	1223	1.6	2.2	1.9
Netherlands	2014	1078	10.8	6.7	8.8
Portugal (j)	2012	818	2.2	1.4(j)	1.8
United Kingdom	2014	2351	13.5	6.9	10.2
LSD					
Denmark	2013	1723	1.6	0.6	1
France	2014	2006	3.7	1.6	2.6
Germany	2012	2142	1.4	0.6	1
Italy (j)	2014	1223	1.5	0.1	0.8(j)
Netherlands	2014	1078	1.4	0.5	0.9
Portugal (j)	2012	818	0.9	0.8	0.8(j)
United Kingdom	2014	2351	3.4	1.2	2.3

Source: European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) Bulletin for 2016 statistics on drug use, individually referenced for each category of drug in Table I (on which male and female statistics are combined).

The most welcomed outcomes of the controversial Portuguese experiment with decriminalisation were the dramatic reductions in what had been the worst HIV and hepatitis problems in Europe plus the **decreasing** uptake of drugs by 15-24-year-olds – Portugal had identified the adoption of drug habits at 15-17 as the most likely age for leading to long-term dependency.

Worst outcomes: Table I shows the UK had the highest ‘worst’ count (12). The 2016 OECD report *‘Building Skills For All: A Review Of England’* blames UK youth employment problems on the woeful literacy and numeracy of our 16-19 year-olds; UNICEF’s ranking the UK for Education at 24th out of 29 on Report card 11 speaks for itself. However, we disagree that educational outcomes are a cause rather than a symptom of earlier life conditions, including parenting and the premature (ill-advised) inclusion of academic subjects in early education at the time when focus on developing social, emotional and communication skills is more appropriate to children’s ‘learning’ age and also forms the bedrock for later academic learning (and life).

Best outcomes: (Table I) shows the Netherlands had by far the highest number of ‘best’ outcomes (11) and no ‘worsts’. Their statistics also reveal both low female alcohol consumption and excellent overall child outcomes.

UK young parents, their children and equality

In 2007, the Department for Children, Schools and Families stated the rate of births to UK under-18s in the most deprived 10% of wards was *nine times higher* than in the 10% least deprived¹¹², suggesting the birth rate to single young teenagers is linked to socio-economic status by a staggeringly high factor. If the propositions in the *The Spirit Level*¹¹³ are accepted, this ‘inequality’ in outcomes between the least and most disadvantaged English wards could lend weight to the ‘equality’ argument and account for *overall* births to our teens being higher than in other western European countries (e.g. Netherlands and the Nordic countries) where the income and/or economic gaps, as analysed in *The Spirit Level*, are far narrower.

In 2016, at 6.8 per 1000, UK live births to 15-17 year-olds were the highest in Western Europe. For Denmark and Netherlands the figures were 1.1 and 1.3 respectively¹¹⁴. Establishing whether these differences are caused by or correlated to differences in social equality would take a separate study, although it is worth noting that both births to single teenagers and the inequality gap are far higher in the US than in the UK. If UK regional deprivation plays an important role in determining births to teens, reporting ‘national’ data on ‘births to teens’ (and other associated factors such as youth alcohol and drug consumption) figures could be a crude misrepresentation.

UK Outcomes for young parents and their children

The information below is taken from the government publication *Teenage Parents Next Steps: Guidance for Local Authorities and Primary Care Trusts*¹¹⁵:

Children born to teenage mothers are more likely to live in deprived areas, do less well at school and disengage from learning early – all of which are risk factors for teenage pregnancy and other poor outcomes. Daughters of teenage mothers are twice as likely as daughters born to older mothers to become teenage mothers themselves... teenage parents and their children are not only facing disadvantage now, but are at risk of transmitting disadvantage down through their children to the next generation...

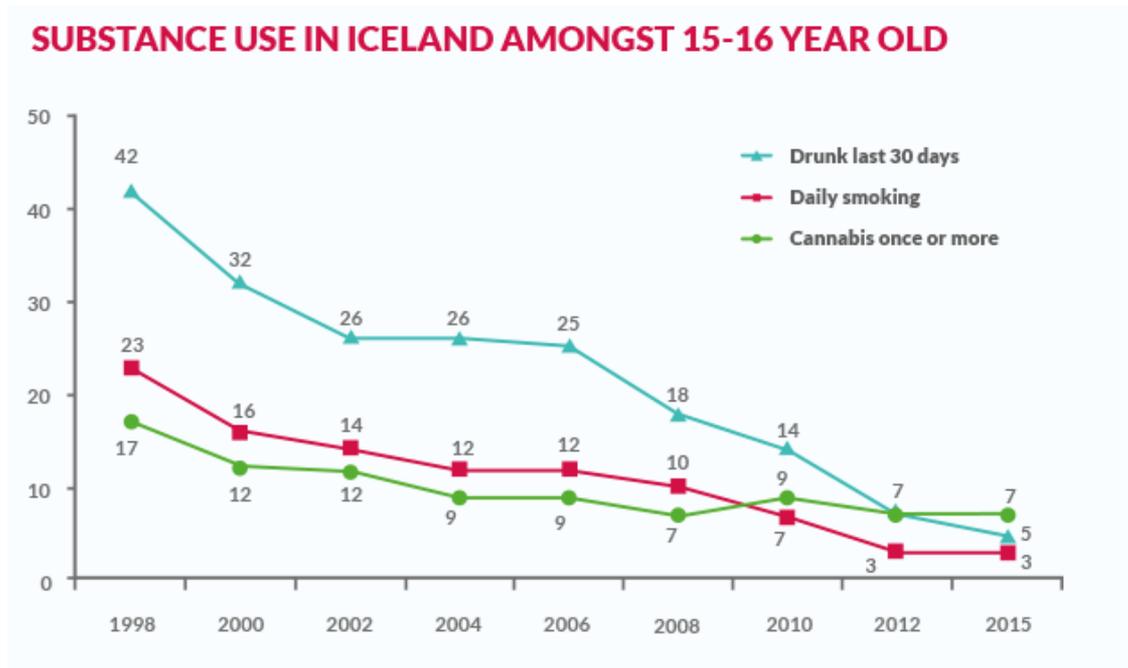
UK young parents and incarceration: *25% of young male offenders in custody are estimated to be fathers, and 39% of their female counterparts are estimated to be mothers... the evidence does point to a range of factors that increase the likelihood of poor outcomes, including: higher rates of relationship breakdown; a greater likelihood of living in a workless household and in social housing; and lower levels of emotional support... It is important to ensure midwifery and health-visiting services provide tailored support for both teenage mothers and young fathers (who report frequently feeling ignored by midwifery and health-visiting services) to address and prevent the problems of late antenatal appointment booking; poor levels of nutrition; high levels of maternal **smoking during pregnancy; low birth weights; higher than usual rates of infant mortality** and morbidity; and low rates of breastfeeding – all of which contribute to the poor health outcomes in children born to teenage mothers.*

Link between poor outcomes and being born to a teenage mother: Research also identifies poorer health and social outcomes for children born to teenage mothers, beyond those evident at the time of birth. For example, the children have higher rates of accidents, such as falls and swallowing dangerous substances, and are more likely to exhibit such disruptive behaviour as conduct, emotional and hyperactivity problems. Research claims the higher incidences of these problems are – at least in part – due to higher levels of poor emotional health among teenage mothers, who also suffer far higher than average and longer-lasting (i.e. persisting for 3+ years) mental health problems following the birth of a child¹¹⁶.

Link between ‘non-adult’ UK female alcohol consumption and violence? The main offence for which ‘non-adult’ males (age 18-20) are in prison is Violence Against The Person (VATP), accounting for **22%** of all non-adult male prisoners. However, VATP offences accounted for **31%** of all non-adult female prisoners. The combined datasets of the 2012/13 and 2013/14 Crime Survey of England and Wales (CSEW, published in 2015) report that **70% of violent incidents** occurring at weekends and in the evening or night are alcohol-related¹¹⁷. This appears to echo the 2018 NHS study¹¹⁸ on alcoholism findings that childhood drunkenness is almost 60% higher among girls than boys (Part 3, Transition into addiction).

Combining statistics on incarcerated young parents and high levels of late evening and weekend hospital admissions for alcohol-related illnesses and injuries, appears to link drunkenness with violent offences among our (‘non-adult’) young women. This raises a question about the impact on their parenting skills when the consequences of heavy drinking include unplanned live births – and most especially the risk of babies being born with some degree of foetal alcohol harm. Here it might be interesting to study the Icelandic cultural changes arising from the 1998 Project Self-Discovery, designed to encourage teens to ‘Say No to drugs’ and to postpone starting to drink alcohol until age 20 (Case Study H).

Table 3:



Intergenerational impact: If (as an impressive volume of research demonstrates) unmitigated adverse childhood experiences lead to educational, employment, criminal, and health-harming dysfunction in later life, the question is whether the current high levels of UK dysfunction reflect ACEs in earlier life and/or in previous generations? The 2016 meta-analysis reported in *The Lancet* claims to detect an intergenerational factor in ACEs. This pattern would fuel continuing cycles of the types of harm likely, in turn, to produce further generations of vulnerable, ACE-ridden young being born to today's already vulnerable adults and teenagers. Here it is worth repeating the WHO and Public Health Wales advice cited in the August 2017 article in *The Lancet*:

To sustain improvements in public health requires a shift in focus to include prevention of ACEs, resilience building, and ACE-informed service provision.

Daughters of teenage mothers are not only twice as likely to become teen mothers as those born to older mothers, they also have the lowest academic attainment and highest risk of economic inactivity in later life¹¹⁹.

Correlation between early age drug consumption and adult addiction: The CASA study of 2011¹²⁰ found 9 out of 10 adult addicts started using drugs before age 18, compared to 1 in 25 who started using at age 21+.

The 2018 NHS study¹²¹ on alcoholism showed 23% of 15-year-olds had been drunk during the preceding 4 weeks, some of them 3 or 4 times (see Table 7 in Part 3).

Domestic violence

The studies on domestic violence referenced¹²² are a tiny sample of the voluminous works on this and its consequences on children who witness it. The consensus is that this particular ACE is a stronger predictor of poor later life outcomes than moderate levels of direct physical punishment of a child. It is sad how most people fail to understand that domestic violence does not have to be physical; shouting is also a harmful form of violence children find very disturbing.

Since statistics for cocaine use in the other high alcohol consuming countries are significantly lower than for the UK, and the combined consumption of alcohol and cocaine can produce unpredictable, volatile, often violent behaviour, it seems reasonable to infer that this UK cultural trend puts our children at higher risk of the ACE of living with domestic violence than their European peers. One (past) NSPCC estimate was of 750,000 UK children growing up in homes characterised by significant abuse of alcohol and/or other drugs.

United States cultural model

The UK tends to follow US rather than European cultural trends – understandably, in view of the common language, strong historical links and a similar profile of wide gaps between lower and higher SES. A brief USA/Netherlands/UK comparison (where the UK generally performs poorly against the 5 other European countries) lends credibility for the argument ‘Greater Equality Makes Societies Stronger’ [Spirit Level]:

Table 4: Comparison of USA, UK and Netherlands

Factor	USA	UK	Neth
Adult obesity % of population, male ¹²³	33.6%	26.2%	18.4%
Adult obesity % of population, female ¹²⁴	34.9%	28.4%	18.8%
Live births to teens aged 15-17 per 1,000 ¹²⁵	14.1	9.2	1.6
Live births to teens aged 15-19 per 1,000 ¹²⁶	29.4	19.7	4.5
Ischemic heart disease per 100,000 ¹²⁷	128	98	50
Liver cirrhosis deaths per 100,000 ¹²⁸	14.9 (m); 7.1 (f)	16 (m); 8 (f)	5.7 (m); 2.5 (f)

In some US states and cities, these deep-seated problems are now being addressed very successfully by using Trauma-informed Care, and creating whole Trauma-informed Communities.

Family breakdown

Several different types of family breakdown are associated with negative outcomes across the life course: divorce, domestic violence, lone parent households, family bereavement etc. Family breakdown is reported by Centrepoin as being the most common cause of youth homelessness.

Single parent UK families – not to be confused with family breakdown:

Statistically, single parent families are 2.5 times more likely than two-parent families to be in poverty¹²⁹. However, it also needs to be understood that:

- There are many thriving, successful single parent families.
- Being a single parent can be a choice rather than result from couple breakdown.
- Children fare much better in a functional single parent family than when subjected to, or witnessing, domestic violence, or feeling rejected.
- When changed status is handled well, a single-parent family is not the same as a ‘broken’ family, even if being single arose through death or divorce.

Youth homelessness

Part 3, Transition into youth homelessness, provides detailed coverage of this tragic and dangerous youth outcome (including the UK legislative framework). Some expansion of

it is included here because becoming homeless is so often the ‘final straw’ in lives already littered with multiple disadvantage.

Those who are homeless invariably also suffer other severe disadvantages. The size of the problem for young people who have ended up on our streets after escaping abuse in the home – or being asked to leave – is under-estimated because not all ‘runaways’ are reported. The ITV documentary *Where Am I Sleeping Tonight*¹³⁰ estimated about a million ‘hidden homeless’ are not claiming or receiving any government support at all. (Key Message VII and Part 3, Transition into youth homelessness).

Role of family breakdown in youth homelessness: Centrepoin¹³¹ found family breakdown to be the single most common cause (or threat) of youth homelessness. WAVE’s research and direct experience with young offenders (of both sexes), young male prisoners and adults living in social exclusion strongly support this conclusion. Reasons cited by those who have left their family home range from being emotionally, physically or sexually abused to being rejected after the remaining biological parent began to have a ‘new’ family with a new partner. Some NEET teenagers felt pushed out because of the cessation of children’s allowance at age 16 (unless in approved education or training). The 2018 weekly allowance is £20.70 for an eldest child, and a mere £13.70 for each subsequent child. This has been unchanged since 2016-17, and increased by just 30p since 2013. This is in sharp contrast to the ‘triple lock’ protection of state pensions, which have increased annually during that same time.

Mental health problems among youth homeless¹³²

- Young people living in hostels/B&B accommodation are 8 times more likely to suffer from mental illness than the general population
- Young people living on the streets are 11 times more likely to suffer from mental illness than the general population.

‘Hidden homeless’

The Missing People Organisation reports over 140,000 minors go ‘missing’ each year. However, by definition, there are no official statistics on the hidden homeless, only media documentaries, but compelling ones featuring the actual children and their lives, their pitiful shelters and daily scabbling for food. Hidden homeless are invariably the runaway children who seek no formal help because they are in some way impaired (including by drug use) or are afraid to be found and returned to abusive homes. It is hard to imagine what conditions would drive a young teenager to such an extreme of personal danger and discomfort – until one hears the truly horrific early life conditions of street children involved in the ‘3 circles’ of drug dealing (Part 3, Transition into gangs), or speaks to adults living in SMD about their childhood experiences.

One striking characteristic of these very disadvantaged young people is their resilience, and perhaps that is what gave them the strength to leave an intolerable home situation, and also the reason they want to find work and remain on the right side of the law while they fight for their independence. They might not currently have an ‘always available adult’ role model (see Key Message IV), but they have each other. Although living conditions are way below acceptable, they often coalesce into a quite satisfactory ‘family’ – when their biological families and/or the ‘system’ failed them in some serious way.

Negative image of the homeless: On the opening of its new village in Granton, Edinburgh, Josh Littlejohn (Co-Founder of social enterprise, Social Bite) said:

'We had a bit of a pre-conception that homelessness might be a result of decisions people make, or as a result of getting addicted to drugs or alcohol, but the story we kept hearing was people typically got dealt some really quite harrowing cards when they were born ... had typically suffered some really quite traumatic childhood experiences, more often than not, grew up in the care system and quite often became homeless in their late teenage years. So it became quite apparent that homelessness ... was very systemic, and it seemed that if you were dealt certain cards in life, it was almost your destiny in a way to end up in that quite desperate situation.'

Similar observations are reported by Housing First projects (including the one that eradicated homelessness in Finland) (Case Study G).

Drawing together the various strands of dysfunction

In summary, the UK is characterised by:

- a. Dangerous cultural trend of combining alcohol and cocaine.
- b. Under-age sex widely considered 'a normal part of growing up' (even by the Family Education Trust) although it often leads to unplanned births as well as high levels of sexually-transmitted infection (STIs).
- c. Very high levels of live births to teens (c.4-6 x Netherlands and Denmark and more than double Germany's level) – putting extreme pressure on health and social care.
- d. Lowest in OECD youth (age 16-19) literacy and 2nd lowest in numeracy (2016).
- e. Increasing levels of NEETs while general unemployment decreased.
- f. High levels of alcohol and drug consumption/dependency among females.
- g. High levels of cocaine use among all age groups, including young parents.
- h. Significant proportion of young parents serving custodial sentences.
- i. Proportionally higher convictions of 'non-adult' females than males for violence.
- j. Highest level of inter-partner violence in the available statistics (including USA).
- k. Higher than average levels of postnatal depression among teenage mothers, persisting for 3+ years after the birth of a child.
- l. Increased risk of accidental harm to children born to teenagers.
- m. Lowest OECD level of youth literacy and 2nd lowest in numeracy (2016).
- n. High levels of youth homelessness, including the 'hidden' homeless.
- o. Increasing levels of NEETs while general unemployment decreased.

KEY MESSAGE IV: Early damage from trauma can be significantly mitigated when children are accepted unconditionally by a reliable, available adult¹³³.

This section is specifically devoted to new research on the key mitigating factor that significantly improves mental health outcomes among those who suffered 4+ ACEs.

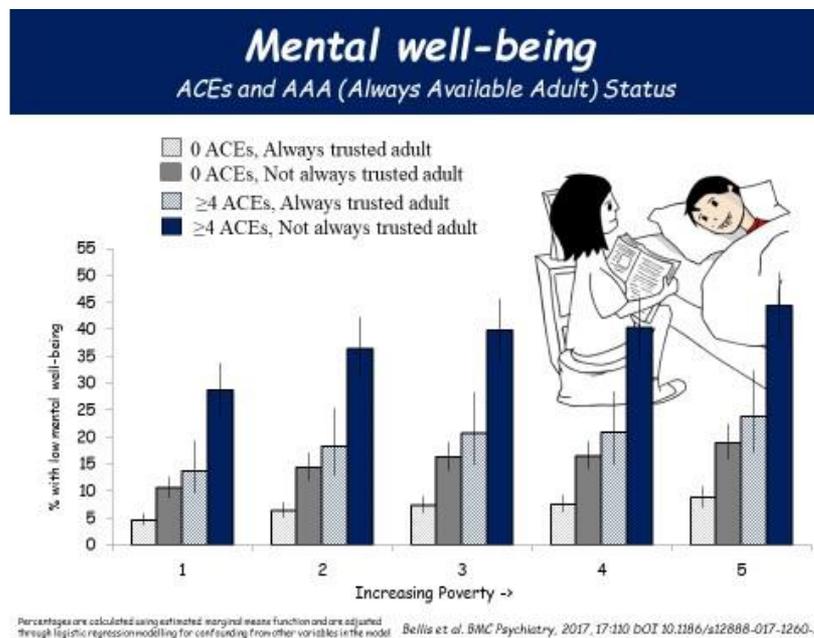
New statistics on protective factors against ACEs

For the first time ever, the 2017 Bellis study¹³⁴ **quantified** how effects of ACEs might be mitigated to reduce later life health-harming behaviours and low mental wellbeing.

Importance to mental wellbeing of an ‘Always Available Adult’ (AAA):

The effects of both ACEs and consistent adult support (AAA) far outweighed that of poverty in the development of harmful behaviour. This point appears to be tacitly acknowledged in the latest Home Office review of serious violence¹³⁵ (which promotes the potential of adult mentors to divert young people from engaging in violence).

The most dramatic finding was that while the presence of such an AAA led to discernible improvements in outcomes from *all* ACE profiles, its greatest impact was in reducing **by over 50%** the adverse effects on the **mental wellbeing** of those who had suffered 4 or more ACEs – an AAA has the most impact among the most vulnerable group.



Assess for ACEs: To harvest the benefits of this dramatic breakthrough, we need to identify the most vulnerable when they are still young enough to benefit from the insight. This means routinely screening for ACEs all children who show signs of learning or behavioural difficulties (and ensuring they have the support they need to double their likelihood of enjoying mental wellbeing).

High mental wellbeing is a key component of resilience – the subject of our next Message.

KEY MESSAGE V: Resilience is a key protective factor (or ‘antidote’) to ACEs that can be developed by adopting social pedagogical and trauma-informed approaches in social services, schools, criminal justice and other public services.

This section expands on Key Message IV above. Here, we define resilience and examine successful systems that contribute to building this crucial attribute for a successful and enjoyable life. There is no formal or precise definition of resilience, but there is no controversy either; it is widely acknowledged to be the ability to suffer setbacks and recover from them, perhaps stronger from the learning involved.

Overcoming adversity and building resilience

The experiences of the subset of children who overcome adversity and produce surprisingly positive life outcomes fuel new understanding of the nature of resilience, and what can be done to build it¹³⁶. Dr Ginsburg sums up what can be ‘said with certainty’ on the subject: *Children need adults who believe in them unconditionally and hold them to the high expectations of being compassionate, generous, and creative; Children and young people live up or down to our expectations; What we do to model healthy resilience strategies for our children is more important than anything we say on the matter.* He identified ‘7Cs’ as essential building blocks for developing resilience¹³⁷:

1. **Competence:** When we notice what young people are doing right and give them opportunities to develop important skills, they feel competent. We undermine competence when we don't allow young people to recover themselves after a fall.
2. **Confidence:** Young people need confidence to be able to navigate the world, think outside the box, and recover from challenges.
3. **Connection:** Connections with others, schools, and communities offer the security that allows people to stand on their own and develop creative solutions.
4. **Character:** Young people need a clear sense of right and wrong and a commitment to integrity.
5. **Contribution:** Young people who contribute to the well-being of others receive gratitude rather than condemnation, and will learn that contributing feels good – and may more easily turn to others for help, and do so without shame.
6. **Coping:** Young people who possess a variety of healthy coping strategies will be less likely to turn to dangerous quick fixes when stressed.
7. **Control:** Young people who understand that privileges and respect are earned through demonstrating responsibility will learn to make wise choices and feel a sense of control.

UK Government on building resilience through physical activity: *Develop initiatives targeting adults who interact with children in the early years; Provide information on the importance of physical activity [and what counts as this]; Integrate physical activity into the daily routine when planning activities*¹³⁸. These recommendations acknowledge the beneficial effects of physical activity, and echo Icelandic practice. However, shortage of funds is impeding their implementation. [Research by Unison](#), based on a Freedom of Information request to 168 local authorities, showed youth services lost more than 2000 jobs and at least £60m of funding between 2012 and 2014; around 350 youth centres closed; 41,000 youth service places for young people and at least 35,000 hours of outreach work by youth workers were cut¹³⁹.

Empathy is also important; again, a trusted adult can model this for a child who either lacks it or has lost touch with it – important because children who are empathic are not

drawn to unkindness or bullying behaviour and, therefore, make not just good friends and classmates but also good parents capable of attuning with their own children. Successful, evidence-based (whole class) empathy programmes are available (e.g. Mary Gordon's Canadian Roots of Empathy programme¹⁴⁰).

Trauma-informed Care – an idea whose time has come?

The US Substance Abuse and Mental Health Services Administration (SAMHSA) defines a trauma-informed approach as: '*... one where people realize the prevalence of trauma, recognize the impact and responses to trauma, and resist practices that could cause more harm*'. In pledging the state of **Wisconsin**'s commitment to the delivery of TiC, (Republican) State Governor Scott Walker made the first state-wide statement acknowledging the importance to damaged people of an ACE-aware, Trauma-informed approach¹⁴¹:

'Trauma-Informed Care shifts perspectives from blaming people for their problems to using the science of ACEs to guide support and the creation of new policies and practices. By building an understanding of how the past impacts the present, connections are made that progress towards healing and recovery...'

The Wisconsin outcomes include savings from a TiC project delivered to the Menominee tribe that resulted in huge reductions in teen pregnancy, smoking, and alcohol and drug abuse.

Washington State: more than 10 years ago, 30 counties brought their community leaders together 'to learn about the science of adversity'. ACE-informed communities have since changed a variety of policies and practices including:

- **Thurston County:** since focusing on substance abuse treatment rather than juvenile incarceration, teen arrests for drugs are down 39%.
- **Walla Walla County:** since increasing youth support programs and community awareness of ACEs, the youth suicide rate is down 59%.
- **Kitsap County:** since increasing nurse home visiting and parenting programs for young families, domestic violence incidents are down 37%.
- **Okanogan County:** since training all teachers and students about ACEs and toxic stress, youth arrests for violent crime are down 66%.

The approach was estimated to save Washington State over \$1.4 billion in a decade.

A (2017) evaluation of **impact on child welfare systems** concluded: '*As children's care teams implement [a Trauma Systems approach], children demonstrate greater improvements in functioning and both emotional and behavioral, regulation and placement stability*'¹⁴²

Trauma-informed schools

UK: Of the many initiatives we've reviewed, one of the most exciting and promising is the pilot project in St Cuthbert's Primary school in **Blackburn** (referred to on p.14). The initiative involved a total change in culture – and a high level of staff training at all levels, as well as buy-in by school governors. All staff were taught that child 'misbehaviour' is a form of communication that needs to be dealt with sensitively.

Outcomes: within one year, standards improved for all pupils; attainment became above national averages for reading, writing and maths; progress for the most vulnerable

pupils has improved significantly, with 51% making better than expected progress. The Ofsted rating rose from 'Good' to 'Outstanding'. The following is from the Ofsted inspection: 'Staff across the school gauge the emotional well-being of pupils at the start of every day. This is followed up by highly trained support staff who are on hand to assist pupils if they have any concerns or worries... School leaders have a very clear focus on pupils' well-being, particularly their mental health. Even small changes in pupils' behaviour are regularly discussed in meetings and very careful consideration is given to the root cause...'

There are many other examples of trauma-informed school initiatives yielding significant benefit. The story of the transformation of **Lincoln High School** can be found in a feature-length documentary on the internet.

San Francisco: The Healthy Environments and Response to Trauma in Schools (HEARTS) Program promotes school success for trauma-impacted students through a whole-school approach utilising a multi-tiered framework. Tier 1: school-wide universal support to change school cultures into safe, supportive and trauma-informed learning environments; Tier 2: capacity building among staff to incorporate a trauma-informed lens into developing supports for at-risk students, school-wide concerns and disciplinary procedures; Tier 3: intensive interventions for students suffering the impact of trauma. A 2016 evaluation of the programme¹⁴³ addressed four questions: (1) Was there an increase in school personnel's knowledge and use of trauma-sensitive practices? (2) Was there an improvement in students' school engagement? (3) Was there a decrease in student behavioural problems? (4) Was there a decrease in trauma-related symptoms in students who received HEARTS therapy? The answers were positive on each score, as shown in following Table:

Outcomes: HEARTS programme		Increase %	Decrease %
Staff knowledge of trauma	Knowledge about trauma and its effects	57%	
	Understanding of how to help traumatised children	61%	
	Knowledge about trauma-sensitive practices	68%	
	Knowledge about burnout & vicarious traumatisation	65%	
	Use of trauma-sensitive practices	49%	
Students' school engagement	Students' ability to learn	28%	
	Students' time on task	27%	
	Students' time in classroom	36%	
	Students' school attendance	34%	
Behavioural problems after 1 year	Incidents involving physical aggression		43%
	Out-of-school suspensions		negligible
	Total incidents		32%
Behavioural problems after 5 years	Incidents involving physical aggression		86%
	Out-of-school suspensions		95%
	Total incidents		87%

Similar positive results have also been found in **Florida** and in **Kansas City Trauma Sensitive Schools** (TSS).

