

ACEs, Places and Status: Results from the 2018 Scottish Secure Care Census

Ross Gibson, CYCJ

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A note on the statistics:

When reporting findings of this research, figures have been rounded to the nearest whole percentage. In a small number of cases this results in the total across all subsections equating to 101%. More precise figures are available within the appendix, or directly from the author should they be required.

Executive Summary

Acknowledging the significant role that accommodation within secure care plays in supporting children who face, take or make a high risk of harm, - and therefore experience extreme vulnerabilities, needs and risks - this study attempts to support practitioners and policy makers to better understand the lives of the children in question. Through the use of a census, a wealth of data has been captured which outlines the profile of children resident within the five secure units in Scotland on one day in 2018.



What are the demographics of children in secure care?

- This report highlights significant demographic shifts amongst the secure care cohort over recent years. One such shift is the increased presence of children from out with Scotland within Scottish secure units, with 37% of children being placed there by an English local authority.
- The population was found to be predominantly white, with a small number of children from Black, Asian and Minority Ethnic backgrounds.
- The gender mix within secure care has changed, with this study reporting higher numbers of girls within this setting than has previously been the case. On the day the census was carried out over 50% of children placed there were girls.
- Data also suggest that more 'older' children are experiencing secure care than was the case previously. Whilst previous studies showed a relatively small number of 16 and 17 year olds were placed within secure, this study has found that close to one third of girls and one third of boys were of this age. The age of children was similar regardless of placing nation.
- Substantial levels of poverty - at rates higher than the general population - have been found within this study. Amongst children placed in secure care by a Scottish local authority, some 80% of children were believed to experience relative poverty and often come from homes within the most deprived areas of the country. Almost half of these children resided within Scottish Index of Multiple Deprivation zones 1 or 2 - the two most acutely disadvantaged areas of the country - yet only 22% of all under 18s live in these areas, amongst the general population. Put bluntly, it is generally the poorest and most socio-economically disadvantaged children who enter the secure estate¹.

¹ The term secure estate is used in the document to refer to the five secure / safe provisions in Scotland which provide care to children. These five entities are distinct from each other, operating as independent entities.



What is the level of exposure to Adverse Childhood Experiences (ACEs) amongst those in secure care?

- Without exception, levels of exposure amongst the secure care population to each of the ten ACEs² were found to be far higher than previous studies amongst the general population.
- Sixty four percent of children in secure care in Scotland had encountered four or more ACEs. Similar levels had previously been reported amongst youth justice populations in Florida and by the Interventions for Vulnerable Youth (IVY) service in Scotland, as well as smaller studies within the secure estate. The prevalence of ACEs amongst the secure care population was found to be far higher than in other groups of children or amongst the general public. This research therefore demonstrates substantial adversity that children within the secure care system have encountered, often across multiple domains.



What impact does gender have upon exposure to ACEs?

- Girls in this sample had encountered each of the ACEs far more often than their male peers, with each individual adversity having been encountered by at least 60% of the female cohort.
- Gender - in its most narrow, binary definition of male and female - appears to play a role in the exposure to ACEs, with highly statistically significant results highlighted within this report. Average rates of exposure to ACEs amongst girls was 5.96, compared to 3.77 amongst boys.



Is there variation in the level of ACE exposure across the different placing nations?

- Placing nation was not found to be statistically significant, despite the initial impression that those children from English local authorities had encountered greater levels of exposure; this is likely to relate to the fact that 75% of children from English local authorities were girls.

² ACEs refer to exposure to physical abuse, sexual abuse, emotional abuse, physical neglect, emotional neglect, witnessing domestic violence, familial substance abuse, familial mental ill-health, familial imprisonment or parental separation prior to the age of 18.



Does socio-economic status play a role in exposure to ACEs within this population?

- Amongst children placed in secure care by Scottish local authorities, a statistically significant relationship was found between living in relative poverty and exposure to ACEs. Amongst this group, those living in relative poverty had an average ACE exposure of 4.89 and those not in relative poverty had an average ACE exposure of 2.55.



What are the implications for practice and policy?

- Many of the findings of this report have been touched on by the recently concluded Independent Care Review. This report is therefore timely, and will hopefully add to the conversation around how to make [The Promise](#) a reality. It also adds to the somewhat limited pool of research on secure care, highlighting demographic shifts in recent years which ought to be taken heed of by policy makers and service designers.
- Given the increased prevalence of ACEs amongst girls in this study, there appears to be merit in devising gender specific, distinct approaches which respond to the particular needs of girls, boys and those who identify as transgender. It may be that ACEs are not only experienced at a different rate and manner amongst genders, but manifest themselves in differing ways.
- The implementation of the forthcoming Secure Care Pathway and Standards Scotland will require the careful consideration of the needs of each child during their entry into secure care, their time within that setting, and upon their transition to future settings. These findings may assist in those endeavours, whilst also going some way towards respecting the rights of children who have experience of secure care. Similar benefits may be encountered amongst those who wish to consider the welfare of children in other settings who face, take or make a high risk of harm.
- The relationship between poverty and ACEs is particularly complex, and the substantial number of children living in relative poverty and in areas of high deprivation is of note, albeit unsurprising. These findings further strengthen the need to take macro level, structural amendments to address rising inequality, chiming with the recent conclusions of the Independent Care Review which articulated the human and economic cost of failing to meet the needs of Scotland's children. As others have noted, attempts to reduce and mitigate ACEs require multi-level interventions, with responsibility for this not lying with any one body.
- A move towards a robust, wellbeing economy could prioritise welfare of Scotland's children, rather than the bottom line of Gross Domestic Product and financial gain. Introduction of Universal Basic Income may well be of benefit in this regard. In the day-to-day lives of children and their families, adoption of anti-poverty strategies

within frontline practice may be one small way of tackling this issue. A return to radical social work practice, which understands personal adversity as being the product of ecological, complex systems and inequalities, whilst seeking to proactively confront these issues is required.

- Fundamentally, this report demands that Scotland steps beyond ACE awareness. Awareness alone will do little to ensure that every child will enjoy a life free from neglect, abuse and harm, and thus does little to protect the rights of children. In order to support children to enjoy a happy, healthy, safe and flourishing childhood, adults - at individual and civic level - must take steps to prevent this harm from being caused to begin with. When that is not possible, supports and services are required that promote recovery, whilst avoiding the risk of repeated and intergenerational exposure to ACEs.

Introduction

An average of 81 children were resident within secure care in Scotland during the year 2017/18, an increase of five on the year prior (Scottish Government, 2019). Although relatively small in numbers, these lives are significantly affected by being placed within a locked setting where their liberty is deprived and freedoms heavily restricted (Hart & La Velle, 2016; Moodie & Gough, 2017). It is an environment that starkly embodies the care and control paradigm, engaging in concepts of safety, security, and public protection from offending (Ellis, 2012; Schliehe, 2015) and is an arena designed to support children with “the most complex needs in society” (Pates, Davies, & Tiddy, 2018:153). Children’s experiences of secure care - highlighted by the [Independent Care Review](#) - are of places that at times lack support and are frightening, but at other times have protected them from significant danger, whilst children have commented on experiencing a sense of hopelessness at times in their stay there (Miller & Baxter, 2019). At the same time, children have acknowledged that secure care has kept them alive at times of crises (Gough, 2017).

The children in question have encountered experiences and displayed behaviours that have been deemed to pose a significant risk to themselves or to others (Miller & Baxter, 2019; Roesch-Marsh, 2012; Schliehe, 2015). Secure care provides accommodation and support to children deemed to require provision within a “highly controlled setting” (Moodie & Gough, 2017:10), and has been described as “primarily a place for containing young people” (Mitchell, Roesch-Marsh, & Robb, 2012:20) who pose and/or encounter heightened levels of risk. Powers to do so derive from a range of regulations and legal instruments (Gough, 2016a; Nolan, 2019; Pates et al., 2018). Even though secure care is the most restrictive and intensive form of residential care (Ellis, 2018; Gough, 2016b; Harder, Knorth, & Kalverboer, 2011), there has been limited research into the lives of the children living there (Byrne, 2018; Hart & La Velle, 2016; Miller & Baxter, 2019).

Adverse Childhood Experiences (ACEs) have become common parlance in social work and public health vocabulary in recent years, providing a model of understanding negative outcomes through a retrospective consideration of the life experiences that have occurred during childhood (Couper & Mackie, 2016; Vaswani, 2018). It is a model which has gained traction amongst politicians and policy makers in the UK and beyond (Edwards, Gillies, & White, 2019; Walsh, McCartney, Smith, & Armour, 2019).

Significant attention has been given to the study of ACEs since first reported by Felitti et al. (1998), with an abundance of enquiries into the prevalence of those ten issues which have gone on to be recognised as the traditional ‘ACEs’ (Lacey & Minnis, 2019), and which are common amongst the youth justice population (Wright, Liddle, & Goodfellow, 2016). Literature regarding ACEs has substantially increased in number over the past three decades (Kelly-Irving & Delpierre, 2019; McLaughlin, Sheridan, & Lambert, 2014), providing a foundation to a growing ‘ACEs movement’ which has now spread to these shores (Davidson & Carlin, 2019; Lacey & Minnis, 2019; Steptoe, Marteau, Fonagy, & Abel, 2019), with policy drivers aiming to make Scotland an ‘ACE-aware nation’ (Davidson & Carlin, 2019; Edwards et al., 2019). Increased awareness of ACEs in Scotland has led to both policy and practice developments, drawing on this expanding literature (Batchelor, Armstrong, & MacLellan, 2019; Lightowler, Robinson, & Leishman, 2017).

The approach - and an uncritical application of the model - is not without criticism. A lack of cultural sensitivity (Hartas, 2019), a failure to take cognisance of the material reality of

people's lives (McEwen & Gregerson, 2019) and a superficial application of ACE 'scores' in some settings (Bateson, McManus, & Johnson, 2019) are amongst the considerable concerns levied against the current application of ACEs. Similarly, a failure to acknowledge the varying impact that some ACEs have compared to others (Couper & Mackie, 2016; McLaughlin et al., 2014) as well as the relevance of age of the child at the time (Hartas, 2019; Kelly-Irving & Delpierre, 2019) have also been highlighted. Despite these criticisms, ACEs have been described as "the lodestar" (Finkelhor, 2018:174) of child maltreatment discussion and debate within the USA where knowledge of, and speculation over, the impact of ACEs across the life course "has rapidly increased over recent years, facilitated by a burgeoning international evidence base" (Ford et al., 2019:132). Research regarding ACEs often purports a sizeable correlation between exposure to ACEs, and a large and diverse range of adversities and challenges, some of which do not manifest themselves until much later in life (Afifi, 2018; McGavock & Spratt, 2012; Walsh et al., 2019).

