

The knot:

An essay collection on
the interconnectedness
of poverty, trauma, and
multiple disadvantage

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**Lankelly
Chase**



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About Revolving Doors Agency

Revolving Doors Agency is a national charity that aims to change systems and improve services for people 'in the revolving door' – people who come into repeat contact with the criminal justice system because of traumatic life events, persistent poverty, and multiple unmet needs such as mental ill-health, homelessness and substance misuse.

We work to create a smarter criminal justice system that makes the revolving door avoidable and escapable, resulting in safer communities. We do this by working alongside national and local decision-makers. We combine lived experience insight, robust research and system knowledge to create policy and practice solutions that work.

About Lankelly Chase

Lankelly Chase is a charitable foundation focused on severe and multiple disadvantage. Our mission is the creation of systems of justice, healing and liberation that enable people who are subject to extreme marginalisation to live with dignity and opportunity in supportive communities. Our mission is to work with partners to change systems of injustice and oppression that result in the mental distress, violence and destitution experienced by people subject to extreme marginalisation in the UK. We don't think any one person or organisation has all the answers; instead we aim to build, nurture and support partnerships and networks which seek to act, reflect on, learn and adapt to how we can all model the change we want to see.

Acknowledgments

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Disclaimer statement

The views and opinions expressed in these essays are those of the authors and do not necessarily reflect the views or positions of Lankelly Chase or Revolving Doors Agency.

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Foreword

By Julian Corner, Lankelly Chase

In his historical study of the invention and reinvention of the concept of 'the underclass,' John Welshman shows repeatedly that the way social problems are defined, and the design of attempts to tackle them, tells us a great deal about the ideologies of the people defining the problem and very little about the actual lives of the people and the families being targeted.

I was reminded of Welshman's¹ work while reading this new collection of essays on the interconnection of poverty, trauma and multiple disadvantage. The framing of multiple disadvantage put forward by these essays is so compelling that it caused me to reflect on why it hasn't always been my main frame of reference. Until a few years ago, I would have viewed poverty and trauma as important contextual factors in understanding multiple disadvantage, but I wouldn't have put them front and centre of any response.

After reading the essays, I revisited a 2002 Social Exclusion Unit report that I helped to research and write, 'Reducing re-offending by ex-prisoners.' This report was widely welcomed at the time and yet it makes sobering reading now. Poverty is hardly mentioned, I found scant references to trauma and abuse, and the analysis of issues faced by women and by black and minority ethnic prisoners is relegated to annexes. It is more sobering still to see that the report's actions and recommendations owe very little to any understanding we may have had of these issues.

In 2002, we would have been surprised to be told that our work wouldn't age well. We believed that we were viewing social problems with as much empirical objectivity as we could muster, that our unprecedented trawl of evidence was unmediated by ideology. So how did we miss or downplay such critical issues?

Many reasons spring to mind, but there is a unifying theme: rights and responsibilities. Our report sought to offer a comprehensive package of 'solutions' to the problems that released prisoners faced, and it framed this as a new deal between the citizen and the state. The state would put in place the support you needed to turn your life around, however if you failed to seize the opportunities offered to you, then there would be, in the words of one Minister, 'no more excuses.'

This deal was both fragile and one-sided. Fragile because the state could never anticipate and address the needs of every prisoner, and so couldn't possibly

keep its side of the deal. One-sided because the consequences of the state failing to provide sufficient support were limited to wasted revenue, whereas the consequences for the prisoner could be catastrophic.

By framing rehabilitation as a 'deal,' it became almost inevitable that poverty and trauma would be marginalised. If the state allowed their centrality, then it was only one or two steps away from acknowledging its own responsibility for failing to prevent these harms. Such an acknowledgement would then take the state perilously close to a *reciprocal* deal, with rights and responsibilities on both sides. Much safer to limit the state within the boundaries of managerialism.

Looking back, it is still curious that a government that was so committed to reducing child poverty and to investing in Sure Start should have been entirely unwilling to join up the dots with its approach to adults. At that point, the state's failings across the lifespan of most prisoners could be laid at the door of 18 years of the previous government. So why didn't Labour attribute the prison population to the Conservatives' failure to prevent poverty and trauma?

The most obvious reason was that Tony Blair knew a large percentage of the public viewed prisoners as entirely culpable, and that his government would be punished for any blurring of that line. He had the political capability to try to shift the public's view, but his criminal justice arms race with Michael Howard while in opposition had blocked that route.

There was another reason though, which relates to the Blair government's belief in 'solutions.' Often within a term of a parliament, and to an arbitrary target, Blair's government believed it could solve an intractable issue through superior design of and investment in services. Such belief could only be underpinned by the most reductive of assumptions: that individual choices were rational, that justice was binary, and that the demarcation between child and adult was absolute. Any blurring risked opening the floodgates to the anathemas of relativism and complexity.

With the government holding complexity at bay, civil servants were able to act. This was an exciting, optimistic time for many of us who hoped to change things for good. And we did do some good. But we also did a lot of harm. Looking back, we were astonishingly naive to think that service provision alone could correct the effects of structural inequality and long-standing injustice on the lives of people who had no reason to trust us.

This essay collection speaks directly to this knottiness. Alongside invaluable updates of the state of knowledge on both poverty and trauma, these essays suggest frameworks

that can help us to incorporate more dimensions into our thinking and action, to join up the dots better, both at the level of individual interventions and at the level of policy. In Professor James Nazroo's terms, these essays allow us to find greater connection between our understandings of the structural, interpersonal and institutional layers.

The proposed frameworks encompass the *therapeutic justice-social ecological* lens formulated by Dr Diana Johns, Jaime de Loma-Osorio Ricon and Dr Eric Dommers, through to the globally recognised capabilities approach which underpins two of the essays. The frameworks are not intended to fully resolve the tensions that arise in relation to multiple disadvantage nor do they hope to perfectly align the different layers. They are not a template for an ideal response. Their intention is to help each of us – practitioner, civil servant or political activist – to locate ourselves within a shared appreciation of the multiple dimensions at play, and to inquire into what would emerge if there were growing coherence between those dimensions.

These essays will undoubtedly give me, and hopefully many others, more tools and structures for three crucial challenges. First, to engage with the interconnections of poverty, trauma, and multiple disadvantage in ways that reduce overwhelm and paralysis and enable action and learning. Second, to examine the degree to which our own practice inadvertently reproduces injustices, and to find ways in which our choices can do more good and less harm. And third, to locate our own ideological lenses clearly enough so that, in the words of Jones, Ricon and Dommers, we are able to "see possibility, potential, growth and a future of radical inclusion".

Despite the challenges and harms documented in these essays, I finished them feeling more optimistic. This isn't because they offer 'solutions.' Precisely because they avoid such reductivism, they lay the groundwork for approaches to multiple disadvantage that are more grounded in the reality of people's lives and that connect those lives to a wider vision of a fair and sustainable society.

1. Welshman, J. (2006). *Underclass: A history of the excluded since 1880*. London: Bloomsbury.

Introduction

By Dr. Philip Mullen, Revolving Doors Agency

People who repeatedly offend now account for about 40% of all offenders,¹ while reoffending accounts for three quarters of all proven offences. While this group may be portrayed by some as hardened criminals, we know that many are trapped in a revolving door cycle of crisis and crime that drives their offending. We also know, through our research and lived experience forums, that these cycles are marked by clusters of significant disadvantage – starting from childhood and continuing into adulthood, and sometimes entrapping multiple generations within families.

Through these conversations with people with lived experience of the revolving door of crisis and crime we have heard about multiple experiences of neglect, abuse, trauma and household dysfunction, and multiple and often traumatic losses and bereavements primarily driven by mental ill-health and drug overdose. We have also heard about experiences of persistent community violence – of friends, family members and neighbours being beaten up, murdered, and subjected to racial discrimination. All these challenging experiences happen in the context of profound poverty, of having no option but to live in unsafe or unsuitable accommodation, being unable to afford enough food to feed the family, high levels of school exclusion, and persistent and intergenerational unemployment.

To capture the complexity and interconnectedness of these issues, many of our lived experience forum members have used the metaphor of a knot. They describe it as capturing how these issues are intertwined but also as giving hope that they can start to be unpicked – they don't characterise the problem as such a tangled mess that it can never be resolved. To do so effectively, however, requires service providers and policy-makers to first take a step back to understand how these issues are knotted together, rather than immediately jumping in to try to resolve a single issue or issues. As a result of taking this step back, our members argue that agencies are better placed to avoid creating additional knots and to see how they can work collaboratively to address these knotted issues more effectively. We have titled this collection 'The Knot' to highlight both the complexity of intertwined

issues of poverty, trauma and multiple disadvantage, and also the necessity of collaborative and well-thought-out responses to effectively address these issues.

At Revolving Doors, we have always recognised that those trapped in the revolving door of crisis and crime face these multiple and knotted disadvantages, but traditionally we have focused more on outcomes and mitigating against these. Our work more recently, however, as highlighted through our 2020-2024 strategy² and New Generation Policing project³, has moved us more upstream, to better understand how poverty, trauma and structural disadvantage combine to create and perpetuate multiple disadvantage.

This essay collection, kindly supported by Lankelly Chase, is a key contribution to the shift in this direction. We aim to support a more nuanced understanding of how poverty, trauma and structural disadvantage create and perpetuate multiple disadvantage, and how we can more collaboratively and systematically respond to their root causes.

In putting the collection together, we chose to approach contributors both across and beyond academia, including through our Research Network on Severe and Multiple Disadvantage, to support wider conversations and debates beyond disciplinary and sectoral silos. As we were eager for the collection to be accessible to a range of audiences, we have also worked with our contributors to consider how their research and arguments can be made in ways that encourage engagement and collaboration between academics (of various disciplines), people with lived experience, practitioners and policy-makers.

Although it is not possible to cover every topic and perspective in just one publication, we hope the collection offers the reader new lenses and frameworks for better understanding the complex interconnections between poverty, trauma and multiple disadvantage. Some of the lenses used to explore these interconnections in the collection include gender, race, human rights and capabilities, age and Adverse Childhood Experiences, place and time, public health, the criminal justice system and Covid-19.