(Unnamed) UK ‘special’ school: Case Study A highlights the different outcomes for two adopted half-siblings suffering severe FASD, only one of whom received a SEN statement and (eventually, at age 11) provided with trauma-informed schooling.

Workforce-related TiC initiatives

First responders have high levels of alcohol use, suicide, divorce, and burnout. Teachers can be deeply affected by trauma in the lives of students. A TiC project in Kansas City collaborated with police and schools to introduce trauma-sensitive practices. Participants reported the training helped them understand how the very thing that makes them good at their jobs – desire to help – can render them vulnerable to secondary traumatic stress.

Wisconsin Workforce Training: Many participants on both the county and state teams reported the dynamics within their agency had changed since starting the initiative... Participants expressed heightened awareness of the impact of trauma, and were modifying their own interactions. Some families also described positive changes in their relationship with social services, as well as improvements to agencies’ physical spaces.

UK police forces: Senior police officers from Ayrshire, Derry/Londonderry and South Wales, attending WAVE workshops on ACE, report major changes in their behaviour, and improved job satisfaction, after shifting to trauma-informed approaches.

Senior officers of the major public bodies in **Derry City and Strabane District** decided to create a **Trauma-informed Community** in that part of the north-west of Northern Ireland (co-ordinated by WAVE Trust).

Trauma-informed approach to offenders

Contrast between opposing philosophies on offenders:

	Punitive segregation	Reintegrative punishment
View of offenders	Dangerous outsiders; different from us	Members of society – like ‘us’ – who have done wrong/welfare cases
General strategy	Build walls between ‘us’ and ‘them’; contain them; defend ourselves	Reformatory and reintegrative punishment: they must be deprived of some rights for some period of time; overall aim: keep their lives as normal as possible and return them to society as equal, productive and valued members
Tone	Coarse, harsh	Civilised, critical/sympathetic

Table 5: Norwegian vs England and Wales recidivism rates

Country	After 1 year	After 4 years
England & Wales (January to March 2000 cohort, 15,713 ex-convicts) ¹⁴⁴	51.4%	74.2%
Norway (2005 cohort, 5,503 ex-convicts) ¹⁴⁵	22.6%	39.2%

ACEs and Trauma-informed Care (TiC)

A general pedagogical approach to educating and caring for children has been widely recommended. We need both ACE-awareness and trauma-informed, practical methods to steer children away from pathways to severe, multiple disadvantage. Happily, there has been growth in interest in the topic in Wales, Scotland and Northern Ireland in

recent years – and, more recently, strong interest in England also, following the Home Office study since 2013, and their strategy on reducing violence (published April 2018).

Developments include the Welsh Government making tackling ACEs the highest health priority; a debate in the Scottish Parliament; a Select Committee Inquiry in the House of Commons; a documentary film ('Resilience') on the topic watched by over 400 civil servants in Scotland; an APPG for Prevention of ACEs formed in the Westminster Parliament in February 2018, and a Cross Party Group for the Prevention and Healing of ACEs in the Scottish Parliament in March and in April 2018, a comprehensive Home Office violence prevention strategy that repeatedly acknowledges the significance of ACEs to both perpetrators and victims of violent crime – and how violent offending can be more effectively combated by Trauma-informed policing and justice system.

The following are extracts from 2 of many reports on TiC: (1) *'Community coalitions are an essential ingredient, and can provide a platform for evaluating the effectiveness of preventive and treatment interventions and monitoring overall community health. Several communities have found that using a trauma and developmental lens greatly helps to identify common interests across divergent sectors, and provides a template for community action.'*¹⁴⁶

(2) *'A trauma informed approach to community building seeks to break cycles of disconnection between residents as well as between systems and the community. This is one step towards the most effective way to address the trauma experienced in communities – eliminate the violence, isolation, and other causes of pervasive and persistent stress.'*¹⁴⁷

Typical characteristics of Trauma-informed Communities

- Different approaches to addressing trauma and building resilience, depending on local resources, cultures and circumstances.
- Although differing in their approaches, communities benefit from networking.
- Cross-agency and cross-sector collaboration is the norm.
- Initiatives build on strengths while addressing challenges.
- Addressing trauma in the workforce is an essential element.
- Communities seamlessly combine education about trauma and resilience with prevention, treatment, supports and social justice.

To outline just one such community (Walla Walla, Washington)

The ACE-aware approach focused on TiC operated here¹⁴⁸ involves the whole community and many sectors and services – a true multi-agency, community approach.

- At least 60% of citizens understand issues about brain development in terms of emotional literacy and regulation, and how these affect people.
- Parents, teachers and pupils have a common vocabulary or *language* about trauma.
- Both inside and outside schools, focus/importance is placed on building resilience.
- All police officers are informed and trained in TiC.
- There is a preference for universal over targeted approaches to TiC.
- School liaison is used for police and pupils to form good relationships.
 - Children who are Police cadets see their involvement as an opportunity to get food for the week, but also to improve their life prospects across the board.

When reviewing the following Key Message, it is important to bear in mind all the positive developments, including the rapidity of Iceland's transformation of its youth culture, and the evidence from Washington State that a switch to Trauma-informed systems saves, rather than costs, money.

KEY MESSAGE VI: With few exceptions, UK systems have not promoted good educational outcomes or resilience, or provided pedagogical or trauma-informed care

Conceptual framework for a system

The words 'system' and 'method' are sometimes confused because of their similarity in meaning, but there are differences: mainly that while system is about principles, method is based on procedures. A feature common to both is orderliness. Ashby's Law of Requisite Variety can be summed up thus: to operate successfully, the governing 'brain' of any system needs to be at least as complex as the components it governs. Ashby's is what is known as an 'iron law', meaning the rules of logic dictate there are no exceptions. It is of course a matter for those designing systems to choose whether to do so with or without adherence to Ashby.

This Law applied to a children's care system would, for example, be built on an overarching conceptual framework that acknowledges the importance of such dimensions in child development as empathy, resilience, ensuring children do not face the school day hungry, ACEs, bullying, physical and emotional health, ethnicity and social and emotional development, rather than one focusing on a very narrow range of measures, e.g. academic learning, language and communication.

Regrettably, it seems the original Integrated Children's Services (ICS) system did not take account of Ashby's Law; the level of variation in set-up and delivery around the UK does not reflect the presence of any 'governing brain'.

Integrated Children's Services system (ICS)

Much of the background to this report came from the plethora of reviews that brought to light flaws in the ICS system dating back to the late 1980s (notably Professor Eileen Munro's *Review of child safeguarding* and White et al's 2-year ethnographic study (*Design dogma and the ICS: A tale of escalating commitment*)).

Dwelling on past flaws can be either a fruitless finger-pointing exercise or a source of learning how to do better. Taking the 'learning' route enables us to detect the basis of a workable system for the future. It is in this spirit we recommend looking for what needs to be done to reverse the identified flaws. For example, various Commons Select Committees dealing with specific aspects of where the system failed its users contain recommendations for how to serve children and families better. In this way, the detractors from past and current systemic procedures are actually contributing to the design of a better, more humane and effective alternative system. Also, the nature of some of the changes included in the Putting Children First¹⁴⁹ pilot initiative, started in mid-2016, came with an admission that the social care 'system' needed to change.

One job of this report is to encourage policy-makers to view past mistakes as proof of just how powerful policy that leads to system and procedural change can be (and what a weighty responsibility they carry). If an ill-advised system can have such an impact as reflected in the numerous reports on the ICS, what could be achieved with a determined, thoroughly thought-through system to transform childhood? Could we achieve with our own young people what Iceland achieved with its teenagers in 17 years (with many positive results showing in 2-3 years)? (Case Study H).

Moving on from ICS by ‘Putting Children First’ (PCF)¹⁵⁰

With the above in mind, this Key Message looks at where we are and what we need to do to change our pathway. First, in understanding and commenting on today (and yesterday), we need to acknowledge the outcomes of past system mistakes.

Challenges facing the UK

Education in England

School-readiness: Public Health England’s ‘A Better Start for London’ study concluded that:

- 2 in 5 lower SES children are not ‘well parented’, and that suitable support programmes positively impact the mental wellbeing of parents as well as children.
- A child’s communication environment is a more dominant predictor of early language development than social background and, in turn, that language proficiency is a key predictor of school success: *‘Parenting in the early years has a greater influence on a child’s life chances than education, wealth or class’*.
- Quantified benefits from investing in pre-school care and education in a manner that amounts to social pedagogy:
 - Every £1 invested in quality early care and education saves up to £13 in future costs;
 - For every £1 spent on early years’ education, £7 has to be spent to have the same level of impact in adolescence;
 - The benefits associated with the introduction of the literacy hour in the UK outstrip the costs by a ratio of between 27 and 70 to 1;
 - Targeted parenting programmes to prevent conduct disorders pay back £8 over 6 years for every £1 invested, in savings to the NHS, education and criminal justice.
- If all children were reading well by age 11, GDP in England in 2020 could be an extra £23 billion¹⁵¹. [attributed by PHE to Save the Children]

The House of Commons Science and Technology Committee (March 2018)¹⁵² (Chaired by the Rt. Hon. Norman Lamb, MP) called for oral and written evidence from a number of experts and organisations. In his extensive oral evidence to the Committee, Professor Edward (Ted) Melhuish (University of Oxford) emphasised the wisdom of delaying the academic focus in favour of language and self-regulation in teaching very young children:

‘...if you can get right language development and self-regulation, which is an aspect of socio-emotional development, by the time children start school, almost everything else will fall into place.’

He echoed PHE conclusions on the role of parents in teaching the young, and on consequences for the UK’s economic development. He also strongly recommended government rectify the ‘missed trick’ of not specifying the exact nature of support it is funding in targeting 2-4-year-olds in the 40% most disadvantaged families, saying this support will yield ‘high quality’ results if focused on helping parents create a suitable home learning environment for teaching their young children.

Secondary school education: The 2016 GCSE results were the worst since 2008 – the year Key Stage 3 was abandoned; The 2016 OECD¹⁵³ review placed England at the bottom of the 24 countries measured; being without any educational qualifications is a common factor among the socially excluded, linking this early disadvantage with the risk

of others that could lead to future descent into SMD; children at highest risk of educational failure and becoming NEET are: the school-excluded, those who have an SEN statement, and those who are, or have been, in Care.

Reducing provision for youth activities: See Government recommendation for increased physical activity (Key Message V above) for Unison research detailing recent cuts in facilities and the staff who provide wholesome physical outlets for children.

Systemic failure of UK Corporate parenting

The 2009 Eurochild National Surveys On Children In Alternative Care¹⁵⁴ observed the available statistics ‘...provide clear evidence that children who have been in care – and in particular in residential care – are more likely to end up homeless; to commit crimes; to have children before the age of 20 themselves; and to have their own children taken into care’.

2016 Commons Select Education Committee on mental health and wellbeing of looked-after children¹⁵⁵ also found a plethora of adverse outcomes in children who were in care, including being: 4 times more likely than their non-looked-after peers to have a mental health condition and 5 times more likely to attempt suicide ... and to face significant ‘bureaucratic’ challenges in accessing mental health support. The committee found Permanence of place to be crucial for looked-after children. Their findings echo those of **Janet Boddy’s** ‘Understanding permanence for looked-after children – a Review of research for the Care Inquiry’ (2013)¹⁵⁶ and The **2012 ‘TACT’ report**, ‘Looked After Children and Offending: Reducing Risk and Promoting Resilience’¹⁵⁷, as well as the **Petrie comparison** of care in 5 EU countries¹⁵⁸, on which England performed worst on:

- Contact between the children and their families.
- Contact between social workers and the children’s families.
- Children’s contact with non-residential friends, and with the community.
- Staff skill in providing emotional support.
- Under-16-year-olds not attending school (Denmark 1.6%; Germany 2.2%; England 11.6%).
- Levels of youth employment (16-18) years: 1/3rd in paid work in Denmark and Germany; 4% in England.
- Incidence of criminal offending: offences per child: Denmark 0.158; Germany 0.092; England 1.730.
- Incidence of violence towards staff.
- Incidence of teenage pregnancy (defined as under 19 years): Denmark: no issue; Germany: half that of England (which is 2.5-3 times the national average).

Petrie also identified that staff characteristics in England explain the higher rates of teenage pregnancy in Care Homes in comparison with Germany, Denmark and Benelux. Close analysis showed a combination of the following 3 staff characteristics accounted for **nearly 30%** of the variation in rates of pregnancies in under-19-year-olds across the countries included in the 2006 Petrie study:

1. higher rates of in-service training,
2. staff offered more fact-seeking responses to hypothetical dilemmas involving young people,
3. staff intending to carry on in their current post for longer.

‘...In the present sample, we may conclude that cross-country differences in the care population did not account for risk of teenage pregnancy; staff characteristics did.’ [Petrie et al, 2006, p.107]

This is particularly significant in view of UK looked-after girls already having 2-3 times the national (high) rate of live births to teens.

In the Houses of Lords debate (2006)¹⁵⁹: ***Baroness Walmsley found***: Only 8% of UK looked-after children obtain 5 good (C+) GCSEs, and only 1% go on to higher education. By contrast a ***Guardian report on Denmark*** found as many as 60% of children in one public Care home setting went on to higher education¹⁶⁰.

UK statistics

- 40% of UK teenage mothers are, or have been, in Care¹⁶¹.
- UK looked-after children grow up to be hugely over-represented in institutional populations (especially prison). c.25% of prisoners have been in care at some point in their lives (Ministry of Justice via Full Facts Organisation).
- Formerly looked-after children are 5 times more likely than the rest of the population to attempt suicide [*Commons 2009 Select Committee's report*¹⁶²].

Although some of these studies and reports are quite dated now, we include them because the 2016 Commons Select Committee reported no improvement, and even added a problem caused by CAMHS policy to withhold mental health support from looked-after children without security of placement (probably those most in need).

WAVE research identified two other potentially significant factors impacting the delivery of services to looked-after children:

- The UK's very variable, generally too large, social work caseloads (see below).
- The (acknowledged) disadvantages arising from sending looked-after children out of borough for economic (rather than safety) reasons.

Youth homelessness: The informal research conducted by journalists and film-makers echoes the findings of Centrepont (see Key Message III) – but to a hugely increased extent in terms of numbers. Such bad experiences as hostels inhabited by adult drunks, or young people who have turned to the 'system' for help but been advised to 'go home' – to a place they can no longer bear to be – or sent to numerous agencies, none of which helps, makes it hardly surprising if so many of these children lose faith in the system and the adult world it represents. Even their one daily meal (usually just a sandwich) is provided by charities (often the Salvation Army) rather than any organised 'system' (charities have volunteers willing to do a nightly 'meal run' while the 'system' tends to confine work to office hours, except for acute emergencies). (Key Message III and Part 3, Transition into youth homelessness).

Not enough social workers to fulfil high levels of UK need? The situation in 2016/17 appeared to be a continuation of insufficient social care to cover the high levels of fundamental dysfunction outlined in Key Message III. One major need for social workers arises from the unusually high levels of teen births, leading to more pressure on the system than in e.g. Netherlands, Denmark and Germany.

Numerous studies point to two other key UK distinguishing features: (a) absence of training and ability in pedagogy in our Teaching, Care and Social Work professions; (b) extreme inconsistency in social worker caseloads across the country, making the availability of good service a geographically-based lottery (reported caseloads varied from 14.6 in Darlington and 45 in North Tyneside).

Table 6: spread of average children's social worker caseloads

Location	Cases ¹⁶³
Darlington	14.6
Co. Durham	23
Stockton-on-Tees	25*
North Tyneside	45

*described as 'significantly above the recommended level' [although no such recommended level appears to be agreed upon]. The (randomly chosen) item from the Community That Care website gives a flavour of the prevailing mood among social workers:

Another burnt out and unwell Social Worker February 16, 2017 at 11:36 pm

'I've held between 24 and 29 cases over the last five years. The ten years prior to that my case load was around 20-22. Even newly qualified workers in the LA I have been based can hold up to 22 cases. It's not safe and workers have an impossible task to juggle everything. I can't imagine having 30 plus cases!! Can you even do the bare minimum for each child and safeguard appropriately with that number? I doubt it. I am currently taking time out of the profession as my physical health has deteriorated to the point that I am chronically ill, it may be work related, it may not... I am feeling a huge difference in my own wellbeing however after just a few weeks out. I feel sad for those who do not have this option and have to keep working at such pace and under what in my view are highly exploitative conditions'¹⁶⁴.

This and numerous similar comments reflect what we heard in our interviews with senior social workers in England, including that up to half the social workers in some local authorities are agency employees, because regular staff just do not stay, and that it is not unusual for newly qualified workers to suffer 'burn-out' within 6 months. For comparison, the caseloads of Dutch 'Guardians' (equivalent to UK Child Safeguarding social workers) are set, by policy, at 15-17 while UK Care system caseloads appear to be passively derived from availability of local budgets rather than national policy or local need – leading to the staffing inequalities revealed in the above table.

The most commonly used phrase by local authority and social work staff was that England's social work provision is 'broken'. The 'internal' and desk-based aspects of social work can take from 25% to 80+% of total time, depending on how the local system is set up. In the worst case, assuming a 50-hour working week (which we hear is not unusual), 80% equates to 10 hours/week to spend with all clients; one family 'on the edge' is likely to need up to 6 hours of intensive work in any given week.

Better performing boroughs where, say, 65% of social work time is freed up to spend with clients (and assuming these, less stretched, social workers work a 40-hour week), would mean 26 hours for client contact – or between 30 and 90 minutes per case per week, depending on caseload sizes (and not allowing for holiday or sickness down-time). Of course, client needs are not spread evenly across time or cases, but such a reasonable amount of time, with a moderate caseload, could make a major difference.

System vs procedures

That there can be such huge variations (25% vs 80%) in social work time on admin/IT 'depending on how the system is set up' suggests a fundamental problem with the ICS might have lain in not following through and designating exactly how the new reporting system needed to be set up, to protect social workers (often of a generation unfamiliar with computer technology) from the frustration that seems to have been widespread.

Besides the problem of the taxing IT burden, social workers also explain that, in the past, there were admin staff who e.g. recorded notes of internal meetings, but that cost-cutting meant these staff were removed, and social workers needed to handle everything themselves – sometimes even to buying stamps so they could send out important letters about vulnerable clients. The happier social workers we interviewed were either supported by IT or admin staff, or both.

Discrepancies of such magnitude in essential procedures indicate the fundamental ‘system’ might not have been quite ready for use when launched.

Shortage of Trauma-informed care (TiC): As covered in Key Message V, one achievable successful outcome comes from Trauma-informed care. It helps not only looked-after children but also has a significant role in keeping children from needing to enter Care in the first place. However, once children have entered Care, TiC improves outcomes in both personal factors and permanency of place¹⁶⁵. At present, although there are some encouraging examples in Pupil Referral Units, and at least one promising trauma-informed school initiative (in Blackburn), TiC is not playing a major part in the UK Care system and environment.

Structural issue in local authorities: Whether child and adult social work is divided matters less than whether those performing it need to answer to two different bosses (the benefits of a flat organisation structure are outlined in Key Message VII and Case Study E). ‘Split’ reporting can create frustration when a social worker in adult social care and another in child safeguarding are dealing with two issues in one family while also answering to two different bosses (because the child and adult social work functions are split in an intermediate layer of management, adding to delays in often highly volatile family situations, and fomenting resentment at both family and professional level).

Much to work with

The above accounts of recent outcomes provide a vast array of material to help refresh a system that allows the UK to hold its head up and reclaim its historic leadership role in e.g. education and welfare (as exemplified by our fine National Health Service – the first of its kind). We face challenges and have catching up to do and will, as always, step up. 19th Century society also faced problem drinking-associated ill-health in the transition from agricultural to the industrialised life – and recovered through a combination the Temperance Movement, legislative curbs to licensing (apart from beer!) and the introduction of factory ‘sports and social’ clubs, to give workers entertaining, positive outlets. That ‘recovery’ lasted until the mid-20th Century, but has been relapsing since then, especially in the past few decades. The latest Home Office Strategy to deal with serious violence is proof positive we can still admit when the course we’ve been following is not the best – and change tack.

Before moving on to Key Message VII, which outlines some already proven solutions to the challenges facing the UK at this point of change, we will leave the last words of Key Message VI to John Seddon¹⁶⁶ of Vanguard Consulting. because of his vast experience in identifying methods that both save money, and produce transformation:

Seizing the greatest opportunity to save money in public services¹⁶⁷

Of the £765bn [2016 figure] currently spent on public services, by far the largest chunk is spent on helping people whose lives have fallen off the rails. People's lives fall off the rails in a variety of ways: infirmity, disability, family breakdown, drug or alcohol dependency, inability to manage finances and/or unemployment. So what happens to people when their lives go wrong and they seek help from the state? You might think that in a civilised society someone would turn up and do what is required to help them get back on track. But that's not what happens.

Instead, people are subjected to a series of assessments – a series because the majority of assessments lead to assessors referring people on to other assessors each of whom, in the recipients' eyes, ask much the same questions. This happens because our services are fragmented. Each of the service providers looks at the person needing help through their own specialist lens. Each is concerned to protect budgets, each uses 'thresholds' to screen out people with what are seen to be insufficient needs. The easiest way to meet activity targets for assessments is to close cases, refer people on.

If a service provider deems someone as deserving of the service they offer, the service provided is most often one that is commissioned. Ministers think the market is the key to reducing costs. Providers quote prices for the services as specified by commissioners. It means that services are, most often, standardised. What you discover is that standardising services means the services don't adequately deal with the variety of people's needs, so people re-present. They go through a series of assessments again and are likely to be offered the same programme. If, as is sensible, they refuse it, since it was no help last time, they are likely to be labelled 'uncooperative'.

This pattern is everywhere and is easily exposed by studying cases – people. The numbers of transactions with fragmented services is always extraordinary and what becomes alarmingly transparent is that there are very few occasions where people's needs are truly understood, hence very few occasions when appropriate help is provided.

Politicians, civil servants and public sector managers all share the belief that demand is rising and, therefore, costs are rising. When you study demand, as I have, you learn that demand is actually stable. That is to say, the original demands people make on health and social care services are stable. We've studied demand into outpatients, we've studied demand into acute hospitals and we've studied demand into social care. In every case the volume of original demands is stable.

What is rising inexorably is failure demand because the services don't work; they don't solve people's problems. People don't disappear, they come back. In many cases, they come back in worse state than when they first presented. By failing to help people, we increase the number of transactions. That's what is rising. In short, the state currently consumes enormous resources to very little end. So if we can design services that help people get their lives back on the rails, we not only increase human welfare – a good end in itself – we will cut expenditure dramatically.

We've been helping leaders to redesign services for people whose lives fall off the rails and this is how it works. First, you need to understand demand in a geography. This is not difficult to do, because you can find out in the geography who is making demands and on which services by looking at data held on computer systems. But it is vital that you understand this demand in citizen terms. Knowledge of the nature of the demand dictates the expertise that you need in your team to go and help these people.

When people put their hand up for help, someone goes straight out to meet them; regardless of the demand. There is no threshold. You make a demand, someone comes straight out to meet you and they are interested in first of all, your 'need' as you would articulate it in your own words. Secondly, having understood your need, they understand your context, what's going on in your life, in your family, in your community, or whatever it

is that's affecting you. Having understood your need and your context, they help you to establish what, for you, would be a good result. What do you need to live a good life in your terms? Or, what do you need to have a good death?

The most important skills required are listening, understanding and helping people understand themselves.

Having established the real need, we look at what the person can do to take responsibility in achieving that end. And then, and only then, we can determine what further support they need from their family, from their community, from the voluntary sector, or from the state, to help them achieve that end. The provision of specialist expertise is only applied where it is needed and where it is seen to be proportionate to actual needs, meeting the recipients' definition of a 'better' life.

What happens next is quite amazing. Lives often get quickly put back on the rails. The cost of the service falls dramatically and most important of all; demand falls.

Working this way, we see that demand falls across other agencies. More importantly, the families and individuals who are being helped gain stability and stop asking for help from public services. Estimates of the financial savings vary from 5% to 40% of operating budgets in the conventional services. We [Vanguard] work to the principle that cost savings cannot be predicted and are emergent; conventional cost/benefit analyses are merely guesses. Having said that, one analyst has estimated that extrapolating the savings we have seen across the entire public sector could save in the order of £16bn.

The accuracy of the prediction is not the important thing. When the costs of people helped in this new design are compared to previous expenditure patterns, large savings are a given. But, much more importantly, as lives get back on track, overall demand falls. Think about that, demand falls; happier people, happier families, stronger communities. Shouldn't that be the purpose of public services?

John Seddon, 2017

KEY MESSAGE VII: A national shift to a user-focused, trauma-informed care system characterised by ACE-awareness, followed by adoption of a pedagogical approach across all aspects of children and family services, would protect against severe, multiple disadvantage.

This final Key Message outlines some suggestions to achieve significant reductions in the number of children aged 2 to 18 likely to suffer severe, multiple disadvantage. It reviews:

- Systems already delivering good outcomes;
- The role of organisation structure in service delivery; and
- Some current methodological and programmatic approaches.

Whether improving outcomes for babies born with foetal alcohol damage, or looked-after children, or those with physical or emotional/social development problems, or suffering from ADHD – or any other disabilities or disadvantage (including mental ill-health, early-onset addiction or alcoholism) – a key constant of our research findings was that ACE-aware, trauma-informed care created the best possible outcomes. It qualifies as a system in its own right because adopting it nationally would fulfil both the need to have arisen out of policy and the principle of caring for the vulnerable. It also implies the need for vastly improved training of delivery staff, in accordance with the new Putting Children First government mandate.

A three-pronged framework of a related, fundamental approach is needed to protect children from risk of SMD: (i) a national shift to a user-focused, trauma-informed system characterised by ACE-awareness; (ii) the adoption of a social pedagogical approach across all aspects of children and family services; and (iii) a model to keep young people healthily busy, similar to the wholesome approach in place across Iceland. Our research shows the seeds of recognition of the need for such a shift are taking root in many places and among many organisations including the Home Office, as published in its April 2018 press release on its Serious Violence Strategy to make a ‘step change’ by taking a more preventive and enlightened approach to reducing violent crime¹⁶⁸.

Recent UK advances in ACE-aware, Trauma-informed Care

ACEs are of growing interest to senior civil servants and academics in Scotland, Wales and Northern Ireland, and in some local areas in England:

1. **The Welsh Government** has committed to prioritise attention to ACEs, including funding for a ‘hub’ to tackle their negative impact in Wales by linking organisations, communities and individuals with people who are knowledgeable, skilled and experienced in this area¹⁶⁹.
2. **NHS services in both Scotland and Northern Ireland** have organised major conferences to publicise the importance of recognising and tackling ACEs, as a public health priority. NHS Scotland issued a summary paper¹⁷⁰ after their November 2016 conference ‘Polishing the Diamonds’, which included a summary of conclusions: ‘... *Moving from a culture of blame, shame and punishment to one of understanding, nurturing and healing is fundamental for supporting individuals and families... Ensuring our workforce has an understanding of the complexity of childhood adversity is essential...*’
3. **The Scottish Government** has set up a high-level ACEs Community of Interest group, comprising the Directorates of Health and Social Care, Learning, Population, Safer Communities and the Chief Medical Officer. The 2017-18 Programme for Government committed to embedding a focus on preventing

- ACEs and, where they occur, addressing their negative impacts by supporting the resilience of children and adults in overcoming early life adversity.
4. **Both Scottish and Welsh NHS** have also promoted community understanding of ACEs by showing the James Redford ACE documentary ‘Resilience’ to local areas around both of their countries¹⁷¹.
 5. **In Northern Ireland**, the NHS has set up, jointly with the **Republic of Ireland**, a 4-year Multiple ACEs (MACE) project¹⁷² to ‘transform the lives of vulnerable children and families who are at risk from multiple adversities in their lives, by identifying ACEs, intervening early and providing nurturing support within their own homes and communities.’
 6. Although **England** was the last of the four UK countries to develop strong interest in ACEs, Public Health England has recently become engaged; the Borough of Blackburn with Darwen has been a leader in establishing a vision to reduce the number of ACEs experienced by local people, and to build the resilience of those who have already experienced ACEs¹⁷³. Following a 4-year study, the April 2018 Home Office strategy for dealing with violent crime¹⁷⁴ (see above) strongly features ACE-awareness and, for the first time, acknowledges that the historic ‘punitive segregation’ system tends to defeat rehabilitation.