Exposure to ACEs has been found to affect some degree of impact upon subsequent substance abuse, alcohol abuse, adolescent pregnancy, life expectancy, suicide, cognitive and physical health, mental ill-health, self-harm, hospital admission, brain development, victimisation, offending behaviour, imprisonment, and violence (E. L. Anderson et al., 2017; Batchelor et al., 2019; Carnie, Broderick, Cameron, Downie, & Williams, 2017; Cleare et al., 2018; Couper & Mackie, 2016; Dube et al., 2001; Fox, Perez, Cass, Baglivio, & Epps, 2015; Hillis et al., 2004; K. Hughes et al., 2017; Levenson, 2016; Loudermilk, Loudermilk, Obenauer, & Quinn, 2018; Marryat & Frank, 2019; Murphy, 2018; Paranjothy et al., 2018; Sacks, Murphey, & Moore, 2014; Treat, Sheffield-Morris, Williamson, & Hays-Grudo, 2019; Vaswani, 2018).

Data suggests a graded relationship between aggregated exposure to ACEs and subsequent negative outcomes (Felitti et al., 1998; Walsh et al., 2019) in a phenomena perhaps described most succinctly as "the pernicious effect of exposure to multiple ACEs" (Cleare et al., 2018:1235). In simple terms, proponents of this approach to public health argue that the greater number of ACEs an individual encounters prior to their 18th birthday, the greater the likelihood of them subsequently experiencing poor outcomes. This has led to calls for preventative actions here in Scotland to reduce risk of ACEs (Hetherington, 2020).

Prior studies have taken place in innumerable settings including universities, hospitals, prisons and schools; some refer to large, general samples of the population, whilst others are particularly niche and specific. This study aims to add to the small pool of research on ACEs undertaken within the niche, institutional setting of secure care (see K. Ferguson & Wylie, 2018; Kibble, 2015; Pates et al., 2018). In contrast, this study benefits from a national approach, adopting the use of a census within all five secure settings within Scotland. In light of these two developments (a lack of data regarding secure care and increased interest in ACEs) this report seeks to fill this gap by examining both the profile of those resident within that environment, as well as illustrating the prevalence of ACEs amongst that cohort.

Previous Studies of Secure Care

Previous studies have shown that there are certain commonalities amongst the cohort of children resident within secure care. Examining secure care and its alternatives, Mitchell et al. (2012) highlight multiple deprivations and adversities experienced by children and their families accessing those services. Themes of deprivation, criminality, mental ill health and a history of physical and sexual abuse amongst the families of children within the secure estate have been found in earlier studies in England (Ellis, 2018; Goldson, 2002; Harris & Timms, 2002; O'Neill, 2001).

In addition to significant levels of criminal behaviour identified in these English studies, heightened rates of sexual abuse, self-harm, absconding and child sexual exploitation has been found (Falshaw & Browne, 1997; Harris & Timms, 2002). The background of children within English Secure Children's Homes is said to feature a complex mix of issues, including - but not limited to - parental involvement in the sex industry, attachment difficulties, domestic violence, trauma and bereavement (Justice Studio, 2014). Byrne (2018) similarly points to attachment disorder and childhood trauma amongst the many challenges faced by children who have entered the secure arena. These fragmented attachments can increase risk of exposure to sexual abuse, which in turn precipitates admission into the secure care estate (Shuker, 2013).

O'Neill (2001) highlights a gendered variation in the means and causes for admission into the English secure estate, with 83% of girls admitted due to welfare concerns, including 73% who had been admitted as a consequence of perceived risk of sexual harm. Ellis (2015, 2018) also comments on the severity and scale of Child Sexual Exploitation amongst the female population of secure care.

More recently, Williams et al. (2019) reports that most children within secure care had experienced 'some or all' (Williams et al., 2019: 16) of the following issues; domestic violence, neglect, parental mental ill-health, physical abuse, sexual abuse, emotional abuse, and substance use. Similar findings have also been found by Pates et al. (2018) and Pates and Hooper (2017). In doing so, they have addressed the paucity of data regarding children in Secure Children's Homes in England and Wales highlighted by Hart and La Velle (2016) and Andow and Byrne (2018).

In Scotland, a 2005 study of 53 children resident within secure estate reported that "most had known significant disruption in their family life, over half having been known to social work services before reaching the age of ten" (Walker et al, 2005:5). Roesch-Marsh (2014) and Creegan, Scott, and Smith (2005) suggest that significant levels of sexual exploitation, allied with low self-esteem, offending behaviour, attachment difficulties, lack of support, and exposure to neglect and abuse contribute to girls entering the secure estate. These, and other factors, may explain the high rates of mental illness and trauma found by Barron and Mitchell (2018).

Recent studies of the Scottish prison population found that 26% of prisoners self-report experience of the care system, with 38% of those having spent time within secure care (Carnie et al., 2017), equating to 9.9% of the overall prison population. Meanwhile, one study of 14 prisoners within HMP&YOI Polmont found that half of participants had

experience of secure care (Nolan, Dyer, & Vaswani, 2017). Given that only 1% of children who are looked after in formal care settings enter secure care each year (Gough, 2017), the case for better understanding of this particular group of children's circumstances is striking.

Whilst previous studies of the secure population in Scotland are fairly dated (see Kendrick et al., 2008; Walker et al., 2005) some steps to address this have been made (see Barron & Mitchell, 2018; K. Ferguson & Wylie, 2018; Gough, 2017; Kibble, 2015) but none have thus far examined the secure care population across Scotland in its entirety.

This piece of research hopes to go some way towards addressing this lack of data by illustrating the profile of 87 children who, on one particular day in 2018, were resident within the secure estate. The study charts the age, gender, socio-economic status and which nation had placed the child in secure care. It then adopts the lens of ACEs to examine prevalence across those particular circumstances. By knowing who resides within the secure estate and what challenges they face, society can be better equipped to deliver the services and support that these children require and deserve, be that within the community, secure environment or elsewhere.



Methodology

This research adopted the use of a census, collecting data about each child resident within the secure care estate on one particular day in 2018; an approach adopted by Hales, Warner, Smith, and Bartlett (2018) in their study of secure settings in England. In order to respect the confidentiality of those resident on that day, the specific date has been withheld from this and future publications. Completed by staff from each of the five secure settings, the census consisted of a series of questions relating to the lives of children in their care, drawing on existing information held by the unit. Basic demographic information such as gender, age and which nation was responsible for their care was gathered. The broad range of questions asked included whether the young person in question had encountered each of the individual ACEs. For each query, the respondent was asked to reply 'yes', 'no' or 'don't know', thus creating quantitative data which illustrated particular features of the lives of children who were resident within secure care on that day. The range of information gathered and the number of responses received meant that a total of 13,224 individual pieces of data was produced. This data was collected through the online tool Qualtrics before being transferred into SPSS software; both systems are commonly used amongst social science researchers. Subsequent publications will communicate the findings relating to other areas of enquiry in due course; this report focusses solely on outlining the profile of those resident within secure care and their exposure to ACEs.

Following agreement to participate from each of Scotland's secure care providers, ethical approval was granted by the University of Strathclyde Social Work and Social Policy Ethics Committee and - where necessary - the ethics committee of the secure unit in question. The children themselves were not involved in this piece of research in order to prevent further distress and harm through repeating or recounting their life stories unnecessarily.

Data was thereafter collected and analysed with the aim of answering the following questions:

- What are the demographics of the children resident in secure care?
- What is the level of exposure to ACEs amongst those resident in secure care?
- Is there variation in the level of ACE exposure across the different placing nations?
- What impact does gender have upon exposure to ACEs?
- Does socio-economic status play a role in exposure to ACEs within this population?

Demographics within Secure Care

A total of 87 responses were submitted from the five secure units. Whilst the secure care estate in Scotland nominally accommodates 84 children, three emergency beds were being used on the day in question. Of the 87 children, 77 identified as 'White British', whilst smaller numbers were recorded as 'Black/African/Caribbean/Black British', 'Asian/Asian British', 'Mixed/Multiple Ethnicity' or 'White Other'. Further details regarding the demographics of children in secure care can be found in the appendix.

Placing nation

Whilst somewhat cumbersome, the phrase 'placing nation' has been used in this report to reflect the country within which the local authority responsible for the care of the child in question is located. This avoids confusion over how to record a Welsh child, having previously resided within an English local authority, now residing within a Scottish secure unit for example.

As Gough (2018) has reported, there has been a significant rise in the number of cross border placements in Scotland in recent years, primarily from English local authorities. This may well be driven in part by a 34% reduction in secure care capacity in England between 2006 and 2016.

Placing nation on day of 2018 census

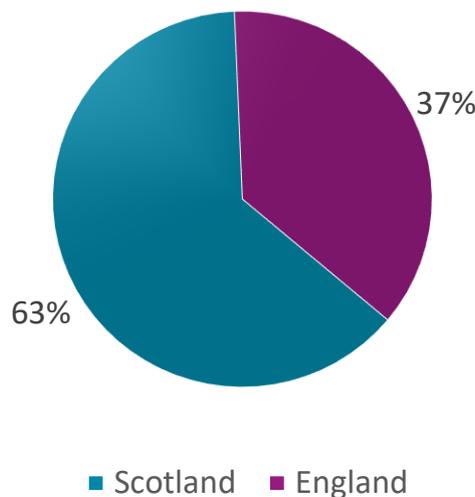


Figure 1

On the day of this study, 63% of residents had been placed there by a Scottish local authority or by the Scottish Government (in cases of young people sentenced to a period of detention) whilst 37% had been placed by an English local authority who, by definition, had been placed there through welfare based routes, albeit a large number of these children had also been in conflict with the law, including acts of violence. A similar finding of 38% was found in January 2019 (Secure Care Strategic Board, 2019), whilst on July 31, 2019 Scottish Government data shows that 33% of children came from out with Scotland (Scottish Government, 2020).

Gender

A stark difference was found amongst the gender makeup of the children resident within secure care. Whilst over half of the children from Scottish local authorities were boys, only 25% of their peers from England identified as such. Amongst those from an English local authority, three quarters were girls, compared to 40% in the Scottish cohort. It is noteworthy that amongst those whose placing nation was Scotland, 4% of children identified as transgender. This gender identity has not been recorded in previous studies of secure care in the United Kingdom such as Kendrick et al. (2008), Walker et al. (2005), Hart and La Velle (2016), Roesch-Marsh (2014) or Pates et al. (2018).

Gender of children (Scotland)

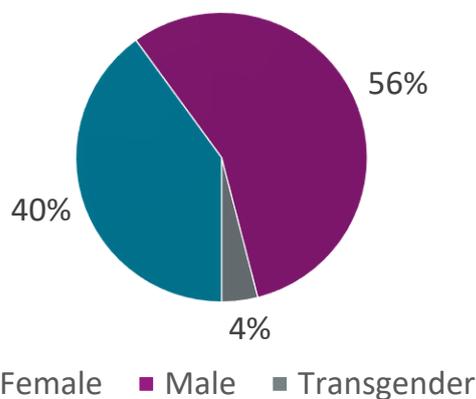


Figure 2

Gender of children (England)

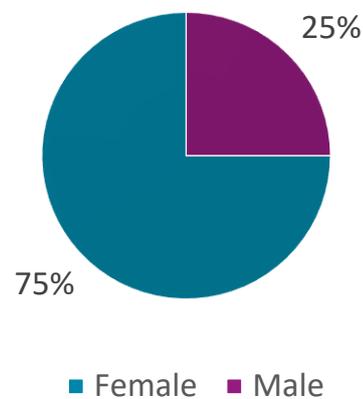


Figure 3

Taken all together, 53% of those in secure care in this study were female, 45% male and 2% transgender. This alone is an important finding, representing the changing nature of secure care in Scotland and the increase in use of that resource to meet the needs, and respond to the risk of, girls. Given the small number of children who identified as transgender, their data has been omitted from later sections which examine ACEs and gender, but have been included when considering other characteristics.