We also hope the collection encourages the reader to pause, reflect on, and have conversations about how we can better respond to these complex interconnections, as service providers, policy-makers, researchers, and people with lived experience, in more collaborative and systemic ways.

At Revolving Doors, we have already started some of these conversations, with many of our contributors discussing their essays at our regional lived experience forums, and reporting that these discussions have helped

to inform their thinking and understanding of the issues and potential solutions. Our lived experience members have also found these conversations valuable, learning more about existing research on the issues and having space to discuss important structural issues at the heart of their contact with the criminal justice system.

While we had initial concerns about how to cover traumatic subjects safely in online forums, our members emphasised the necessity of exploring challenging topics to work towards positive systems change. In response, we have worked closely with our members to further develop our online forum model to minimise the risk of discussions being re-traumatising while also providing space to discuss challenging topics. These conversations between our contributors and lived experience membership will continue through our upcoming series of podcasts, to be launched in early 2021, to further explore interconnections and our systemic responses to them.

In the collection's opening essay, **Dr Diana Johns**, Senior Lecturer of Criminology at the University of Melbourne, and **Jaime de Loma-Osorio Ricon** and **Dr Eric Dommers**, both practitioners working for a community hub, explore the interconnectedness of poverty, trauma and multiple disadvantage in a disadvantaged Australian neighbourhood. They argue that lenses of social ecology, therapeutic justice and a continuum of harm help to illustrate the processes by which exclusion and marginalisation become layered with shame, and how trauma and disadvantage become embedded across generations. They also illustrate how different kinds of interactions between practitioners, children and families, compared to current practice, are necessary for interrupting these processes of exclusion and marginalisation.

Next, **Professor Tracy Shildrick**, Professor of Inequalities at Newcastle University, reviews labour market, economic and political changes over the last few decades and the impacts these have had on rates of poverty and inequality in the UK. Through exploring the emerging impacts that Brexit and Covid-19 are having on the poorest in UK society, she investigates the question of 'where next for poverty and inequality in the UK' and for policies in mitigating this.

Dr Deborah Morris, Consultant Clinical Psychologist and Lead for the Centre for Developmental and Complex Trauma, St Andrew's Healthcare, and **Elanor Webb**, Senior Research Assistant at the Centre for Developmental and Complex Trauma, review the impact that models of trauma-informed care (TIC) have had on improving care and quality of life for people who have experienced trauma. They argue that while TIC models represent a positive advancement, they pay insufficient consideration to the gendered needs (across the gender spectrum) of those who have been exposed to trauma. TIC models also create artificial divisions between psychological and physical health needs. They put forward an inclusive gender-mainstreamed approach to address these shortcomings and to more holistically meet the needs of the diverse groups exposed to trauma.

Professor James Nazroo, Professor of Sociology at the University of Manchester, critiques how policy, public and academic understandings of race and ethnic inequalities are often based on everyday and common-sense understandings of what ethnicity represents, leading people to explain such inequalities in terms of supposed inherent ethnic differences. He argues that to inform more effective policy and practice responses to ethnic inequalities, a more robust approach to theorising racism is needed, an approach he proposes in his essay encompassing interconnected structural, interpersonal and institutional dimensions.

Dr Sarah Anderson, Lecturer of Criminology at Edinburgh Napier University, reviews existing literature and focuses on police contact and imprisonment to explore the roles that the youth and adult criminal justice systems in the UK play in perpetrating harm against people who often also have past histories of trauma. In doing so, she raises critical questions about what recognising the traumatising effects police contact and imprisonment could mean for criminal justice policy and practice in the UK.

Dr Michael Smith, Associate Medical Director of Mental Health and Addiction Services for NHS Glasgow, and **Katy Hetherington**, Childhood Adversity Lead for Public Health Scotland, explore the limitations of the Adverse Childhood Experiences (ACEs) model in explaining health inequalities in Scotland. They argue that considering ACEs within a capabilities framework, based on social justice, human connectedness and rights and freedoms, can help to inform a more effective public health response to the interconnections between poverty, adversity, trauma and multiple disadvantage.

Miranda Keast, independent researcher, explores, through her previous work with Fulfilling Lives Lambeth, Southwark and Lewisham (London), how a human rights approach, when combined with a capabilities lens, can be used by practitioners and policy-makers to inform more effective responses to people facing multiple disadvantage. Her recommendations, developed through discussion with practitioners from Fulfilling Lives, include the use of human rights impact assessments by practitioners, services providing greater flexibility, and for service providers to co-produce services alongside those who face multiple disadvantage as a way to help promote people's capabilities.

Finally, **Professor Antonia Bifulco**, Professor of Lifespan Psychology and Director for the Centre for Abuse and Trauma Studies at Middlesex University, critically reviews the different perspectives psychologists use for understanding childhood trauma and its impacts on later life. She argues that it is only by taking a multi-perspective view that we can better understand the impacts childhood trauma has across people's lives and provide more effective care to those who face, and have faced, such trauma. Based on her own research, she also illustrates how partnerships between academics and practitioners can help inform better care provision to adolescents looked after by the state.

1. Ministry of Justice. 2019. *Offenders convicted for indictable offences by previous criminal history, year ending March 2009 to 2019*. Table Q61. London: Ministry of Justice.

2. <http://www.revolving-doors.org.uk/file/2434/download?token=75C9zzC1>

3. <http://www.revolving-doors.org.uk/blog/new-generation-revolving-door>

Essay one

A continuum of harm: How systemic interactions can multiply and entrench complex disadvantage



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Summary

Introduction

Together, as academics and practitioners, we explore the interconnectedness of poverty, trauma and multiple disadvantage in one of Australia's most disadvantaged postcodes, which we call 'Redlands'. In showing how everyday encounters with adults in authority can cause harm, we take up the challenge to recognise the "impact of interactions with formal and informal social structures, institutions and processes upon the lives of children and young people" (Armstrong, 2004, p.110).

Literature review

We briefly review relevant literature on trauma, multiple disadvantage and social exclusion, outlining the Australian and local context to set the scene for our discussion.

Conceptual framework

We explain how we use the concepts of *therapeutic justice*, *social ecological theory*, and the notion of a *continuum of harm*, as a framework for our analysis.

Case studies, analysis and discussion

We draw on our work and practice experience in Redlands, using case studies to show how everyday encounters with authority unfold in the lives of children and families living with poverty and trauma, and how they can elicit reactions that exclude and punish. We explain how these interactions can normalise experiences of exclusion within families, and how trauma and disadvantage can become embedded across generations. We also show how interactions with children and families can become positive, and how therapeutic intervention can interrupt these patterns.

Conclusion

We conclude our discussion by highlighting the universal issues that Redlands illustrates, and the policy and practice implications of thinking and working through a therapeutic-ecological lens.

Funding

Victoria Government's Department of Education and Training funded the work we describe as 'Project Redlands' in this paper. A range of philanthropic funding has also been critical to developing the project since it began in 2017.

Everyday encounter #1: 'Sally'

Sally, a 35-year-old mother of five, attends her first appointment at the local health centre to develop a mental health care plan. Sally is accompanied by her community support worker, Helen. The doctor greets them both, invites them to sit down and asks Sally what has brought her to see him.

Doctor: Good afternoon, I'm Dr Smith. How can I help you today?

Sally: [announces loudly] I'm fucked in the head!

Doctor: Excuse me, Ms... we don't tolerate any abusive behaviour in this clinic. I'm sorry, we'll have to end this appointment.

Helen: Are you kidding doctor? She wasn't abusing anyone – she was just describing her state of mind!

Doctor: I'm sorry. We have a zero-tolerance policy. If you don't leave now, I'll have to call security.

Sally: It's OK Helen, my bad! Let's go...

action available at that moment with "if you don't leave now...", which serves to alienate doctor from patient and divest the exchange of human empathy.

Sally's apparent docility suggests she is used to being 'at fault' and being put down (literally and figuratively). Her low expectations of people, particularly those in authority (who may have let her down before), are thereby reinforced. This experience might shape Sally's willingness to engage with medical professionals in the future, and her belief that they might be trusted to help her. Perhaps more important, however, is the potential impact on Sally's family. Would she be likely to take her son 'Ted' to see a doctor following this encounter? What sort of assumptions might she pass on to her children?

To explore some of these complexities we apply a twin conceptual lens – combining *therapeutic justice* and *social ecological theory*. Using this lens, we firstly explain how everyday encounters with authority unfold in the lives of children and families living with poverty and trauma, and how they can elicit reactions that exclude and punish. Secondly, we show how, by amplifying and reproducing the effects of trauma, such interactions can normalise experiences of exclusion within families. This can embed trauma and structural disadvantage across generations and communities. Lastly, we draw on our experience working in Redlands to show, through this theoretical lens, how adult interactions with children and families can become the site of positive interaction and therapeutic intervention, which can interrupt these patterns. Before explaining these concepts and their implications further, we present a snapshot of a Redlands child's interaction with adults in authority.

Everyday encounter #2: 'Brayden'

12-year-old Brayden lives with his little brother and sister, his mum and his stepdad, Matt, who moved in a few months after Brayden's dad went to jail. Brayden is riding through the shopping centre on his scooter when two security guards tell him to stop. When he keeps riding, they grab him by his clothes to confiscate the scooter.

Guard 1: Hey, I've told you kids – no riding inside! I'll take that scooter...

Brayden: Piss off, you fuck'n dogs! That's mine!

Guard 2: If you want it back, you can come and get it later from the security office. But make sure you bring one of your parents.

Brayden: (Scared, mumbles to himself) Matt's not gonna like this...

Introduction

This paper explores the interconnectedness of poverty, trauma and multiple disadvantage in one of Australia's most disadvantaged postcodes, an urban neighbourhood characterised by entrenched social and economic deprivation, drug-related crime and family violence. For the purposes of our discussion, we will call this place 'Redlands'².

This setting highlights universal issues: how children growing up amid these (or similar) social conditions can be harmed, not only by the direct consequences of exposure to family and social adversity, but also through their own and their communities' entanglement and everyday encounters with services and systems – education, health, child protection and criminal justice – and with adults whose role affords them some authority. In this way, we take up the challenge to recognise the "impact of interactions with formal and informal social structures, institutions and processes upon the lives of children and young people" (Armstrong, 2004, p.110).