Social pedagogy: BA degrees in this are now offered by the Universities of Aberdeen, Canterbury Christ Church and Central Lancashire; the University of Salford offers an MA in social pedagogy; while East Anglia and Newcastle offer MAs in which social pedagogy is a major component. Other UK universities have course modules in social pedagogy as part of degree programmes in youth and community work, social work or working with families. University College London has a Centre for Understanding Social Pedagogy (CUSP) which conducts R&D and supervises doctoral students with an interest in social pedagogy in the UK and cross-nationally¹⁷⁵. The Centre is planning to develop national occupational standards, professional qualifications and a Social Pedagogy Professional Association (SPPA), and will be developing and disseminating high quality social pedagogy training across the UK.

‘Putting Children First’ (PCF)¹⁷⁶

Since 2016, the government has committed to remove the causes of social work failures attributed to the late 1980s Integrated Children’s Services system (ICS): PCF is based on 3 pillars of social work reform: People and leadership; Practice and systems; Governance and accountability, currently being trialled in 8 local authorities. It means major restructuring of social work, which is welcomed by social workers, and appears positive.

Recommended systems from other countries

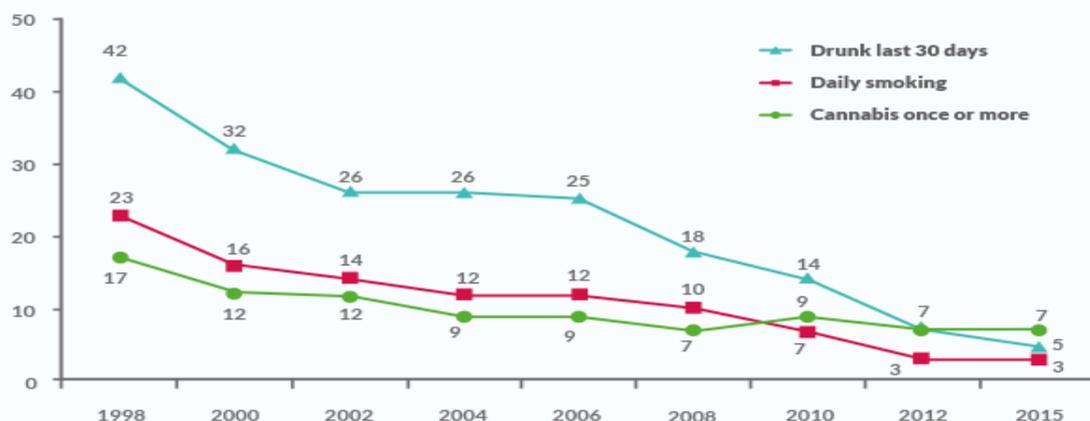
Case studies B and F-H summarise the major features of systems from Portugal, Netherlands, Finland and Iceland. Norway and the US are included, to show how Norway achieved low recidivism rates, and to announce the US (evaluated) benefits of Trauma Systems Therapy (TST).

1. The **Portuguese** system relates solely to how decriminalising drug use not only reduced it among the young but also reduced prison over-crowding (from 140% to 101% of capacity), and radically improved their severe drug-related health problems of HIV, Hepatitis C, Tuberculosis and STIs (Case Study B). In view of the strong role of drugs (especially crack cocaine) in UK youth violence, perhaps the thorny issue of

decriminalisation might be reviewed in light of the extensive scientific evidence Portugal used in making this very controversial decision.

2. **United States** Trauma Systems Therapy (TST): Key Message V outlines many US initiatives with positive outcomes. These include a 2017 US study¹⁷⁷ evaluating the effectiveness of system-wide reform to implement trauma-informed care via Trauma Systems Therapy across a large, private child welfare system.
3. **The Netherlands** models a quite holistic system, in terms of education, work ethic, social care (including for mothers of new-borns and for looked-after children) and integration of immigrant populations (Case Study F). Partially decriminalised cannabis is credited for reducing numbers of prisoners.
4. **Norway's** prison management is enlightened 'reintegrative punishment' vs our UK 'punitive segregation'. We recommend adopting both their policy for prisoners and for training prison officers (3 years' – including in psychology – vs the UK's 10-12 weeks). The potential prize would be reducing 2 and 4-year recidivism respectively from 51.4% and 74.2% to 22.6% and 39.2% (Key Message V).
5. **Finland's** holistic approach to education and health resulted in educational outcomes that became 'the envy of the world' (Case Study G). Their most recent achievement is in using the Housing First approach and becoming now the only European country *reducing* homelessness. This national commitment claims to have eradicated street begging and street living. Even the registered homeless are placed with friends or families until a permanent home can be found or built. Temporary shelters are being phased out. In Finland, homelessness does not mean being on the street; it means lacking a permanent residence.
6. Since 1998, **Iceland's** policies for its unruly youth transformed them from being some of the drunkest European teens to top of the 'cleanest living' league. Combined smoking, alcohol and cannabis use were reduced by well over 90% by 2015. The format is: stricter regulations on buying, or allowing young people access to drugs or alcohol, high levels of parental involvement (by signed contract), curfews, and ready access for families with children to sport, hobbies, arts and crafts, and music (graph below and Case Study H). The positive outcomes of this generation of clean-living young can now also be seen on the global sporting stage – that a population of a mere 320,000 can enjoy such success is perhaps the best possible advertisement for handling the UK drug and alcohol youth culture.

SUBSTANCE USE IN ICELAND AMONGST 15-16 YEAR OLD



Recommended UK Systems: Local authority organisation structures

The organisation structure adopted in local areas is crucial to effective inter-agency collaboration. A soundly designed system ensures the vital component of true inter-agency collaborative working is not only encouraged and acknowledged but is also inherent, and rewarded at the individual level. When reward is omitted, very busy people, whose work appraisals relate solely to one defined sphere of activity, are likely to prioritise getting their own work done over the good of the whole whenever that involves collaborating with ‘outside’ agency colleagues.

In interviewing local authority executives and senior social workers, we heard how the ‘inter-agency collaboration dream’ fizzles out in the face of large workloads and competing priorities – multi-agency ‘team’ meetings being only partially attended, or repeatedly rearranged or cancelled. Such time-consuming going through the motions of the ‘dream’ adds to waste rather than productivity or quality of services.

Replacing the traditional ‘silo’ culture and structure with more enlightened and effective approaches to child and family services is already proving successful in some of the UK boroughs interviewed for this study. This is encouraging because it means inter-agency collaboration *can* work, but is just not always being worked well. John Carnochan (former Head of the Scottish Violence Reduction Unit) understood this:

... So, the challenge is how we work together, and that’s the difficult stuff; the uncomfortable truth, the notion that there isn’t such a thing as a conflict-free zone because of all those little things – your funding, your idea, your group, your borough... We need to stop that¹⁷⁸.

Because the successes in both Bridgend and Highland Region can be partially attributed to their flat organisational structures for managing service delivery to children and families, combined with active ‘child-focused’ policies and practice, we are including both under the Structures heading of recommended systems:

Bridgend transformation – whole Council approach

In Bridgend, following the shock of being placed on ‘monitoring’ by Estyn (HM Inspectorate for Education and Training in Wales), the collaborative style was taken to the extreme of the whole top Council Executive (including the CEO) sharing an open-plan space (and their PAs sharing another). This restructuring of management was in sharp contrast to the former ‘silo’ culture (when different departments were often located in separate buildings), and made it easy for informal consultation and liaising among all the strands in the complex machinery of local government. Close proximity played to the individual strengths of people who, in the original ‘silo’ structure, might have met only formally. Differing opinions were discussed and consensus reached.

This essentially collaborative style was further cemented by a ‘One Council’ vision that held every member, irrespective of role, responsible for child safeguarding. (See Case Study D for a detailed prescription to achieve transformation very quickly).

Highland Region Streamlined Reaction (HRSR)

The Highland approach was evolved to deliver on the GIRFEC (Getting It Right For Every Child) philosophy and commitment (Case Study E). As well as some detail of how

this excellent approach worked, the case study shows the Highland organisation structure designed to streamline and simplify working and reporting methods. In addition to the benefits of a simplified, flat organisation structure, Highland ensured success via a multi-agency governing Board to allocate budgets across various services. This guarantees collaboration across every function (including Police and Probation) likely to be involved in an event in a child's life. This seems a sensible model to adopt if, as a nation, we are determined to see multi-agency, collaborative-style working.

While systems and structures call for sound and sensible use of supporting IT, the Highland model was implemented well almost two decades ago when the recording system was still largely paper-based; it had not yet become fully electronic in 2014 when the organisation structure shown in the Case Study was produced.

Welsh investment in preventing homelessness

The Housing (Wales) Act 2014 brought forward a strengthened 'prevention and relief' duty. Welsh local authorities now have a duty to *prevent* homelessness for all eligible households threatened with it, within 56 days, irrespective of priority need or intentionality. For those who become (or are already) homeless, the local authority has a duty to relieve by helping secure accommodation. The report (by Shelter Cymru¹⁷⁹, whose caseworkers are embedded in some Welsh prevention teams), reviewed progress 6 months after the Act came into force. It shows a mixed picture of teething problems and successes, and variability of outcomes between regions as well as inconsistencies in caseworker attitude. On balance, outcomes look promising, but do not yet amount to national commitment to the Housing First method working so well in Finland. The Homelessness Reduction bill proposes a similar legislative framework be introduced in England, to strengthen the statutory safety net.

Methodological approaches to services to children and families

Two innovative methods to overcome local authority obstacles to good service delivery were identified:

1. Pre-October 2015, all health visitors reported to Health. **Hertfordshire** overcame local services challenges by securing a DfE grant to employ 12 (non-hospital) health visitors to report directly to the Council;
2. **Stockton** reduced social work time on admin from c.80% to 30-35% by reassigning IT/admin duties to appropriately skilled workers, leaving their highly trained, vocational social workers free to do their jobs.

Programmatic methods – brief outline of recommended programmes

1. **Dorset Healthy Alliance**¹⁸⁰ This was a targeted, non-stigmatising, preventive programme focused on 9-16 year-olds, rooted in broad collaboration between parents, schools, social services and Probation. Its primary focus was preventing truancy, theft and school exclusions (and the attendant social and neighbourhood consequences, including youth offending). Outcomes included improved child/parent reconciliation, reduced child referrals, improved academic achievements, reduced truancy, vandalism, theft from schools and school exclusions (and resultant anti-social consequences). It paid back 111% on initial investment (rising to 250% if broader criminality is included).
2. **Nurture Groups:** The introduction of this (Not For Profit) initiative to mainstream schools is already significantly improving outcomes for not only children who disrupt

lessons but also for the general cohort. Expansion of this could benefit the whole nation. It is being implemented in both Scotland and Northern Ireland with very good results.

3. **Empathy programmes:** Usually delivered in primary schools, and suitable for all ages. See Case Study C for the preventive effect of empathy on school bullying.

Conclusions about systems, structures and methods (or approaches)

Our overall conclusion and recommendation is that the UK would benefit from adopting a social pedagogical system in parenting, education and care (one term we found in our research was 'Parents are the first pedagogues' and, indeed, there is a programme called Parents as Teachers, or PAT – described in WAVE's 2010 International Update, available at www.wavetrust.org). This would imply an ACE-aware, trauma-informed system, especially for children. The approach would naturally include sound parenting education, and would benefit people of all ages and whatever their problems – including: rendering it unnecessary for many children to be removed from mainstream schooling; reducing the 72% recidivism rate among leavers of young offender institutions; and reducing the numbers institutionalised for mental ill-health. Professor Melhuish believes very good use of the government funds for the 40% most disadvantaged 2-4 year-olds would be to provide programmes for their parents, to enable them to create good home learning environments for their children.

National adoption of a social pedagogical system will take time, but we can make great improvements in outcomes by e.g. creatively combining a blend of the Netherlands education and care systems with specific ACE and TiC approaches (including the TST system thriving in the US, the Icelandic 'Project Self-Discovery' for teenagers, the Finnish Education and Homelessness system and the Portuguese drug reform laws).

A particularly sound approach to transform our own intergenerational alcohol and drug problem would be to adopt nationally the tried and tested Icelandic approach to youth culture (Case Study H) because it succeeded at a time when Iceland's youths appeared hopelessly out of control. With so many UK parents desperately concerned their children will be stabbed or shot in gang warfare, the involvement of parents and the imposing of curfews could have a very beneficial knock-on effect in terms of parenting in general. The reward: peace of mind and (for poorer families) subsidised membership to a wide range of sports and activities – occupations to divert young people from the 'mischief' of smoking, drinking and taking illicit drugs.

APPENDIX to Part I

Foetal Alcohol Spectrum Disorder

The adverse experience of any form of foetal alcohol harm is a significant contributing factor to lifetime severe, multiple disadvantage. It is suffered by an estimated 3+%^{181,182,183,184,185} of UK infants. This life-long condition is irreversible and represents the biggest single ‘cause of “mental retardation”’ [sic], in babies born in the Western World^{186,187}. While that term is now widely regarded as too stigmatising, and has been largely replaced by ‘intellectual disability’, it needs to be acknowledged that the latter is a rather catch-all term that includes such neurological damage as Downs Syndrome, infant hypothyroidism, and the effects of the mother taking the anti-convulsive drug valproate in pregnancy – as well as FASD.

Our research suggests a significant proportion of challenging teenage parents and children in our schools, mental health services, young offenders’ institutions endure the (very often undiagnosed and untreated) effects of FASD. This condition has the distinguishing features of being entirely avoidable by abstaining from alcohol in pregnancy; it also has distinctive secondary (behavioural) effects (See ‘The primary consequences of FASD include’ paragraph below and Case Study A).

How FASD occurs: alcohol consumed *at any stage* during pregnancy can reach the foetus by crossing the placenta. The slower (than adult) foetal metabolic rate results in proportionally higher blood-alcohol concentrations that: i) impede delivery of oxygen and nutrition to the foetus, ii) can harm the development of tissues and organs, and iii) cause permanent brain damage. Ongoing research is seeking to identify the specific liver enzymes that render some girls and women more vulnerable than others to this tragic outcome. Until all the parameters have been established scientifically, the only safe amount of alcohol to consume when pregnant (or at risk of becoming pregnant, because the damage can have been done anytime from conception) is that recommended by the World Health Organisation and the Danish Government: none.

The primary consequences of FASD include: hyperactivity; attention deficits; deficits in sustained and focused attention and cognitive flexibility; planning difficulties; learning and memory problems; new memories not consolidated; and difficulties with arithmetic, receptive language, verbal processing and social understanding¹⁸⁸. While the similarities between ADHD and FASD are obvious, they are not the same; FASD is far more serious and needs distinctly different treatment. For instance, Streissguth et al¹⁸⁹ highlighted secondary difficulties for children born with FASD: average IQ is 85.9; ninety per cent of sufferers have some form of such diagnosable mental disorders as personality disorder, schizophrenia, addiction and depression; 50% have some form of mental health problem or criminal justice confinement; 50% display some form of sexually inappropriate behaviour. Other challenges include failure to understand cause and effect, poor regulation of emotion, disruptive school experience and problems with employment¹⁹⁰. In her Foreword to the BMA report on Foetal Alcohol Spectrum Disorder¹⁹¹, Professor Sheila the Baroness Hollins says:

‘It has long been known that maternal alcohol consumption can have damaging effects on the fetus. Yet the stark reality is that a large number of children are born every year in the UK with lifelong physical, behavioural and/or cognitive disabilities caused by alcohol consumption during pregnancy. Worse still, there is a scandalous lack of support for these children, who live and grow up with the impact of their impairments without the

educational, emotional and social support they require to fulfil their potential... They are also frequently affected by a range of secondary comorbidities, including such social and mental health problems as substance abuse or sexual inappropriateness, educational difficulties, or crime and consequent incarceration...'

WAVE's work with UK Health Boards shows that FASD mostly goes unsuspected, undiagnosed, or misdiagnosed (usually as autism or ADHD). This masks its true incidence and deprives afflicted children of appropriate treatment, which exposes them to the secondary disabilities that develop when there is a poor fit between someone blighted by FASD and their world¹⁹². Since FASD is such a clearly damaging Adverse (pre)Childhood Experience, warranting the best possible Trauma-informed Care, tackling it is crucial to any serious initiative to reduce the incidence of SMD.

Case Study A illustrates the obstacles to correct diagnosis experienced by the adoptive parents of two babies with FASD born to the same alcoholic young mother and how, two decades on, the (by then) young adults' problems remain so severe they are unlikely ever to be able to live independently. The following (short) extract from the case study illustrates a fraction of the misleading and contradictory information given to the adoptive parents of their two (wrongly diagnosed) children:

For Ryan and Tracey, the diagnoses we were given did not seem to fit what we observed. If Ryan had Asperger's syndrome, where was the characteristically obsessive behaviour? If Tracey was autistic, why did she enjoy meeting others so much? And why did alcohol turn both of them into aggressive, violent and antisocial beings when other autistic or Asperger's kids we knew would instead shun society and turn inwards on themselves?

We recommend anyone engaged in policy related to alcohol and pregnancy read the whole case study, because it reveals the fallacy that all the problems caused by consuming alcohol in pregnancy can be solved for the child by removal from the biological mother at birth.

The basis of WAVE's 3% compared with WHO's 1% FASD estimate

In 2014, the WHO Guidelines for the identification and management of substance use and substance use disorders in pregnancy were published. Its overarching principle is that *'Preventing, reducing and ceasing the use of alcohol and drugs during pregnancy and in the postpartum period are essential components in optimizing the health and well-being of women and their children. There is no safe level of alcohol use during pregnancy...'* ('Prevention of harm caused by alcohol exposure in pregnancy', WHO, 2016)

Several times during our research (e.g. in contact with Public Health England), we came across references to a WHO estimate of general prevalence of FASD as only 1% of live births. Our reasons for disagreeing with this estimate reflect the differences between three different methods of estimating prevalence: Two methods which were most common until a few years ago: 'Passive Surveillance' and 'Clinical Studies', both of which tend to under-estimate prevalence, and a more expensive but more comprehensive approach, now increasingly used, known as 'Active Ascertainment'.

On investigation, we believe the origins of the WHO estimate may be based on a series of over 30 clinical studies reviewed by Abel and Sokol^{193, 194} and Abel¹⁹⁵ in the 1980s and 90s, from which an estimated FASD prevalence of 0.9% may be deduced; and a 2001 meta-analysis by May and Gossage in which a mix of 19 Passive Surveillance and Clinical studies also produce an estimate of about 1%. However, more recent studies have

demonstrated that both ‘passive’ and ‘clinic-based’ methodological approaches significantly underestimate the true incidence of FASD^{196,197,198,199}.

The most reliable method for estimating FASD prevalence is the active ascertainment approach, through which entire schools or communities are studied, and self-selection is largely eliminated as a source of bias. The method is time-consuming and expensive, and little used traditionally, but many such studies have now been conducted, and the results indicate levels of 3% or above.

Evidence that previous estimating method are incomplete

1. A 2001 study by Clarren et al. of children in first grade of Elementary School, found only one in 7 they identified as having FAS had been detected in previous clinical studies.
2. An Abel study that included 5 UK studies, 4 Australian studies, 3 from Spain and 16 from a combination of Canada, Denmark, France, Italy, the Netherlands, Portugal, Sweden and Switzerland, found only three of these studies reported any FAS cases at all.
3. In a 1999 study by Stoler²⁰⁰, one of 19 infants with documentation of maternal alcohol use was noted by the paediatrician to have possible alcohol-related features, in contrast to 7 (of the 19) identified by a trained examiner.
4. Mukherjee, Hollins and Turk²⁰¹ report that Stoler studied 40 high-risk pregnancies to see if foetal alcohol syndrome was detected in the offspring. A specialist research assistant identified 16 cases resulting from these pregnancies; not one of which had been identified by routine paediatric screening.
5. Little and colleagues (1990)²⁰² reported that all 40 new-borns in a large Texas hospital, who were strong candidates for an FAS diagnosis (i.e. born to heavy-drinking mothers and displaying most of the physical features of FAS), left hospital without any diagnosis.
6. In 2014 May, Baete and a team from 6 US universities carried out an active ascertainment study with first graders in a ‘representative Mid-Western City’. The authors comment that ‘... *surveillance systems, prenatal clinic-based studies, and special referral clinics have proven inadequate for determining the prevalence of FAS or FASD... [and] are believed to be underestimates*’. Their study arrived at an estimated prevalence for FASD of 3.6%²⁰³.
7. Fox et al²⁰⁴ (citing a study of paediatricians and associated staff²⁰⁵), found more than two-thirds of respondents reported a lack of training as the primary reason for not making a diagnosis; more than half had no formal training in recognition, diagnosis, or treatment of FAS; and two-thirds thought this diagnosis would stigmatise the family and child. The lack of training had a cascading effect: clinicians do not recognise and document physical and behavioural characteristics that might lead to a more complete clinical evaluation or serve as a trigger for a records-based surveillance system to identify a child as at risk of FAS.
8. Maternal prenatal records are not routinely linked to a child’s birth or neonatal record, meaning any prenatal alcohol exposure documented is not seen by paediatric clinicians who need to interpret physical or behavioural characteristics of the child.
9. Some clinicians are hesitant to consider possible prenatal alcohol exposure in the diagnosis of behavioural and learning problems because services or interventions specific to FASD are either unavailable in their community or clinicians are unaware of such services.

10. UK Hospital admission for alcohol-related conditions in women aged 15-44 increased by 41% between 2002/03 and 2007/08. These statistics were (unbelievably) not associated with increased FASD-detection in their offspring. Morleo, Woolfall, Dedman et al (2011)²⁰⁶.

The authors of that study concluded, and this is a crucial recommendation: 'That to understand the full extent of underreporting, an active ascertainment study is required.'

Accuracy benefits of the Active Ascertainment methodology

Like Morleo and colleagues in 2011, May and Gossage stated in 2001 that the active ascertainment method is the most likely to provide a full picture of FAS/FASD prevalence: *'Active case ascertainment methods have at least three advantages. One, the primary focus is on finding children with FAS at appropriate ages [3 to 12 years] for accurate diagnosis by clinical specialists. Two, active, effective, and comprehensive outreach in a large general population is most likely to uncover children with FAS and alcohol-abusing mothers at the highest risk. Three, by studying entire communities or populations, this method can eliminate much selectivity, and generally ensure wide representation...'*

Some examples of Active Ascertainment FASD estimates

- At the time of the 2001 meta-analysis, the one qualifying (i.e. not confined to a particular ethnic group) US active ascertainment study carried out, on first grade students in Washington State. resulted in an estimated 2.8% with FASD (Clarren et al. 2001²⁰⁷): the 'non-qualifying' studies (all of native Americans) all showed much higher levels of FASD.
- In 2006, May, Gossage and others carried out a thorough analysis of first-grade school-children in Italy²⁰⁸. Using two denominators for prevalence estimation, a conservative one and a strict sample-based estimate, the indicated FASD prevalence in this Italian province was 3.5% overall.
- In 2015, May, Keaster et al carried out a 3-year Active Ascertainment study on a group of 1,278 first grade children from all 17 Elementary Schools in a Rocky Mountain Region city. The study suggested an FASD level of 4.7%²⁰⁹. 40% of parents did not agree to allow their children to participate in the study, possibly biasing the results.
- In January 2017, the Lancet published a review, *'Estimation of national, regional, and global prevalence of alcohol use during pregnancy and fetal alcohol syndrome: a systematic review and meta-analysis'*²¹⁰, whose figures translate to a European average of 3.4% for FASD.
- In February 2018 the Journal of the American Medical Association published new FASD prevalence studies for 4 communities in the USA²¹¹. These showed a 'most conservative' estimate of between 1.1% and 5.0%, and a weighted estimate of between 3.1% and 9.8%.

Conclusions about incidence of FASD

Based on the foregoing analyses, and in line with the advice of the numerous academics referenced, we propose the figure of around 1% prevalence, based mainly on Passive Surveillance and Clinical Studies, produces a falsely low estimate of FAS and FASD while the true rate of FASD in Western Europe is 3-4%.

Compared to Italy, with its estimated 3.5% FASD figure, the UK has: 73% higher alcohol consumption per capita; 477% higher heavy episodic drinking at age 15+; 100% higher heavy episodic drinking from age 15-19; and 70% higher deaths from liver cirrhosis

amongst females. These comparisons combine to deter us from believing the UK figures for FASD are likely to be below the European average. Rather, we have many reasons to believe they will be above it. We therefore conclude that the level of FASD in the UK is likely to be a minimum of 3+%, and might well be higher, especially in the heavier drinking areas such as the north-east and north-west.

The estimated number of UK children aged 2-18 in 2016 was 12.4 million²¹². If just 3% of these children were born afflicted by some variant of FASD, that would mean there are over **three hundred and seventy thousand** children and young people across the UK, of whom only a small minority are correctly diagnosed and treated – or between quarter and half a million future inhabitants potentially living in severe, multiple disadvantage if they do not have lifelong protection and care.

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PART 2: CASE STUDIES

CASE STUDY A: Adverse outcomes from foetal alcohol harm

Numerous references have been made to the dangers of foetal alcohol harm throughout the report. We are informed by members of the medical profession that the condition known as Foetal Alcohol Spectrum Disorder (FASD), which is the most serious form of this blight on lives, is visible to the trained naked eye immediately following birth. However, because training is lacking or inadequate, the condition often remains undetected until after children begin to walk, when extreme clumsiness and lack of coordination become obvious.

The following, published in The Guardian newspaper on 30th September 2009, was submitted anonymously by the adoptive mother [all names had been changed to preserve anonymity]. The headline was:

'We didn't know our babies had been damaged by alcohol'

Ryan and Tracey both suffered brain damage in the womb. Their adoptive mother, writing anonymously here, fears the children of Britain's bingeing generation face a life of emotional trauma.

When Martin Narey, chief executive of the children's charity Barnardo's, called for many more children to be taken into care at birth to stop them being damaged beyond repair by inadequate parenting, I thought of Ryan and Tracey [not their real names], two of our three adopted children. Our son has just passed his 21st birthday in prison. He is on remand, awaiting trial for various violent offences. Tracey, his 19-year-old half-sister, is doing better. But if she were not living at home, she would undoubtedly be putting herself in dangerously threatening sexual situations. She is simply not capable of living safely on her own.

Through the arduous and harrowing process of raising them, we have come to realise that children can be 'damaged beyond repair' long before they are born. And the cure may require of society much more dramatic policies than merely taking babies away from inadequate parents.

We adopted Ryan as a one-year-old, a frail little chap who had been taken into intensive care because his birth mother had badly neglected him in the first couple of weeks after he was born. He had been fostered for almost all of his short life. The social workers told us that his mum "had learning difficulties" and had been abusing alcohol and illegal drugs.