Of particular note is the heightened number of girls found amongst this population on the day, with 46 being the greatest on record during the 20 years for which data is available (Scottish Executive, 2003a, 2003b, 2004, 2005; Scottish Government, 2010, 2019, 2020).

Age

Girls' ages ranged from 12 to 17, with a mean age of 15. This was mirrored amongst the boys. When separated between the two placing nations, it is of interest that the range slightly changes. Both boys and girls placed by Scottish local authorities tended to be older than their counterparts from England. More details regarding this can be found in the appendix.

Age of girls in secure care

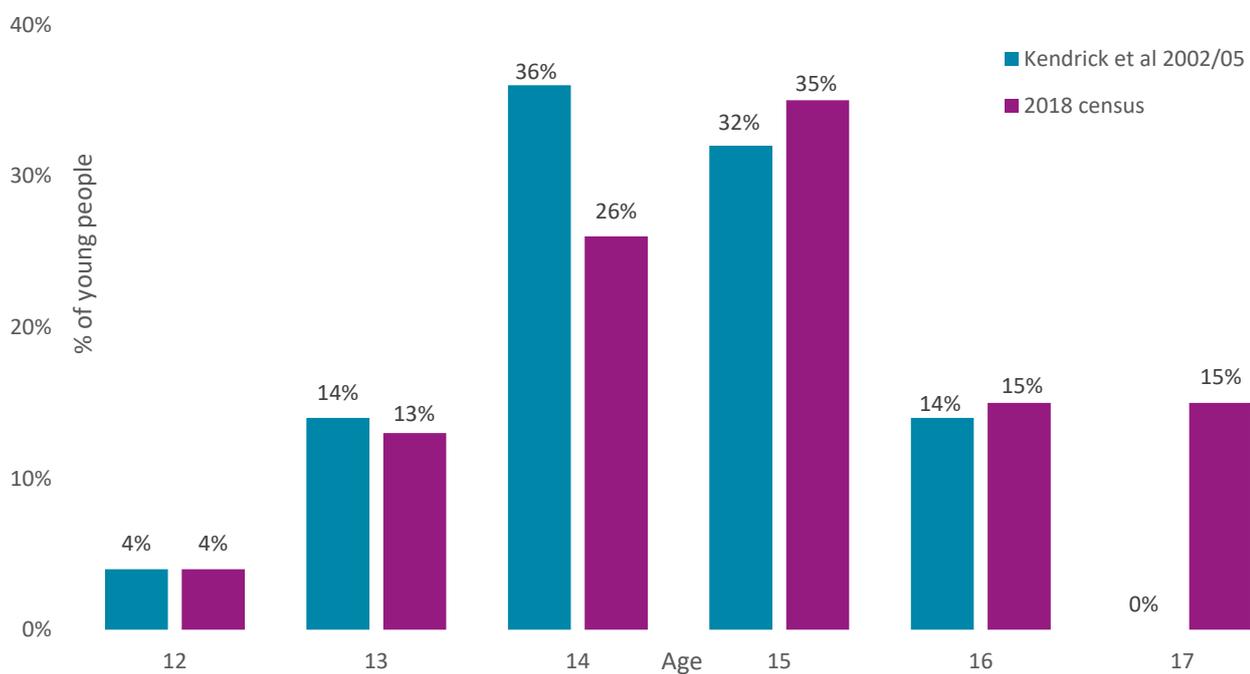


Figure 4

Of note is the presence of 17 year old girls in the 2018 census, something that was not found when Kendrick et al. (2008) reported on the profile of children in secure care over the years 2002 to 2005. Overall, there has been a shift in the age of girls within secure care during this time frame, with close to 65% of girls being aged 15 or above. In Kendrick's previous study, this was less than half. The change of profile of boys within secure care over that period has been even more pronounced.

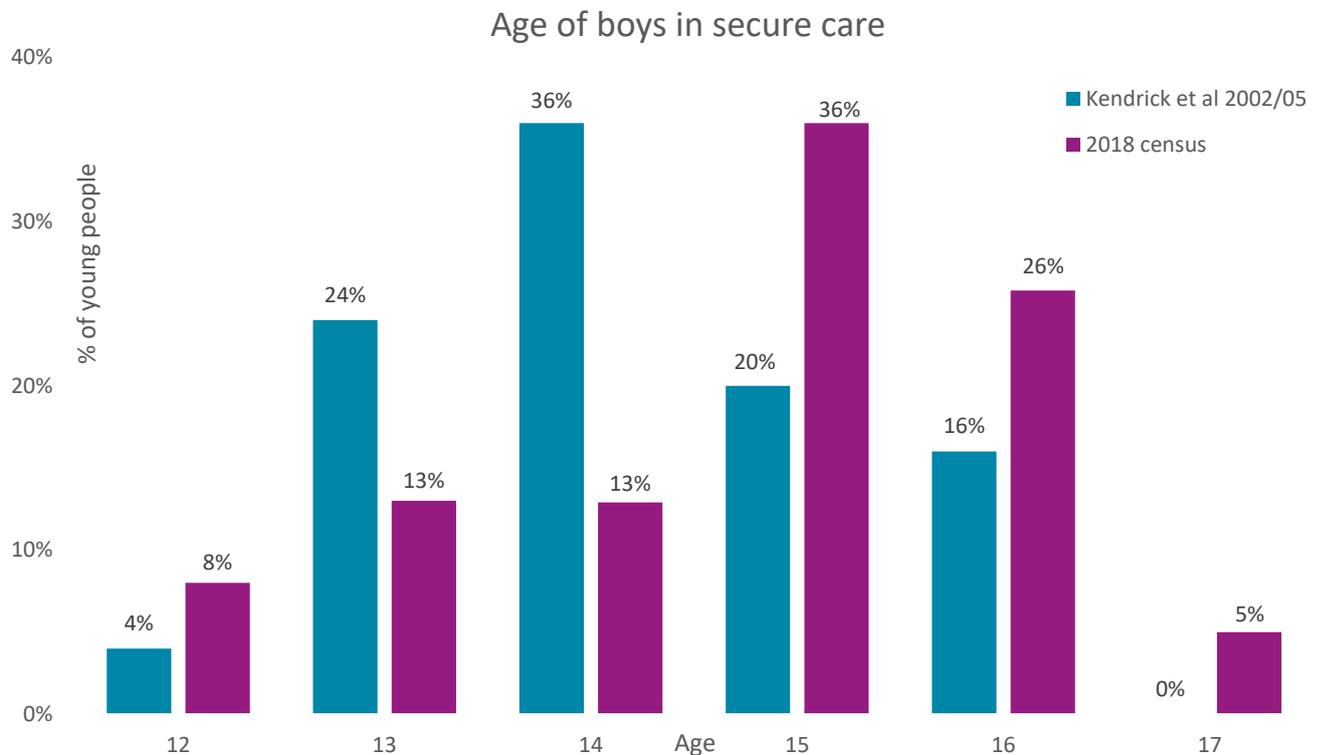


Figure 5

This study found that boys aged 15 and over constituted 67% of the male population, whilst Kendrick et al. (2008) reported that the same age group accounted for just over one third of the boys in the 2002-2005 cohort.

One explanation for this change - in both boys and girls - could lie in the perception of secure care as being 'the last resort' (Schliehe, 2016), perhaps reflecting [Article 37\(b\) of the UNCRC](#), with a variety of other resources being employed prior to the use of secure care. During this process children will age, resulting in an older profile amongst the secure care population in 2018. The introduction of the [Whole System Approach](#) in 2011 may also have played a role in this, with [Early and Effective Intervention](#) absorbing many of the referrals relating to children in conflict with the law, thus contributing to significant reductions in referrals to the [Children's Hearing System](#). This, in turn, may have helped to de-escalate acts of criminality that could otherwise have developed into a pattern of behaviours, whilst also raising the age of those children who are eventually referred to the Principal Reporter. This approach is not without its critics, with Gillon (2018) warning of the unintended consequences of inadvertently introducing children into formal systems. Routine continuation of Compulsory Supervision Orders post the age of 16 (Henderson, 2017) may also contribute to this development, mindful that those children who are not provided with the protection and support associated with a Compulsory Supervision Order would spend any periods of remand or custodial sentence within a Young Offenders Institute, rather than a secure setting. This should be seen as a positive development given the experiences of children within a Young Offenders Institute reported by Nolan et al. (2017).

A degree of caution ought to be noted with regards to making comparisons between the two time periods, with the scale of cross border placements during that period not being recorded in any database known to the writer. As such, it may be the current picture is

skewed somewhat by the presence of children from out with Scotland in a way that was not the case in the early 2000s.

Socio-economic status

Within the field of social work practice, poverty and deprivation levels are routinely so high that for some practitioners they “constitute a normative backdrop, something unremarkable and unremarked upon” (Morris et al., 2018:367). As such the results of the census were perhaps unsurprising. Taking heed of UNESCO’s definition of relative poverty,³ 80% of children from Scottish local authorities who were in secure on the day of the census were believed to live in relative poverty; for children from English local authorities that figure was 72%, with a further 15% rated as ‘unknown’. Amongst those whose placing nation was Scotland, a disproportionate number of children came from families residing within the most deprived postcodes in the country, drawing on the [Scottish Index of Multiple Deprivation 2016 \(SIMD\)](#).

Measuring SIMD is not merely about considering income levels across a particular area, but draws on levels of health, employment, education, housing, crime and access to services to determine the overall level of deprivation experienced by that community. Whilst useful in highlighting the broader picture, it is not without its flaws (Fischbacher, 2014). Someone who lives in an area of high deprivation may enjoy a comfortable life with substantial human and social capital, for example. As a general tool however, it is a mechanism which provides an understanding of the circumstances within a particular community, particularly in light of Sapolsky (2004), Rivenbark et al. (2020) and Browman, Destin, Kearney, and Levine (2019) who highlight a broad range of health and social risks that are faced, taken or made by those living in the most disadvantaged communities. Likewise Graham, Jordan, Hutchinson, and de Wet (2018) articulate the role - amongst other issues - that socio-economic disadvantage plays in multiple risky behaviours amongst children. Meanwhile, Bywaters et al. (2016) articulate the complex, interconnected and eternally intertwined relationship between poverty and child neglect and abuse. Living in poverty has been shown to impact upon manifold area of a child’s life, including birth weight, nutrition, academic performance, mental wellbeing and mortality (McCartan, Morrison, Bunting, Davidson, & McIlroy, 2018). Exposure to ACEs have also been shown to correlate with socio-economic inequality (Allen & Donkin, 2015).

Whilst 22% of all children in Scotland reside within SIMD 1 or 2 collectively, 45% of residents within secure care from a Scottish local authority grew up in an area categorised as SIMD 1 or 2. A total of 21% of children across Scotland reside in SIMD 9 or 10, however there was no representation from these areas amongst the secure care population on the day of the census.