The snapshot of 'Sally's' experience above illustrates several things: the doctor's use of his title to assert his authority and to depersonalise the interaction, the use of the plural "we don't tolerate" and "we have a zero-tolerance policy", distancing himself from his actions, and the closing down of any alternative course of

Trauma, disadvantage and social exclusion

We adopt a deliberately naturalistic definition of trauma as "an overwhelming experience that can undermine the individual's belief that the world is good and safe" (Berry Street, 2013 in Brunzell *et al.*, p.64). We understand complex trauma as resulting from abuse, neglect or being subject or witness to violence, and that an individual's response to such experiences can have lasting effects on physiological stress-response systems and brain circuitry (Anda *et al.*, 2006; Perry, 2009; Shonkoff, 2010). Increasing recognition of the powerful, long-lasting effects of trauma on human development underpins the key tenets of trauma-informed practice: to avoid re-traumatisation and further harms; and to focus, instead, on building relationships of trust that, in turn, provide the medium for building mutual respect, reciprocity, and increasing psychological resources (Brunzell *et al.*, 2016).

Disadvantage has its roots in a complex interplay of factors, many of which have compounding effects. In Australia, around 12-14% of children live in poverty and around 19% of children in single-parent families live in poverty (Phillips *et al.*, 2013). Other factors linked to child disadvantage include: parental unemployment; mental illness, disability and chronic disease; family breakdown and dysfunction, including family violence; unstable accommodation; being Indigenous; and living in rural or remote parts of Australia where employment and access to services are limited (McLachlan *et al.*, 2013).

The most disadvantaged postcodes in Australia are marked by disadvantage that is multidimensional, embedded and persistent over time (DOTE, 2015). And, as the US National Scientific Council on the Developing Child (2004) reports, families who experience poverty, mental health issues, substance abuse and domestic violence are less able to provide their children with the material and psychological support they need to thrive. Similarly, an Australian Government report into deep and persistent disadvantage notes that gaps in the capabilities of children from disadvantaged families appear very early in their lives and set a trajectory for poor outcomes later in life (Productivity Commission, 2013).

Living amid entrenched and persistent disadvantage, where experiences of violence, abuse and neglect are also common, has obvious causal implications for high levels of trauma and for social exclusion, as children's and families' ability to participate in education and access to services and citizenship are limited (Wilkinson & Marmot, 2003, p.16). As Shonkoff (2010) explains:

When early experiences are fraught with threat, uncertainty, neglect, or abuse, stress management systems are overactivated, and the consequences can include disruptions of developing brain circuitry as well as the establishment of a short fuse for subsequent activation of the stress response that leads to greater vulnerability... (p.359)

Though Shonkoff links these biological responses to increased risk of chronic disease, we might equally connect them to vulnerability to further disadvantage and exclusion, given that "social exclusion also results from racism, discrimination, stigmatization, hostility and unemployment" (Wilkinson & Marmot, 2003, p.16). According to the World Health Organization, these factors result "in a continuum of inclusion/exclusion characterised by unequal access to resources, capabilities and rights which leads to health inequalities" (Popay *et al.*, 2008: 2). This highlights that the factors that lock individuals, families and communities into deep and persistent disadvantage are not only the experiences of trauma and disadvantage, per se, but also the societal and systemic reactions they engender. In this way, stigma and exclusion serve to perpetuate structural inequalities and add material harm to marginalised lives.

The local context

The place we call Redlands is one of Melbourne's consistently poorest suburbs, and one of the most disadvantaged in Australia. Its families experience markedly high levels of poverty, long-term unemployment, ill health, family violence, substance abuse, child maltreatment, intergenerational imprisonment and other indicators of multiple, deep-rooted, 'hard-to-shift' disadvantage (DOTE, 2015; ABS 2016). Redlands children generally show low levels of literacy and high rates of developmental vulnerability, conduct and behavioural problems, school refusal, disengagement, dropout and suspension, and referral to other schools and/or support services. Although known for its cultural diversity, as well as its wonderful stories of courage, resilience, generosity and solidarity, Redlands is a traumatised locality, plagued by troubling and relentless levels of entrenched poverty, illness, crime, drug abuse and suffering. For children growing up in Redlands, life can be extremely tough.

One example of local practice that seeks to address some of these harms is what we call 'Project Redlands.' In response to requests from local school principals, Project Redlands was established at the local community centre as a flexible learning programme for children at severe risk of disengagement from primary school because of poor school attendance or 'problematic behaviours,' including swearing, property damage, and violence towards adults and other children. Project Redlands was designed around the premise that students referred by local schools for severe emotional dysregulation were likely to have experienced trauma and a dysfunctional home environment.

Accordingly, the project includes a focus on working with parents, as well as three days a week of trauma-informed education drawing on therapeutic education models. These include Attachment, Regulation and Competency (Kinniburgh *et al.*, 2005), Collaborative and Proactive Solutions (Green, 2016) and the Berry Street Education Model (Brunzell *et al.*, 2016). These are strengths-based approaches that – based on empathic awareness of the effects of complex trauma

1. All names in this paper are aliases to protect the anonymity of real people living in the place we call 'Redlands.' The quotes, though not necessarily verbatim, reflect real conversations and situations witnessed and/or narrated by/to one or more of the authors, and recorded in their personal reflections. We've included these scenarios to illustrate common experiences in people's everyday lives in the setting we describe.

2. The *Dropping off the Edge* (DOTE, 2007, 2015) reports map postcodes across Australia by colour, according to various indicators of social and economic disadvantage. Blue is 'most advantaged'; green 'advantaged'; yellow 'disadvantaged'; and red 'most disadvantaged' (see maps by state or capital city: <https://dote.org.au>).

on children's development and behaviour – seek to build trusting relationships with children, over time, as the grounds for engagement in experiential learning. They seek not only to address self-regulatory and attachment deficits, but to build and strengthen children's psychological resources (Brunzell *et al.*, 2016).

Project Redlands' first principle is to do no further harm. A high staff-student ratio (often 1:1) allows a focus on providing a safe and nurturing environment, learning about each student's interests and aversions, building trust and creating an atmosphere of safety in the context of predictable, respectful relationships (Perry & Szalavitz, 2017). As Perry & Szalavitz (2017) affirm, the 'best' therapeutic intervention "increases the quality and number of relationships in a child's life" (p.80). Trauma science has thus informed and validated Project Redlands' approach to working with children. Less well understood, however, is how systemic interactions that fail to acknowledge these underlying issues may add or compound harms in the lives of already vulnerable children; and how these harms pervade families and communities. In exploring how trauma, disadvantage and social exclusion connect and reproduce each other, through the lens of therapeutic justice and social ecology (outlined below), we seek to deepen this understanding.

Therapeutic justice

Therapeutic justice draws on the field of therapeutic jurisprudence, which grew out of mental health law in the 1980s and has begun to shape justice-related practices around the world (Wexler, 2008). From this perspective, professional intervention in the lives of children and families can be *therapeutic* (helpful, supportive, strengthening, promote wellbeing) or *anti-therapeutic* (unhelpful, damaging, impairing, undermining) (Wexler & Winick, 1991, 1996). Responses to children's behaviour can be anti-therapeutic through action or omission: from "interventions that corrode the well-being, strength, and capacity of a community and its children" (Johns, 2018, pp.43-44), to a justice system that simply fails to address young people's mental health needs (Geary, 2013). Thus, every action professionals or adults in authority undertake or avoid can have either harmful or helpful (or neutral) effects on children in their charge or care.

This lens offers an important way of understanding harm: as a continuum along which seemingly benign actions are seen in terms of causes and effects that connect them to other more serious actions' causes and effects. For example, we can trace continuity between the abusive language of custodial staff using coercive, violent means of control and referring to young detainees as 'c*nts'³, and language used by teachers who describe difficult children and families as 'feral' (as we have observed). Both reflect degrees of contempt, disgust and disrespect for the young people in their care. Both represent behaviour antithetical to their role and responsibilities. Both cause harm, directly

or indirectly, through stigmatising, dehumanising and distancing. We can locate Sally's experience along the same continuum, in that her doctor's action – though superficially benign and ostensibly legitimate – potentially reinscribed imprints of Sally's traumatic history.

This notion of a continuum – connecting the 'ordinary' harms of everyday language or stereotyping to more serious harms of violence and abuse of power – is particularly relevant in the context of traumatised children because their hypervigilance and emotional dysregulation, due to previous negative experiences, can lead to further interpersonal conflict and communication problems with adults in institutional settings. Thus, traumatised children are both more likely to provoke harmful reactions *and* more susceptible to such harms. We explore this in further detail below.

The *continuum of harm* thus offers a way to conceptualise the complex relationships between poverty, violence, multiple disadvantage, the physical and psychological effects of trauma on child development, processes of exclusion and criminalisation (particularly of children and young people), and structural inequalities and the legacies of colonisation (manifest in racist assumptions and practices). Amid such complexity, everyday encounters with authority (by act or omission) too often add yet another layer of harm to people's lives. Importantly, in line with ethical principles of beneficence and non-maleficence (Jahn, 2011), this view obliges us to recognise and explain how harms can be perpetuated at both the macro and micro level.

A social ecological framework

To help us understand the interrelationship between children, families and their social environments, and the persistence of poverty, trauma and disadvantage over time, we also apply Bronfenbrenner's social ecological⁴ framework to our analysis. Bronfenbrenner (1994, 1995) described five nested systems or interrelated ecologies that comprise a person's social environment: the microsystem, mesosystem, exosystem, macrosystem and chronosystem.

The *microsystem* comprises the child and their relations with immediate family, friends, school and neighbourhood – those closest to them in proximity and influence. Microsystemic interactions directly shape the growing person's everyday experience and emerging identity through family relationships, power hierarchies, traditions, norms and preferences in the context of local community factors. The ecology of the local shopping centre, for example, includes being known as 'you kids' (implying 'troublesome') by the local security guards.