Apart from his small size, Ryan's difficulties first surfaced when he was three. He was terribly clumsy – he kept tripping himself up each time he tried to run. Other indicators – delayed speech and concentration problems – took me to our GP. An occupational therapist told us our son was severely dyspraxic, a problem of damage to nerve cells in the brain

Tracey was born to Ryan's birth mother 16 months later. Social workers took her from her mother straight away. We adopted her, too. She also had co-ordination problems, and was strangely passive, but from the beginning she was a determined child.

Over the years our children's problems became more apparent. We sought in vain for an

explanation of their behaviour. Only recently have we begun to suspect the factors that have probably caused the nightmare that we (and they) have endured. If our explanation is right, it has important implications for government policy on alcohol. Only recently has it become apparent that the very different quality of education and support our two children received may explain why Tracey seems to cope better with her heritage than Ryan with his.

Tracey was the luckier one. It did not seem so at the time. She behaved so aggressively at primary school that her head teacher described her as 'an animal' and 'evil'. She persuaded us to get Tracey a 'statement of educational needs'. Then followed several years during which Tracey's behaviour worsened and we went from professional to professional. At 11, she was diagnosed as having an autistic spectrum disorder and severe attention deficit hyperactivity disorder (ADHD). As a result, she was admitted to a school for children with special needs and was provided with a caring and supportive secondary education, suited to a child with her difficulties.

Ryan stayed in mainstream schools. At secondary school he couldn't cope, and retreated from his difficulties and the ridicule of the other kids by finding cannabis. He would go missing and roamed the streets. At home he cried, threatened to kill himself, talked of how much he hated school, how the other boys and teachers laughed at him. His drug-taking progressed to "skunk", although we didn't know it. We knew he was unhappy, and pleaded for him to be statemented. His secondary school refused to co-operate. He was truanting a great deal, and although we didn't realise it he was already involved in petty crime.

The crimes gradually became more serious. We pleaded with Ryan to stop; the magistrates told him they never wanted to see him again in court; the youth justice officers tried to reason with him. The crimes continued, sometimes even the same day he was sentenced, or the day after he had been in court. One of the youth justice team told me: 'Your son's going to prison'. I wanted to scream at the man that it was his job to stop this, not advise me to accept the inevitable.

Then Ryan hit the alcohol. Immediately the offences became violent. When he got drunk or high on something, he hit, punched and swore at us and broke things. Windows and mirrors were smashed, door panels broken, all of us were bruised. Then he began slashing himself with razors, knives and any sharp object he could find. He stole from us all. In between the drunken bouts he was affectionate and loving, scared of what was happening, but unable to explain it to us. He clearly didn't understand it himself.

At school, Tracey's problems persisted. On one occasion she locked herself and other classmates in the library and the helpless teachers could only watch through the glass door as she swung, whooping, from the low roof beams over the other children's heads, jumping down from time to time to spin the little boy with cerebral palsy round and round in his wheelchair in frighteningly fast circles. She bit, hit, kicked, swore at and punched other children, her teachers and us. She was banned from swimming after she held another child's head under the water

Thanks to the wondrously long-suffering and understanding teachers in her secondary school, however, this malevolent and self-destructive human whirlwind metamorphosed slowly into a young lady who generally behaved well. But in one respect, she shared her brother's problems.

After she left school, she began drinking alcohol with friends, always away from home. We would find her so drunk that she could not stand up, lying in the middle of the road. She was often in the town centre, sprawled on a bench with alcoholics, drug dealers and homeless people. Tracey increasingly seemed drawn to putting herself into sexually threatening or exploitative situations with men, despite our attempts to keep her safe. She simply did not seem to understand the danger she was in, or what might happen to her. On one occasion, I found her with a group of about seven men in the park. I told her to come with me, but she refused at first. It was only when we were well away from the group that she admitted how frightened she had been.

But why have our children had so much difficulty, especially when affected by alcohol? We have sought an explanation for 20 years. Despite what child psychotherapists told us, we know that it is not simply because of their adoption. Our oldest child, also adopted, is a hard-working and conscientious young woman with a university degree and a steady boyfriend. For Ryan and Tracey, the diagnoses we were given did not seem to fit what we observed.

If Ryan had Asperger's syndrome, where was the characteristically obsessive behaviour? If Tracey was autistic, why did she enjoy meeting others so much? And why did alcohol turn both of them into aggressive, violent and antisocial beings when other autistic or Asperger's kids we knew would instead shun society and turn inwards on themselves?

It was while we were tussling with these questions that we came across the condition known as foetal alcohol spectrum disorder (FASD). It affects children whose mothers drink alcohol during pregnancy. We discovered that research into FASD had been carried out for many years in the US and Canada. Professor Ann Streissguth of University of Washington School of Medicine, who began her research on foetal alcohol effects 30 years ago, found that children affected by prenatal alcohol exhibit anger and hyperactivity, impulsive behaviour and poor judgment. They have difficulty learning from the consequences of their behaviour and keeping themselves safe, their sexual behaviour is inappropriate and they have low self-esteem. A high proportion fail at school, abuse drugs and alcohol, and have trouble with the law. Few manage to live independently.

Suddenly many characteristics of our children's behaviour started to make sense. We knew that their birth mother was abusing alcohol and illegal drugs before Ryan was born, and she continued until Tracey was born. Could it be that the brains of both children were severely damaged before they were born? As we read further on this subject, we found that foetal alcohol spectrum disorder is the leading cause of preventable birth defects, and the most common known cause of cognitive impairment in children. A report published in 2007 by the British Medical Association, entitled 'Fetal alcohol spectrum disorders', suggested that, worldwide, perhaps one in every 100 babies is born with FASD.

We can no longer have Ryan living with us. With no community support, no protected accommodation and no one apart from us, his family, who will help him, he will join the many others in our prisons who suffer the same disabilities that Ryan's birth mother has given him.

Tracey could, unsupported, continue to place herself in sexually threatening situations, or among people who can endanger her – especially if she returns to drinking alcohol. With our continued support, and while she stays at home, she appears to be maturing and becoming an adult. She was given a temporary job by a major supermarket, owing to

her disabled status, and has just been offered a permanent post with another. She still lashes out violently at us sometimes, but now only verbally, and she has learned to control herself at work – even when faced by violent and angry customers. She also says she does not ever want to drink alcohol again.

But there are many Ryans and Traceys. Two support groups aim to publicise their plight: FASawareUK and NOFAS-UK. But we found few medical experts, in our long search for help, who knew anything about the long-term impact on adults whose mothers drank while pregnant. And in the UK we have one of Europe's highest levels of alcohol use and binge-drinking among adolescents, and the highest rate of teenage pregnancies. Yet we are not even collecting statistics on the numbers born with FASD.

The consequence is that the UK is in danger of producing a generation of children born with irreversible brain damage caused by their mothers' drinking during pregnancy. Permanently brain-damaged in the womb, they will be impulsive, unable to plan or see the consequences of their actions, or to empathise with their victims; and too often they may end up committing senseless crimes.

And in the UK we are doing almost nothing to stop it.

CASE STUDY B (part I): Decriminalisation of drug use in Portugal

Reason for inclusion in this report

Because addiction/alcoholism is involved in so many cases of severe, multiple disadvantage, including homelessness and risk of early death, it is important to continue to strive to understand this dreadful blight now affecting so many UK young. Case Study H (on Iceland) below provides the latest thinking on ‘coping’ nature of addiction, while the US experience of returning veterans from Vietnam shows a recent historical event that is, to say the very least, thought-provoking (outlined in Part 2 below). We will start with Portugal’s experience:

Portugal’s location on the south-western border of Europe makes it a gateway for drug trafficking. It is a transit nation for trafficking of cocaine from Brazil and Mexico, heroin from Spain, hashish from Morocco, and liamba (the local word for herbal cannabis) from Southern Africa. The following extract is from the Cato Institute’s Greenwald²¹³ Whitepaper ‘Lessons for Creating Fair and Successful Drug Policies’ reporting in the US in 2009:

‘Political Climate in Portugal Pre- and Post-decriminalization

‘The political impetus for decriminalization was the perception that drug abuse – both in itself and its accompanying pathologies – was becoming an uncontrollable social problem, and the principal obstacles to effective government policies to manage the problems were the treatment barriers and resource drain imposed by the criminalization regime. Put another way, decriminalization was driven not by the perception that drug abuse was an insignificant problem, but rather by the consensus view that it was a highly significant problem, that criminalization was exacerbating the problem, and that only decriminalization could enable an effective government response.’

So while, by the standards of many European countries, Portugal did not suffer a serious drug usage problem, by the early 1990s it was suffering numerous, very serious *drug-related* health problems arising from the needle-sharing inherent in an increase in injected heroin. Of chief concern were HIV and AIDS, but tuberculosis and hepatitis (B and C) were also soaring.

Decriminalisation occurred only after extensive study by an elite commission, Comissão para a Estratégia Nacional de Combate à Droga (Commission for a National Anti-Drug Strategy). That commission was created ‘in response to a rapidly rising drug problem in the 1990s, principally, but not exclusively, involving heroin use. Notably, the 2001 change to the Portuguese legal framework was intended to implement ‘a strong harm-reductionistic orientation’, and ‘the flagship of these laws is the decriminalization of the use and possession for use of drugs’.

Before decriminalisation became law in July 2001, Portugal’s ever-tougher attempts to legislate against drug use had failed. It could fairly be said that ‘informed’ decriminalisation (recommended by the above Commission in 1998) was a final (desperate) bid to combat drug-related health issues by a switch away from a ‘*criminal penalty model*’ towards ‘*clinical treatment and the qualification of the drug user as a patient and not as a criminal*’ (Trigueiros et al., 2010)²¹⁴.

The report 'What can we learn from the Portuguese decriminalisation of illicit drugs'²¹⁵ contains detailed tables, including comparing the use of 3 categories of drugs i) all illicit, ii) cannabis, iii) cocaine, between Portugal, Italy and the EU, states:

'By 1999, Portugal had the highest rate of drug-related AIDS in the European Union and the second highest prevalence of HIV amongst injecting drug users (EMCDDA 2000). Drug-related deaths had increased in Portugal to a peak of 369 in 1999 (an increase of 57 per cent since 1997) (Instituto Portugues da Droga e da Toxicodependencia 2000). There was also growing concern over the social exclusion and marginalization of drug users.'

Perhaps the statistic of most interest and significance in a report for 2-18s is that adopting the drug habit had declined among school students aged 15-16 by 2007 (described as the most significant age for predicting later lifetime prevalence). In the same period, although street prices of drugs (other than cannabis) remained stable in neighbouring Spain, they reduced significantly in Portugal; this was interpreted to reflect a drop in demand (Spain's cocaine use is far higher than that in Portugal). For these reasons, the report concluded that the price reduction on the streets of Portugal reflected a drop in demand rather than increased supply.

How 'decriminalisation' works²¹⁶

The Commissions for the Dissuasions from Drug Abuse (CDTs) are civil institutions which deal with people caught when buying, in possession or using up to ten daily doses of any illicit substance. They were created by Law n.30/2000 (enacted in July 2001) and were conceived 'as essential to achieve positive outcomes from decriminalisation' through the 'dissuasion of occasional drug users and treatment of dependent drug users' (Hughes, 2005:131). They operate in each of the 18 districts of continental Portugal and in the independent regions of Madeira and the Azores.

The law stipulates that the Commissions be composed of three members (quorum is two), responsible for deciding on each case, promoting health and dissuading from use. The members are appointed by the Ministries of Justice and Health: the member appointed by the Ministry of Justice has to be a legal expert, the other two usually are a health professional and a social worker. A multidisciplinary 'technical team' supports the Commission members: this can be composed of clinical psychologists, social workers, lawyers and administrators, which organise the casework and offer the diagnostic tools to enable the Commissioners' decision making²¹⁷.

Another strand in Portugal's 'dissuasion' strategy was establishing 70 (in a population of 10 million) needle exchange centres around the country. These provide 'safety packs' containing not only sterile syringes but also condoms, to combine eradicating health risks of needle-sharing with both the sexual transmission of HIV and other diseases – and unplanned pregnancies.

One very significant benefit to Portuguese criminal justice was a significant reduction in prison over-crowding as well as freeing up police and court time. Before decriminalisation, the Portuguese prison capacity was over-subscribed by 40%; afterwards this reduced to just 1%.

A very important factor in the new approach was to manage the rehabilitation of those dependent on drugs by the removal of the problems of former drug users obtaining employment. Because they no longer face the stigma of criminal records to

declare to future employers, they have been enabled to get their lives back on track far more easily. This exchange of stigma for support also removed the fear of asking for help with problem substance use. People assessed as addicts began to receive their daily 'dose' of entirely safe drugs at local centres. This alone is credited with the dramatic reductions in the drug-related deaths, which are usually associated with the adulteration by suppliers and drug dealers rather than the drug itself. It also accounts for reductions in certain crimes related to drug-seeking. It would seem logical to infer that the availability of 'legally' provided drugs for addicts is also responsible for the fall in street prices of illicit drugs – Portugal's policy is putting drug dealers out of business.

No soft option: To date Portugal is the only whole country to have taken a national approach relating to *all* drugs that not only does not criminalise users and addicts, it supports them back into a drug-free life. However, it is certainly no 'soft' option: the 'administrative' punishment for the 'misdemeanour' of recreational drug use among non-addicted users includes hefty fines, requirement to attend at police stations and/or carrying out community service, all of which can be imposed outside of the criminal justice system, and are in line with the 'dissuasion' policy (and possibly the reason why Portuguese adolescent use of drugs is on the decline – and Portugal has not become the feared 'haven' for foreign drug users).

Flaw in the Portuguese system

The sole flaw we uncovered in our research was inadequate succession planning to replace the tripartite Commissions as the original incumbents came/are coming up to retirement age. If such a reform were to be adopted in the UK, we would strongly recommend including robust succession planning to ensure continuity of the essential expert input of the Legal/Health/Social work components inherent in the original Portuguese Commissions.

Other places engaged in decriminalisation

We heard that Australia, Switzerland, some states in the USA and Vancouver have also adopted decriminalisation programmes. Also, as is well known, the Netherlands has partially decriminalised cannabis (but with strict regulation of amounts that can be grown or possessed).

As noted in the 'Discussion' section below, the success or not of attempts to reform drug laws appear to rely more on the method than the policy – e.g. the success of 'Drug Courts' in southern Australia vs the failure of the policy in Western Australia.

1. **In Vancouver** outcomes were far more encouraging: deaths from overdoses reduced by 80% following decriminalisation; as in Portugal, the drugs that Vancouver patients received in the government-sponsored programmes were unadulterated. Perhaps that initiative grew out of, or is somehow linked to, Professor Bryce Alexander's 'Rat Park' experiment in Vancouver (outlined below in Part 2).

Discussion from the 'What we can learn' report

Because it certainly is neither the role nor intention of our report to promote or discourage the decriminalisation of the use of currently illicit drugs, we will end this section by giving, verbatim, the 'Discussion' from 'What Can We Learn From The

Portuguese Decriminalization Of Illicit Drugs?’ (page 1017), which appears thoughtful and balanced:

In the first decade of this century, it has often been claimed that we are witnessing a general shift towards punitive penal policies and the use of crime policies to legitimate neoliberal governance (Garland 2001; Simon 2007). The counter-example of Portugal, which has seen both an extension of the welfare state and a reduction in the penalization of vulnerable drug users, supports critics who have argued that such general theorizing underestimates the complexity of developments, both at home and abroad (Hannah-Moffatt 2002; Zedner 2002; Young 2003; Loader and Sparks 2004; Hutchinson 2006). The appeal of the punitive turn in contemporary penalty is by no means universal. Indeed, the Portuguese decriminalization stands in stark contrast to it, given its adoption and continuation for reasons of human rights, social solidarity and acknowledgement of the failure of punitive policies.

In the run-up to the 2009 general election, the incumbent Prime Minister gave a speech in Lisbon at the European Monitoring Centre on Drugs and Drug Addiction (Socrates 2009). He used this opportunity to boast publicly of his decisive role in the introduction of the 2001 reform. He pledged his continuing support for it. Penal populism was evidently not in play here. Southern-European countries including Portugal, Italy and Spain have followed a different path from the neo-liberal, Anglo-Saxon economies. All had totalitarian regimes in the last century. When emerging from dictatorship, all three nations adapted their constitutions to recognize rights to citizenship and limit interference by the state in the private lives of citizens. And all have undertaken changes within the criminal justice arena to reduce criminalization by the state (Solivetti 2001; Gamella and Jimenez Rodrigo 2004). The need to examine the wider intellectual and political contexts in which crime policy develops should also warn us against the temptation to attribute changes in policy, or their effects, to the simple causal impacts of any particular, one-off legal change. For example, we would dispute Greenwald’s (2009) tendency to attribute positive changes in Portugal to decriminalization alone. Many other factors, including expanded treatment services and an ageing population of heroin users, have contributed to the positive results observed.

Yet, the reform provides important evidence for the debate on the impacts of decriminalization. It demonstrates that – contrary to some predictions – decriminalization does not inevitably lead to rises in drug use. It can reduce the burden upon the criminal justice system. It can further contribute to social and health benefits. Moreover, such affects can be observed when decriminalizing all illicit drugs. This is important, as decriminalization is commonly restricted to cannabis alone. Our research suggests that current theories and assumptions about decriminalization are themselves in need of development.

Decriminalization is often discussed as if it is one, simple, unitary concept. But there are several forms of decriminalization in practice internationally (Uitermark 2004; McLaren and Mattick 2007; Baboret al. 2010). None of the other models is as explicitly linked to dissuasion, treatment and integration as the Portuguese approach.

Each of the models will have its own sources, costs and benefits, which are in need of further research if we are to understand how they could be transferred across national borders. Our studies of the Portuguese decriminalization over a number of years have further illustrated the challenges in assessing the impacts from such a reform and the need to recognize the importance of the timing of assessment in relation to implementation. The effects of the Portuguese reforms appeared much less positive during the early years, when implementation was more problematic (Hughes and Stevens 2007). Some difficulties were an inevitable side effect of adopting a new reform. Others were less controllable. These difficulties make it harder to compare impacts at a given time against the potential future impacts of decriminalization. While there are calls in all forms of research for repeated assessments, this is particularly necessary in regards to decriminalization, where the heated debate makes such reforms particularly susceptible to uninformed criticism. Many reforms

are evaluated only early on in their adoption, which may lead to underestimation of their true impacts. One case in point is the South Australian cannabis expiation notice scheme. The Portuguese (and South Australians) have therefore done well to maintain the reform in spite of such difficulties.

Other jurisdictions such as Western Australia have not been so fortunate, and are in the process of overturning a hard-fought-for reform (Barrett 2009).

Conclusion: In the Portuguese case, the statistical indicators and key informant interviews we reviewed suggest that since decriminalization in July 2001, the following changes have occurred:

- small increases in reported illicit drug use amongst adults;
- reduced illicit drug use among problematic drug users and adolescents, at least since 2003;
- reduced burden of drug offenders on the criminal justice system;
- increased uptake of drug treatment;
- reduction in opiate-related deaths and infectious diseases;
- increases in the amounts of drugs seized by the authorities;
- reductions in the retail prices of drugs;
- significantly reduced over-crowding in prisons.

By comparing the trends in Portugal and neighbouring Spain and Italy, we can say that while some trends clearly reflect regional shifts (e.g. the increase in use amongst adults) and/or the expansion of services throughout Portugal, some effects do appear to be specific to Portugal. Indeed, the reduction in problematic drug users and reduction in burden of drug offenders on the criminal justice system were in direct contrast to those trends observed in neighbouring Spain and Italy.

Moreover, there are no signs of mass expansion of the drug market in Portugal. This is in contrast with apparent market expansions in neighbouring Spain. The problem is that it is impossible to state that any of these changes were the direct result of the decriminalization policy. It also remains unclear whether the observed impacts were influenced more by the policy or its implementation. Could better implementation of the CDT model have led to better outcomes? This is an argument put forward by many in government, but it is unfortunately untestable.

The information we have presented adds to the current literature on the impacts of decriminalization. It disconfirms the hypothesis that decriminalization necessarily leads to increases in the most harmful forms of drug use. While small increases in drug use were reported by Portuguese adults, the regional context of this trend suggests that they were not produced solely by the 2001 decriminalization. We would argue that they are less important than the major reductions seen in opiate-related deaths and infections, as well as reductions in young people's drug use. The Portuguese evidence suggests that combining the removal of criminal penalties with the use of alternative therapeutic responses to dependent drug users offers several advantages. It can reduce the burden of drug law enforcement on the criminal justice system, while also reducing problematic drug use.

A key implication of this article is the need for more nuanced discussions of decriminalization, with acknowledgement of the different models and approaches that can be adopted and of their various costs and benefits. A further implication is the need for ongoing study of reforms over time. But, ultimately, the choice to decriminalize is not simply a question of the research. It is also an ethical and political choice of how the state should respond to drug use. Internationally, Portugal has gone furthest in emphasizing treatment as an alternative to prosecution. Portuguese political leaders and professionals have by and large determined that they have made the right policy choice and that this is an experiment worth

continuing. Portuguese policy makers suggest that adoption of such a reform requires time to develop the infrastructure and the necessary collaboration between the criminal justice and health systems. They contend that such reform, while not a swift or total solution, holds numerous benefits, principally of increased opportunity to integrate drug users and to address the causes and damages of drug use. As this paper has shown, decriminalization of illicit drug use and possession does not appear to lead automatically to an increase in drug-related harms. Nor does it eliminate all drug-related problems. But it may offer a model for other nations that wish to provide less punitive, more integrated and effective responses to drug use.

CASE STUDY B (part 2): Addiction – USA veterans back from war

A disease of social isolation and/or hopelessness?

It was widely accepted that 20-40% of those posted to Vietnam were regularly using heroin, to the point of being clinically addicted. The US government braced itself for these soldiers' return. In fact, no real problem ensued. Instead, the rate of addiction among the veterans remained unaffected at the national average (5%). Amazingly, very few of them even needed to seek any treatment or rehabilitation. Simply being back with their families, and not in constant fear of their lives, was enough incentive for them to abandon the heroin habit as rapidly as they had adopted it. This led scientists to understand that drug dependency is not quite the purely 'physical' problem formerly assumed; it is highly conditional on the environment and other life factors.

*'... Since 95% of those who were addicted to narcotics in Vietnam have not become re-addicted, the situation does not appear to be as severe as originally supposed. Myths as to the persistence and intractability of physiological narcotic addiction were dispelled. A major negative effect has been the difficulty that soldiers with less-than-honorable discharges due to drug abuse have had in obtaining jobs. Other long-term effects from drug use are less clear and are difficult to separate from the overall effects of the war.'*²¹⁸

The above quote about returning Vietnam veterans (from the 1976 American Journal of Drug and Alcohol Abuse 'Drugs, Vietnam, and the Vietnam veteran: an overview') renders questionable any hypothesis that addiction *permanently* changes the brain, and reveals the role of circumstance in the process of (at least) continued addiction, leaving space for the probability of recovery when the quality of support provided is appropriate to the individual.

Social isolation and addiction

As part of a move in the long-running war on drugs, a study was set up to persuade Americans of the evil and addictive nature of cocaine and heroin. This involved putting a lone rat in an otherwise unoccupied cage and giving the animal a choice of two sources of water: laced with cocaine or unadulterated. The rat chose the cocaine water, and had soon died from overdosing.

But in the 1970s, Bryce Alexander, a professor of Psychology in Vancouver noticed something odd about that initial experiment, from which the important conclusion that addiction lay entirely in the substance had been widely interpreted. He noted that the rat was put in the cage all alone, and had nothing to do but take the drugs. What would happen, he wondered, if we tried this differently?

So he built 'Rat Park' – a lush cage where the rats had coloured balls, the best rat-food, and tunnels to scamper down, and plenty of friends and sexual partners – anything a rat could want – and a choice between cocaine-laced or plain water.

Because the rats in Rat Park did not know what was in them, all the rats tried both water bottles. What happened next was startling: these rats with such good lives did *not* like the drugged water. They mostly shunned it, consuming less than a quarter of the drugs the isolated rats used. None of them died. While all the rats who were alone and unhappy became heavy users, none of the rats who had a happy environment did.

The next phase of Professor Alexander's study was to take the 'solo' rats and expose them to 57 days (the maximum safe time, by which they would be well and truly 'hooked' without being actually dead) and introducing them to Rat Park. Although these poor animals did suffer some twinges of withdrawal, they chose to partake in the social life rather than continue with the drug-infused water.

Heroin vs morphine

The above experiments (deliberate in the case of the rats but incidental (or 'accidental') in the case of the Vietnam veterans) led to question why, since heroin is another name for the diamorphine routinely administered in hospitals, so many people who have had long and painful illnesses or injuries can be given quite high dosages of morphine for many weeks or months – and then stop taking the drug, go home and not be addicted? The answer was: drug addiction is not so much in the substance as in the 'cage' one inhabits. These patients return to their homes and families, and have no further need for chemical escape.

Link with ACEs

Aware of the horrifying statistic that those with 6+ ACEs are 46 times more likely than those with no ACEs to be injecting drug users, the above 'experiments' formed the trail that led us to speculate whether the reason children who grow up with ACEs are those most vulnerable to addiction might lie in the quality of their 'cage'? And by cage we mean not just their home environment, but their ability to form hopes, dreams, ambitions and expectations. The experience of 'bad' things happening means children are deprived of opportunities to develop expectations or habits that lead to such 'good' things as joy, success and satisfaction that would be protective against 'escaping' into alcohol or drug-induced states of mind either as early as possible in life or, failing that, as an adult.

This theory does not account for why ACEs can be directly related to such higher risks of so many 'purely physical' health problems (e.g. heart, liver and lung disease) even after lifestyle issues have been excluded from the equation, but the research is clear that the highest risks are of mental health problems, interpersonal and self-directed violence and drug or alcohol dependency. These existing findings are confirmed in the August 2017 article in the *Lancet*²¹⁹.

CASE STUDY C: Link between school bullying and later SMD

Using bullying behaviour as a childhood coping mechanism can blight whole lives. Being bullied can also put children at risk of multiple negative outcomes throughout life. Both groups are among the most prone to social exclusion. Early life conditions that are left unmitigated when first presenting in school can start a cascade effect. This is a particular risk in cases where children are suffering from harsh parenting:

- lack of (or loss of earlier) empathy, leading to:
 - callous or bullying behaviour among peers,
 - then to later personal violence that leads to:
 - unstable family lives, physical abuse of partners and/or children,
 - depression (among both perpetrators and their victims)
- domestic violence that can lead to family breakdown, followed by
 - general violent offending, that leads to:
 - incarceration, that can lead to:
 - abuse of substances (including in prison) and after release,
 - social exclusion, and, at its extreme:
 - severe, multiple disadvantage.

What the science tells us: Bullying as a predictor of future violence

In Farrington & Ttofi's Cambridge 'Study in Delinquent Development', 411 South London males were followed up from age 8-10 to age 48-50, using repeated face-to-face interviews and searches of criminal records. The result was that bullying at age 14 predicted:

- violent convictions between ages 15 and 20,
- self-reported violence at age 15-18,
- low job status at age 18,
- drug use at age 27-32, and
- an unsuccessful life at age 48.

These 'results held up after controlling for explanatory and behavioural childhood risk factors at age 8-10'²²⁰.