³ The study asked respondents to judge whether the child’s family were living in relative poverty as defined by UNESCO, which “defines poverty in relation to the economic status of other members of the society: people are poor if they fall below prevailing standards of living in a given societal context” (UNESCO, n.d.).

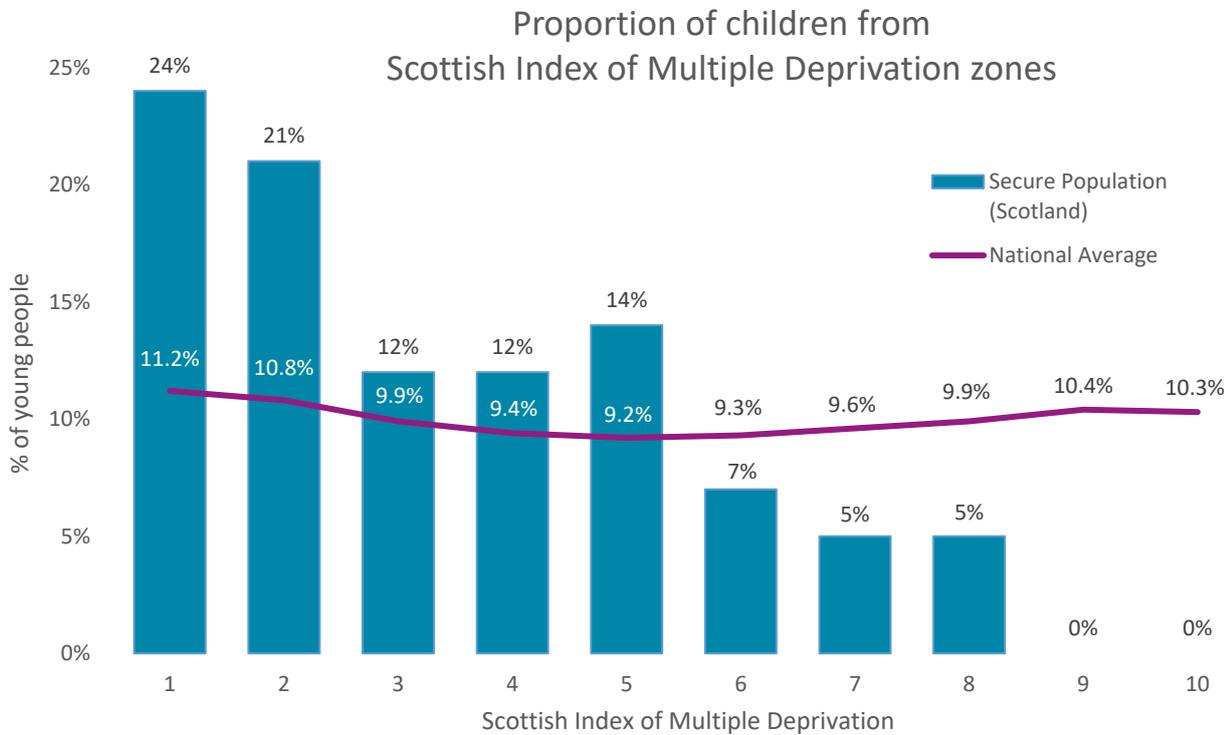


Figure 6

It is not possible to directly compare the [English Index of Multiple Deprivation 2015 \(EIMD\)](#) to its Scottish counterpart due differences in the way the factors are measured, and which indeed which factors are included in the calculation. It is possible, however, to say that someone in SIMD1 is within the 10% most deprived areas in Scotland, and someone in EIMD1 is in the most deprived decile in England, and so on and so forth. Amongst those who had been placed by an English local authority there was a similar trend in terms of their exposure to deprivation, albeit that information regarding EIMD was missing in 10 of the 32 responses.

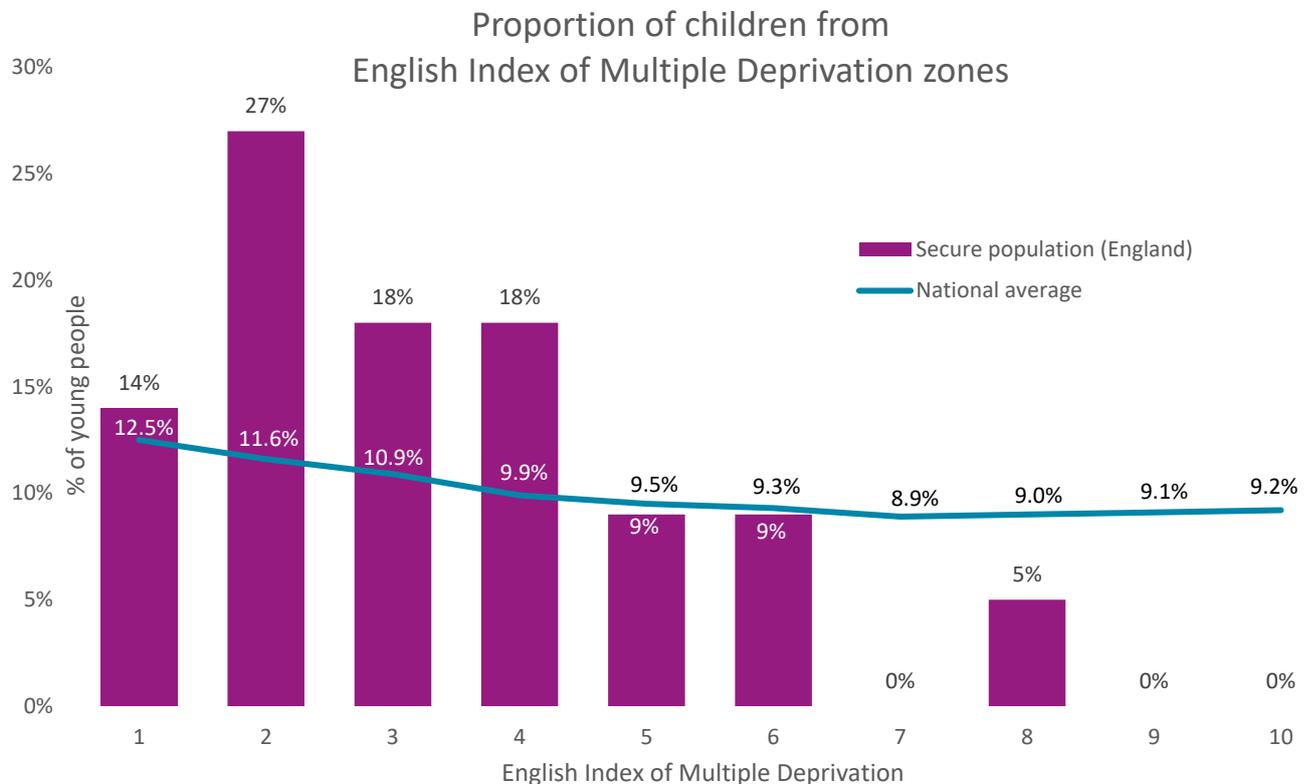


Figure 7

This study shows that 41% of children resided within EIMD 1 or 2, however the Office for National Statistics suggest that only 24.1% of under 18s in England live in these postcodes. Similarly, EIMD 3 and 4 accounted for 36% of children amongst this cohort, yet only 20.8% of the national population in England.

Secure Care and ACEs

As in Vaswani's study of children deemed to pose a high risk of harm to others, and in receipt of consultation at the IVY service (2018), aggregated exposure to ACEs is far higher within the secure care population than amongst the general population. Research suggests that 54% of the Welsh population, 54% of the English population and 35% of Scottish children⁴ have avoided exposure to ACEs (Bellis, Ashton, et al., 2015; Bellis, Hughes, Leckenby, Perkins, & Lowey, 2014; Marryat & Frank, 2019), with the figure dropping to 7% amongst the IVY population (Vaswani, 2018). By comparison, 98% of the secure care population in this study were believed to have encountered **at least** one ACE. This is similar to previous studies elsewhere, with 97% of children at Rossie secure unit, 97% in Kibble and 100% of children at Hillside secure centre in Wales exposed to at least one ACE (K. Ferguson & Wylie, 2018; Kibble, 2015; Pates et al., 2018)

Of note is the increased numbers of children amongst the secure population who had encountered four or more ACEs, with that level believed to be the 'tipping point' that leads to

⁴ Marryat & Frank adopted a truncated ACE inventory in their study of Scottish children, and thus their findings are not as directly comparable as others referenced elsewhere in this report.

significantly increased likelihood of encountering negative life outcomes (Bellis, Ashton, et al., 2015; K. Hughes et al., 2017; Smith, 2018). Some 64% of children within secure care on the day of the census had encountered four or more ACEs; this compares to 12% amongst higher education students in Northern Ireland, 14% in a generic Welsh population study and 8% amongst a study of English adults (Bellis, Hughes, et al., 2015; Bellis et al., 2014; McGavock & Spratt, 2012).

This figure of 64% is also higher than in two studies that examined the prevalence of ACEs amongst children with a history of displaying violence, namely 59% in the IVY study (Vaswani, 2018) and 52% amongst American children in the justice system (Fox et al., 2015). This finding echoes that of K. Ferguson and Wylie (2018) where 75% of residents within one secure unit in Scotland were found to have encountered this level of ACEs.

Number of ACEs experienced by children in secure care

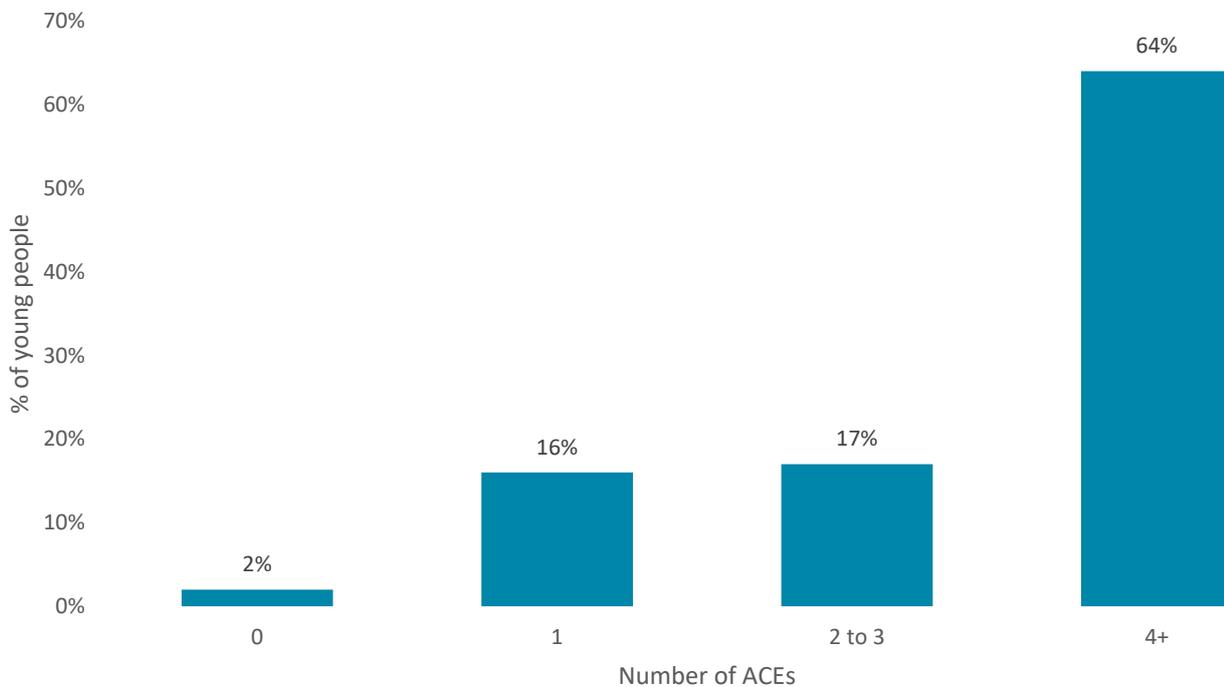


Figure 8

Gender and ACEs

Data relating to two transgender children have been excluded from this section of the report due to the small sample size and in order to maintain and respect their confidentiality. Of the remaining 85 residents, 46 were girls and 39 were boys.