Mesosystems encompass "linkages and processes that connect two or more settings containing the developing person" (Bronfenbrenner, 1994, p.40) – relations between friends and neighbours, or between

home and school, for instance. On the other hand, *exosystems* comprise links between settings outside the individual – such as "between a young person's home life and a parent's criminal activities or social networks" (Johns *et al.*, 2017, p.7), or family interactions with services and agencies – which have an impact on the child.

The *macrosystem*, within which these ecologies are embedded, includes socio-political structures, cultural norms, customs and beliefs, operating nationally and globally, which shape the socio-cultural and economic resources and opportunities available at the local community level. Interactions between these four systems occur in a temporal context: the *chronosystem*. This relates to past, present and future: from the child's growth; to day-to-day changes in their home environment; to historic factors such as the impact of colonisation on Aboriginal lives.

In the context of trauma, this temporal aspect is important. Trauma fragments and disrupts memory and people's capacity to learn and self-regulate, through the processes outlined above (Anda *et al.*, 2006; Perry, 2009; Shonkoff, 2010). Therapeutic intervention, therefore, must take place over time, as Bronfenbrenner (1995, p.620) emphasised, "through processes of progressively more complex reciprocal

interaction". The interactions and interplay between these ecological systems, simultaneously and across time, thus shapes a person's development and sense of self. We see that a child's social 'environment' is not just a single setting but a constellation of interconnected settings, within which their development unfolds and is shaped via increasingly complex interactions. Children, especially, use these interactions to make sense of their world and their place in it. This gives us a way to understand how layers of trauma and complexity play out in people's lives and how therapeutic intervention may work to engage with those lives.

Through a combined *therapeutic justice-social ecological* lens, then, we can see how critical it is to understand the potential for harm that 'ordinary' interactions with authority might hold; and how everyday encounters can have a significant impact on the psychological growth and development of vulnerable children. Zooming in, through this lens, to understand the ways in which traumatised children are susceptible to harms and likely to elicit harmful reactions, we return now to Brayden, and then Sally's son, Ted. Both were enrolled in Project Redlands by local schools seeking support to manage their behaviour and to meet their learning needs.

Brayden

8.45am: Brayden is woken up by the screams of his baby brother, Josh. Josh has been crying for a long time but neither his mum nor Brayden's stepdad, Matt, are waking up after a big night. Brayden is exhausted after spending much of the night playing computer games, partly to distract him from the fear of violence caused by a loud quarrel between two of Matt's friends. He quickly prepares a bottle of formula for Josh, wakes up his sister Shanae and they get ready to go to school. There are no clean school T-shirts and no food to put in the lunchbox. He carries Josh to his mum's bedroom. When she wakes up, she gives him money for breakfast and something for the lunchbox and says: 'Off you go buddy, youse will be late for school. Love youse!'

On the way to school, Shanae asks him if he heard the fight last night. He doesn't trust Matt, who started living there a few months after his dad went to jail. He tells his sister: 'Just ignore them, he's a fuck'n junkie, and you should've been sleeping, stupid bitch!'

9.25am: He drops Shanae in her class. He is incredibly worried about her, his mum and all his siblings, afraid that something terrible will happen, and it will all be his fault again. Arriving in his class, he notices a few kids looking at him as he enters:

What are you looking at you fuck'n retard? I will freak'n punch you!

Brayden, what did we talk about yesterday? Mind your language mate, that's your first warning!

It's not fair sir, they were getting all cocky!

3.45pm: Brayden and Shanae walk past Redlands community centre where a youth worker greets them warmly...

Hi Brayden, hey Shanae! Brayden, how are you doing buddy? You're not looking all that happy!

I think I'll get in trouble when I get home, mister.

How so?

After school I was at the shops and the guards took my new scooter, they said to come back with one of my parents if I want it back. My stepdad won't like this!

What did you do?

Nothing, I was just riding, I swear! But I did tell them to fuck off when they grabbed me...

How about I come with you so that we can get the scooter?

Would you really do that?

Of course! Shanae, are you happy to hang around the centre until we come back?

3. As recorded in ABC TV's 4Corners (2016) 'Australia's Shame' documenting staff abuse of young people in the Northern Territory's Don Dale Youth Detention Centre.

4. Though Bronfenbrenner described a 'bioecological' framework in his post-1990s writing, we use the more general 'social ecological' model here to emphasise the relational over the individual, in line with our purpose.

Brayden's story – a therapeutic justice-social ecological analysis

Brayden's microsystem of home and family is disrupted, dysfunctional, barely able to meet his physiological (sleep, hygiene, food, physical safety) or psychological needs (emotional stability, love, positive attention). His day-to-day life is characterised by heightened levels of anxiety and hypervigilance, particularly around the adults in his home. His anger and aggression towards his sister reflect normalised levels of violence within these close relationships, as well as his concern for her safety (*"you should've been sleeping"*). His admonition to his sister to *"just ignore"* the adults' fight and that his stepfather's *"a fuck'n junkie"* also hints at the normalisation of drug use (and associated crime) in his world (exosystem). His dad being in jail is another example. It's a volatile ecology of pervasive harm.

As the eldest child, Brayden must support his siblings – Josh, a toddler, and Shanae, who also needs to be dropped off at school. His sense of duty and responsibility for looking after his younger brother and sister comes from fear about

safety – his own, his siblings' and his mother's. Although he is working hard to support his immediate family, the accumulated physiological and psychological stress affects Brayden's ability to function well at school, within the school grounds and the classroom. He sometimes operates on a hair trigger – a 'short fuse' (Shonkoff, 2010) – responding heedlessly and hot-headedly to staff and other students. His anxiety – and possibly shame that he is unable to keep his family safe – is manifest in his anger towards the classmates looking at him, and his complaint that *"it's not fair"* when he gets into trouble for swearing and threatening them.

Although he understands the (mesosystemic) normative values of staff and other students, he is aware that he can't always meet these expectations, and he reacts defiantly to any perceived threat or potential criticism. Despite these challenges, Brayden manages to retain composure when his teacher challenges him (an adult in authority, who addresses him firmly but respectfully), providing a 'moral' justification for his behaviour (*"they were getting cocky"*) while maintaining a respectful relationship (*"Sir"*). These microsystemic interactions suggest the teacher is setting clear behavioural expectations and boundaries to help Brayden try to meet them, helping to reinforce Brayden's

Sally's son, Ted

Ted is a kind and joyful 12-year-old, the eldest of Sally's five children. Like many kids growing up in Redlands, Ted's experience is one of complex trauma. He lives with his mother, his stepfather and his four siblings in a two-bedroom social housing unit. Both adults struggle with mental health concerns.

"I hate school": Ted's school experience has been extremely fragmented. Though never diagnosed with either an intellectual disability or autism spectrum disorder, he has attended a local mainstream school, a specialist autism school and another special education setting. Sadly, as none were able to successfully engage him, he spent more than 12 months at home. Towards the end of year 4, Sally enrolled him at one of the local partner schools, which subsequently referred him to Project Redlands.

Ted presented with severe language impairment, both receptive and expressive language difficulties and articulation delays. Frequently hyper-aroused, and verbally and physically aggressive, Ted showed high levels of distress, agitation and self-harm. His first weeks at Project Redlands saw many instances of Ted punching or slapping his head on hard surfaces, smashing windows, punching walls, threatening to smash equipment, fleeing the grounds and threatening to kill himself by running across the road. Daily challenges reflected Ted's previous classroom experiences. He energetically resisted formalised learning, especially literacy-related tasks, which elicited comments such as: "I hate school!", "Fuck this" and "I'm bored."

Over time, however, Ted's increasing sense of safety allowed him to settle into the rhythms of the Project Redlands space. As his relationships with staff and other students grew, Ted started to demonstrate a whole new side of his identity, ripe with humour, generosity, insight and imagination.

Building trust with Mum: While Sally always acted as a loving and protective mother, her capacity to engage with the education system was limited. She was suspicious of schools and agencies, possibly due to frustration with her son's situation and her own traumatic history. To start building trust, Sally was continuously welcomed into the learning space and, at the end of each day, the team always communicated Ted's successes to her, as well as any challenges.

Gradually Sally became more open to conversations about Ted's learning, and more willing to talk about common goals and the steps needed to achieve them, such as a behaviour management plan with boundaries and strategies shared between home and Project Redlands. Through this process, Sally also shared some of her own needs, and staff were able to connect her with and support her access to support services. Her decision to seek psychological help, and her request to be supported in this process by Project Redlands staff, was a major milestone. Sadly, however, as the opening vignette revealed, the medical practitioner's response was more harmful than helpful.

identity as a valued member of the class, notwithstanding his angry outburst. While we could see the teacher's 'first warning' rebuke as over-reactive (and thus potentially negative), overall Brayden's relationship with his teacher represents a *therapeutic* interaction (helpful, supportive, strengthening, promoting wellbeing), in stark contrast with regular *anti-therapeutic* experiences in his day-to-day life.

Brayden's local area (microsystem) offers some opportunities for him to interact with peers and relax a little, riding his scooter through the shopping centre. But even there he gets into trouble, having his scooter confiscated, which risks further trouble with his stepfather (potential mesosystemic harms). A positive aspect of his mesosystem involves the youth worker accompanying him to get his scooter back from the security guards, representing a parental figure where none is available (a helpful exosystemic interaction). This worker avoids making judgements and offers only assistance, including looking out for Brayden's sister, Shanae. Positive meso- and exosystemic interactions – between his family, youth worker and others in the local community – highlight the importance of therapeutic, non-harming actions to build a strong sense around Brayden that he has at least one reliable adult there to help him, to trust him to do the right thing, and to support him even when he's in trouble.

Sally and Ted's story – a therapeutic justice-social ecological analysis

Ted's home/family microsystem is complex and fraught, materially and emotionally. Sally and her partner struggle with their own mental health problems, and the five siblings share one bedroom, hampering the children's physiological needs for sleep, hygiene and regular meals. These factors have also made it hard for Ted's psychological needs to be met; for years his associated developmental needs have remained undiagnosed and untreated. His fragmented school attendance has impeded his learning and social development, so that Ted struggles to relate to adults and other children. Appearing to lack control over his emotions, he can be verbally aggressive and volatile, using self-harm as an avoidance measure and to display his emotional distress.