Farrington et al's major meta-analysis of 'School Bullying, Depression and Offending Behaviour in Later Life'²²¹ found that:

- Bullying perpetration at school was a highly significant predictor of offending on average six years later in life. The summary Odds Ratio of the unadjusted effect size across 18 studies was OR = 2.64. After controlling for other childhood risk factors, the adjusted effect size across 15 studies was OR = 1.89 and still significant. This value of the OR suggests that being a bully increases by more than 50% the risk of later becoming an offender.
- Bullying perpetration was significantly related to later depression. The unadjusted effect size across 16 studies was OR = 1.61. The adjusted effect size across 13 studies was smaller (OR = 1.41), but still statistically significant. This value of the OR suggests that being a bully increases by about 30% the risk of later becoming depressed.

Victims of bullying

- The probability of being depressed an average of seven years later in life was significantly greater for victims of school bullying than for other students. The unadjusted effect size across 30 studies was OR = 2.05 and the adjusted effect size

(after controlling for childhood risk factors) across 19 studies was OR = 1.71. This value of the OR suggests that being a victim of bullying increases the risk of later becoming depressed by about half.

- Being a victim of bullying increases the risk of later becoming an offender by 10%.

Pathway from bullying to criminality and drug abuse: Violent prisoners, who started bullying when still at school, are more likely to learn criminality than be rehabilitated in our prisons, where they are also at risk of being exposed to their first experience of Class A drugs. The Centre for Social Justice 2015 'Drugs in Prison'²²² reports:

Drugs have been a problem in prison for decades. Politicians have regularly identified this and promised change, without success. The data show that drugs are still a significant issue in prisons in England and Wales:

- Just under a third (31%) of prisoners admit it is easy to get drugs in prison;
- 29% of prisoners admit to having a drug problem on arrival to prison;
- Of prisoners who have used heroin, almost 20% report first trying it in prison.

Research findings

Numerous US studies concluded a 'zero-tolerance' attitude to disciplining children does not work and is actually counter-productive²²³. Children cannot be bullied (or 'punished') out of bullying, for that just teaches them might is right at all times.

Actions to combat school bullying

The TV personality, Jodie Marsh, studied the latest US methods to combat school bullying, and has been achieving great success with Year 9 pupils in schools heavily affected by bullying. The key message put across is 'bullying is uncool'²²⁴. Perhaps the most significant part of the initiative was in bringing the children together and into real, rather than virtual, contact with each other. The example televised showed both chilling examples of bullying, especially cyber bullying among girls, and very moving ones of how empathy that appeared to be lost could be revived.

Empathy programmes

Originally designed to teach children basic facts of caring for an infant, these (e.g. Mary Gordon's Canadian Roots of Empathy programme²²⁵) programmes are delivered to whole classes, mainly in primary schools. They are more popular in Northern Ireland and Scotland (where half the local authorities deliver them to at least some of their schools) than in England.

Empathy programmes are entirely suitable for secondary as well as primary school pupils also, especially since increases in ability to talk about feelings and reductions in bullying are side-effects of this type of teaching – and bullying is a worse problem at secondary than primary level.

CASE STUDY D: Bridgend Child's Journey project

Overview

This ground-breaking initiative demonstrates the power of a unifying 'one Council' approach to transforming outcomes for children by starting with transforming the management culture, methods and attitudes to all aspects of relevant policy. Bridgend's speedy and dramatic example of significant outcome improvements rose from the ashes of a Council placed on 'monitoring' (a polite term equivalent to 'performance management'). Yet Bridgend did far more than bring its outcomes up to the required standard; it achieved transformation. Important components of this were focus on prevention and developing 'ACE-awareness'.

The uncompromising commitment to teamwork by top management was expressed by the whole team sharing one open plan office; in the past they were often located well away from each other, sometimes in different buildings – the typical 'silo' culture we hear is so prevalent in local authorities. This huge cultural shift not only provided a role model to filter down through all the layers of delivery, it also moved the ethos from ultra-cautious, expressed in e.g. the exceptionally high level of looked-after children, to a problem-solving 'can do' approach characterised by a highly functioning 'early help' system (graphically outlined below) that radically reduced the number of problems that might, if not tackled soon enough, have led to a pre-emptive (and sometimes premature) removal of children from their homes.

In December 2014 Bridgend was judged 'to have made sufficient progress in relation to the recommendations following the inspection of October 2012.... [that it was] no longer in need of Estyn monitoring and ... [removed] from further follow-up activity': Since the inspection in October 2012, outcomes for learners have improved in all the main indicators in the Foundation Phase and in key stages 2, 3 and 4. For most indicators, the rate of improvement has been faster than the Wales average over the last two years.

How Bridgend brought about change

Key to the approach was a strong focus on performance, understanding the story behind the data, a deep understanding of analytical and behavioural dynamics, and the rigorous challenging of practice methods.

Rapid transformation of the operations of the Directorate was critical to the change process. The particular focus was to strengthen prevention and early intervention, to form a continuum of support for families, especially those with children on the edge of care or with additional learning needs. This approach paid close heed to the ACE findings in the U S and England, which were later replicated in the Wales ACE study.

The transformation programme concentrated on the development and implementation of a whole systems framework to manage family pathways from early intervention to statutory intervention. This 'early help' method ensures children, young people and their families receive support at the earliest opportunity.

Six key messages describe the whole system approach

- ✓ *Joint assessment of the whole family*

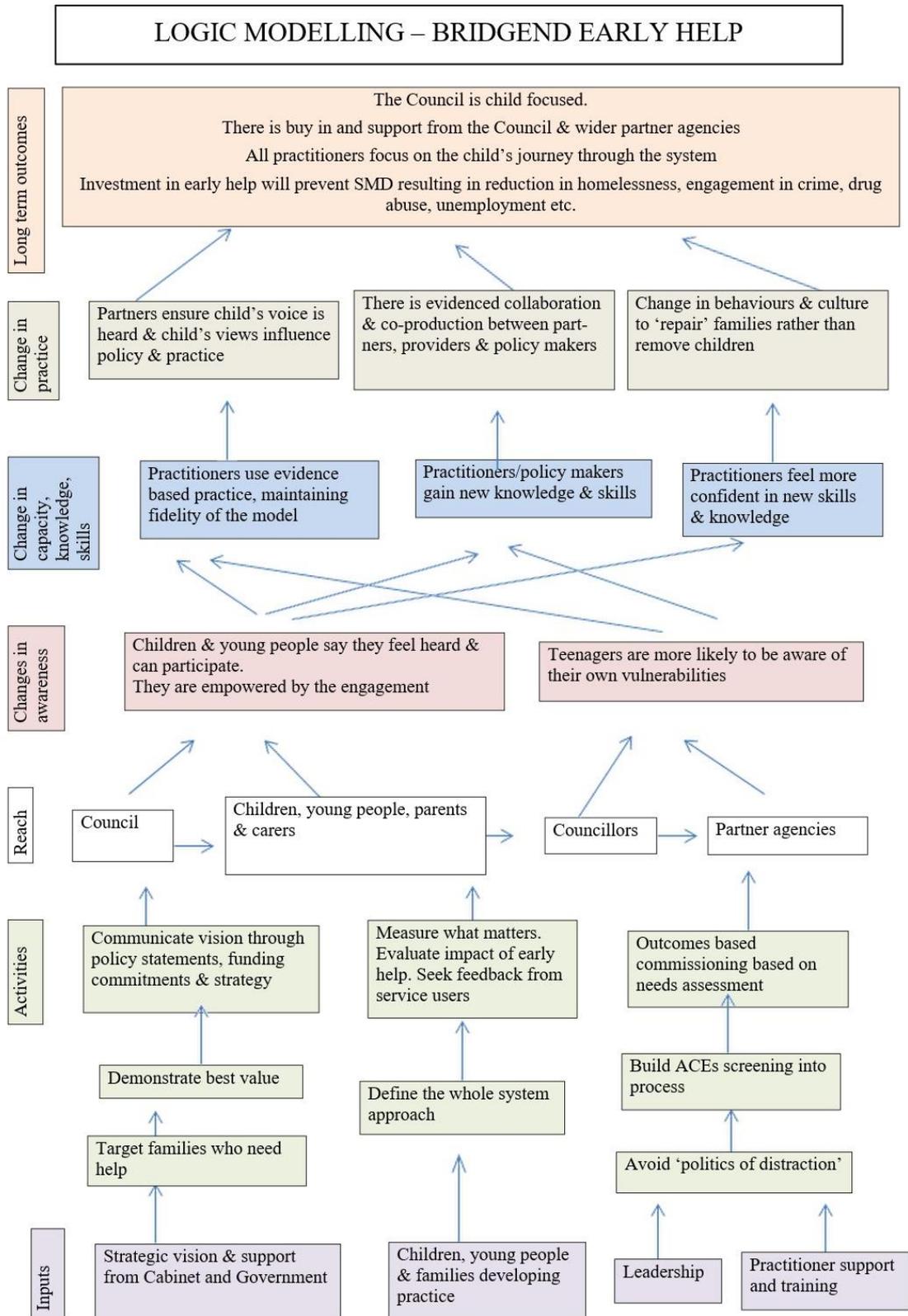
- The whole system approach has a joint assessment framework at its heart, with a commitment to a holistic way of working by tailoring packages of support to the needs of children and their families.
- ✓ *Understanding Children's Needs and the Levels of Need Pathway*
 - Children's needs met at the most appropriate level. Common understanding by partner agencies of need and response, including of levels of needs and relevant service response, with a clear step up and step down process to allow children to move up and down the levels of need support pathway.
- ✓ *No Wrong Door*
 - There is NO WRONG DOOR to accessing children's services; any one door is established as a route of access into children's services.
- ✓ *One Key Worker*
 - The importance of one key worker to be the lead worker with the family whichever part of the system they are in. Cases are not handed on unless it is clear that a specialist service lead is required.
- ✓ *Targeting Families*
 - Bridgend targets whole families rather than waiting for referrals.
- ✓ *Early Intervention and Prevention*
 - The emphasis is on early intervention and prevention to identify and meet needs at an earlier stage before they become more complex.

Tangible improvements between entering and release from Monitoring

- Steady reduction in numbers of LAC, from 412 to 370 (-10%); first reduction in 6 years
- Number of LAC in out-of-county placements significantly reduced by limiting provision to when children are in danger of sexual abuse
- Child protection plans fell from 179 to 120 in a year (lowest rate since 2007)
- For the first time in many years, Children's safeguarding budget balanced (removing planned need to draw down earmarked reserves)
- Learner outcomes improved in all the main indicators in the Foundation Phase and in Key Stages 2, 3 and 4
 - KS3 and KS4 Level 2+ performance above national average
 - at KS4, performance of pupils eligible for free school meals (FSM) improved significantly (Bridgend now ranks 3rd in Wales), facilitated by a token system for ALL meals that removed any stigma of FSM among this older age group
- LAC leaving school with no qualifications reduced from 21% to zero
- Number of NEETs halved (at 3.4%, became one of lowest in Wales)
- Number of 'not known' young people reduced from 49 to 9
- Rate of fixed term exclusions now below Wales average
 - Days lost per exclusion now among lowest in Wales
- Level of persistent absentees reduced in both primary and secondary schools
- Steady increase in primary and secondary school attendance
 - 2014 secondary school attendance rates above Wales average (first time in 5 years)

The setting up of the Early Help Model provides a structure that cuts through the bureaucracy usually involved in formal referrals and that, combined with the commitment for every council member to be responsible for child-safeguarding, brought about a significant cultural change – and a reduction in costs of looked-after

children. One structural factor that makes such profound change more easily achievable in Wales than England is that Education and Wellbeing come under the same governing/inspection body, while child and adult Safeguarding are jointly governed by a separate body. See table below the Bridgend Early Help Model:



CASE STUDY E: Highland Region

WAVE has been aware of the unique, ground-breaking work in Highland for over a decade. This closely follows the approach of Professor Losel's 'chain reaction' in which intervention at any age (or stage) in dysfunction can halt further incidences of problems (because of the natural malleability of the human brain). So, although by its nature the Highland Region Streamlined Reaction (HRSR) is 'responsive', it is set up so thoughtfully that its effect amounts to a high level of prevention of future problems.

The goal of the HRSR project was to get things right for children from the first time they appear on the radar as being at risk, so they do not appear again later. This was judged to be both more responsible and cost-effective than the previous typical model of viewing resource constraints as sufficient reason to avoid adequate intervention very early on in presenting problems. It also offers an example of the 'right first time' approach to overcome what John Seddon²²⁶ calls 'failure demand' arising from the need for both other agencies and service users to apply repeatedly for support to any given source of service.

Among the principles adopted, to enable this shift to happen:

- a. Management of risk
- b. Integrated Children's Services and joined up working
- c. Streamlining processes of response and reaction to risk
- d. Set up of Social Work overhauled and changed

To improve management of risk, Highland re-examined its processes, changed how agencies were organised to assess and manage risk, and introduced streamlined systems to improve reaction. Similar to Bridgend's Child's journey through the system, the Highland introduction of Integrated Children's Services and joined-up working began by studying the typical pathway of a child through *life* and his or her potential contact with outside agencies. This involved identifying where in this pathway the earliest intervention could ensure the best long-term outcome, and then using that information to develop more effective practices.

This work was highly outcome-focused. The streamlined processes were designed to make significant reductions in reports and meetings, vastly reduce bureaucracy and create a single point of management for each child. For example, there is only one Plan and only one type of meeting for any child, whether the issues affect disability, schooling, risk, housing, domestic violence, family alcoholism or anything else. Further information on the management of at-risk children is shown below under the Child's Plan meeting.

The core principle is that early intervention must be immediate if it is to stop issues escalating and, irrespective of who triggers this (school, health services, police), they must work in an integrated manner across the various agencies to ensure fast response to need.

Highland Region structure

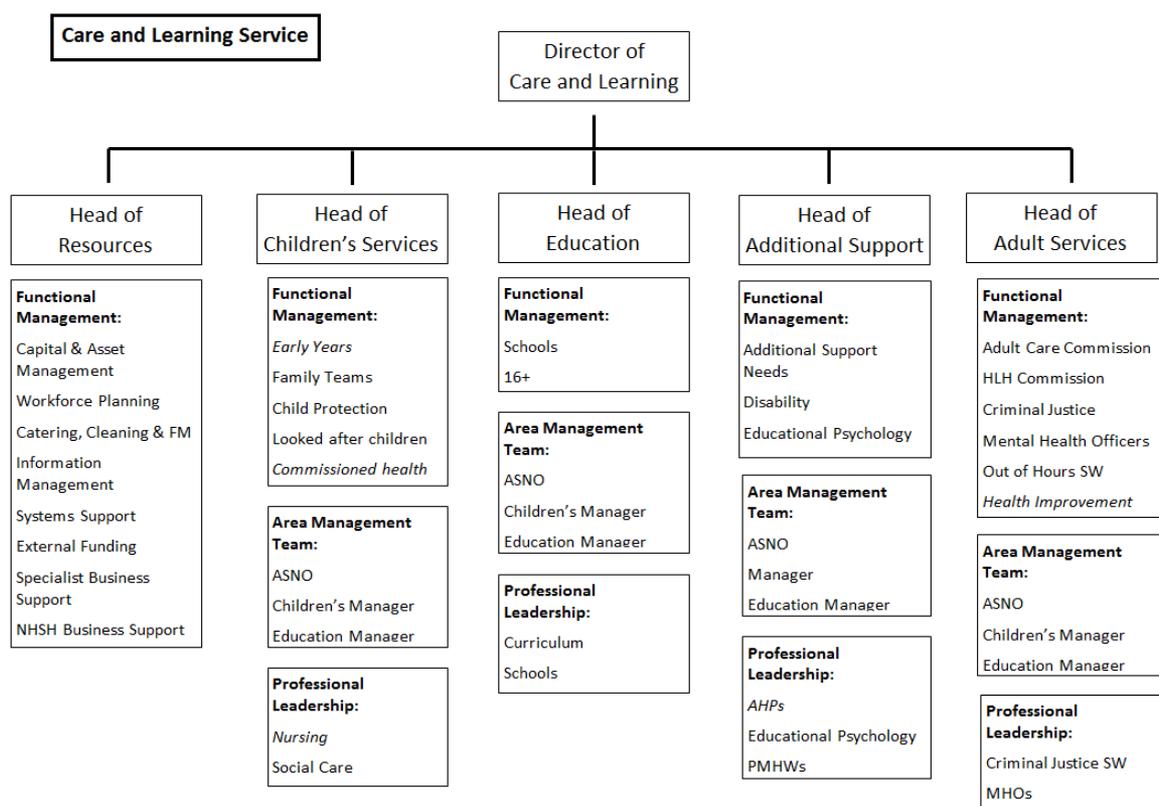
Highland's Children's Services structure is flat rather than hierarchical, so each departmental head reports into the Director – thus integrating Health; Education; Social services to adults, children and families; Additional support; and Resources.

Within this, social work is set up quite differently from English models and is, for example, better integrated with schools and police.

One category of social worker is located within schools (essentially one per school, or group of small schools in outlying rural areas) and works closely with head teachers in providing support to children who are, or possibly could be, at risk. An interesting statistic is that social workers in Highland Region spend no more than 25-30% of their time on bureaucracy. In 2009 the General Secretary of UNISON reported the corresponding figure for England as 80%.

Senior staff in Highland say the impacts of the changed systems are reflected in much improved statistics for child protection, looked-after children, offending and substance abuse.

We show below the **Education and Care organisation structure** referred to in Key Message VII of the main report:



The overall Highland design for transformation in child outcomes comprised:

- Implementation Plan
- Transformational change in each agency and across children's services
- Support from dedicated team and change management structures
- Training programmes ... continuing
- Comprehensive and integrated practice guidance
- Some new posts and structures

Child's Plan meeting

All decision-making comes from this meeting, attended by everyone necessary for the decision, generally a core 5: one each from Education, Social Work and Health, plus

the child and the family. Children usually attend their own Plan meeting; if they cannot, their views are gathered in advance. As appropriate, there may be representatives from Police, a Care Home or Foster care etc. The key figure in the system is the QARO (Quality Assessment and Review Officer).

The QARO's role is to (1) obtain information from the lead professional in advance of the meeting, (2) chair the meeting, and (3) produce summary meeting notes.

All QAROs are registered Social Workers. However, their role is independent of mainstream social work, and entails accountability for the Quality Assessment function; thus they also have responsibility to gather aggregate data, give feedback from their meetings etc.

The QAROs report into an ISC (Integrated Service Co-ordinator), one for each of 3 geographic areas in this huge, 10,000 square-mile, region. The ISCs are described as the 'glue in the system'. They are part of a range of integrated services staff funded by a joint committee from different agencies; they link the agencies e.g. Education, Housing, Health, Police etc. in their geographic areas; each ISC leads 2 QAROs and reports to the Head of Children's Services.

Another, more junior set of integrated workers are the Integrated Service Officers, who operate across agencies, like the ISCs, but on the front line working with nurses, schools, local social workers etc. Most of their work is done within Universal Services.

Finally, within Integrated Services come the Children's Services Workers, the hands-on social workers within (or associated with) the schools.

Children Service Workers are unqualified social workers assigned to/located in schools, working across the rest of the team. They are empowered to be productive, skilled people doing very important work – and generally doing it for over 70% of their time. The contrast with most UK local authorities is stark.

We met social workers in England who remembered when their presence in schools was not only quite usual but very valuable – e.g. helping pupils through incidents of sexual abuse that could eventually lead to those helped telling their trusted social worker of a friend who might be suffering in the same way, and encouraging the friend to confide in the social worker. Especially in large and impersonal schools, this type of specialist on-site support can be very helpful for pupil morale (as well as being cost-effective). In researching for a different project, we heard that, in recent decades, teen pregnancy increased in schools where the post of School Nurse was abandoned. It seems teenagers find it easier, more convenient, more private and less embarrassing to ask the Nurse about contraception than to visit a Family Planning Clinic.

Highland outcomes

As with the Nordic countries, because Highland's reasons for introducing the HRSR were to do 'the right thing' in pursuit of the philosophy of Getting It Right For Every Child (GIRFEC), they did not collect data systematically to show impacts (which, of course, reduced the admin/data collection burden on staff). Instead, they just designed, and then evolved, methods to deliver well, and to meet the needs of a population scattered over a 10,000 square mile area.

We visited them in Inverness to carry out a broad appraisal of changes over the decade of operating the Streamlined Rapid Reaction system. Although external factors (e.g. immigration and population changes), make interpretation challenging, existing data that show:

	2003	2009	2010
Number of persistent offenders	57	25	12

- Rate per 1000 children age 0-15 on the Child Protection Register fell from 3.0 in 2004 to 1.6 in 2009 (since risen to 2.2, which Highland say reflects an influx of migrants who did not previously benefit from the HRSR system).
- Far less social work time spent on bureaucracy and more on direct client contact.
- Staff estimate looked-after children at risk fell by 15-20%.

The reply to our query why the Highland system has not been adopted by other Scottish authorities was that it is very specifically designed for the needs of that specific region, and that a key component of its success has been the ‘learning’ nature of its evolution; it is not the same now as it was 10 or even 5 years ago. It evolves and is shaped by a mind-set based on individual responses to individual challenges, and does not set out to be a ‘one-size-fits-all’ approach for different areas. In short, it focuses very much on method, and could be interesting for closer study to evaluate wider dissemination.

While admiring the modesty of this position, we believe the approach contains fundamentally sound principles that could be adapted to fit most local authorities, especially the integrated working resulting from (a) the flat structure and (b) locating social work support at the point of need. A south London social worker who once worked inside schools says this was by far the most effective structure both for preventing problems and gathering intelligence about, for example, sexual abuse in the families of friends of pupils who already trusted the social worker – and way before the problem had escalated to crisis point.

CASE STUDY F: Netherlands education, care and social factors

Although it might be more realistic to recommend a blend of the Bridgend and Highland approaches for UK general local authority use, we were particularly impressed with the Netherlands' approach to education, care and other social factors (including a strong work ethic and integrating asylum-seekers and immigrants).

Although we cannot claim the Netherlands to be perfect, they do have very much better than average outcomes ranging from childhood happiness through educational achievements, to the respect owed to social workers and the skills needed by teachers, all of which would benefit from transformation in the UK. Here is a basic overview of the Netherlands system.

Education system: As in many European countries, especially Nordic, there is a social pedagogy approach to education and children's general care in the Netherlands – in fact, social pedagogy can be defined as 'where education and care meet'.

Compulsory education applies from age 5 (as in the UK) to 18 (the final 2 years can be part-time until the attainment of a diploma). However, most children start primary school (*basisschool*) the day after their fourth birthday, with many children transiting from childcare or preschool centres (for which most parents qualify to receive a government allowance).

Preschool education from age 2 is the start of a continuum that stretches through to Grade 3 (age 6). How it differs from other systems is the emphasis on social engagement and 'preparation for academic learning' – which does not start until age 6. Over 60% of young children attend pre-school, and the best results are reported for those who attend for the full 4-year programme (age 2-6) which is integrated into the general education system²²⁷. The scheme for this age group includes a high degree of parental involvement. Low income families (including emigrants) became prioritised following the recognition of problems faced by non-native-speaking children when they arrived in primary school.

Dutch culture prioritises balance and collaboration over competition, and 'happiness' over academic achievement – and they do consistently have among the 'happiest' children of all the countries included in routine surveys. The time for children to play is recognised and honoured, meaning there is very little pressure, and generally very little (if any – but this depends on individual school policies) homework given to under-10s. However, the heavier secondary school homework (up to 3 hours of it daily) comes as a culture shock to many. The perhaps surprising outcome of this policy is that Dutch children's happiness is not purchased at the price of educational underachievement – it would be more accurate to say the opposite is the case.

At age 12, all children are tested and then given a (non-binding) *suggestion* for which of 3 basic types of education would best suit their leanings and abilities:

1. preparatory secondary vocational education (VMBO),
2. senior general secondary education (HAVO) and
3. pre-university education (VWO).

In this system, children who are not academically inclined are not forced to go through 4-5 years of academic learning in subjects they are unlikely to call upon in their working lives.

Only students taking the VWO route can apply to university. In this way, the Dutch system pre-sorts students based on academic ability. As a result, Netherlands universities have a certain minimum standard (of teaching) that some lower ranking UK universities might lack.

Education is designed to fit the child, and any failure is blamed on the teacher – so any ‘pressure’ is transferred from the children to the teaching staff (who do feel resentful, because not just the ‘system’ but the children blame teachers for pupil failures). However, teacher responsibility is a key characteristic of the pedagogical approach.

The national egalitarian culture is taken to the point of banishing competition for grades prior to the lead-up to final exams for the education certificate. Because of this, the majority of complaints are of the system heavily favouring ‘collaborative mediocrity’, at the expense of excellence. So, rather than a fundamentally competitive system where routine (annual) evaluations result in graded outcomes, in the Dutch system the teacher sets a minimum standard for the whole class. Children then either pass or fail, without differentiating grades.

Of course, the children will (almost) all have already been pre-allocated to the most suitable curriculum (and, by definition, cohort) for their strengths and abilities, which is what the government believes accounts for so many of them being keen to continue with ‘self-learning’. However, the lack of acknowledgement for achieving excellence can frustrate for the brighter or more ambitious pupils who would prefer to be seen to ‘win’. Competitiveness is actively discouraged, and called ‘trimming tall poppies’.

Pupil grades do matter for entry to University: e.g. top-scoring final year secondary school students on the pre-university path can go straight into medical school.

The consensus was that a key advantage of the ‘pre-sorting’ at age 12 means the most gifted or hard-working students are not held back by those with lower standards of achievement, since each of the 3 types of secondary education is broadly suited to the average of all those included in it.

Educational outcomes: The apparently relaxed attitude and lack of pressure to compete or work ‘hard’ achieves surprisingly good outcomes: A 2017 OECD study found Netherlands’ 16-24 year-olds had the third highest literacy and second highest numeracy²²⁸, while the (2015) PISA²²⁹ scores for 15-year-olds showed the UK one place ahead of the Dutch in Science, their students were well ahead of the UK on both reading and mathematics – and, of course, English is compulsory at all levels of the Dutch secondary education system.

Ranking (72 countries)	Science	Reading	Maths
UK	15 th	22 nd	27 th
Netherlands**	17 th	15 th	11 th
Finland	5 th	4 th	12 th
Singapore*	1 st	1 st	1 st

*Although Singapore came top in all 3 categories in the same year (2015, the latest published) and as outlined above, we do not feel it would be appropriate or useful to recommend such a culturally different system for the UK.

***In viewing these results, it needs to be borne in mind that Finnish and Netherlands schools are state-funded while the UK results are from a mixture of state and private-funded schools.*

University education: All 13 Dutch (state-funded) universities are in the top 200 Times Higher Education World University Rankings; 10 are in the top 100. At c.£1,500, fees are low, avoiding financial stress on young people after graduation – and perhaps also reducing the sense of ‘normality’ of being in debt? Students need to score at least a 6/10 for English Language and Literature for their high school finals, or they cannot graduate. Most university Master’s (and an increasing number of Bachelor’s) degrees are conducted in English.

Netherlands’ school bullying: Latest estimates are of c.10% of Netherlands’ 10-14-year-olds reporting being bullied (5% of this behaviour is of the cyber variety). Netherlands’ sources acknowledge this age group as the ‘prime’ one for bullying, because children are starting to ‘find their identities’. These figures compare favourably with the (very varying) levels of UK bullying, including 38% of 10-12 year-olds reporting being hit by classmates in the past month (Good Childhood Report).

Netherlands Social inclusion policy

The formal Dutch position is that social rights and duties are two sides of the same coin, which means those capable of work must work: ‘... *because participating as a working member of society is the best manner to avoid social exclusion*’. It is also acknowledged that certain groups might need ‘support in finding their place in the labour market’. Those groups include older people, the disabled, families on low income, ethnic and other minorities, the homeless, and those with addiction problems.