Without exception, girls in this sample had encountered each of the ACEs far more often than their male peers, with each individual adversity having been encountered by at least 60% of the female cohort. Whilst prevalence amongst males was lower, exposure rates remained substantially higher than has been found in other UK studies (for example McGavock & Spratt, 2012).

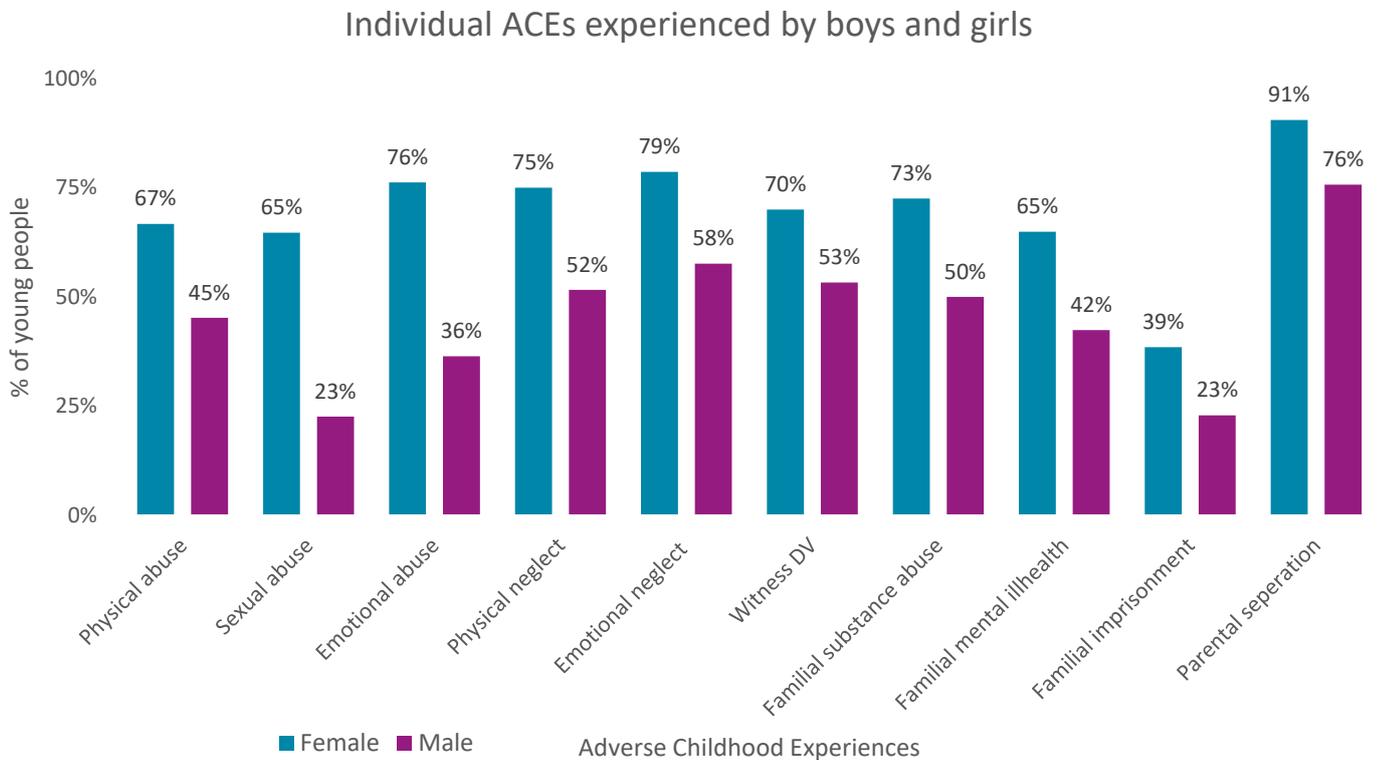


Figure 9

It is also worthwhile noting the gender differences in relation to aggregated exposure, with 82% of girls having encountered four or more ACEs, compared to 49% of boys.

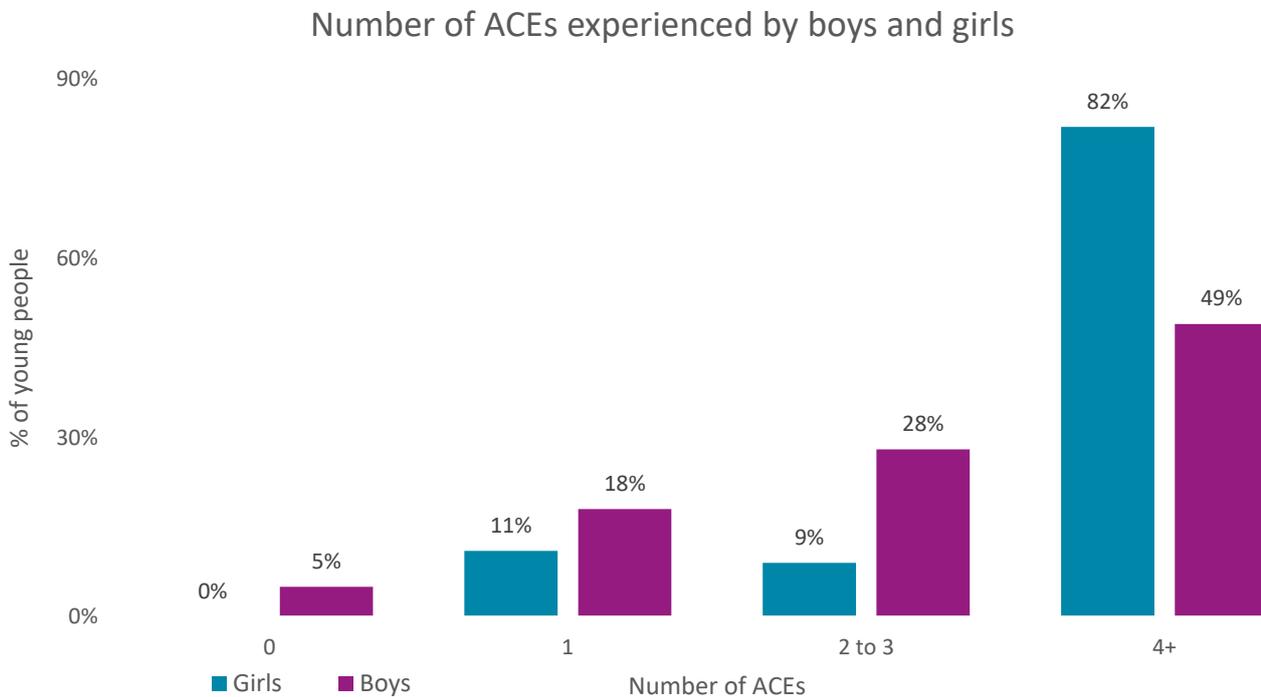


Figure 10

Whilst the impact of these issues upon individual children will of course vary, analysis of the aggregated levels of exposure to ACEs shows a mean aggregate of 3.77 ACEs for boys , echoing the 3.74 found in previous IVY studies (Vaswani, 2018), however the mean aggregate of 5.96 ACEs amongst girls resident in secure care was considerably higher than the 4.95 found amongst their contemporaries in the aforementioned IVY study. Further analysis demonstrated a statistically significantly relationship between gender and ACEs, with girls more likely to be exposed to ACEs than boys.⁵

Similar findings have been found within the youth justice system in Florida, USA (Baglivio et al., 2014). As Vaswani (2018) states, this may well relate to increased likelihood of ACEs being detected or reported amongst girls, and may also reflect higher rates of resilience amongst that cohort. This occurs in the backdrop of an even split in rates of child protection registrations amongst boys and girls (Scottish Government, 2019), but with boys consistently being referred to the Children’s Hearing System more often than girls. Haahr-Pedersen et al. (2020) provide further analysis of the gendering of ACEs, finding that girls were more likely to experience multiple adversities in comparison to boys. As such, the above noted findings may not only apply to those within the secure arena, but to other marginalised, at risk, or vulnerable populations.

⁵ An independent *t*-test comparing boys (M=3.77, SD=2.59) and girls (M=5.96, SD=2.69) demonstrated that overall exposure to ACEs was found to be statistically higher amongst girls in this population. The independent *t*-test showed that ($t(83) = -3.80, p < .001$)

Placing nation and ACEs

Data regarding all children were considered in this analysis, which showed that with the exception of witnessing domestic violence, rates of exposure to ACEs were higher amongst children from English local authorities compared to their counterparts from Scottish jurisdictions. Rates of exposure to each of the ACEs are substantially higher than had been found in previous studies of the general population (see Bellis et al., 2014; McGavock & Spratt, 2012), with most individual ACEs being experienced by over 50% of children from both placing nations.