Sally appears to be equally ill-at-ease with authority figures such as school or agency staff in the local community (Ted's mesosystem). Over time, however, the welcoming attitude of the Project Redlands staff towards both Ted and Sally has helped establish trust and mutual respect. This has enabled staff to organise links with community agencies (potentially positive exosystemic links for Ted), including the medical centre.

The hostile reception that Sally encountered with the doctor (a harmful mesosystemic interaction) meant that her own trauma and personal and family mental health issues remain unaddressed. Sally's self-deprecation

and withdrawal masked her shame, which a more sensitive and skilled doctor may have perceived and responded to. That her suspicion and mistrust of authority figures may be reinforced has negative exosystemic implications for Ted, who may sense and emulate his mother's distrust of medical professionals. The doctor's attitude (possibly) reflected deep-seated class-based (macrosystemic) prejudice which may limit Sally's family's access to healthcare in the future. And while trauma and disadvantage continue to shape the family's everyday experiences of interacting with the world, their ability to participate socially and economically is also constrained. This is how macrosystemic factors play out in individual lives; how poverty, multiple disadvantage and trauma are interconnected and continually reinscribed, reiterated and rendered so difficult to escape. Fortunately, the therapeutic alliance that Project Redlands has managed to build with Sally and Ted has so far withstood this setback, buoyed by and modelling optimism, imagination and persistence.

Discussion

Our analysis of the social ecologies above highlights degrees of harm arising in Sally's, Ted's and Brayden's interactions with adults in authority. Their behaviours and reactions are illustrative of "early experiences... fraught with threat, uncertainty, neglect, or abuse" and the "short fuse" that can result (Shonkoff, 2010 p.359). Their experiences show that even harms perpetrated inadvertently, without malice or intent, can have significant and lasting impacts on children and adults living with complex trauma and who may be habituated to stigma, shame and marginalisation.

Such interactions can reproduce "racism, discrimination, stigmatization, hostility and unemployment" (Wilkinson & Marmot, 2003, p.16) which, by limiting people's access to services and social and economic participation, results in social exclusion. This, in turn, reinforces and entrenches multiple interrelated conditions of disadvantage, including ill health and poverty. Thus we have shown how individuals, families and communities become locked in deep and persistent disadvantage not just through experiences of trauma and deprivation per se, but through structural and systemic inequalities, institutional processes and failings they encounter, as well as interpersonal and societal reactions they elicit. The interaction of all these things can add material, psychological and symbolic harms to existing layers of vulnerability.

We also see that harm may be enacted unknowingly, perfunctorily or routinely. For instance, the shopping centre security guards were likely oblivious to possible harmful outcomes of confiscating a scooter from a child living amid volatility and violence. The doctor's automatic response to Sally's swearing may have embodied underlying prejudice and distaste, based on middle-class assumptions about decency and civility, which alienated him from his role and his patient. Numerous schools' failure to meet Ted's developmental, behavioural and learning needs could be seen to reflect the bias of an education

system geared towards the needs of children who fit a specific 'learner' model, which thereby excludes those who don't. Such examples hint at the institutional and systemic rigidity, risk aversion and inertia that operates at the macrosystem level to shape practitioners' default responses and implicitly constrain therapeutic practice.

There are other explanations, however. For people working in community settings, frequently characterised by unrelenting fiscal and professional scrutiny and pressure, daily stress and system failures can lead to compassion fatigue, which can give rise to misunderstandings, misinterpretations and ultimately to further harms. In addition, practitioners' own traumatic experiences – either direct (such as doctors being subject to violence from patients in the past) or vicarious (through daily exposure to others' trauma) – can trigger defensive responses that can be harmful to themselves and others, including colleagues and clientele. All these factors contribute to the cycles of harm that entrench and reiterate the conditions we have described, by generating ripple effects through people and places that persist through time.

Our *therapeutic justice-social ecological* lens and the *continuum of harm* notion give us a way to conceptualise the complex interrelationships between poverty, violence, multiple disadvantage, and the physical and psychological effects of trauma on human development, as well as a window into what we might call the 'soft' and 'hard' processes of stigmatisation, discrimination, criminalisation and exclusion. Importantly, this conceptual toolkit highlights two things: firstly, how harm can be perpetuated via macro- and micro-level processes, as well as the intricate interactions in between, in different temporal contexts; and secondly, that we need to recognise this interconnectedness, acknowledging harms of the past and present, to avoid reproducing further harms in the future.

Conclusion

Our contribution combines theoretical and practical insights from our collaborative work in and around the place we call Redlands. This setting highlights universal issues:

- The ways in which adults in authority interact with children and families can stigmatise, shame, alienate and thereby harm already vulnerable people's lives, adding layers of exclusion and marginalisation to existing personal and intergenerational trauma, and reinscribing patterns of shame, fear, violence, and dysfunction.
- Harm can be enacted inadvertently yet still have pervasive effects.
- Interventions frequently fail to acknowledge or address the impact of broader social factors and economic conditions on people's capacity to make changes in their lives.

Furthermore, our Redlands example has practice implications, showing how:

- Along a *continuum of harm*, we can connect seemingly benign actions or omissions with the harms of more explicit, obvious violence or abuse.
- Professional interactions can work to improve the lives of children and families who have experienced trauma and the multiple disadvantages of entrenched and systemic socio-economic inequality.
- Therapeutic intervention can take place through ordinary relationships of trust and respect, and everyday encounters with practitioners and adults in authority.
- A *therapeutic justice-social ecological* lens can help practitioners recognise and challenge the macrosystemic institutional and cultural biases that circumscribe their practices, to make their exo/meso/microsystemic interactions more inclusive, more responsive and more *therapeutic*.

Lastly, and perhaps most importantly, rather than seeing this neighbourhood in deficit terms, we can apply a *therapeutic justice-social ecological* lens to refract our view of Redlands and children growing up there, to see possibility, potential, growth and a future of radical inclusion.

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Essay two

Where next for poverty and inequality in the UK?



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Summary

Economically, the UK is an extremely unequal society. Low paid, insecure work was already widespread, but has become even more so over the last few years as labour markets have been deregulated. This has meant that many more people are struggling to meet basic, essential daily needs, despite in most cases having at least one family member in work. This economic disadvantage does not just hinder day-to-day life but permeates every aspect of life, through negative health and education outcomes and limiting life chances in general. Poverty and economic disadvantage are particularly damaging for children and young people. The scarring effects of poverty all too often follow individuals through into adulthood.

After the economic crash in 2008, the government imposed austerity measures in the UK, affecting those on low incomes most acutely, and making those experiencing poverty even poorer and more insecure. The UK also voted to leave the European Union (EU) in 2016, formally leaving in 2019. At the time of writing (October 2020) it is still unclear if any sort of deal can be agreed by the December 2020 deadline, leading to much economic uncertainty. The economic and political context in the UK was therefore already complex and volatile even before the global Covid-19 pandemic hit in early 2020. Whether the effects of the pandemic, lined up against the emerging impacts of leaving the EU, will prompt a change of direction on issues of poverty and inequality is uncertain – only time will tell. In this context lies the central question of this essay: where next for poverty and inequality in the UK?

Introduction

The UK is an economically unequal society. Research from the High Pay Centre has clearly and consistently exposed the huge gaps in workers' pay that, at least in part, underpin this economic inequality. In 2019, in research undertaken annually with the Chartered Institute of Personnel and Development (CIPD), the High Pay Centre reported that FTSE 100 CEOs took home a median pay package worth £3.61m – 119 times greater than the median annual wage of a UK full-time worker (£30,353). Furthermore, the highest paid FTSE 100 CEO received a total pay package of £58.73 million, 1,935 times the median annual salary of a full-time UK worker (CIPD/High Pay Centre, 2020). Yet, reference to median wages is somewhat misleading as an increasing number of people earn significantly less than the median wage and even the government's own statistics show that many adults in work are also unable to escape poverty (Department for Work and Pensions (DWP), March 2020). So it is not simply an issue that salaries vary so widely, but that for those at the lower end of the income scale it has become increasingly difficult to secure a decent, secure and regular salary that takes them away from poverty (Joseph Rowntree Foundation (JRF), 2016).

The labour market has altered significantly over the last few decades, with many pointing to increased polarisation between better quality work and jobs that are insecure and poorly paid, or often both. This reflects what Goos and Manning refer to as a polarisation between 'lovely' and 'lousy' jobs (2003). At the 'lousy' end of the scale are low paid and insecure jobs; jobs where too many people become trapped in what is sometimes known as the 'low-pay, no-pay' cycle, moving between work and unemployment often repeatedly and over many years (Shildrick *et al.*, 2012a). Low paid and/or insecure work (including the proliferation of zero hours contracts) is estimated to impact around five million workers and their families, a quarter of whom are 'key workers' (Living Wage Foundation, 2020). It is sobering to note that in-work poverty is now one of the main causes of poverty in households in the UK (Hick & Lanau, 2018; Bourquin *et al.*, 2019). So it is not difficult to see why Innes argues that in-work poverty has become 'the problem of our times' (2020, p.4). The unemployment benefit system has also been subject to much change over recent decades, with claimants having seen the value of benefits decline and the process of claiming becoming more hostile and debilitating than ever before, leading to a proliferation of food bank use, destitution and hardship (Garthwaite, 2016; Wright *et al.*, 2020).

This paper has three main sub-sections exploring this challenging context. The first looks at the general context of poverty and disadvantage in the UK. The second builds on this to look at the impacts of Covid-19 on poverty and inequality. The third and final substantive sub-section offers some thoughts on the future direction to mitigate against some of these inequalities.