Because people of Turkish and Moroccan origin are more likely than locals to be unemployed, the Netherlands handles its influx of immigrants by being relatively tough on the obligation to integrate: compulsory integration courses are delivered. Shortly after arriving, new immigrants have to attend courses in Dutch language and ‘society’ (culture); in return, they receive help finding work.

There is strong commitment to protecting the current state-of-the-art welfare system, and the Dutch are resolved to ensure its safety in the face of the pressures the high proportion of ‘greying’ population will put on future generations of workers.

Recent developments in Netherlands’ child protection

In recommending the UK consider exploring the advantages of the Dutch system, it is important to understand it has not been without some of the social problems we know so well – but rather that they seem to have dealt with them more positively.

The highest profile and most shocking child tragedy was the (2004) ‘Savanna’ case²³⁰ (a chronically under-nourished child of 3 who, having been taken into care, was returned to her mother, who then murdered her, possibly accidentally in the course of hideous ‘punishment’ designed to ‘shut her up’). The case received huge adverse publicity. Worse still for the Netherlands Care profession, the ‘Guardian’ (senior social worker) who made the decision to return the child home was charged in the criminal court (subsequently acquitted, but censured for neglecting to do her job properly).

The initial reaction was as fear-driven as the reactions to UK child tragedies that led (we were told) to the Integrated Children’s Services (ICS) system being ‘rushed through to implementation’; also, as in the UK, the social work profession in the

Netherlands suffered greatly. The case made such an impact that recent history is divided into two time frames: 'pre-' and 'post'-Savanna. Comment by a family Guardian shortly after the Savanna case:

'... there was a lot of fear in how people acted in the months afterwards. Everyone was so afraid it could happen on their watch. Cases proceeded faster; children would be put on the child protection register sooner. And for a while there would be a request every Friday to go and get a child that needed to be taken away from their parents before the weekend... Better safe than sorry is the trend now... And children aren't placed back with their parents as easily as before.'

Looked-after children statistics soared across the Netherlands as more and more safety precautions were introduced.

'We have to fill in long lists about the parents, the children, the interaction between the parents and between the parents and the children, which are then reviewed by behavioural scientists. It is very formal and has led to a bigger workload. The underlying principle is fine though, it is all about the safety of the child.'

At this point, we could be quoting any UK social worker speaking about the ICS system they felt was an 'over-reaction' to a small number of tragic events. However, between the Savanna tragedy and 2010, the Netherlands evolved to contain much of potential benefit to the UK. Measures include:

- a. An umbrella agency for the 15 separate youth welfare agencies;
- b. Reduced caseloads with fewer children (16, down from 25) assigned to each Guardian;
- c. Decisions must be made by a team, rather than individuals;
- d. Risk-analysis made a priority, and
- e. 24-hour crisis telephone number.

Netherlands vs UK teen pregnancy rates

Compared to the UK, not only do Netherlands' girls postpone engaging in sex 1-2 years longer, their rates of youth unemployment and NEET (for both the younger and older NEET age groups) are significantly lower, and their youth literacy and numeracy skills are higher, improving their employability. Perhaps, quite simply, they have more to gain by avoiding unplanned pregnancies. Also, although there is a spike in drinking at age 15-19, this tails off very quickly: the overall statistics for Netherlands' alcohol consumption and drinking habits do not place the country among the heavier drinking group comprising Denmark, France, Germany and the UK, but closer to Italy (the lowest consumers of alcohol in the 6 countries studied in depth).

Netherlands vs UK child life satisfaction measures (UNICEF)

In the UNICEF Innocenti report card 11²³¹, League Table 4 ranks countries on the size of the relative life satisfaction gap for children. This measures how far those with the lowest levels of life satisfaction fall behind their peers. On this measure, the smallest relative life satisfaction gap was found in the Netherlands, ranking it first out of the 41 countries measured.

On balance, we feel there is a reasonably good cultural fit between the Netherlands and the UK, especially since their collaborative style of education achieves far better results in terms of literacy and numeracy.

CASE STUDY G: Finnish health-focused education system

Scandinavian education in general

As can be seen from the statistics in UNICEF Innocenti report cards and PISA scores, the countries of Scandinavia appear to have vied with each other and the Netherlands for the success in both educational outcomes and child wellbeing. We had sound reasons for selecting just Finland and Netherlands for inclusion in our Case Studies, (and this is no reflection on the outcomes in Norway, Sweden and Denmark); Iceland merits its own study of youth culture for different reasons, and also scores very well on the formal international measures. If this report included penal systems for adults, Norway would have merited a Study; instead we have included references to various aspects of their (excellent) system throughout the document.

Finland

Like Netherlands, there is no severe cultural clash between any Scandinavian country and the UK, an issue we considered seriously in promoting systems of potential merit (and, e.g., not proposing any of the very successful education systems in e.g. Japan or Singapore). Cultural compatibility enables us to suggest 2 systems coming from opposite procedural approaches, although the basic philosophies are not dissimilar:

Finland equalises children by keeping all abilities together while Netherlands ‘streams’ children at age 12 or entry to secondary education. Recent Finnish history also enable us to demonstrate two sides of the education coin:

1. How a ground-breaking, health-based policy produced 4 decades of educational results that made their system the ‘envy of the world’, and
2. How easily a country can begin to lose its exceptional edge – at least in the 3 PISA academic measures – when investment in education is cut.

The Finnish system was designed to combat high levels of heart disease caused by high consumption of dairy food without compensating by sufficient physical exercise. Therefore the revolutionary Finnish approach to schooling focuses strongly on physical exercise (2-3 hours daily, especially for children under age 8) and nutrition (all children receiving nutritionally balanced, free school meals).

Equality of opportunity is stressed in every sense. To keep all children of the same age together through school, c.30% were, until recently, provided with additional support. However, the 2012 PISA scores showed Finnish academic scores had begun to slip (but not significantly) and, in the 2015 iteration (released in December 2016), the slide continued in all three categories: 11 points in science, 5 points in reading and 10 points in math. To repeat the table in the Netherlands Case Study:

Ranking (72 countries)	Science	Reading	Maths
UK	15 th	22 nd	27 th
Netherlands**	17 th	15 th	11 th
Finland	5 th	4 th	12 th
Singapore*	1 st	1 st	1 st

Philosophy behind the de-segregated approach

By allowing the most advantaged and disadvantaged children to grow up together fosters familiarity through lifelong history, and leads to kindness and tolerance of differences rather than inequality and division in adult life. The result was that the gap

in achievement between Finland's highest and lowest educational performers was the narrowest on record. That gap has now begun to expand in response to reduced 'special' educational provision and classroom support. The result of withdrawing some 'special needs' support is that achievement equality of the lowest performing 30% of children has been reduced.

Although its academic results have slipped on the PISA measure, Finland remains at the forefront of innovative educational development (currently trialling classrooms with no desks or seats, in the belief many children learn best by moving around and collaborating – incorporating classrooms into the physical health agenda).

All Finnish schools follow the social pedagogical approach of allowing 'children to be children'. No formal homework is handed out (or just a very few minutes as they reach their mid-teens – and whether or not they do it appears to be quite optional). Because assessments are viewed with disdain, Finland remains resolved to take a far broader view of education than the limited focus of the 3-yearly PISA evaluation; their prime focus remains strongly on health (so there will be even more physical activities in schools). Their philosophy also favours emphasis on the arts (for example, the Finns invariably speak at least two foreign languages (often considerably more than that – e.g. English, French, German, Spanish, and Swedish).

There is also good nursery and early years' play/education provision, and children do not start formal (academic) school until age 7 (the same age as Estonia, Latvia and Lithuania, while age 6-7 is standard in Denmark and Sweden, and 6 is the start age in Austria, Belgium, Czech Republic, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Norway, Poland, Portugal and Spain). This is compatible with the philosophy of Fit-2-Learn²³² ('academic' learning is best confined to the auditory realm up to age 7, because of the suitability of stages of brain development to the differing modes of learning; it also fits with the theories of Bruner, and supports Professor Melhuish's contention that early years' education is best confined to social, emotional, language and communication).

Cause of Finland's performance downturn:

Having identified Finland as an excellent example of combining education and health, we believed it was important to understand why such an enviable record appears to be slipping. Explanations vary. The Washington Post²³³ put some of those questions to Pasi Sahlberg, a Finnish educator and leading figure in education policy and the author of the best-selling book, *Finnish Lessons 2.0 What can the world learn from educational change in Finland*: His response:

'Finland has been living with a very serious economic downturn since 2008 that has affected education more than other public sectors. Sustained austerity has forced most of Finland's 300+ municipalities to cut spending, merge schools, increase class sizes, and limit access to professional development and school improvement. The most harmful consequence of these fiscal constraints is declining number of support staff, classroom assistants, and special education personnel. Finland's strength earlier was its relatively small number of low-performing students. Now, the number of those pupils with inadequate performance in reading, mathematics and science is approaching international averages. In Finland this is probably the most significant driver of increasing inequality within education. A Finnish adage for this could go something like this: Equity in education arrives on foot but leaves on horseback.'

Others believe the impact of the sudden need to cater for immigrant children who do not speak Finnish (said to be a particularly difficult language) has been underestimated; some believe it is, at least partly, a result of the Finnish education system not focusing on assessments and not designing its system with PISA evaluations in mind. Still others believe the recent significant drop in male (vs female) academic performance is because (excluding time watching TV), Finnish boys spend 4+ hours daily on electronic devices. Pasi Sahlberg says:

'Finally, what Finland should learn from these recent results is that reducing education spending always comes with consequences. It is very short-sighted to think that high educational performance and continuing betterment of schools would be possible when resources are shrinking. Whether Finland's politicians and bureaucrats take these lessons seriously remains to be seen.'

Whatever the reason for the dip in education performance, it is clear Finland is very ill-placed for international economic competition. The massive reduction in Nokia sales (plummeting from 20% to 'negligible' of Finland's export income) in the wake of the Smart phone and Android development has hit the little country hard. Their basic export business is in raw materials, again hit hard as other countries contract manufacturing during the long period of global (and, especially, Eurozone) economic downturn. Also, Finland's labour costs are some of the highest in the Eurozone (on a par with Germany's) while its productivity (hours worked/GDP) is below the average. One result of the persisting gap between supply and demand is a general 5% reduction in wages.

Understandably, in response to the inherent geographic disadvantage that reduces Finland's competitiveness on the global scene, it has felt the need to begin to sacrifice the decades-long 'winning formula' of its revolutionary education policy. This seems a sad waste since the policy had moved Finland from a predominantly blue-collar to white-collar workforce that, for some years, was able to take the lead in e.g. mobile phone technology. Expert commentators do not expect Finland's economic performance to return to the 2008 levels until 2020.

A more in-depth study of what worked so very well and exactly which cost savings have been having the best and worst impacts might provide very useful insights not only for Finland but perhaps for the UK and other countries. Although we have superior resources, UK productivity is almost identical to Finland's (while Ireland's is significantly higher).

Homelessness in Finland

See Part 3, Transition into Homelessness for a brief outline of how Finland used the Housing First principle to eradicate street begging and homelessness. Like the Scottish Social Bite organisation, Finland put major resource into phasing out temporary accommodation and replacing it with (new build) sustainable, affordable housing.

Housing First initiatives are succeeding in places around the world, including a number of areas in the UK, Canada and the USA. However, for it to succeed nationally, it needs to be elevated to national policy level; otherwise homeless people will continue to have to 'jump through layers of hoops' before being awarded a permanent home. Following the success of Finland's initiative, the UK Government has allocated £28 million to trial Housing First in Liverpool, Manchester and the West Midlands²³⁴.

CASE STUDY H: How Iceland got its teens to ‘say No to drugs’

This January 2017 *Atlantic* report explains how curfews, sports, and understanding the brain chemistry of children all contributed to a dramatic curb in substance abuse in the country. The insights in the article came from Gudberg Jónsson, an Icelandic psychologist, and Professor Harvey Milkman, an American psychologist who teaches for part of the year at Reykjavik University. Highlights include:

- Twenty years ago, Icelandic teens were among the heaviest-drinking youths in Europe, and the streets of Reykjavik felt unsafe on weekend nights.
- Today, Iceland tops the European table for the cleanest-living teens.
- The transformation took place between 1998 and 2015.
 - The percentage of 15- and 16-year-olds who had been drunk in the previous month plummeted from 42% in 1998 to 5% in 2016.
 - The percentage who have ever used cannabis is down from 17% to 7%.
 - Those smoking cigarettes every day fell from 23% to 3%:



This turnaround was achieved by a method both radical and evidence-based, and relied largely on what might be termed enforced common sense. Milkman:

‘This is the most remarkably intense and profound study of stress in the lives of teenagers that I have ever seen. I’m just so impressed by how well it is working.’ ... and argues that if it were adopted in other countries, the Icelandic model could benefit the general psychological and physical wellbeing of millions of young people, ‘not to mention the coffers of healthcare agencies and broader society’. He explains how he was in the eye of the storm of the drug revolution in the early 1970s, when he was doing an internship at the Bellevue Psychiatric Hospital in New York City and ‘LSD was already in, and a lot of people were smoking marijuana. And there was a lot of interest in why people took certain drugs’.

His doctoral dissertation concluded that people would choose either heroin or amphetamines depending on how they liked to deal with stress. ‘Heroin users wanted to numb themselves; amphetamine users wanted to actively confront it [stress].’

After Milkman’s work was published, he was among a group of researchers drafted by the US National Institute on Drug Abuse to answer such questions as: why do people

start using drugs? Why do they continue? When do they reach a threshold to abuse? When do they stop? And when do they relapse? He found that *'Any college kid could say: Why do they start? Well, there's availability, they're risk-takers, alienation, maybe some depression... But why do they continue? So I got to the question about the threshold for abuse and the lights went on – that's when I had my version of the 'aha' experience: they could be on the threshold for abuse before they even took the drug, **because it was their style of coping that they were abusing.**'*

Then, at Metropolitan State College of Denver, Milkman was instrumental in developing the idea that people were getting addicted to changes in brain chemistry: *'active confronters were after a rush – they'd get it by stealing hubcaps and radios and later cars, or through stimulant drugs... Alcohol also alters brain chemistry and ... is a sedative that sedates the brain's control first, which can remove inhibitions and, in limited doses, reduce anxiety. A key conclusion was that 'People can get addicted to drink, cars, money, sex, calories, cocaine – whatever. The idea of behavioral addiction became our trademark', says Milkman.*

This idea spawned another:

Why not orchestrate a social movement around natural highs: around people getting high on their own brain chemistry... it seems obvious that people want to change their consciousness – without the deleterious effects of drugs?

By 1992, Milkman's team in Denver had won a \$1.2 million government grant to form Project Self-Discovery, which offered teenagers natural-high alternatives to drugs and crime. They got referrals from teachers, school nurses and counsellors, taking in teenagers from the age of 14 who didn't see themselves as needing treatment but who had problems with drugs or petty crime.

We didn't say to them, 'You're coming in for treatment'. We said, 'We'll teach you anything you want to learn: music, dance, hip hop, art, martial arts.' The idea was that these different classes could provide a variety of alterations in brain chemistry, and give them what they needed to cope better with life: some might crave an experience that could help reduce anxiety, others may be after a rush.

At the same time, the recruits got life-skills training, which focused on improving their thoughts about themselves and their lives, and the way they interacted with other people. Milkman says:

The main principle was that drug education doesn't work because nobody pays attention to it. What is needed are the life skills to act on that information. Kids were told it was a three-month program. Some stayed five years.

In 1991, Milkman became a consultant to the first residential drug treatment centre for adolescents in Iceland.

What Icelandic teens do instead of drugs, alcohol and general mischief

Everything imaginable from indoor skating to badminton and ping pong. There is an athletics track, a geothermally heated swimming pool and (artificial pitch) football. The young no longer hang out in the park, because they're in after-school classes in these facilities, or in clubs for music, dance, or art - or on outings with their parents.

What changed? To effect these dramatic changes, other far-reaching changes had to be made:

- It became illegal to buy tobacco under the age of 18 and alcohol under the age of 20;
- Tobacco and alcohol advertising was banned.
- Children aged 13-16 were prohibited from being outdoors after 10 p.m. in winter and midnight in summer (still in effect; in summer it is broad daylight at midnight in Iceland).
- Links between parents and schools were strengthened through parental organisations which, by law, had to be established in every school, along with school councils that included parent representatives.
- Parents were encouraged to attend talks on the importance of spending a *quantity* of time with their children rather than occasional 'quality time', on talking to them about their lives, on knowing who their children were friends with, and on keeping their children home in the evenings.
- 'Home and School', the national umbrella body for parental organisations, introduced agreements for parents to sign:
 - The content varies depending on the age group, and individual organisations can decide what they want to include.
 - For children aged 13 and over, parents can pledge to follow all the recommendations, e.g. not to allow their children to have unsupervised parties, nor to buy alcohol for minors, and to keep an eye on the wellbeing of other children.
- These agreements educate parents and also help to strengthen their authority in the home (argues Hrefna Sigurjónsdóttir, director of Home and School).

What it cost

State funding was increased for organised sport, music, art, dance and other clubs, to give children and young people alternative ways to feel part of a group, and to feel good, rather than through using alcohol and drugs. Those from low-income families received help to take part. In Reykjavik, for instance, where more than a third of the country's population lives, a Leisure Card gives families 35,000 krona (£250) per year per child to pay for recreational activities.

Indirect as well as direct benefits? Could the significant rise in the percentage of children taking part in organised sport four or more times a week be bringing benefits beyond raising stronger, happier, healthier children and reducing Health and Criminal Justice costs? Could it, for instance, have anything to do with Iceland's crushing defeat of England in the Euro 2016 football championship? The population of Iceland is a mere 320,000.

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²¹³ Glenn Greenwald is a constitutional lawyer and a contributing writer at Salon. He has authored several books, including *A Tragic Legacy* (2007) and *How Would a Patriot Act?* (2006).

²¹⁴ Trigueiros, F., Vitória, P. and Dias, L. (2010). *Rather Treat Than Punish: The Portuguese Decriminalization Model*. Submission to the 11th meeting of the Criminal Justice Platform, 29th May, Strasbourg, France, pp 28 [online] Available at:

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²¹⁵ Stevens, A., Hughes, C.A. (2010). What Can We Learn From The Portuguese Decriminalization of Illicit Drugs? *British Journal of Criminology* [online] available at: <https://academic.oup.com/bjc/issue/50/6>

²¹⁶ Silvestri, A. Gateways From Crime To Health: The Portuguese Drug Commissions. Available at <http://webcache.googleusercontent.com/search?q=cache:1eNjyMNxZVgf:citeseerx.ist.psu.edu/viewdoc/download%3Bjsessionid%3DE0B9C0EC9BF5931510FCE9FCA85FADD6%3Fdoi%3D10.1.1.730.9605%26rep%3Drep1%26type%3Dpdf+&cd=1&hl=en&ct=clnk&gl=uk>

²¹⁷ Ibid

PART 3: TRANSITIONS IN CHILDHOOD

Introduction

This resource is intended to convey the understanding gleaned from our research into the child's journey through life and through the system. It makes recommendations for commissioners of services who deal with unpredictable issues (or 'Non-universal' transitions) affecting 2-18-year-olds. A separate resource for service commissioners for under 2s is contained in *Conception to age 2 – the age of opportunity*; available to download free from the Publications section of www.wavetrust.org.

Since this report is intended for the whole UK, sources of recommended action are necessarily general in nature because the exact responsibility for different aspects of services to children and their families varies between different regions and also in line with the differing structures of local authorities. For example, responsibility for child and adult safeguarding is combined in Wales; responsibility for Education and Care is combined in (at least) parts of Scotland. Even in England (where Ofsted prevails and offers some consistency) the Royal Borough of Kensington & Chelsea recently replaced the function of the (more usual) Director of Children's Services with a Director of Family Services. Also, children's social workers are sometimes included in Health, sometimes report directly to the Council (or both, as in the case of Hertfordshire); sometimes they work directly for or in Education, or some of them might be placed inside schools by the local authority.

In view of these variations, we have concentrated on the function, confident the target audience for this 'resource' will be fully informed of where, in their particular structure, responsibilities lie for the various service functions that would be involved in carrying out our recommendations.

All children make numerous 'normal' transitions during the years from age 2 to 18. Although these are not the subject of our report, there is one exception: the change in risk factors at around age 11 (generally at entry to secondary school) which manifest in 3 ways:

- risk of harm **from** others (the same as for younger children)
- risk of harm **to** others (possible, but usually minimal in younger children)
- risk of harm to **themselves** (very rare in younger children)

NON-UNIVERSAL TRANSITIONS (at any age)

Introduction

All too often, these later transitions are 'progressions' from earlier ones. However, we do need to separate the various 'occurrences' (e.g. into and out of Care, being NEET, youth justice, gangs, addiction, etc.) to clarify the characteristics of such potential mileposts along the road to dysfunctional lives that lead to severe, multiple disadvantage and social exclusion. Young people who have been enabled to develop resilience can thrive despite being both school-excluded and in Care; we equally know from ACE studies that there are many children whose lives are characterised by quite high level of ACEs, but who are neither taken into care nor school-excluded, yet they can experience high levels of problems, including physical and mental ill-health, addiction, contact with Criminal Justice and even homelessness. There are also children who bear no identifiable 'markers' for later adverse outcomes but who still suffer them. This section aims to shed light on some of the most common negative

transitions, and to help policy-makers and commissioners of services identify how best to help those undergoing them.

INTO/OUT OF CARE SYSTEM

These children are in our care; we, the state, are their parents – and what are we setting them up for...the dole, the streets, an early grave? I tell you: this shames our country and we will put it right. The Rt. Hon. David Cameron MP, Prime Minister, October 2015

Key Message I contains a summary of the bulk of our research on ACEs, and Key Message VI gives our findings on UK Education and Care (including latest Commons Select Committee on Education and, especially, on looked-after children and the performance of CAMHS for those disadvantaged by lack of ‘permanency of place’). Key Message VI also provides an overview of the current problems faced by social workers generally (and caseloads in particular).

Key Message VI quotes a particular point about those transiting out of care²³⁵:

Adolescence and leaving care are times of both opportunity and high risk, especially for those who have mental health problems or are offenders. Although leaving care has been the focus of research-based legislation and guidance, and there is some excellent practice, it remains a period in which resources are stretched and young people can slip through the net.

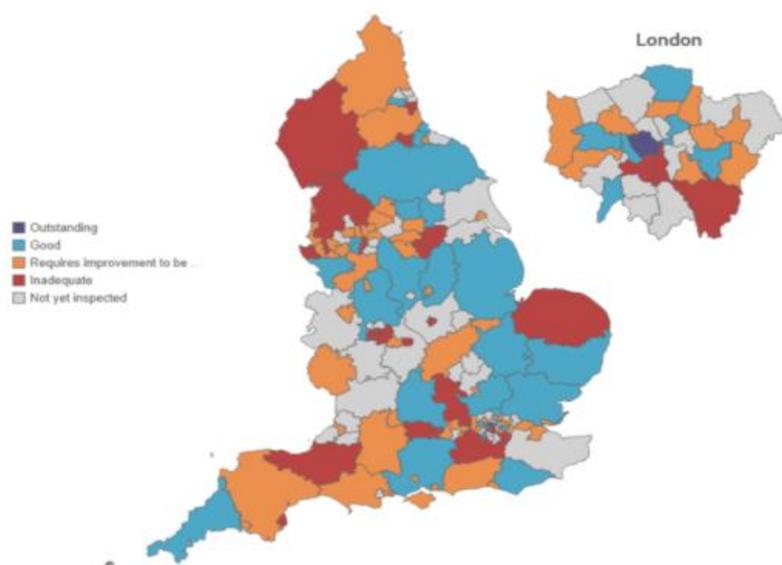
... and goes on to link this sensitive time with later offending.

Despite the very high cost of Care, a review by Lord Laming for the Prison Reform Trust²³⁶ found half the children in youth custody came from foster or residential care, and that about half of the thousand children in custody in England and Wales have experienced the care system, despite fewer than 1% of all children in England, and 2% of those in Wales, ever being in care.

It also found that keeping a young person in a secure children’s home costs more than £200,000 a year while the annual cost of a place in a young offender institution is about £60,000 [other estimates for these this range between £140,000-145,000; the G4S cost was quoted at £145,000 per child p.a.].

The map below gives a bird’s eye view of the variable outcomes of Care homes in England and Wales:

Map 1: SIF inspection overall effectiveness judgements from November 2013 to September 2016



<https://www.gov.uk/government/publications/local-authority-and-childrens-homes-in-england-inspection-outcomes-as-at-30-september-2016/local-authority-and-childrens-homes-in-england-inspection-outcomes-as-at-30-september-2016>

Specific recommendations for looked-after children

1. Fulfil the recommendations of the Commons Select Education Committee²³⁷ for the mental wellbeing of looked-after children.
2. National and local government to implement the extensive recommendations from the detailed finding of the excellent Nuffield-funded University of East Anglia Report on what is needed to protect looked-after children from entering the Youth and Criminal Justice systems²³⁸
3. Take account of the Boddy recommendation for permanence of place.
4. Use the Petrie findings in Key Message VI as guidelines for what can be achieved with alternative approaches to Care.
5. Fulfil the 2008 Commons review recommendation to appoint a pedagogically qualified professional at each institutional care location, and generally increase NVQ3 staff qualifications.
6. Adopt the Bellis recommendation of an 'always available adult' to mentor these children.
 - a. This could be achieved by enrolling community volunteers who share some focused 'special interest', sport or hobby of each particular child.
7. Enrol pregnant looked-after girls in an intensively supportive Family Nurse Partnership programme from 2nd trimester to child age 2 (to stop the intergenerational cycle), and:
 - a. Extend this to age 26 when first-time mothers are seen to be vulnerable (as is the practice in the Netherlands, with very good outcomes).
 - b. Revive the (successful) Community Mothers²³⁹ initiative (volunteer, experienced mothers guide young, inexperienced ones).
8. Inform adoptive and foster carers fully about children's past histories – to give them a choice and warn them of signs of early risk manifesting in later childhood.

9. Raise strong awareness of the dangers of both smoking and alcohol during pregnancy.
Current inconsistent advice about avoiding alcohol in pregnancy is confusing and potentially dangerous.
10. Build awareness of, and use as a guide, the Ginsburg 7Cs (building blocks of resilience); combine this approach with trauma-informed care.
11. Consider adopting the Eurochild key recommendations, including:
 - a. Making the collection of comparative data on children in alternative care a key political priority.
 - b. Taking action to support the deinstitutionalisation of children and moving towards the provision of a range of integrated, family-based and community-based services.
 - c. Providing a framework to support investing in a children's workforce that promotes inclusion and allows delivery of personalised services.
 - d. Reducing risks of social exclusion, by ensuring no child is taken into care because of poverty, disability or ethnic origin.
 - e. Ensuring children with Care experience and their families have a voice.
 - f. Involving children, young people and their families in the decision-making processes affecting them directly and in the development of alternative Care policies/services.

Who needs to take action? A collaborative effort involving schools, families, Social Services, Health, Education – in fact, all government and non-government agencies.