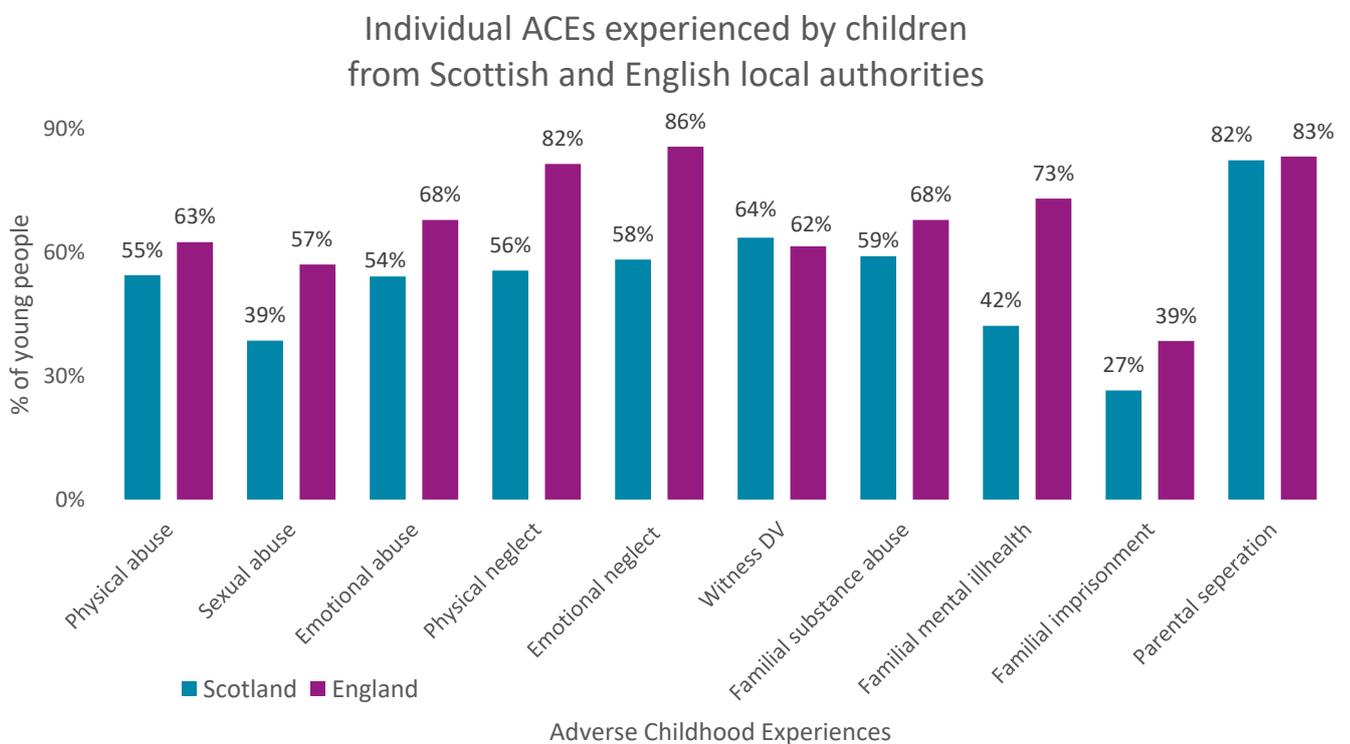


Figure 11

Not only do these findings demonstrate the heightened rates of exposure to each of these ACEs, they also provide evidence of heightened exposure to four or more ACEs. This study has shown that 60% of children from Scottish local authorities and 72% of their peers from English authorities have encountered four or more ACEs, with a combined average of 64%.

Number of ACEs experienced by children from Scottish and English local authorities

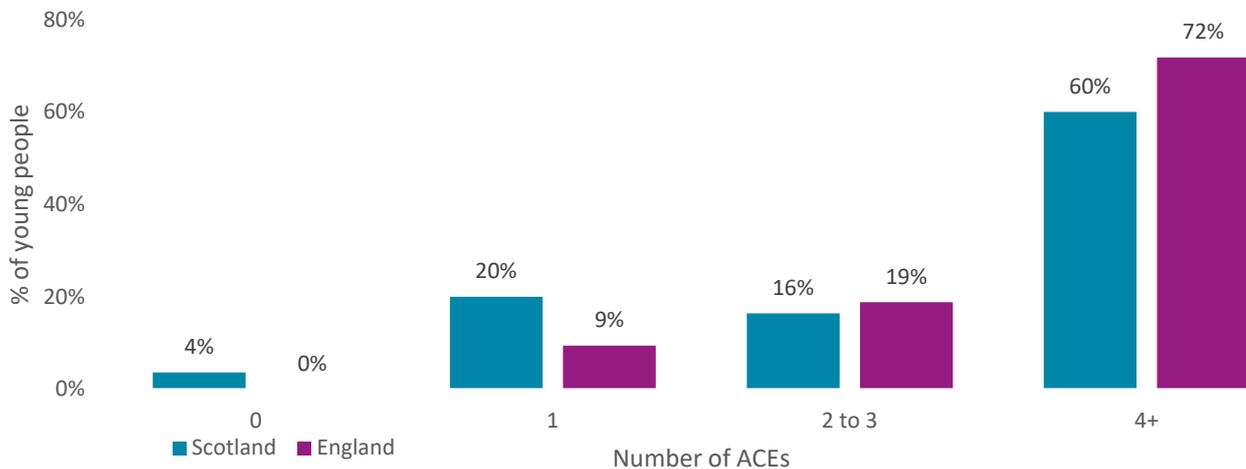


Figure 12

Mean rates of exposure amongst children from a Scottish local authority was 4.42. Amongst those placed by an English local authority that figure was 5.63. Having run a statistical test, however, no statistically significant relationship between the placing nation and exposure to ACEs was found⁶. This suggests that exposure to inflated rates of ACEs relate to other factors, aside from which nation had placed the child in secure care. Gender may well be one such factor as has been highlighted previously in this report. It is worth remembering that 75% of those placed in secure from an English local authority were girls, with statistical significance found in their exposure to ACEs. It is also worthwhile remembering that legal routes into the secure estate varies depending upon which placing nation the child lives in, with children from out with Scotland being placed into this environment by virtue of welfare based grounds, albeit that offending behaviour often featured amongst their presentation. This may in turn explain the apparent increased exposure amongst the cohort from England that one may have understandably, although erroneously, assumed was due to their placing nation. Whilst these findings are not statistically significant, it has demonstrated the heightened exposure to ACEs amongst the children from England examined by this census.

Socio-economic status and ACEs

On the day of the census, some 80% of children from Scotland and 72% from England were believed to reside in relative poverty. Given the size of the sample and the incomplete data from England, the author chose not to analyse the relationships between relative poverty and ACE exposure within that cohort and therefore the following discussion solely relates to children whose placing nation was Scotland.

⁶ Children from Scottish local authorities were found to have mean ACE exposure of (M=4.42, SD = 2.8). Amongst children from English local authorities this was found to be (M=5.63, SD=2.89). An independent t-test showed that (t(85)=-.833, p=.059).

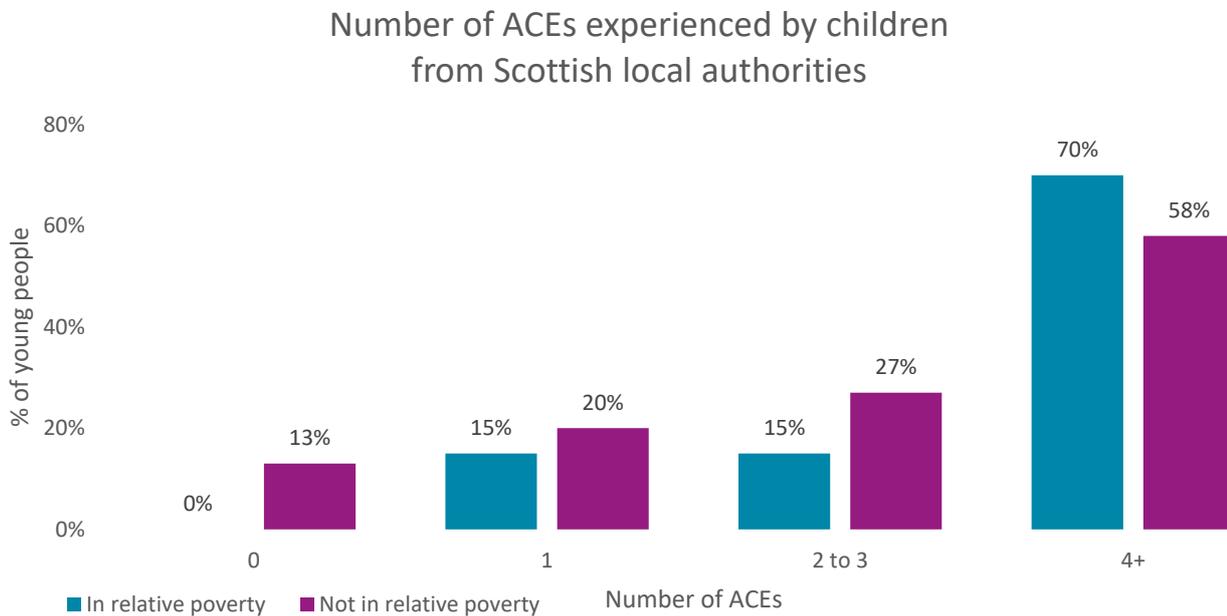


Figure 13

Amongst children whose placing nation was Scotland, those living in relative poverty had a mean ACE exposure of 4.89 and those not in relative poverty had a mean ACE exposure of 2.55. A statistical test was undertaken in order to examine aggregated levels of exposure to ACEs between those living in relative poverty and those not in relative poverty. The findings demonstrated a strong statistical significance in the relationship between living in relative poverty and increased exposure to ACEs.⁷

Previous studies have also demonstrated a higher prevalence of ACEs amongst the most deprived areas (Bellis et al., 2014; Walsh et al., 2019), with American authors stating that poverty aids in the accumulation of ACE exposure (M. Hughes & Tucker, 2018). In the UK, authors have highlighted the interplay between ACEs and deprivation, poverty, and inequality (Couper & Mackie, 2016) and with child poverty (Lewer et al, 2019), with some going as far as saying “we know that there is a strong correlation between events labelled ACEs and the experience of family poverty”. This study has provided new evidence to support this position, with strong statistical significance found in this instance.

Further evidence of this interplay is found when considering which zone of the respective nation’s Index of Multiple Deprivation the child’s family live in. As shown in Figure 14, children from SIMD zones 1, 2, 5, 6 and 7 had an average ACE exposure of over 4. However, the small number of children within some zones - SIMD 8 for example - result in these findings being less reliable. No children had originally lived in SIMD 9 or 10.

⁷ This study found a significant difference in aggregated levels of exposure to ACEs between those living in relative poverty (M=4.89 SD=2.74) and those not in relative poverty (M=2.55, SD=2.30). An independent t-test of the mean levels of exposure to ACEs amongst these children showed that ($t(53)=2.61, p=.012$).