The normalisation of poverty

The Joseph Rowntree Foundation, one of the key charities working to address poverty in the UK, defines poverty as when your resources are below your minimum needs. Thus:

Poverty affects millions of people in the UK. Poverty means not being able to heat your home, pay your rent, or buy the essentials for your children. It means waking up every day facing insecurity, uncertainty, and impossible decisions about money. It means facing marginalisation – and even discrimination – because of your financial circumstances. The constant stress it causes can lead to problems that deprive people of the chance to play a full part in society. (JRF, 2016, p.4)

The JRF updates its Minimum Income Standards annually, outlining what different family types need to reach a minimum standard of living. Importantly, the calculations are based on what the general public think is necessary for a minimum standard of living. Every year their analysis finds that many families and individuals are falling well below what the public perceive to be needed to live (Davis *et al.*, 2020). Poverty, as both a concept and a condition, is rarely properly understood in the UK. Many people hold the view that poverty is something associated with developing countries and not something that is readily observed in their own country (Shildrick & MacDonald, 2013). It is also difficult to understand that poverty exists given the general wealth of our country and it is simply the case that people, quite understandably, tend to compare their lives with those around them who are often in relatively similar financial situations (Shildrick & MacDonald, 2013). This tends to mean that even those who are experiencing poverty – sometimes deep poverty – prefer to distance themselves from it and describe themselves as 'just managing' or 'getting by' or simply being just a 'bit hard up' (Shildrick & MacDonald, 2013). A strong part of the reason for this is the stigma and shame that is associated with any sort of economic disadvantage in the UK. This prevents any factual and serious understandings of disadvantage and its causes (Tyler, 2020).

Where poverty is acknowledged, both political and popular explanations in the UK tend to focus on poverty as being a problem that people bring on themselves through laziness and a lack of interest in work. In so doing, claims are made that 'the poor' constitute some sort of 'underclass' (Murray, 1990). Despite little, if any, foundation in evidence (Tyler & Jensen, 2015; Tyler, 2015; Welshman, 2013) these popular discourses have much purchase both with the general public and, particularly over recent years, have done much to feed political and policy discourse and decision-making. As a result, unemployment policy has tended to work on the presumption that those out of work need to be forced towards the labour market by a punitive out of work benefit system (Wright *et al.*, 2020).

By contrast, discussion of the real causes of poverty – low paid, insecure employment and inadequate support via the out of work benefit system – are rarely discussed in either public or popular debate (JRF, 2020). Thus, it is frequently seen as justified that those who need to

claim out of work benefits are subject to increasingly harsh forms of conditionality. Recent research by Wright *et al.* (2020, p.284) highlights this harsh conditionality. They found that claimants found visiting the job centre "intimidating and criminalising" and reported feeling "humiliated, angry, despairing and resentful". While participants in the research were not against conditionality and reciprocity in principle, they were often left with feelings of "shock, confusion" and "fear and shame" as a result of encounters with the out of work benefit system.

These findings are consistent with a large body of research that shows that claiming out of work benefits, far from being a welcome experience, is something that claimants overwhelmingly prefer not to do and indeed will avoid if at all possible, even if making a claim is necessary for their livelihood (Shildrick *et al.*, 2012a; 2012b; Garthwaite, 2014; Garthwaite, 2015a; Garthwaite, 2015b; Fletcher *et al.*, 2016; Fletcher & Wright, 2017; Fletcher & Flint, 2018; Fletcher, 2019). The widespread use of sanctions, sometimes leaving people destitute, has been described as 'cruel and degrading', causing untold damage for individuals and families and in some cases even contributing to the death of claimants (Wright *et al.*, 2020, p.279). The rhetoric the current government employed in the early days of welfare reform, particularly the then Secretary of State for Work and Pensions Iain Duncan Smith (2010-2016), regularly involved divisive but politically effective sound bites referring to people "languishing behind closed curtains", while their neighbours headed out to work. These rhetorical political tools, or what I call 'poverty propaganda' (Shildrick, 2017), did much to capture the public's imagination and foster consent for welfare reforms that are harsh and unforgiving, particularly for those already poorest in society.

The impacts of these welfare reforms were evaluated in November 2018 when the United Nations Special Rapporteur on Extreme Poverty and Human Rights visited the UK with his team of researchers. After gathering evidence from many working on the front line across the four nations of the UK, as well as researchers and academics, the conclusions of the Rapporteur and his team were clear, both on the scale of poverty in the UK and its causes:

Although the United Kingdom is the world's fifth largest economy, one fifth of its population (14 million people) live in poverty, and 1.5 million of them experienced destitution in 2017. Policies of austerity introduced in 2010 continue largely unabated, despite the tragic social consequences. Close to 40% of children are predicted to be living in poverty by 2021. Food banks have proliferated; homelessness and rough sleeping have increased greatly; tens of thousands of poor families must live in accommodation far from their schools, jobs and community networks; life expectancy is falling for certain groups; and the legal aid system has been decimated. The social safety net has been badly damaged by drastic cuts to local authorities' budgets, which have eliminated many social services, reduced policing services, closed libraries in record numbers, shrunk community and youth centres and sold off public spaces and buildings. The bottom line is that much of the glue that has held British society together since the Second World War has been deliberately

removed and replaced with a harsh and uncaring ethos. A booming economy, high employment and a budget surplus have not reversed austerity, a policy pursued more as an ideological than an economic agenda. (UN, 2019, p.1)

Added to this bleak assessment, it has been argued that, when measured against the current value of UK Gross Domestic Product (GDP), the negative economic impacts of Brexit will be two to three times greater than the effects of Covid-19 (Sampson, 2020). While the economic impacts of both remain hard to precisely predict, the pandemic coming on the back of the critical period of leaving the EU can only be doubly challenging. It is to the specific impacts of the pandemic on poverty and inequality that this paper now turns.

Covid-19, poverty and inequality

It was against the challenging backdrop described above that at the start of 2020 the Covid-19 pandemic started to take hold and spread across the globe. As the pandemic has progressed it has become ever clearer that existing inequalities are being exposed, and further that the pandemic has badly exacerbated these inequalities.

At the time of writing (October 2020), the UK is grappling with the widely predicted second wave of the pandemic. The death rate in the UK remains high in comparison to other countries, particularly in Europe (Office for National Statistics (ONS), 2020a) and all indications are that the pandemic will remain with us for the foreseeable future. The pandemic greeted an economy that was already weakened by the global economic crash in 2008, subsequent austerity measures and the vote to leave the EU, so unemployment was rising even before the pandemic hit (Lynch, 2020). As the pandemic unfolded the country moved into a semi-lockdown. (Although frequently referred to as a full lockdown, many key workers continued to work and the 'rules' were only loosely enforced, meaning compliance was varied. In many other European countries lockdowns were tighter and more strictly enforced.) Nonetheless, this period of partial lockdown had a huge economic impact whereby the UK economy shrank by a record 20.4% in April (ONS, 2020b).

As the UK started to open up, at least to a degree, over the summer, there were some signs of slight recovery, but certainly not to the extent hoped for. Evidence showed the UK economy grew by 2.1% in August 2020, significantly less than the 9.2% it grew in February 2020 (ONS, 2020c). Even at the start of the pandemic, when at least a significant number of workers were protected by the government's Job Retention Scheme, it was clear that many people very quickly joined the ranks of the unemployed:

Claimant unemployment – a measure of all of those who are unemployed and claiming social security benefits – has risen by 1.6 million in two months to 2.8 million. This is the highest level since 1993, 1.2 million higher than the last recession and the largest increase since unemployment benefits were created nearly 100 years ago. (Wilson, 2020)

All predictions are that job losses will continue and likely accelerate leading the UK into a deep recession that could last for some time (Hensher, 2020). As Bangham and Leslie (2020) argue, it is also important to note how such a recession is likely to particularly affect those who are already the most disadvantaged in society:

Many sectors of the economy have been effectively closed following the outbreak of coronavirus, and a third of private sector employees have been furloughed. For workers adversely affected by the crisis, financial savings have a key role to play in maintaining living standards: wealthier families can dip into their savings to make good lost income; but those without social buffers have to find other ways to make ends meet via the social security system, or via family and friends. (Bangham & Leslie, 2020, p.8)

As the quote above illustrates, unemployment and job losses are not being equally felt across UK society. Evidence tells us that particular groups tend to be more vulnerable to both unemployment itself and the scarring effects of unemployment into the future (Gardiner *et al.*, 2020). Younger and older workers tend to be impacted badly in times of recession and the same has been true during the Covid-19 pandemic (*Ibid*). Gustafsson (2020) reports that "one-third of 18- to 24-year-old employees (excluding students) have lost jobs or been furloughed, compared to one in six prime age adults, with these experiences more common amongst employees in atypical jobs". The Resolution Foundation recently looked at the likely generational impacts of the initial phases of the pandemic. The report makes for sobering reading, particularly in a period when the prospects for poorer young people were already declining compared to their parents:

*It appears that post-lockdown impacts may be more clearly tilted towards the bottom of the age range. By July, younger adults had become the most likely to fall behind with housing payments; young people risk long-term employment and pay 'scarring' effects from starting careers in a downturn; the prospects for a post-coronavirus home ownership increase among aspirant buyers appear limited; and the removal of temporary welfare boosts looks set to provide a major drag on the incomes of young and childrearing-age adults. (Gardiner *et al.*, 2020).*

Evidence also suggests that job losses will continue to grow, with some sectors much more badly affected than others. Hospitality, tourism and travel have been particularly hard hit (*Ibid*). Rapidly growing rates of unemployment have also been reflected in the increases in claims for out of work benefits, with 3.2 million individual claims being made between the initial partial lockdown in March and June (DWP, 2020). But it is not just the economic effects of Covid-19 that are being felt unevenly. It has become clear that some groups are more at risk from the health impacts of Covid-19 than others. A Public Health England (PHE) report into the differing impacts of the virus highlights how older age, ethnicity, male sex and geographical area, for example, are associated with the risk of getting the infection, experiencing more severe symptoms and higher rates of death (PHE, 2020). Most of these risk factors follow pre-existing economic inequalities in the UK. Even

before the pandemic it was clear that particular groups, as well as those living in particular parts of the country, experience poorer health outcomes (Marmot, 2020). The preliminary research at the time of writing noted that:

Comparing to previous years, all-cause mortality was almost four times higher than expected among Black males for this period, almost three times higher in Asian males and almost two times higher in White males. Among females, deaths were almost three times higher in this period in Black, Mixed and Other females, and 2.4 times higher in Asian females compared with 1.6 times in White females. (PHE, 2020)

Furthermore, social class is important, as those from poorer backgrounds have also been found to be more at risk of the disease (PHE, 2020). This is not surprising in many ways, given what we know about pre-pandemic health inequalities for those on lower incomes (Bambra *et al.*, 2020). Yet, the official statistics, which can only ever tell part of the story, are as sobering as they are depressing. They show that those in deprived areas are over twice as likely as those in less deprived areas to die from Covid-19 (ONS, 2020d). Ethnicity and income inequality have also been found to be independently associated with significantly more negative outcomes.