South London foster mother's recommendations

All foster carers need to be trained (and supported) in acceptable models of therapeutic parenting. Example of what this might look like:

- a. *An introduction to therapeutic parenting included in preparation training groups.*
- b. *Therapeutic parenting as a mandatory course for foster carers, once approved and then every three years. Set a minimum amount of hours; 1-day training courses are not enough.*
- c. *Foster parents also need to be supported. This could be through therapeutic parenting support groups and/or mentoring programmes.*
- d. *Set up a fund for therapeutic support for looked-after children. [in line with that for adoption]*

INTO PERMANENT SCHOOL EXCLUSION

The suggestions and observations concerning school exclusion are made in the hope that the current plight of some children spending many months with no educational provision whatsoever will be rectified. We also hope the words Michael Gove, uttered back in 2007, will eventually result in policies and action to decouple inability to thrive in mainstream school from high levels of entry into the youth and adult criminal justice systems:

'All the dangers and warnings are there – all the red lights are flashing. These are young people who are almost certain sooner or later to come into contact with the criminal justice system. We have to think hard about what we can do.'

When it comes to education, a supportive, resilience-building, social pedagogically- and trauma-informed system would be guided by holding as a self-evident truth that there are ‘no bad children’, only children unsuitably placed for their innate abilities or whose upbringing has rendered them socially and emotionally challenged (and perhaps highly challenging). A plethora of evidence, ranging from anecdotal reports to research and statistical studies, reveals the terms ‘school exclusion’, ‘suspension’ or ‘expulsion’, to be counter-productive²⁴⁰.

As can be seen from the evidence of delivering trauma-informed care (Key Message V), better outcomes are achieved by avoiding negative attitudes. However well-intended, negative terms do reveal negative attitudes to the listener. Assuming we follow neither the Finnish policy of keeping children together nor the Netherlands one of ‘streaming’ before entry to secondary school, a more positive attitude would be reflected in such terms as ‘transferred’ or ‘placed’ [in alternative establishments better equipped than mainstream school to fulfil the child’s needs]. Obviously, it would undermine the intention if positive terms are adopted before enough alternative places to contain the most challenging children actually exist.

Even those school-excluded children fortunate enough to be placed in good alternative educational establishments are likely to relate to the ‘excluded’ label as stigmatising rather than meaning, as it so often does, the gift of extra (expensive) support. In WAVE’s work with young offenders and prisoners, having been ‘school-excluded’ loomed very large in their negative self-image, and added to an expectation of never doing well in a society that had ‘rejected’ from a young age.

If suitable support, including to gain educational qualifications after a child’s emotional, behavioural and basic educational needs have been met, is offered to all, we could see a significant drop in the numbers of disadvantaged school leavers who go on to swell youth and adult prison populations. To pay 3 times the standard mainstream cost to meet a disadvantaged child’s needs in a daytime setting is a fraction of the cost likely to ratchet up if they ‘live down’ (to quote Ginsburg) to the negative expectation implied in the term ‘excluded’. Above all, it is a missed opportunity to frame extra support as a positive contribution to children’s lives rather than a signal they are somehow outcasts because they failed to cope (or be ‘contained’) in mainstream education. Consider the financial costs, and potential savings, if timely support were provided via specialist education:

Table 7 – types of education provision

Establishment type	Approximate annual cost per child/adult
Mainstream school	Primary: £4,900; Secondary: £6,300 ²⁴¹
PRU or specialist school	£18-26,000 [varying estimates for varying provision]
Secure children’s home	£200,000 ²⁴²
Young offender institutions	£60 ²⁴³ to 145,000 [Laming and various]
Prison for adults	£40,000 (excluding cost of capital)

Review educational provision?

Not all children can do well in schools focused on academic achievement. Since estimates of the numbers of excluded children who are also classified as having Special Educational Needs (SEN) vary, perhaps the UK could review the Netherlands’ system of streaming children at age 12, to enable those of non-academic inclination (or ability) to train vocationally – and thereby avoid the boredom and disruption experienced in

mainstream school. We also heard of a very successful vocational school in Bruges, where non-academically inclined children are taught catering²⁴⁴ and ‘... turn out some of the best chefs and hospitality staff in the country’. (See also Case Study F: Netherlands and G: Finnish (former) model of providing additional support to c. 30% of its children to keep them together in mainstream classes, which provided a sound recipe for ultimate social equality and inclusion). There are many choices, and policy-makers need to make some important decisions if the UK is to retrieve its place as a world-leader in Education and commerce.

Review disciplinary methods?

In the US, extensive research following numerous, high profile problems among the school population has dubbed ‘zero tolerance’ as counter-productive and responsible for deteriorating academic outcomes and less safe schools – the exact opposite of what was foreseen and intended in adopting the approach. Children were found to respond positively in a culture of democratic collaboration, including the ‘restorative justice’ model that allows a child to be redeemed through being (a) ‘heard’ and (b) allowed to make reparation²⁴⁵.

So, for instance, instead of sending UK children home on a fixed-term exclusion basis (when they are quite likely to be out in the community, unsupervised, and not at home during the school day anyway), perhaps consider keeping them in school *longer* and setting them tasks to redeem themselves? Since the law now allows schools to operate detention without issuing 24 hours’ written notice to parents, this would be easier than in the recent past. However, our key recommendation remains that any very troubled schoolchild first be included in a Nurture Group (if necessary, for the full 4 terms) to help resolve inner and outer conflict.

Improve teacher skills

We welcome the recent government pledge to ‘*train every teacher in not just how to tackle serious behaviour issues, but how to deal with low-level disruption that stops children from learning properly*’. That pledge, plus the Commons Select Committee recommendation that basic Initial Teacher Training be expanded to include awareness of mental health, could combine to support our teachers in their challenging task, and improve outcomes for not only the children in their care but for all society.

‘SPECIAL’ SCHOOLS AND PUPIL REFERRAL UNITS (PRUs)

These are the types of setting excluded children are transferred to after their ‘failure’ in mainstream schools. This ‘failure’ does not occur overnight in some vacuum, but will usually be an outcome of earlier problems and disadvantage and, no doubt, after much work and effort on the part of teachers. The need to attend a PRU can be either a step on the pathway to SMD or an opportunity to avoid that pathway.

Good PRUs include adult role models who provide the protective factors to foster resilience and good outcomes referred to in Key Message I on ACEs. What such teachers do amounts to a blend of social pedagogy and trauma-informed care. Their key advantages over mainstream teachers are not only their specialist training but also their small class sizes; it would be impracticable for the level of attention a PRU teacher can give each pupil to be delivered to the few most disadvantaged in a class of 30 – unless the majority of the cohort were to be severely neglected (or the cost of education were to soar).

Some statistics reported in a News article on 31 October 2015²⁴⁶ by Oscar Quine on the very successful Limes Academy PRU and other activity-based establishments for school-excluded children. The following section is paraphrased from his report:

- Despite additional pressures, 24% of PRUs matched The Limes in achieving an Outstanding rating in Ofsted's most recent round of inspections – compared with only 11% of mainstream schools.
- More than 20,000 pupils are catered for by 'alternative provision', the umbrella term under which PRUs fall.
- Because of the need for a high staff-to-student ratio, the units tend to be small, with some teaching just a handful of pupils.
- The capacity of the largest PRUs, of which The Limes is one, is around 120.
- The aim is to put as many pupils as possible back on an even keel and then reintroduce them to mainstream education.
- PRUs also provide education for teenage mothers and for children with physical and mental health issues that prevent them from thriving in mainstream school.
- Staff at PRUs are trained in psychological diagnostic techniques – and pupils are frequently found to have communication or educational difficulties.
- PRU staff say some children had adopted bad behaviour in mainstream school as a defence to distract teachers from seeing they do not understand what is being taught.
- PRUs receive GCSE-age pupils with the academic abilities of a primary school child.
- There are also very able pupils (with emotional problems) presenting in PRUs who can be reintegrated into mainstream schools to take their exams.
- One Head teacher remarked that the needs of some children in PRUs were often very basic: they needed to be fed.

'Children will often come to us in moments of chaos. Some of these kids have had more things happen to them in the first 10 years of their lives, will have had more emotions to process, than you and I will have in a lifetime.' [The Head of the Limes Academy]

Mr Quine acknowledged that a minority of PRUs do still fit the unreconstructed view of the sector drawn on in the negative Government Review that followed the 2011 London riots. However, this is usually because some local councils, in the absence of a better option (or tempted by cut-price provision) send children to unregistered facilities (often sports or youth clubs) willing to take on the responsibility (but are closed off from scrutiny). He commented that such facilities are in the minority and do not represent the generally very good work of dedicated, accountable PRUs.

In acknowledging the success of many PRUs, it is impossible to ignore the high staff-to-student ratio. For example, the Pendlebury Centre makes use of drama therapists, a cognitive behavioural therapist, a bereavement councillor, social workers, a family liaison worker, psychotherapists for both the children and the staff – yet the spend at this school falls well short of that of the average PRU.

Specific recommendations

1. Children in a disadvantaged group can be helped by the PREP initiative (Parenthood and Relationship Education Project (PREP) Scotland), as focus on life skills is relevant and fit well with the current delivery in a good PRU (see www.wavetrust.org).

2. Provide leavers with individual employment/career guidance to avoid the risk of becoming NEET.
3. When children's problems include a bad home situation, prioritise them for housing support (to avoid any risk of youth homelessness).
4. Consider elevating their status to that of looked-after children, with the same privileges recommended by the Commons (2016) Select Committee on Education²⁴⁷.
5. Whatever the status of the children, prioritise educating those teaching them in the subjects of trauma-informed care and the 7Cs of resilience, as recommended in the following section on looked-after children.

Who needs to take action? Education, Health, Social Services and Housing, as appropriate.

INTO/OUT OF YOUTH JUSTICE SYSTEM

As quoted earlier, the 'TACT' report, 'Looked After Children and Offending: Reducing Risk and promoting Resilience'²⁴⁸, linked children who needed to be looked-after with offending, and provides detailed risk factors and recommendations. It acknowledged that youth offending services have developed constructive models for prevention and intervention, in particular in relation to restorative justice, and are now required to work in partnership with children's services to reduce offending by looked-after children. Although it pre-dated the 2016 Laming report, it stated that protocols between the police and residential care are widely used to address the problem of the inappropriate criminalisation of looked after-children through court appearances for minor offences in their placements, but remained concerned about how well protocols and other strategies have been implemented in some areas.

One of its key research findings is that risk factors for youth offending coincide in most cases with factors experienced by looked-after children, with an accumulation and interaction between them (e.g. abuse being associated with anxiety and problems with attention which, in turn, affect behaviour at school and may contribute to offending).

Direct link between being looked-after and later offending?

As also referred to earlier, the Laming Report found UK children with experience of the Care system to be 6 times more likely to be involved in youth justice than those who remain within the family. Another finding was that police are sometimes involved in situations that would normally be dealt with by parents (e.g. if a child 'stole' food from the kitchen of his Care home or a teenager trashed his room). The report recommends social services and criminal justice agencies work together better, and that the police improve practices of prosecution of children and young people in Care.

Age of criminalisation: The very young age at which we criminalise our children lies at the heart of the quality of future outcomes (and self-perception) they are likely to enjoy. The stigma of a criminal record at such a young age would not occur in a society operating trauma-informed care; nowhere is that more important than when a child's family situation has resulted in the need to be taken into Care.

The MOJ policy:

'Punishment is an essential part of the justice system, but on its own it does not stop people reoffending. Almost half of all adults leaving prison are reconvicted within a year.'

Perhaps it is time for Society to make up its mind whether it is serious about rehabilitating young offenders or wants to punish or banish them. It seems illogical to classify under-18s as children for some purposes yet as criminals for others.

With youth reoffending rates even higher than adult (72% vs 46%)²⁴⁹, a system focused on criminalisation and punishment fails children, victims and communities. If anything, these statistics show most children were too immature to consider consequences.

Here it is worth repeating the opposing philosophies to offending (in general), for nowhere is this more relevant than to those who find themselves outside the law while still children:

	Punitive Segregation	Reintegrative Punishment
View of offenders	Dangerous outsiders People who are different from 'us'	Members of society – like 'us' - who have done wrong/welfare cases
General strategy	Build walls between 'us' and 'them' Contain them Defend ourselves against them	Reformatory and reintegrative punishment They must be deprived of some rights for some period of time. But the overall aim is to keep their lives as normal as possible and to return them to society as equal, productive and valued members
Tone	Coarse, harsh	Civilised, critical/sympathetic

By far the simplest solution to divert children from the criminal justice system is to raise the minimum age of criminal responsibility. The majority of European countries treat a child committing a crime as a welfare matter. For example, in the Nordic justice systems, put in place at the turn of the 20th century, no 'offender' under age 15 (now 14 in Denmark) is processed through the criminal justice system, and many young adults are also supported by social welfare even if they have committed a criminal act.

By comparison, our system (the history is briefly outlined in the 'Discussion' section of Case Study B) is set up to respond primarily through punishment, with the justice system picking up and criminalising where the welfare system has not intervened early enough (or well enough). Statistics show that children entering the criminal justice system often have a plethora of welfare needs underlying their behaviour. By increasing the likelihood of recidivism instead of supporting these children, we harm not only them but also their potential future families and victims – and society.

A recent survey of 90 countries found that the most common age of criminal responsibility (adopted by c.25% of the sample) was 14 years. Taking into account the international experience, in 2007 the UN Committee on the Rights of the Child came to a more definitive view as to what constitutes an internationally acceptable minimum age, noting that: *'States are encouraged to increase their lower minimum age of criminal responsibility to the age of 12 years as the absolute minimum age and to continue to increase it to a higher age level.'* In other words, they believe age 12 is too young.

Against this background, it is perhaps unsurprising that the UN Committee on the Rights of the Child has consistently criticised England and Wales for its low age of criminal responsibility. Although Scotland has the lowest age of criminalisation (8 years), this is offset by legislation forbidding prosecution before age 12 – until then, any child’s ‘criminal’ activity is treated as a welfare matter.

Across Europe, the age of criminality is usually 16 or 18; some countries maintain 15 or 14; a minority still use age 12 (detailed statistics are provided by the National Association for Youth Justice²⁵⁰). Children’s ability to comprehend, and apply reason to, the full extent of the implications of their actions is reflected elsewhere in our laws, e.g. that they must be 16 before engaging in sexual activity, 17 before obtaining a provisional driving licence, and 18 before voting, drinking or smoking. The current age (10 years) of criminal responsibility is out of step with current evidence, UN recommendations, other UK laws and international norms.

A longitudinal study of 4,100 children²⁵¹ found that the further enmeshed into the formal criminal justice system children become, the more harm is done and the more likely they are to reoffend. In 2011, the Royal Society report to consider the role of neuroscience in determining an appropriate age of criminal responsibility concluded:

‘At the age of ten, the brain is developmentally immature, and continues to undergo important changes linked to regulating one’s own behaviour’.

Youth ‘secure estates’

The privatisation of this sector was fraught with scandal, allegations of brutality, bullying, corruption and even killing (of a vulnerable 14-year-old who suffocated while held in inhumane restraints). Although there had been complaints for many years, it came to public attention only when exposed in the January 2016 Panorama secret filming²⁵². Many young people housed in such establishments have severe learning handicaps that make them targets for institutional bullying and humiliation – by the staff employed to protect and help them. The **G4S**²⁵³ ‘homes’ featured in Panorama were eventually taken over by the government. Again, it is worth repeating that Prison Officers in Norway receive 3 years of training – and that is for adult prisoners.

The Centre for Social Justice report, ‘Breakthrough Britain’²⁵⁴ identified ‘four key shortcomings, to be addressed if outcomes are to be improved:

1. *The youth justice system continues to function as a backstop: sweeping up the problem cases that other services have failed, or been unable, to address;*
2. *The system is often operating in a way which promotes rather than reduces offending;*
3. *There continues to be too much focus on functional process at the expense of life-changing outcomes; and*
4. *The importance of relationships to preventing offending and facilitating rehabilitation, emphasised to us consistently in our evidence hearings, continues to be overlooked.’*

The real question is: where in the youth justice system is there a demand to provide what young offenders need to build their resilience and equip them for productive lives? Since these are the group (a) most likely to have been looked-after following very adverse early life experiences and (b) most vulnerable to going on to populate our prisons, and then fall into lifelong severe, multiple disadvantage, it would seem

self-evidently practical and expedient to foster their latent ability to be resilient, independent and productive.

So, while it is both necessary for a system to include secure institutions for the purposes of **rehabilitating and helping** increase the education of young offenders and, in some cases, protecting the public, there have been severe failings in the approaches taken and methods of delivery. It is clearly counter-productive to put young people who already have behaviour problems into a brutalising environment likely to reinforce daily that 'might is right'.

*What the mental health statistics say about youth in UK custody*²⁵⁵

- 10% of 13-18 year olds in custody suffer anxiety.
- 43% of young people in prison have ADHD [usually associated with learning difficulty because of the 'attention' difficulty].
 - As described earlier, foetal alcohol spectrum disorder is frequently misdiagnosed as either autism or ADHD (and treated inappropriately).

Specific recommendations

Effective rehabilitation would be pedagogical in nature, run by highly-trained 'emotionally intelligent' staff, and might perhaps look more like an enclosed commune or 'secure boarding college' than a prison, and could be a 'crash course' in being well parented/learning sound parenting (i.e. trauma-informed care), including firm boundaries – something most of the inhabitants will never have experienced. The standard Norwegian penal system might be a good place to start to study the key factors of a system with high success rates for both staff and those incarcerated in it.

1. Policy-makers need to get off the fence on the question of punitive segregation vs reintegrative punishment – if the aim is rehabilitation.
2. Apply custodial *placements* (not *sentences*) only when indicated as needed to protect the public, the families of offenders or the offenders themselves.
3. Combine flexibility of placement lengths with creativity in setting behaviour and educational targets to merit re-entry to society (not *release*, as from prison).
4. Use a combination of PRUs and good Care homes – not prisons with 'guards' who insult, mock and physically maim those in their care (as shown in the secret Panorama filming).
5. Introduce a culture of respect for and by everyone involved (key to the success of good PRUs).
6. Resolve disagreements/problems by an internal mediation process.
7. Democratic peer panel to decide appropriate restitution if someone is out of line.
8. Encourage voluntary reparation or restitution when others have been harmed or deprived by what a child did either (a) to warrant the placement or (b) within it.
9. Employ at least one pedagogically qualified professional and appropriate ratio of psychologists/therapists to number of children at every location.
10. Provide every child with a mentor, to increase resilience and build capacity to trust.
11. Use projects (e.g. gardening, cooking, building, decorating, art, music) to give children something to achieve and take pride in.
12. Train children for entry to the labour market – much crime is committed by unemployed, unskilled people of all ages; UK levels of NEETs are very high.
13. Ensure adequate nutrition and opportunities for exercise and games.

14. Encourage non-electronic hobbies (reading, writing, painting, acting, music-making, board and physical games).
15. Teach basic cookery, housekeeping and (where necessary) personal hygiene.
16. Place in Nurture Groups children with behavioural problems.
17. Never 'expel' a young offender without a home and work or school to attend.
18. If children return to school or are old enough to work but do not have a home, or the family home is in some way toxic, phase their return to the outside world with the opportunity to return to the placement 'community' to sleep.
19. Provide aftercare in the form of regular group meetings and opportunities to volunteer and mentor newcomers.
20. Aside from incarceration, use as sole punishment: banning of devices capable of being used for virtual/video games, and all except communal TV – for the duration, to use the time away from 'normal' society as an opportunity to experience a culture of collaboration and human (rather than virtual) relationships.

By helping embed pro-social values, this largely 'liberal' sounding approach could save many young people from lives of severe and multiple disadvantage.

Who needs to take action? Government, Youth and criminal justice services, Health (including CAMHS), Social Services.

INTO (AND OUT OF) GANGS

'Recreational' vs profit-driven violence?

At the WAVE/Met Police/London boroughs conference²⁵⁶, John Carnochan (of the SVRU) presented the peculiarities of Glasgow gang 'recreational' violence. This involves rival gangs arranging battles, exactly as though they were football fixtures, but to play out cycles of inherited score-settling.

In contrast, much of the London youth gang activity is profit-driven. It appears from this that the motives for gang activity are quite different between London and Glasgow. We did not establish whether the 'post-code' gang wars of London are purely 'recreational/territorial' or profit-driven drug-related, or some mixture of both.

Gangs – exclusive 'clubs', but dangerously inclusive to try to leave?

WAVE experience of gang members – 'An End to Violence' programme

From 2009-2013 WAVE took a group of twelve 18-25-year-olds through our 'An end to violence' programme in a Class B Surrey Prison for males. The first year comprised 12 monthly group sessions interspersed with one-to-one meetings, to enable prisoners to speak in confidence about anything they were reluctant to air in the group. Following their release, they received individual support at WAVE's offices for a further 2-3 years.

All participants were volunteers. The only requirements were willingness to work in a group and a minimum reading age of 11. The group included 5 members from the same gang (two of whom were 'founder/leaders'). We found that:

1. All had histories of physical and emotional abuse and/or learning difficulties.
2. Most were already fathers and many had been in their gang (and in and out of Youth Offending) for as long as they could remember.
3. Although a few of them were bright and literate, it had not been possible for the prison education department to identify 12 young inmates with a reading

age of 11 who were also interested in participating in the course, so we did the best we could with some who were barely literate (and whose literacy improved dramatically during the course).

4. Most were aged 18-20; only one was 25 (a reformed, very senior, gang leader, who had undergone an epiphany during the Forgiveness Project he attended before our course).
5. All participants felt that giving up violence could never be an option if they remained in their gang, and that it would be equally impossible to return to their home 'turf' and not participate in the gang (they had considered this before volunteering for the programme). Because their culture was based on drug-dealing and burglary, crime and violence were integral to gang economy.
6. Many of them had been shot or stabbed, or both, by rival gang members in the past, sometimes on multiple occasions (and had scars to prove it).
7. They always knew their attackers, but maintained a strict code of silence and 'sorted' it privately – which led to a state of continuous feuding, including killings, without police intervention.
8. After undergoing preliminary processes that convinced them successful life is possible without violent crime, they all pledged to give up violence.
9. One of our group had to be put in 'isolation' within the prison during the programme because he was attacked in visiting time by a friend of someone from a rival gang. Fortunately, his isolation included all usual privileges for good behaviour, including an escort to attend our course.
10. The participants were easily persuaded of the dangers of their lifestyle, but had great difficulty avoiding it on release (all but one of them were released within a year of our starting the course; and one was deported, leaving 10 for follow-up support).
11. The non-gang members of our group had severe emotional problems that led to either self-harming or acting out violence on the public. In these cases, the key breakthrough came from identifying the 'offending state' and teaching them to handle it.
12. After release, we found the Probation Service obstructive on the issue of participants' need to avoid their 'home turf'. They would not allow attendance at Probation in an alternative nearby town, although we explained the dangers to a former gang member appearing on local streets, from both his own original gang and from rival gangs.
13. Probation facilities were inadequate: the local office had no inside waiting area, so the young men were forced to wait in the street (someone from WAVE waited with them because they were in terror for their lives).
14. The gang member who had had to be put in isolation in prison was shot in the head and chest while queuing in a food shop a week after his release; he barely survived, and came to WAVE for help the day he was discharged from hospital. We were able to help him secure work and a home out of the borough, where he remains happily employed and settled with his partner (they have since had two children). His initial objective in giving up his lucrative, high status gang life was to settle, have children and give them a safe, law-abiding future.

Results and insights: we found all our participants capable of empathy and remorse, but having suffered hideously in childhood and been outcasts from an early age, including being school-excluded. Almost all came from huge families (up to 17 children), usually of the 'blended' variety, comprising one mother and multiple fathers – each new 'parental' partnership being 'sealed' by additional child(ren). After building trust in us, a couple of them decided to train as mentors to the younger children

(aged 10-12) who are on the edges of gangs, to discourage them from following the dangerous path that leads to prison, injury or death.

When we last checked (over 3 years after their release) only one of the group had reoffended. The one about whom we had the most concern had not, although he sometimes threatened he would for no reason other than to secure food and shelter (his step-father and mother, who had borne further children together, had ejected him from the family home). At the time, the national statistic for recidivism was 46% within the first year of release.

Role of drug dealing in gang culture

It is not unusual for (London) gang membership to extend to over 200, including a large number of 10-12 year-olds. In our work with the young prisoners, we heard that the propensity to violence among those they fondly termed their 'young ones' horrified even them. Pressed for an explanation of what might cause this, they said 'video games' (especially the recent technological 'improvements' in the interactive, very violent ones flooding the UK market).

The '3 circles' of drug dealing: As identified by Kids Company and outlined at the above-mentioned WAVE/Met Police/London Boroughs conference in November 2007, gang 'structure' consists of three circles of drug peddling in cities, especially inner cities. In the centre of the circle is the (adult) chief supplier, an established gang member; the next circle is made up of children who receive the drugs from this adult, to sell on the streets and outside schools, and it is these schoolchild 'customers' who form the third, outer circle. The criminal at the centre of the circle gets children involved in drugs from an early age by making part of their 'payment' in drugs, which guarantees a degree of 'loyalty' – and silence when caught.

The children involved in the 'second' or 'inner' circle are the most disadvantaged in society and have similar, or worse, histories than those we worked with in prison (including a young boy who had to sleep with a knife under his pillow from the age of 4). The drug-dealing children in this circle are described as 'truly feral', often coming from backgrounds of horror so bad they run away as soon as they have the strength; some are as young as 8 or 9. Being even the lowliest members of a gang gives them a sense of belonging, albeit in the 'street' family; something they never had in their biological family, and they are therefore motivated to be hugely loyal, even when they have not developed a drug habit.

Although these inner 'circle' children are a small minority, their influence is broad and hugely toxic, because their 'clients' – the outer circle – are the higher SES 'imitator' children whose generous pocket money enables them to afford drugs. Prices are pitched low to ensure future custom. The violence inherent in the lives of the inner circle spreads to their 'customers' and, thus, impacts the whole cohort.

Therefore, unless there is an interruption in gang culture, inner 'circle' children will naturally go on to become suppliers themselves and form the drug-dealing, violent gangs of the future – capable of killing anyone in their way. Naturally, at least some of the outer circle children are likely to continue to be their customers.

Mental health problems among gang members [courtesy of Young Minds]

- 86% will have conduct problems
- 59% will have anxiety disorders
- 34% will have attempted suicide
- 25% will have psychosis
- 20% will have depression
- 30% of female gang members identify as self-harming or at risk of suicide

To punish or rehabilitate?

As quoted above, the following official statement reflects the cultural/psychological conflict between the reflex to punish and enlightened rehabilitation:

'Punishment is an essential part of the justice system, but on its own it does not stop people reoffending. Almost half of all adults leaving prison are reconvicted within a year.'
[2015 MOJ policy paper on '2010 to 2015 government policy: reoffending and rehabilitation']

This contrasts strongly with the Nordic philosophy of withdrawing privileges (especially freedom of movement) while treating offenders with respect and supporting them to adopt pro-social lifestyles on their re-entry to the community.

Of all the problems of youth dysfunction, gang activity is the most challenging, because mental health problems are so inherent in its structure. What is missing from the statistics is the percentage of inner city gang youths and children who are not only dealing in Class A drugs but are also addicts. We know from our clients that these figures are likely to be high because substance dependency begins young (usually age 12-14). We also know that otherwise law-abiding people turn to 'dealing' to help fund their drug habits. With drug usage and mental health so interconnected, the figures for drug usage and dealing need to be well researched.

Clearly, even the youngest gang members will have lost their childhood innocence and trust in adults. These 'lost' or 'lone' children will become what Professor Losel calls that tiny minority who cause the vast majority of social woe – and cost. In this context, it is difficult to understand the decision to make vast reductions in borough and neighbourhood policing. Perhaps this short-sighted decision might contribute to explaining why the UK has become the top Class A drug-consuming country in Europe? We know very dedicated and concerned police officers who are as dismayed as we are by these policy decisions, but it is very difficult to know how to act when new policy rejects recently successful methods: friendly, trusted police presence in schools to work with younger children who are related to drug-dealing gang members. It is heartening to see that Nottingham has just (April 2018) committed investment in police presence in schools, albeit to reduce and prevent local knife crime – which is very high among the drug-dealing community. Their policy will be published this summer.