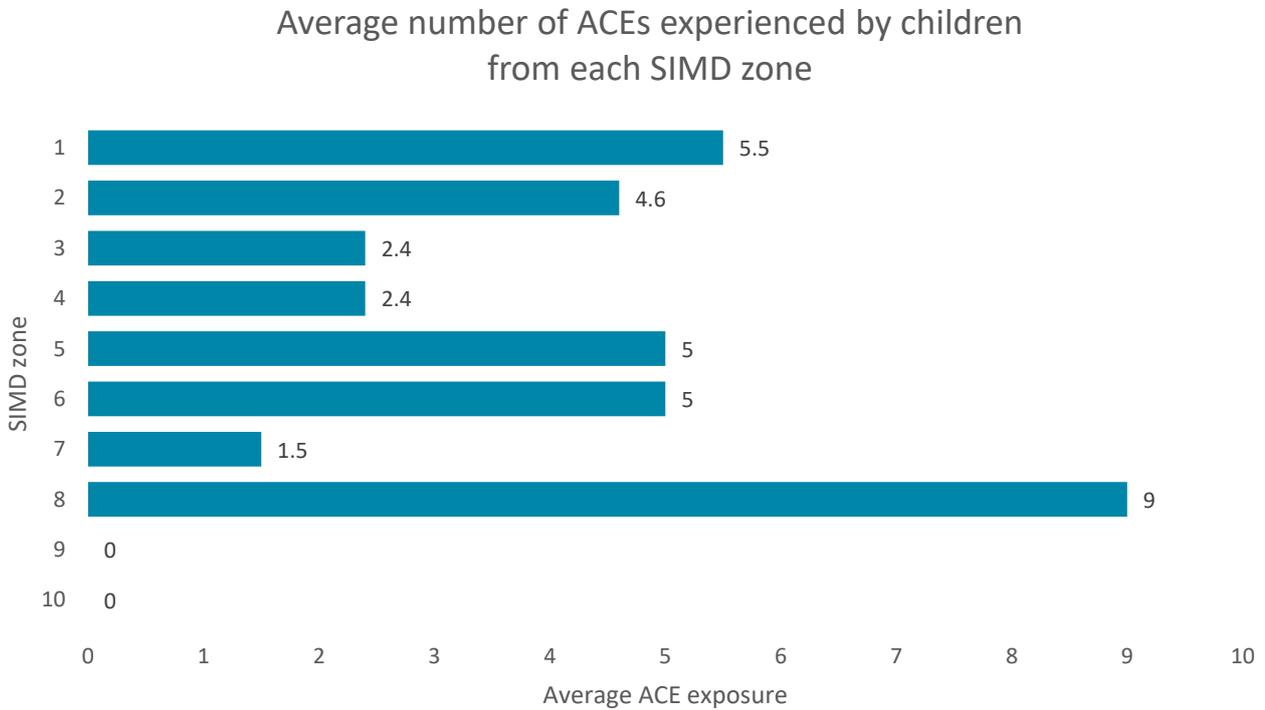


Figure 14

Amongst those children who had been placed by an English local authority, none had originated from EIMD zones 7, 8 or 9; again highlighting the increased multiple deprivation that this population encounters. As this Figure 15 illustrates, each EIMD zone had an average ACE exposure of at least four.

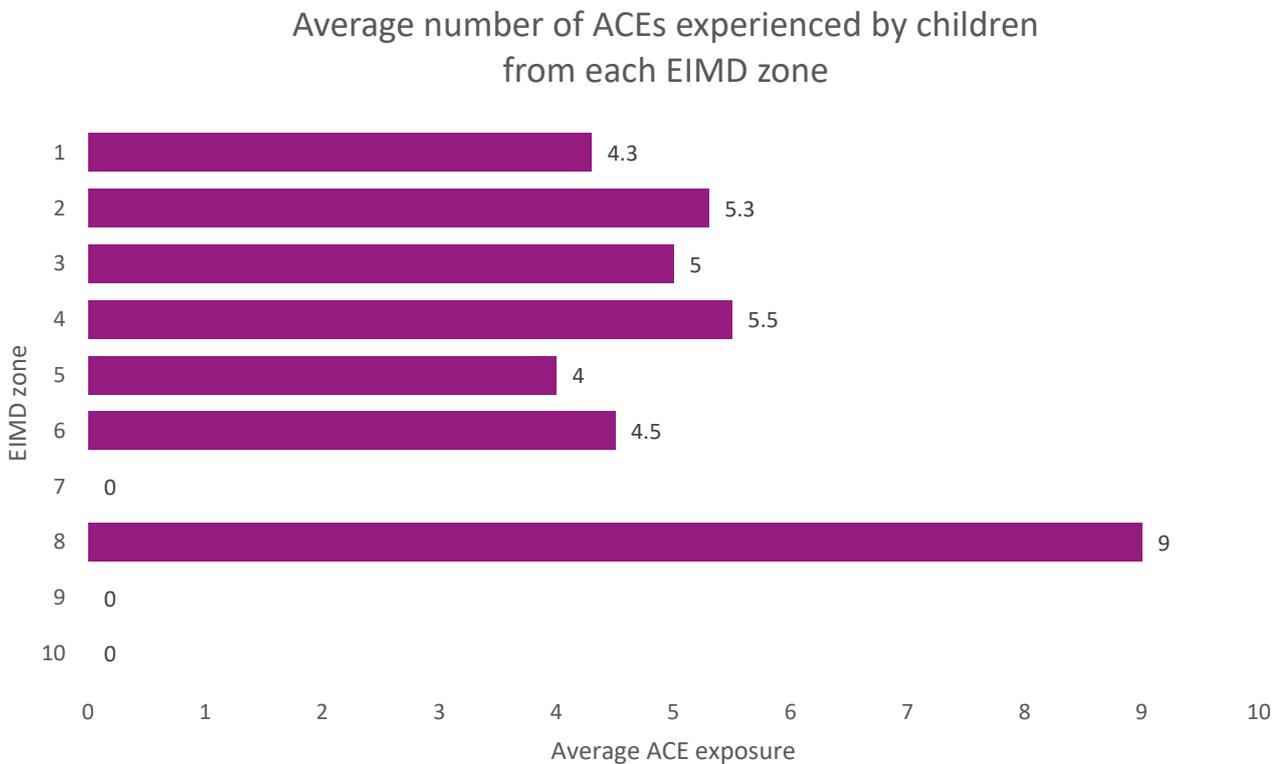


Figure 15

Whilst this is further illustration of the significant adversity experienced by this particular cohort, some zones accounted for only a small number of children and thus some caution should be noted when considering the weighting apportioned to these findings. Further studies are therefore required. As a consequence of the smaller sample size within each zone, it is not possible to assert statistical significance; exposure to ACEs occurred fairly evenly amongst those zones which were represented. The absence of any children from the most affluent 20% of the populations in both Scotland and England is an important point, and suggests that children who require care in a secure environment have not enjoyed the luxuries and benefits associated with the most affluent communities. It is therefore reasonable to argue that in addition to financial adversity, the difficulties imposed by community deprivation - as measured by SIMD and EIMD - have a strong association to heightened rates of ACE exposure, and to life experiences which precipitate admission into a secure setting.



Discussion

There are caveats to these findings, including some methodological issues highlighted earlier in this report that mean that these findings are likely to be under representative given the small sample size. Given the particularly difficult lives that these children have often encountered, heightened levels of ACE exposure are to be expected, with Vaswani (2018)

previously questioning the use of such an approach when studying high risk populations. Furthermore, this study is merely a snapshot and these findings do not necessarily represent the secure care population on a day-to-day basis; future censuses may provide data which corroborates or contests these results. It is also worth noting that exposure to ACEs are just one tranche of challenges that children within the secure estate encounter, and there are other factors that may shed light on the pathway that children have taken en route to that setting. Other life experiences which may contextualise the pathways into secure care will be explored in future publications, offering additional perspective on the lives of our society's most vulnerable children.

Through providing an examination of the prevalence of ACEs amongst this particular cohort of young people, this study has sought to address the dearth of research relating to the profile of children within the secure estate highlighted by Andow and Byrne (2018) and Byrne (2018). Consideration of these findings could assist practitioners and organisations to better understand the lives of those young people who may benefit from secure care, mindful of the need to plan and provide care within the secure estate that meets the needs of children (Independent Care Review, 2020). Certain features of their profile have been highlighted, affording a greater understanding of their demographics. As those with experience of working in and around the secure care sector would rightly have predicted at the outset of this study, the level of exposure to ACEs amongst this cohort is both broad and substantial. Not only are aggregate levels of exposure high, but each of the ten ACEs have been encountered by a large number of the children. These may well contribute to their current vulnerable state. Awareness of such heightened levels of ACEs could help in developing services to respond to them, whilst stressing the need to support families, communities and services to prevent them in the first place. For some children, that could result in far different outcomes later in life, including negating the need to utilise care in a secure setting. To achieve that aim funding and energy may be required at earlier stage, thus avoiding the 'failure demand' that sees government spending huge amounts of money in an attempt to remedy poor policies and service delivery from years ago (Trebeck & Williams, 2019).

The findings of this study echo McAra and McVie (2010) who highlight the coexistence of vulnerability, risk taking and risk to others amongst teenage populations. Whilst multiple and myriad reasons may influence the pathway that a child pursues prior to entering secure care, it is noteworthy that a substantial majority of the children had encountered four or more ACEs; the point at which likelihood of negative outcomes is believed to increase. Whilst this report does not claim that exposure to ACEs are **the** primary causal factor that resulted in these children entering secure care, a strong presence and prevalence has been demonstrated. Given the nature of these life events, it is perhaps understandable that these experiences correlate with situations featuring a high risk of harm, which in turn leads to admission into secure care due to the risks posed by, or imposed upon, the child. A variety of mechanisms should be considered in such instances, including CARM and child protection measures (Dyer, 2017), with specific consideration of appropriate risk management strategies reported by Murphy, Nolan, and Moodie (2020) that seek to ground children's rights at the core of practice.

Whilst making the case for greater levels of preventative action, these findings do not necessarily address the gap in knowledge regarding effective prevention highlighted by K. Ferguson and Wylie (2018). It does give a better understanding of the factors that children facing, making or taking significant risk of harm may have encountered, and calls on the disparate and distinct components of the care system to take action. A lack of action can

lead to children unnecessarily entering the secure estate (Byrne, 2018); indeed, children and young adults themselves cite unmet need as a causal factor of the behaviours that lead to admission into secure care (Gough, 2017), thus impinging on their right to liberty. Whilst each secure care provider and frontline practitioner will be acutely aware of challenges faced by our most vulnerable children, these findings are perhaps a reminder to broader society as to the compelling and critical need to prevent these occurrences, rather than merely raising awareness.

However, it is of paramount importance that the presence of childhood maltreatment and abuse (including ACEs) is not blindly accepted as predetermining the lives and trajectories of those who have encountered these issues. ACEs neither precisely predict the map ahead of us, nor do they look backwards with clarion vision, with White, Edwards, Gillies, and Wastell (2019) reminding us that the majority of people who encounter ACEs go on to lead fulfilling lives. There is nothing set in stone with regards to the life trajectories of the children studied in this report, and the 87 children in question may have entered secure care for a multitude of reasons. As Widom clearly argued three decades ago, her research “did not show ... that every abused or neglected child will become delinquents, criminal or a violent criminal. The linkage between childhood victimization and later antisocial and violent behaviour is far from certain, and the intergenerational transmission of violence is not inevitable” (Widom, 1989:164). Amidst the deterministic pessimism of much of the ACEs literature, practitioners, policy makers and - most importantly - the children themselves ought to remember that children with experience of secure care are far more than a mere accumulation of adversities; they have the potential to lead lives of their choosing and enjoy positive outcomes. All of this makes the task of deciding when the state should intervene - and when it should not - even more complex, and raises considerable ethical and philosophical challenges for frontline practitioners.

Setting aside arguments which frame each of these ten issues as harmful or traumatic, at a fundamental level everyone has the right to a childhood free from ACEs; each of them can have detrimental, deleterious effects in a variety of forms. Achieving this calls for the “development and evaluation of programs that prevent the occurrence of childhood adversities in the first place” (Finkelhor, 2018:178), with primary prevention preferable to reactionary responses. In striving to be the best country in the world for children to grow up, greater adoption of approaches that can reduce domestic violence, parental mental ill-health and the other adversities measured in this study is needed. Doing so would be a step towards the preventative, early intervention support called for in The Promise (Independent Care Review, 2020) and in recent Public Health Scotland studies (Hetherington, 2020). This change, however, may require the shift in fiscal resourcing and civic planning advocated by Trebeck (2020), Trebeck and Williams (2019) and Christie (2011). At secondary prevention level, one way of addressing the intergenerational transmission of violence - be that physical, psychological, sexual or structural - that Widom (1989) spoke of is through provision of intensive and effective support to those who encounter ACEs, and indeed all other forms of maltreatment, disadvantage, trauma or misfortune. Devising and embedding approaches which support children to overcome these difficulties could reduce adverse outcomes. To that end Lester et al. (2019) report that those who have encountered ACEs require multi-modal, flexible services founded upon human relationships and trust. These are notable features of The Promise (Independent Care Review, 2020), and should therefore be promoted in the coming years.