The exact reasons for these differences will only become clear in time, if at all, but some things are already known. Not only do those on low incomes tend to have poorer health in general, they are also concentrated in the sorts of jobs that have been shown to be more at risk for contracting Covid-19. Those working in the care sector, particularly care assistants and nursing auxiliaries; those who drive passengers in road vehicles, including taxi and mini-cab drivers and chauffeurs; those working as security guards and in related occupations; and those working in care homes have all been shown to be at higher risk for contracting Covid-19 (ONS, 2020e). For both BAME communities and those on lower incomes the precise analysis of what has happened will be complex, but as PHE (2020, p.4) points out: "Covid-19 has replicated existing health inequalities and in some cases increased them."

The ongoing impacts of Covid-19 are likely to be negative, multiple and long-lasting for families on low incomes. The impact of loss of life, possibly of key earners and/or major parenting figures, will be long-lasting, perhaps across multiple generations. For example, it was reported that in a school in Middlesbrough, an area of the UK with high levels of deprivation and one of the highest incidence rates of Covid-19, at least 40 pupils had lost a relative to Covid-19, including parents in their 30s (Look North, June 2020).

There is little research into the impact of such bereavement on children and young people. However, what is out there shows that bereavement can have significant impacts (not only, but mostly, negative) on young people's longer-term life trajectories (MacDonald & Shildrick, 2012). Again, this is a hidden dimension of what it means to experience poverty in the UK, with those in poverty more likely to experience bereavements of people dying prematurely and not from old age (Marmot, 2020), a trend with a history long before the pandemic. The impact of not being able to say proper goodbyes, either in the last

days of that person's life or through the traditional funeral gatherings as a result of social distancing rules, is also likely to have long-term effects on children and young people.

Additionally, existing research has shown how children from poorer backgrounds have long been disadvantaged in our education system (Reay, 2017), with Covid-19 exacerbating these inequalities. For example, research shows that already disadvantaged groups (those in receipt of free school meals, from lower educated and single parent families and those from certain BAME backgrounds) have been found to spend significantly less time on school work during lockdown than those from more affluent families (Bayrakdar & Guveli, 2020).

Indeed, the pandemic has worsened the situation, as 1.1 million more people face poverty at the end of 2020 as a result of the Covid-19 pandemic. The Institute for Public Policy Research (IPPR) recently found that over 200,000 more children are likely to be affected by poverty as job losses continue to hit families (Parkes & McNeil, 2020). For many families, life was hard before Covid-19 and without targeted policy interventions it will only get worse if the pandemic, and the systemic inequalities that preceded it, are allowed to proceed unchecked.

Where next for policy to address poverty in the UK?

In many respects, the UK is at a critical moment. We have left the EU, and with or without a deal, the repercussions will be lasting and momentous. The Covid-19 pandemic is also likely to continue for some time along with all of the issues and uncertainty it has thrown up, and will continue to throw up, in its wake.

As outlined earlier in the essay, the UK was following a particular political and policy path when the global Covid-19 pandemic hit in early 2020. Economic inequality was rife and deeply embedded, and poverty was widespread. In-work poverty is also now the main cause of poverty in households of the UK. As Judge and Slaughter argue, "welcome to the age of in-work poverty" (2020, p.4). Tackling the injustice of insecure and poorly paid work must be a priority for reasons of fairness and social justice. There are some, albeit small, signs that an awareness of the problem of 'poor work' is coming onto the political agenda, although efforts to properly tackle it have been slower to materialise.

The Taylor review (Taylor, 2017) was commissioned by the government, led by the then Prime Minister Theresa May, because of concerns over this noted increase in insecure work. The conclusions were clear in that significant change was required to tackle the growth in exploitative employment practices. The Good Work Plan (Ferguson, 2020) followed at the end of 2018, seeking to adopt 51 of the 53 recommendations made in the Taylor Review. Yet, progress in adopting these has been tediously slow. A review of progress on the Good Work Plan published in 2020 shows that in reality only six have been acted upon,

although discussion and consultation continue and further progress may well yet be made in the coming years, albeit nowhere near as quickly as needed (Ferguson, 2020).

In a departure from political rhetoric and policy, the Covid-19 pandemic has shown how state investment can be used to support workers, provided there is political will to do so. The Job Retention Scheme has meant that many people have, at least in the short term, retained their jobs and a significant part of their income. Transport was also heavily subsidised so trains and buses could continue to run. But as Jarvis points out, all this investment was directed to private companies, as the bus and train companies, as with most public services, had fallen into private hands over the last decades of neoliberal policies (Jarvis, 2020). This policy of privatisation could change, as Jarvis notes: "The public has become far more aware of just how vital our public services are – and just how vulnerable they are to shocks, and how ill-prepared privatisation has left them for crisis." We could therefore start to see a shift in public opinion in the coming years against privatisation of public services, and perhaps in turn associated shifts in governmental policy.

As the numbers claiming Universal Credit (the UK's social security system) soared because of Covid-19, changes were also rapidly implemented. Claimants were no longer required to attend in person, and while this move was made to relieve the pressure on the system rather than the claimants, it did show how quickly changes can be made if there is a will to do so. The inherent unfairness of recent welfare policies is also being quietly exposed as more and more people are turning to the welfare system, many of whom have never before claimed out of work benefits.

For example, the two-child limit that came into effect in 2017 meant that families were no longer able to claim child benefit for any third or subsequent children, support for an out of work couple with three children fell by at least £80 a week in real terms between 2010/11 and 2019/20 (Sefton *et al.*, 2020, p.5). The policy, as with many changes to the welfare system brought in over recent years, resulted in lowering incomes for families, just when they were facing difficult life challenges. The policy was based on a very simplistic understanding of how family and life planning works – and sometimes doesn't – for all families. Unforeseen circumstances can affect any of us, and it is perhaps this that Covid-19 has illustrated so clearly. As one of the respondents in Sefton *et al.*'s work on the two-child limit put it:

*Everything was okay up until the Covid-19. We had our own business and were paying to look after our own family with no benefits. Now our income is zero, so it is hard to manage with four kids. Just so gutted that coronavirus has happened. (Couple, four children, not working, North East) (Sefton *et al.*, 2020, p.11)*

Whether the influx of people claiming out of work benefits will help challenge the stereotypes of the 'welfare scrounger' outlined earlier in this paper remains to be seen. There is, of course, a danger that it could serve to harden attitudes towards the supposed lazy scrounger as 'the other' that everyone wants to distance themselves from (Shildrick & MacDonald, 2013). It is this sort of divisive politics that has dominated in the UK for some time.

In recent years, traditional political affiliations have seemingly disintegrated as voters grapple with frequent elections, and political allegiances that were once taken for granted seem to have withered and waned (Curtice *et al.*, 2019). The vote to leave the EU was in many respects indicative of this political uncertainty and flux. So momentous and impactful has the referendum and its result been for the UK that 'leaver' and 'remainer' identities have become "new political and social fault lines" (Curtice *et al.*, 2019, p.13), leaving a nation divided at a time when unity seems more important than ever. Some have argued it was the impoverished communities (like many in the North East of England for example), the so-called 'left behind' that were largely responsible for the leave vote. Research has shown that while the reality is more complex, groups who feel locked out of the benefits of capitalism, residing in deprived communities who often feel 'left behind' (Goodwin & Heath 2016) were more likely to support leaving the EU. As research has shown, there is no shortage of anger and frustration as well as first-hand knowledge of the lack of opportunities in these communities, for example, in parts of the North East, and other impoverished areas up and down the country (Shildrick, 2017). That for some people the anger at their lack of opportunity was directed towards the EU is perhaps unsurprising, given the leave campaign's emphasis on the magnificent-sounding sums that might come back to the UK (Stone, 2018).

In the most recent general election in December 2019, analysis indicated that a Conservative majority was enabled by an influx of votes from what were seen as traditional Labour heartlands, the so-called 'red wall'. The vote was largely driven by the 'get Brexit done' mantra that Boris Johnson used to seemingly convincing effect, along with promises of inward investment and a greater commitment to 'levelling up', particularly in parts of the North. Recent research by the Resolution Foundation has found that many households in the so-called 'red wall' stand to lose around £1,000 a year under forthcoming proposed cuts to welfare due to come in in April 2021 (Bell *et al.*, 2020), so support may be fragile and fleeting unless promises of levelling up turn into concrete actions.

What has also happened over recent years is that many issues of inequality, inequity and injustice have come to the fore, but rather than being shared concerns, they have fractured opinions and fostered further division. Those experiencing poverty and work-related disadvantages (the 'low-pay, no-pay' cycle) demonise others in similar situations, resorting to popular tropes (also frequently deployed by some politicians) to label others as workshy and as claiming benefits fraudulently (Shildrick & MacDonald, 2013). Drawing on stereotypes might be easier than grappling with the complexities of the labour market, for example, but it is also useful for political parties wishing to steer public opinion away from issues that government could address and instead keep the focus very clearly on the individuals affected.

The Black Lives Matter campaign provides a recent and timely apposite example, where deep-rooted injustice and discrimination seems disconnected from the wider structural context in which racism flourishes and can be exploited for political gain (as it was by the leave campaign in 2016). As the Runnymede Trust and the Centre for Labour and Social Studies (CLASS) have argued in their important race and

class toolkit, all too often issues of disadvantage and structural inequality can cut across both race and class (for example, poverty, poor access to services, housing and health services):

Ordinary people in the UK have been actively held back by precariousness, lack of voice, prejudice and loss of community space; from the rural towns of Northern England to the tower blocks of London. Instead of seeing their voices and struggles centred on the political agenda, communities have been divided and pitched against one another in the public debate, often along the lines of Brexiteers/Remainers, deserving/undeserving, British/foreigner, white/BAME, white/migrants. 'Divide and rule' tactics have fuelled scaremongering and prejudice against migrants and people of colour and distracted us from addressing the urgent issues facing communities today: a rigged system privileging a wealthy few at the top. This needs to change. (Runnymede Trust and CLASS, 2019)

The 'divide and rule' tactic referred to above is divisive but it is also politically useful to those who have power and wealth in a society such as ours to maintain these divisions. Being clear on the causes of poverty and the inequalities in both opportunities and who has access to them might lead to the electorate accepting – and demanding – different political decisions.