As we saw in our work with established gang members, leaving a gang is no safe or simple option. Rescuing those children already involved will be a challenge on those grounds alone, without considering their very likely addiction problems, but it is not a challenge we can afford to shirk. Sir Ian Blair was totally committed to the early prevention message²⁵⁷ but, regrettably, resigned shortly after the mayoral election following the Serious Youth Violence conference in late 2008.

Specific recommendations

1. Review/reverse the policy to reduce numbers of community police.
2. Increase outreach to the youngest children involved in gangs, with a view to taking them into Care, where they can (at least theoretically and in some instances) be provided with food, shelter and trauma-informed support, including medically-supervised detoxification, where appropriate.
3. Adopt an ‘armistice’ approach to young drug-dealing gang members, rather like that used to obtain the voluntary surrender of knives – again, including detox if necessary. This would give many young people the opportunity to change their lifestyle from choice, with better long-term results for them and society.
4. Set up a Commission to study, or update, the research that resulted in Portugal’s 2001 drug law reforms, as outlined in Case Study B (part I), and which supported not only addicted users but addicted user/dealers in rehabilitation, without criminalising them and wrecking their chances of future employment.

In support of the above recommendations, the findings of the recent APPG on drug reform laws (published September 2017) condemns both the criminalising of drug users and withholding potentially valuable relief of cannabis-based medicine from patients in acute or chronic pain, or undergoing chemotherapy.

Who needs to take action? Government would need to legislate on the status of drug use; Police and Social Services would need to engage with young gang members in an ACE-aware, trauma-informed manner; Health would need to facilitate rehabilitation; CAMHS would need to provide the missing mental health support.

INTO BEING NEET

As with the transition into Pupil Referral Units or special school, this transition is an outcome of many years of missed opportunities in education and guidance. As outlined in the 2016 OECD²⁵⁸ recommendations for England’s youth provision, by the time young people are officially ‘NEET’, they are firmly on the road to social disadvantage and exclusion. Handled well, this transition can be an opportunity to take effective action to halt the downward spiral of many young lives caught up in the ‘zero status’ of being NEET.

- The UK population rate of NEETs is proportionally twice that of our adult unemployed (Table I).
- While general UK employment statistics were improving in the recent past, levels of NEETs were increasing.

In terms of their educational outcomes, the UK young are characterised by:

- Some of the lowest levels of literacy and numeracy in the developed world [OECD]
- No improvement in core abilities and skills over those of the previous generation [OECD]
- Many young NEETs do not actively seek employment or training [OECD].

When becoming NEET follows permanent school exclusion, or involvement with youth or criminal justice, the transition can amount to a toxic set of lifetime habits, including drifting into gangs and/or becoming parents before being equipped to lead productive, responsible lives – a key step towards intergenerational dependency.

NEET/Unemployed young people and mental health issues²⁵⁹

- 1 in 5 long-term unemployed young people feel they have nothing to live for.
- 1 in 4 long-term unemployed young people have been prescribed antidepressants.
- 1 in 4 long-term unemployed young people have self-harmed.

Since poor mental health can be both a cause and an outcome of life circumstances, becoming and remaining NEET, and supported by the state, can quickly become a hopeless situation.

Specific recommendations

The following outline ideas are drawn from the Dutch policy that everyone capable of working needs to work. In this context, the word 'need' does not mean a social or moral obligation for young people to work (they are already receiving benefits to live), but rather that development of self-esteem and independence, their mental, physical and emotional wellbeing *demands* they be productive rather than dependent. The above statistics on NEET mental health (courtesy of Young Minds) reveal that idleness, however seductive and habit-forming, is never a satisfying way of life.

One way to take responsibility for past parenting and education policy failures would be to stretch provision of training (and re-training) initiatives for the young and unskilled, to include:

1. Introducing a NEET-specific policy to provide unskilled (paid) employment combined with part-time study to replace the current benefits system, both to:
 - a. protect NEETs from periods of idleness caused by the difficulty of finding jobs for the unskilled/poorly educated, and
 - b. provide them with a second chance to gain qualifications as well as work experience.
2. Ensuring NEETs who no longer live at home have adequate accommodation, even if they are not yet 18, because nobody could hope to be satisfactorily housed and independent on the £4.05 hourly rate for age 16-18s.
3. Running compulsory lifestyle courses (including on relationships, parenting, nutrition, basic cookery, housekeeping, budgeting, personal hygiene and the perils of drugs and alcohol).
4. Offering work/career guidance, and other support needed to help young people realise their ambitions, including in gaining qualifications.
5. Ensuring NEETs have a purpose – a reason to get up in the morning, to live and improve their circumstances and opportunities.

Who should take action: Education, Social Services, Youth Justice, Health, Work & Pensions.

This rather 'tough love' approach would take committed collaboration between national and local government, Education and third sector organisations; possibly also collaboration with local industry. We are aware of government-supported apprenticeship schemes that offer training to the young, unskilled and unemployed. However, the official statistics on NEETS suggest these initiatives do not come close to handling the problem.

We heard reports of employers who 'discharge' even the best performing apprentices as soon as they reach age 18 (and qualify for the minimum living wage) – because

there are always dozens of younger NEETs to replace them at far less cost. Closer collaboration between all the agencies concerned could include reviewing rules designed to protect young people from exploitation that, in reality, can render them undeservedly unemployed at age 18 – after they have worked hard to learn a trade but have, overnight, become too ‘expensive’ to hire. Again, CAMHS would need to offer mental health support – even if the young people were not in permanent placements.

Potential benefits:

The announcement of such a policy could have the effect of:

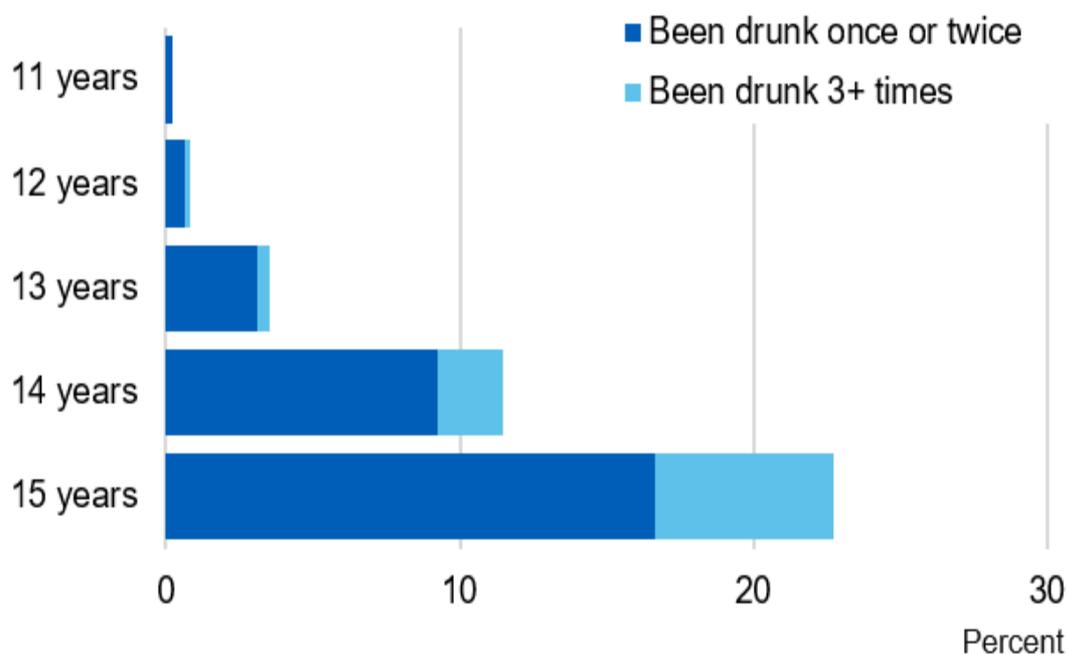
1. Encouraging NEETs and current students to study (to increase employment choices, since they would have to do at least some work to receive money);
2. Providing a net gain to the public purse, currently estimated to be losing in excess of £550 million per annum just from supporting NEETs (not counting all the indirect costs associated with the social consequences of so many supported but essentially idle youths);
3. Providing NEETs with purpose, increased self-esteem and ambition;
4. Diverting NEETs from unstructured recreation time that so often results in the use of drugs/alcohol/gambling and the toxic pursuit of (violent) virtual gaming;
5. Reducing youth antisocial behaviour;
6. Reducing gang membership (and related crime);
7. Reducing levels (and public expense) of youth offending in general;
8. Reducing (both visible and hidden) youth homelessness and the associated risks (sexual abuse/assault/‘prostitution’ – although we would argue that, where young people are concerned, the term ‘prostitution’ should be replaced with ‘sexual abuse’, even when money changes hands);
9. Positively impacting youth mental health (and reducing costs to the NHS);
10. Reducing teenage pregnancy.

Such an approach would not only go some way to reducing multiple adverse outcomes, it could contribute to fulfilling the challenge laid down by the OECD for England.

INTO ADDICTION (INCLUDING ALCOHOLISM)

Problem drinking is a very high risk in a nation where alcohol is so readily available, advertised and seen as both ‘normal’ and ‘cool’. Combining that cultural factor with any combination of ACEs, being looked-after and/or behavioural problems leading to school-exclusion (that does not result in immediate transfer to specialist, alternative provision) is a recipe for a natural tendency for the young to want to try alcohol. Then add the very particular UK habit of psychoactive drugs (cocaine especially) and you have a potent cocktail of temptation for young minds. Here are some of the recorded statistics

A 2018 NHS study of youth alcohol consumption²⁶⁰ shows 23% of 15-year-olds admitted having been drunk in the past 4 weeks; that of those who drank alcohol, 70% were supplied with it by parents or guardians; and that girls (11%) were more likely to have been drunk than boys (7%).

Table 7: England's child drunkenness (by age, over a 4-week period)

Risks of child alcohol consumption: it puts children at risk, including of sexual abuse by adults, unplanned pregnancy and consequences to their own children, if born alive.

The study title 'Adolescent Substance Use: America's No.1 Public Health Problem' by the National Center for Addiction and Substance Abuse (CASA, 2011)²⁶¹ reveals the seriousness of the problem:

- 9 out of 10 adult addicts started using drugs before age 18, compared to 1 in 25 who started using at age 21+.
- Consumption of alcohol, use of tobacco and marijuana, and abuse of prescription drugs is on the rise among teens:
 - 75% of high school students have used addictive substances;
 - 20% of them meet medical criteria for addiction).

In the US, entry to high school (equivalent to UK Year 9) is referred to as the 'make or break' time for educational and life outcomes.

(The UK is culturally quite similar to the US, but drinks more – at least as adults)

WAVE's recurring experience in helping recovering addicts is that early experience of alcohol swiftly moved on to both alcoholism and use of psychoactive drugs.

The adolescent brain is quite different from that of an adult²⁶², and onset of all sorts of addiction is faster and more lasting if the habit starts before age 18. Brain imaging shows very different formations between them – e.g. the adolescent brain is still developing in the areas governing decision-making, judgment, impulse control and emotions. Teens are not only more likely than adults to take risks and try out new things (e.g. tobacco, alcohol and other drugs), they are also likely to hear the word 'risk' as an exciting challenge rather than a warning of something to be avoided²⁶³, meaning there is a biological reason behind the apparent fruitlessness of trying to persuade teenagers to behave safely by pointing out risks.

1. **Drug addiction** afflicts many quite young children caught up in the youth gang culture or the '3 circles' described under the Transition into gangs above (experience reported by Kids Company in November 2007).
2. Understanding addiction as a way to protect children from SMD is outlined in more detail in Case Study B.

Link between substance addiction and ACEs

The experience of 'bad' things (or ACEs) happening might deprive children of opportunities to develop lifestyles that lead to such 'good' things as happiness, success and satisfaction that would be protective against 'escapist' tendencies. This link is explained in Case Study B, Part 2 (research into the ease with which 95% heroin-addicted Vietnam veterans abandoned their habit on returning home, and the 'Rat Park' cocaine experiment by Professor Bryce Anderson of Vancouver).

Variation on the Temperance movement?

Virginia Berridge, author of the (excellent) 'Temperance – Its history and impact on current and future alcohol policy'²⁶⁴ writes:

This report examines the history of temperance, and how it can inform alcohol policy in the present and future. Published at a time when alcohol consumption has occasioned much public and media debate, the report relates the past to the present by examining the culture of drinking, and how it could be changed. In the past, temperance helped to create a 'respectable working class' and an ethos which would now be called 'social capital'. The report explores whether this culture can be brought up to date. It also discusses the role of the media, of pressure groups and of local government, the prominence given to women's drinking, the potential for religious influence in a multi-cultural society, health messages about alcohol, and alliances between medicine, public health and the police.

The report also reviews the political possibilities for alcohol. For the first time for many years, alcohol is a political issue, as was temperance. The report looks at whether those with an interest in health should work with the drinks industry, explores the role of international networks of influence and considers how the history of action against tobacco can inform future alcohol strategies. The study concludes that the history of temperance offers many options for the present. It will appeal to all interested in alcohol issues and the development of policy.

Specific recommendations

1. Adopt the transformational Icelandic approach detailed in Case Study H, especially the Table showing the outcomes since persuading the young to say 'No' to drugs (and reversing the previous tendency to widespread youth drunkenness and smoking). This could have the enormous benefit of breaking the currently established intergenerational pattern of heavy substance use.
2. Review and consider adopting the Portuguese approach of treating addicts as in need of treatment, and providing adequate rehabilitation and therapy, instead criminalising or stigmatising them (Case Study B, Part 1).
3. Like Portugal, Issue very stiff fines and community service sentences, plus reporting weekly to police stations, to 'recreational' drug users who are not (yet) addicts but who often sell drugs to their peers, to fund their own use.

Who needs to take action? Such major decisions as changes in the age when young people can legally buy/be given alcohol and total freedom of movement, and/or the decriminalisation of drug use, would require major changes in law by central Government. The huge difference in adult addiction levels relating to starting to consume drugs before age 18 or after age 21 ought to encourage at least a serious review of the Icelandic system (Case Study H).

INTO YOUTH HOMELESSNESS

We open this section with news of a relatively small but ambitious social enterprise, Social Bite, because its experience is so typical of the surprising truths those who help homeless people discover. Dedicated to ending homelessness in Scotland, Social Bite provides (cafeteria-produced) food, support and jobs to the homeless communities in Edinburgh, Glasgow and Aberdeen, working also to end people's isolation and exclusion by helping them overcome barriers. In short, it offers the 'whole package' needed to put blighted lives back on track: food, work, shelter and support. On the opening of its brand new village in Granton, Edinburgh, Josh Littlejohn said:

'We started to ask people their stories and how they became homeless, and it became a bit scary really. We kept being told [more or less] the same story. We had a bit of a pre-conception that homelessness might be a result of decisions people make, or as a result of getting addicted to drugs or alcohol, but the story we kept hearing was people typically got dealt some really quite harrowing cards when they were born and when they came into the world; had typically suffered some really quite traumatic childhood experiences, more often than not, grew up in the care system and quite often became homeless in their late teenage years. So it became quite apparent that homelessness wasn't an issue about individuals or individual decision-making, but it was very systemic, and it seemed that if you were dealt certain cards in life, it was almost your destiny in a way to end up in that quite desperate situation.' Josh Littlejohn, (Co-Founder of social enterprise, Social Bite)

Josh Littlejohn's words reflect WAVE's experience of dealing with homeless people. Similar explanations have also been reported by every Housing First project (including the one that is credited with eradicating homelessness in Finland).

For young people (especially when it follows a period of incarceration), homelessness is often the 'final', or confirmatory, transition into what can truly be called social exclusion. The road leading most people to homelessness is littered with conditions and transitions that usually start very early in life. Therefore, high levels of youth homelessness could be said to be the definitive symptom of how society, or the 'system' is and has been comprehensively failed its young.

Those caught up in the toxic cycle that culminates in homelessness before age 18 are the most vulnerable of all. Even young gang members have the security of their 'gang family', however toxic; above all else, young people need a sense of belonging.

When the young homeless are past members of the 'school-excluded club', and especially when they have been identified as having special educational needs, the outlook for the rest of their lives is bleak. They are 21st Century 'outcasts' who fall prey to every imaginable misfortune from poor (or practically no) diet, addiction/alcoholism, mental health issues and levels of desperation that lead to escalating criminality. Often, prison becomes their only place of (relative) security.

However, not all young homeless are dysfunctional; as will be seen below, many are merely very unfortunate and their plight results from family breakdown. These young people need and deserve support, and to be consulted about how best this can be given: some need to remain separated from their families while others can be supported in being reconciled with theirs. Here there really is no one-size fits all.

Homelessness in Finland – successful example of Housing First

In Finland, there are no street beggars and no (or very few) street homeless on any given day (or night). Despite being a far poorer country than the UK, and at the time when UK numbers of homeless were soaring, Finland took practical steps to resolve its homelessness problem. As reported on ITV²⁶⁵ in December 2017 these steps included an active, community-involved ‘Housing First’ policy. Anyone in need is provided with a permanent place to call home.

An early step in the process was altering its emergency ‘shelter’ policy from ‘night-time only’ to keeping shelters open 24 hours a day while phasing out temporary accommodation and replacing it with sustainable, affordable housing. The outcome: there are no longer any homeless people living on the streets of Finland.

UK Legislative framework

The following facts are taken from Centrepoin’s rigorous and detailed review of successful studies on homelessness prevention (primary, secondary and tertiary). Their (excellent) report on ‘What works’ in preventing youth homelessness²⁶⁶, estimates around 83,000 young people to be receiving help from homelessness services each year, and as many as 150,000 asking their local authorities for help because they are already homeless, or at risk of it. By the time young people present as homeless, they are often at crisis point after their family relationships have completely broken down.

Homelessness legislation in England is centred on priority need as a means of establishing who is owed the main rehousing duty by the local authority. The criteria for being statutorily homeless – and therefore owed a duty by the local authority – is set out in the Homelessness (Priority Need for Accommodation) (England) Order 2002 and includes:

- Young people aged 16/17 not owed a duty as a looked-after child or care leaver under the Children Act 1989
- Care leavers aged 18-21 who were in care between the ages of 16-18
- Over 21 and is vulnerable as a result of being in care, being in the armed forces, being in prison or who is fleeing violence or threats of violence

Local authorities report that, since 2011/12, the number of 16-24 year-old homeless applicants in England accepted as in ‘priority need’ by their local authority had *decreased* from 17,380 to 13,270 – while film-makers are reporting up to a million ‘hidden’ youth homeless in our streets or ‘dossing down’ with friends.

At the time of researching the subject for this report, homelessness prevention in England was outside the statutory legal framework. Under the Homelessness Act 2002, local housing authorities have a duty to carry out a homelessness review and publish a homelessness strategy based on the results. While this is the responsibility of

the local housing authority, the Act stipulates that social services should ‘give reasonable assistance as required’.

Local authorities are also duty bound to record all cases where positive action either succeeded or not in preventing or relieving homelessness. Because the data cannot be broken down by age, the picture is less clear for youth homelessness. Research conducted in 2015, based on freedom of information requests, suggests that prevention and relief among young people is almost three times higher than in the official all-age data: 9.5 per 1000 16-24 year olds were offered prevention and relief support, compared with 3.7 per 1000 for all ages within the same local authorities.

While prevention and relief may be life-saving for many young people in crisis, it does not amount to ongoing support via statutory duty. Local authorities are much less accountable for the support provided via non-statutory channels, and very little is known about the ways in which homelessness has been prevented or relieved, beyond top line statistics. There are (anecdotal) reports of homelessness prevention being used as ‘gatekeeping’ to **prevent** people from making a homelessness application; also some applicants do not know whether they have been helped via the prevention or the homelessness application route, because their options were not fully explained.

The Housing (Homeless Persons) Act 1977 also places a duty on local authorities to provide advice and appropriate assistance, even if the person is not in priority need. Worryingly however, an estimated 30,000 young people are turned away from their local authority every year in England and Wales.

In Wales, the Housing (Wales) Act 2014 brought forward a strengthened ‘prevention and relief’ duty. Welsh local authorities now have a duty to prevent homelessness for all eligible households threatened with homelessness, within 56 days, irrespective of priority need or intentionality. For those who become (or are already) homeless, the local authority has a duty to relieve by helping secure accommodation.

The Homelessness Reduction bill proposes a similar legislative framework be introduced in England to strengthen the statutory safety net.

Centrepoint concluded that (as with most conditions):

- [As described above under the NEET transition], the cost/benefit of preventing youth homelessness would yield a net benefit of over £500 million per annum.
- NEETs definitely get the ‘short straw’ in available provision when they are too young to qualify for the national ‘living wage’.
- The cost of NEET homeless increases once the young people reach age 18 [and qualify for the minimum ‘living wage’].
- Family mediation resolves many problems that would have resulted in youth homelessness – at a fraction of the cost to the public purse.

[See end of this Transition for Centrepoint’s detailed, formal recommendations on what to do to ease this serious UK problem]

‘Hidden’ youth homeless

By definition, there are no official statistics on hidden homeless, only media documentaries, but compelling ones featuring the actual children and their lives, their pathetic shelters and daily scrabbling for food. We heard informal estimates of as

many as a million 'hidden' UK homeless, mostly young people who are at the very margins of society. In many cases, these are the 'missing' children who do not want to be found and returned to abusive homes. It is difficult to imagine what home conditions would drive a young teenager to such an extreme of personal danger and discomfort – until one hears of the street children involved in the '3 circles' in drug dealing, and speaks to adults living in SMD.

The Missing People Organisation reports that over 250,000 people are reported missing each year, 140,000 of whom are minors. We need to allow for the chilling reality that not all children who flee home are ever reported as missing.

Although it is certainly not a recommended way to benefit from the factors that build resilience, what is most surprising is that many of these disadvantaged young people do not become antisocial or get on the wrong side of the law, and also avoid turning to alcohol or drugs – as also reported by Social Bite in the opening quote to this section. Some of the pleasant, sober and sensible teenagers featured in the TV documentary *Where Am I Sleeping Tonight*²⁶⁷ recounted tales of being placed in hostels that also house much older (usually drunk) men who seemed so threatening a boy would feel safer among his own age group, even when this meant sleeping rough, rather than in a comfortable hostel room (but without a lock on the door). So, having fled an intolerable family home, they flee the hostel and again make themselves homeless – but now with the added obstacle that they have 'refused help'.

Sofa surfing: The most fortunate minority of 'hidden' homeless manage by 'sofa surfing' among friends who have homes. One of the most 'fortunate' girls in the above documentary was thrilled to secure an under-stair cupboard as her semi-permanent home in an already seriously over-crowded home of a friend. Any permanent address was crucial to being in a fit state to obtain employment. It was obvious these young people were victims rather than 'scroungers' – all they wanted was a place, however tiny, where they could wash, eat and sleep so they could find work and begin 'normal' independent lives. They all had convincing reasons for not wanting to return home.

One striking characteristic of these very disadvantaged young people is that they often are already highly resilient, and perhaps that is the reason they want to work and remain on the right side of the law while they fight for their independence. They might not have the requisite 'always available adult' role model, but they have each other, are friends and care for each other. Although living conditions are a long way below acceptable, they have coalesced into an often quite satisfactory 'family' – when their biological families and the 'system' have failed them in some serious way.

The informal research conducted by journalists and film-makers echoes the findings of Centrepont – but to a hugely increased extent in terms of numbers. Such bad experiences as hostels inhabited by adult drunks (which technically breaks the rules), or young people who have turned to the 'system' for help but been advised to 'go home' – to a home where they can no longer bear to be – or sent to numerous agencies, none of which helps, makes it hardly surprising if so many of these older children lose faith in the system and the adult world it represents, and band together for mutual care. Even their one daily meal (usually just a sandwich) is provided by charities (often the Salvation Army) rather than any organised 'system' (charities have volunteers willing to do a nightly 'meal run' while the 'system' tends to confine work to office hours, except for acute emergencies).

Although some fortunate young homeless are placed with the YMCA and are eventually helped into work and subsidised accommodation, the demand is too great for current third sector organisations to handle. Despite the best efforts of e.g. the very dedicated YMCA staff, their young charges have been living chaotic lifestyles lacking any routine or discipline for so long (often starting with school exclusion or running away from home, or both) it can be very difficult to embed new habits to turn these young people into reliable employees... so even those who find jobs often quickly lose them again. This is not through unwillingness to work but because they have lost touch with such basic habits as regular sleeping and waking patterns.

As with NEETs and gang members, the answer is two-fold: prevention and taking the trouble to put in place procedures to keep young people safely, gainfully occupied. The people who estimated the million 'hidden' homeless were clearly all responsible, apolitical professionals who move among these young people daily, so there is no reason to suspect them of exaggeration.

Clearly, adoption of the recommendations of Centrepoin [end of this section] would significantly alleviate the problem, by facing it in all its complexity and identifying which level of prevention or intervention best suits each case. Outside of that, the most successful programme we identified was Housing First, run in various forms in a number of countries – and is exactly what it says: it gets people off the streets and under a roof, and then supports them in resolving their issues (see above for Finnish example of the success of this approach). The basic philosophy is that people cannot begin to resolve any of their other problems when they have no home base where they can safely sleep, wash and eat.

Role of family breakdown in youth homelessness: Centrepoin found family breakdown to be the single most common cause (or threat) of youth homelessness. Our research supports this conclusion, as did our direct experience with young offenders (of both sexes), young male prisoners and adults living in social exclusion.

Reasons cited by those who have left the family home range from being emotionally, physically or sexually abused to being unwelcome after the remaining biological parent went on to have a 'new' family with a different partner. Sometimes teenagers felt pushed out because of the cessation of children's allowance at age 16 (unless in approved education or training). In 2016, the weekly allowance was £20.70 for a sole or eldest and £13.70 for each subsequent child – a pitiful sum for such high levels of human suffering and potential adverse outcomes for the rest of a life.

Mental health problems among youth homeless²⁶⁸

- Young people living in hostels/B&B accommodation are 8 times more likely to suffer from mental illness than the general population
- Young people living on the streets are 11 times more likely to suffer from mental illness than the general population.

Centrepoin's formal recommendations on homelessness are that

Central government should:

1. Implement a cross-departmental strategy on homelessness to co-ordinate the necessary action on prevention from multiple departments. This must be reflected at the local authority level.

2. Conduct a national review of mediation services and the efficacy of different approaches, with a view to ensuring that effective mediation is available in every local authority.
3. Ensure that holistic early family support, regardless of the child or young person's age, is championed in the government's Life Chances Strategy.
4. Introduce a homelessness prevention duty and a stronger advice and information duty.

Local authorities should:

1. Signpost all young people, irrespective of priority need, intentionality or local connection status, who present at housing services for advice and information or make a homelessness application to an independent advocacy service.
2. Have youth specific emergency/temporary accommodation that is suitable for young people requiring respite from the family home while an assessment is undertaken and appropriate support is put in place for the whole family.
3. Assess levels of staff turnover in teams working directly with vulnerable families. A strategy must be implemented to address the causes of staff turnover and to put tangible solutions in place.

WAVE also recommends: national adoption of the Housing First principle to eradicate homelessness. If such a relatively poor country as Finland can do this successfully, it seems a shame if we cannot.

Who needs to take action? Cross-departmental (multi-agency) working involving all agencies from Housing to Social Services and Mental health would need to be involved in many cases. Some simpler cases could be resolved by (social work) counselling to broker reconciliation between the young person and his or her family.

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