Whilst acknowledging that the ten ACEs themselves may not be directly responsible for the circumstances that precipitated admission into secure care, these findings offer some suggestions as to what issues community services and secure care placements may wish to focus on when designing the interventions and supports that aim to promote secondary prevention. In designing our services here in Scotland, do current supports reflect the sizeable proportion of children who have encountered sexual abuse? Are existing training regimes mindful of the substantial emotional neglect that these children have faced? Answering these, and other, questions may be one means by which secure care practitioners could provide the “therapeutic, trauma informed support” (Independent Care Review, 2020:80) that children require, and which is more difficult to provide within custodial settings (Vaswani & Paul, 2019). Likewise, local authorities and community based resources could recalibrate their provision in order to support children upon transition into subsequent accommodation.

Scotland will incorporate the UNCRC into Scots’ law in 2021. Becoming a rights-respecting nation calls on Scotland to understand the needs of their children, so that these needs can be adequately met. That is true for all children, including those who face, take or make a high risk of harm (Lightowler, 2020). These findings provide some indications of what those needs are, and can equip practitioners in and around secure care to plan services and interventions appropriately. By doing so, Scotland can avoid the alarming situation where children enter the secure care environment due to a lack of appropriate resources within the community (Moodie & Gough, 2017). When doing so, policy makers and practitioners ought to be mindful of the incoming Secure Care Pathways and Standards Scotland. In seeking to deliver the ‘responsive care and support’ that these standards call on, an understanding of the particular needs, risks and vulnerabilities of those entering their care is essential. This report - and forthcoming reports - are therefore timely, providing a basis from which local authorities, secure placements and all other relevant stakeholders can reflect on provision before, during and after secure accommodation.

Mindful of the statistical significance found when viewing ACEs through the lens of gender, this report may also add weight to calls for gender specific responses for those who enter the secure care environment, a point once again echoed by the Independent Care Review (2020). On this occasion at least, there appears to be a greater prevalence of ACEs amongst girls in secure care. This may be systematic of a greater prevalence of ACEs amongst girls in general, rather than an indicator of anything particularly different about those children who face, take or make the highest risk of harm. Nevertheless, practitioners and policy makers may wish to consider programmes, responses and approaches that are specifically tailored to girls or to boys, whilst the presence of a small number of children who identify as transgender means that services in both the community and secure care must continue to personalise their responses.

At a macro level, the increased prevalence of ACEs amongst girls who encounter high risk of harm ought to lead to consideration of how Scotland - and the UK - treat, respond to and protect this group of children. Setting aside the continuous question of whether risk leads to ACEs or ACEs lead to risk for one moment, the results of this research show that girls encounter ACEs more often than boys, and at a rate that makes gender a statistically significant factor. As a nation which seeks to address the persistent inequality, misogyny and oppression of women and girls, this finding should lead to consideration of what changes at societal and civic level need be affected that *could* lead to improvement in this area. Owing to the nature of much of the abuse that is perpetrated against girls, that

ultimately means addressing the behaviours of older, adult males and providing education and support to boys as they grow up. The author is mindful that abuse can be perpetrated by females, although is also aware of the decades of evidence which highlight the enormity and proportion of this issue.

Undoubtedly, the rising age of children in the secure care environment is something that practitioners will be aware of as they carry out their role. Policies and provision within secure care will have developed over this time, meaning that secure care is more of a setting that responds to the needs of older children than was the case in previous years. These findings may serve to remind those in positions of authority of this change in profile, and subsequently calibrate community supports accordingly. The older profile may also be interpreted as the success of the Whole System Approach in diverting children away from formal services wherever possible.

The presence of 16 and 17 year old children is yet further evidence that secure care is a valuable and needed resource for children of that age. Providing equity within the Children's Hearing System by addressing the anomaly over the age at which a child can be referred to the Principal Reporter would therefore be a step towards providing appropriate care to this age group. In doing so, a safe and secure environment would remain available to all children up to the age of 18, and minimise the risk of children entering the custodial estate, homelessness services or adult mental health settings due to this anomaly. Furthermore, it is evidence that secure care can support older children and ought to be utilised in place of custodial settings, where therapeutic support is less embedded, or indeed possible (Vaswani & Paul, 2019).

These findings also stress the need to provide extensive, comprehensive and effective supports to those who have previously resided within secure care. Noting the increased risk of social and health difficulties - at least at large, population level - faced by those who have encountered four or more ACEs, policy and welfare provision ought to consider the manner in which supports are designed and delivered to children and young people making the transition to the community, as well as into adulthood. Policy makers should be exceptionally mindful of increased mortality amongst those who experience residential care (Murray, Lacey, Maughan, & Sacker, 2020), and Care Inspectorate (2020) findings regarding the deaths of looked after children, with a large proportion of these children having experienced care within a secure setting. The moral imperative alone means that the state ought to be responsive to the potential long-term health inequalities encountered by this cohort. The implementation of continuing care provisions to those leaving secure care - as called for by Independent Care Review (2020) - is perhaps one way of achieving this, thus linking children and young adults into services and supports that assist them to make the transition into adulthood. This could be supplemented by extended, specialist mental and physical health provision for those who have resided within secure accommodation, with Hetherington (2020) recently suggesting means by which public health measures could be adopted.

The presence of poverty and socio-economic disadvantage is particularly alarming. With some 80% of children from Scottish local authorities living in such environments there is a clear need for action. The mechanisms to achieve this are well rehearsed and more extensively examined elsewhere, but surely in light of growing chasms between those in SIMD1 and those in SIMD10, and the imminent economic pressures caused by COVID-19 (Nicola et al., 2020) the need to act has never been so urgent. As many have stressed, addressing the striking rates of poverty is of paramount urgency given the interconnected

nature of poverty, ACEs and multiple deprivations encountered later in life (Allen & Donkin, 2015; Bramley et al., 2019; Lewer et al., 2019; White et al., 2019). Existing inequalities have been widened by recent circumstances, with those from socio-economic disadvantaged groups experiencing a disproportionate effect from COVID-19 (G. Anderson, Frank, Naylor, Wodchis, & Feng, 2020). In response, increased welfare provision to children and families has been suggested (Maddison, 2020), but as Trebeck (2017) and Dorling (2015) state, such measures are merely sticking plasters to the wound: structural change is required. It may be that a move to a wellbeing economy, as advocated by Trebeck (2020) within the Independent Care Review's conclusions, could be a vehicle to address these inequalities, with Higgins (2020) outlining measures that Scotland ought to take in the post-COVID world to develop a 'robust wellbeing economy'. Preliminary findings of the Universal Basic Income (UBI) experiment show that the general wellbeing of citizens is improved when in receipt of UBI (Kangas, Jauhiainen, Simanainen, & Ylikännö, 2019). This improved wellbeing could translate into homes which are more relaxed, less stressful and result in reduced exposure to ACEs. Whilst it may be speculative to describe this approach as being a panacea, steps towards UBI or similar instruments which prioritise people over profit could deliver the treatment that is required, providing both economic stability for families and improved wellbeing.

Achieving macro level change will take time, during which children and their families will continue to experience significant levels of poverty and socio-economic disadvantage. That is why interventions are required across multiple levels of society, not merely affecting the economy but the day-to-day life of those in need (Allen & Donkin, 2015; Hetherington, 2020). That requires the re-establishment of, and recommitment to, anti-poverty policies which have sadly receded since community rooted, radical social work practice faded out of fashion (Butler-Warke, Yuill, & Bolger, 2020; Turbett, 2018) whilst neo-liberal, managerialist approaches have gained prominence (Cummins, 2018; I. Ferguson, 2018). A refocus on fierce anti-poverty practice, framing it in terms of social justice (McCartan et al., 2018) seems apposite, with Scotland's Children and Young Person's Commissioner repeatedly describing poverty as the biggest human rights issue facing children. As Scotland strives towards UNCRC incorporation and becoming a rights-respecting nation, binding poverty to the cause of children's rights seems both principled and paramount.

Conclusion

The profile of children accessing secure care has changed in recent years, with greater numbers of girls, older children, transgender children and a substantial number of children from out with Scotland. Each of these changes will have an impact on the design, nature, atmosphere and needs of that setting. Children - and indeed childhood - change and evolve over time. These findings may assist those involved in the provision of care to children who encounter a high risk of harm to do likewise, developing approaches to care that reflect the lives of the children in question. These approaches are not limited to the secure environment, but to community settings, schools, residential houses, Young Offenders Institutes and hospitals.

Almost without exception, children within secure care have encountered substantial exposure to ACEs, with statistical significance found when considering gender and living in relative poverty. In isolation these matters can have detrimental effects upon a child; their potency is only enhanced with the presence of other adversities, such as the substantial

rates of neglect, abuse and hardships experienced by the most vulnerable children in our society. The coming years may well be crucial in shaping how we seek to remedy this. The economic base upon which our state is built has been ruptured by the impact of COVID-19, how Scotland chooses to rebuild from here will have immeasurable consequences upon the lives of those most in need of support.

Ultimately, adequate resourcing of services and interventions that have robustly evidenced their ability to prevent these episodes from occurring must remain a priority, in concord with those that ameliorate their impact. These steps could reduce the risk of these factors contributing to circumstances which necessitate care within a secure setting. By doing so, Scotland may not only be able to respect the rights of children who face, take or make a high risk of harm, but move beyond mere awareness of ACEs to a state of prevention and recovery.

Appendix: Response data

Placing nation	No.	% of relevant population
Total children in secure care	87	100%
Placed by Scottish local authority	55	63%
Placed by English local authority	32	37%

Gender of children (total)	No.	% of relevant population
Girls	46	53%
Boys	39	45%
Transgender	* ⁸	2%

Gender of children (Scotland)	No.	% of relevant population
Total children	55	100%
Girls	22	40%
Boys	31	56%
Transgender	*	4%

Gender of children (England)	No.	% of relevant population
Total children	32	100%
Girls	24	75%
Boys	8	25%
Transgender	0	0%

Age of children (Girls)	No.	% of relevant population
12	*	4%
13	*	4%
14	12	26%
15	16	35%
16	7	15%
17	7	15%

Age of children (Boys)	No.	% of relevant population
12	*	8%
13	5	13%
14	5	13%
15	14	36%
16	10	26%
17	*	5%

⁸ Asterisk denotes that less than five children identified within that particular group

		Gender	
		Girls	Boys
Placing Nation	Scotland	Age range: 14-17	Age range: 13-16
		Mean age: 15	Mean age: 14
		Median age: 15	Median age: 15
	England	Age range: 12-17	Age range: 12-17
		Mean age: 15	Mean age: 15
		Median age: 15	Median age: 15

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