The idea that welfare dependency is widespread and that poverty is caused by individual failings is also well embedded in our political system. For too long there has been a narrative perpetuated, at times, by all political parties and the media that individualises blame and stereotypes people. This has been particularly pronounced in politics since 2010, but it is not new. The causes of poverty are inadequate social security (that supports people properly when they need it), and increasingly the failings of the labour market that keep working individuals and families in poverty. It is telling that over half of care workers are paid below the real living wage and they are five times more likely to be on a zero hours contract (Shaheen & Jesse, 2020).

Frances O'Grady, leader of the Trades Union Congress, has said the Covid-19 crisis might be a turning point in our history. She argues that it should be, not least because it made visible the previously invisible army of low paid essential workers. She argues that when we look back and reflect on the pandemic, "many of our stories will be about the working people who kept Britain running, frontline workers who put their own health on the line to look after the rest of us", many of whom were also low paid (O'Grady, 2020). Whether the tide will start to turn remains to be seen. The upsurge in caring for our neighbours that has taken place in virtually every corner of our country and the clapping for the NHS may well be forgotten in the economic and social pain that will inevitable follow in the coming years. As Reay points out:

Keeping people stuck in segregated areas, in demeaning jobs without sufficient income and consigned to a life with little hope and prospect that things will get better can breed racism and bigotry, ignorance and narrow-mindedness. Such attitudes have nothing to do with the intrinsic qualities of the people themselves and everything to do with the consequences of their circumstances. (Reay, 2017, p.197)

Conclusions

I have written this paper at a time of deep uncertainty and change, when the UK looks increasingly insular, troubled and isolated in a world that is in turmoil. But, there is an opportunity for change. It won't happen overnight, perhaps not in my lifetime, but we have an opportunity to start to recalibrate and focus more on what sort of society we want to be. Never has the international comparison of lives and life experiences been so readily exposed as through the Covid-19 pandemic, as different countries' approaches have been compared and picked over for better or worse. Change is coming whether we like it or not. Whether that change will be for the better will lie with the decisions made by those elected to represent us, but we can all play our parts. We can highlight injustices, challenge prejudice and misguided political rhetoric, and press for policy decisions that are in all of our interests, not just for the few.

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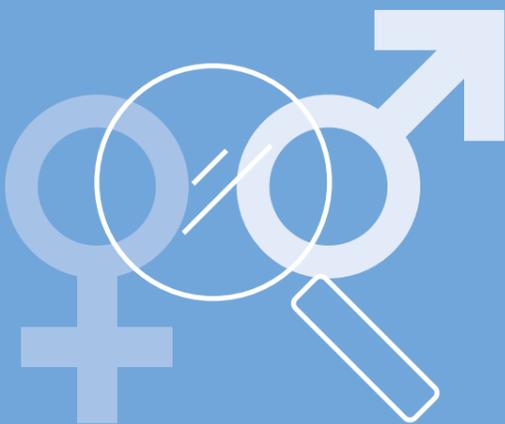
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Essay three

Understanding multiple inequalities and trauma needs through a gendered lens: The case for inclusive gendered approaches to trauma-informed care



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Summary

Introduction

Increased recognition of the lifelong impact of trauma has led to the development of 'trauma-informed' models of care within mental health services. Such models are a welcomed and much needed initiative. Trauma-informed care (TIC) has the potential to improve outcomes of care and quality of life for people who have experienced trauma.

However, while TIC models represent significant advancement, they have largely evolved outside of consideration of the gendered nature of those exposed to trauma's needs.

Limiting efficacy by failing to recognise gender's key role

Failing to consider the key role of gender at all levels of national policy and service development, delivery and evaluation arguably limits the efficacy of these approaches. National policy and service development also tend to perpetuate the artificial division of psychological and physical health needs resulting from repeated trauma exposure.

Recognising gender needs across the spectrum

Equally, it is important that approaches recognise, reflect and include different gendered needs across the gender spectrum. The lack of consideration of an inclusive approach to gender contributes to the continued invisibility of males and gender minority groups in trauma literature and services.

Conclusion

Through adopting an inclusive, gender-mainstreamed approach that ensures gendered budgeting, commissioning and workforce planning, TIC services will be better placed to meet the holistic needs of the diverse populations they serve.

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Introduction

Exposure to trauma and its enduring impacts is a significant humanitarian, social and economic concern. Increased awareness of trauma has been mirrored in attempts to develop trauma-focused treatments and embed 'trauma-informed care' (TIC) models in mental health settings. Broadly defined, TIC and specialist trauma services reflect organisational frameworks that recognise and give eminence to the profound consequences arising from facing adversities such as exposure to abuse and violence, and homelessness.

These models, however, largely evolved in a vacuum where the policies, structures and scope of services that seek to respond to trauma needs gave limited considerations to key intersections such as gender and race. While gender is one of many intersections that has profound impacts over the lifespan, adopting a gendered approach to trauma care provides an encompassing and transformative *anchor* for services to develop holistic approaches and reduce fragmentation of services. The failure to consider gender as an inclusive construct at all strategic and operational levels and stages of care is arguably a key limitation in current 'trauma-informed' services, affecting people across the gender spectrum.

Part one of this essay will summarise evidence outlining the gendered experiences of trauma, demonstrating the need for a comprehensive gendered approach to trauma care. Part two will outline the challenges this evidence poses for traditional, and current, trauma-informed care models. Finally, to conclude the essay, we outline how a gendered approach to trauma can be implemented to ensure that services are equitable and accessible to all.

Part 1: Gender, gendered needs and multiple inequalities

The focus of any discussion exploring gendered trauma firstly needs to address the complexities in defining gender, in order to adopt an inclusive approach that delineates needs across the gender spectrum.

Gender has, historically, been considered synonymous with biological sex, and explored largely within agendas focusing on female¹ inequalities. In recent years, definitions of gender have been revised and are now rooted in social constructionism. The scope of investigation for gendered needs has also been extended to include the experience of males, transgender and non-binary² populations, and

additional intersections of race, disability, class and age. Drawing on inclusive definitions³ we offer the following definition of gender, which we use as the basis for this essay:

Gender refers to [expected] socially constructed roles, [valued] attributes and identities that society considers [appropriate] for women and men. Gender roles are thus considered learnt, to a degree socially imposed, and context- and time-dependent, and as such, are changeable according to societal developments. In addition, and as noted by Stonewall, while people are born and assigned a female or male [sex] at birth, it is through social influence that they learn to be girls and boys who grow into women and men. The distinction between gender and sex is acknowledged, as is the distinction between assigned sex at birth and self-identified or self-categorised gender, which may also reflect non-binary and fluid identities.⁴

Gender has certainly evolved into an expansive and politicised construct. Definitions of gender are not purely academic, and debates around characterisations of gender have a profound impact on people's legal rights, their sense of place in society and on government policy. Although encouraged, debates can, at times, become focused on circular discussions about *what* constitutes gender at the expense of exploring its *impacts* on an individual's place in, and experience of, society. The stance we take in this essay is that gender, in all its defined forms, can exacerbate structural inequalities and amplify marginalised status; in particular, in ways that increase the risk of being exposed to trauma and its enduring effects. As such, we argue that trauma-related services can best support people when anchored in a gendered approach.

Why gender matters: the evidence for a gendered approach to trauma

Analyses of different social identities show that gender, including male, female, trans and non-binary statuses, significantly contributes to the risk of trauma exposure, and our understanding of that risk. Inequalities arising from gender are complex and multi-layered, with the presence of intersections, such as race, either deepening or elevating its impact. Adopting a gendered approach to trauma is *not* to suggest a hierarchical relationship whereby one inequality is given primacy over others. Instead, this approach views gender as an *anchor* from which the needs of wider social inequalities can also be considered, allowing for a more inclusive and responsive model of care.⁵ Key evidence demonstrating the importance of adopting gendered approaches to care will now be considered.

Statistics have long revealed that, across the lifespan, females experience greater exposure to events that can traumatise in childhood and adulthood, including physical

and emotional neglect and parental mental illness (Haahr-Pedersen *et al.*, 2020). Females are also comparatively more likely to experience prolonged and repeated exposure to trauma (Kimerling *et al.*, 2018), including more severe forms of aggression within relationships (Chapman & Gillespie, 2019). They are also more likely to experience sexual and labour trafficking and contraception coercion, particularly those who are homeless, refugees or from ethnic minority groups (Gerber, 2019). Additionally, emerging evidence suggests the risk for exposure to familial and domestic violence may also be especially high for trans-females (McKinnish *et al.*, 2019). The prevalence of trauma is also significantly increased in females who encounter mental ill health and the criminal justice system, with females in secure services⁶ reporting increased exposure to childhood trauma and repeat victimisation in adulthood (Dolan & Whitworth, 2013).

Such increased risk occurs in the context of differential social inequalities experienced by male and females, which further impact on the prevalence of trauma and associated treatment needs. Globally, females experience comparatively greater social inequalities including lower socio-economic status. This status also has a greater impact on mortality, compared to males (Kimerling *et al.*, 2018). Furthermore, entrenched socio-economic inequalities echo through healthcare policies, with wide-ranging analyses suggesting that healthcare policies invariably reflect the dominant (male) gender and (white) cultural groups in society (Morgan *et al.*, 2018; Council of Europe, 2020). As a result, gender inequalities in health systems in relation to roles, finances, service models, values and quality assurance can lead to inappropriate service models and allocation of resources which ultimately perpetuate existing inequalities and fail to address the health needs of all sections of society.

Simply put, gender inequalities in health policies may be reflected by higher incidence of trauma symptoms in females. The direct consequences of social inequalities and their impact on trauma are evidenced by the examples of reproductive policies, legal frameworks around sexual violence and policies and practice relating to intimate partner violence. For example, in the US, states that protect women's reproductive rights and report lower gender inequalities also report lower levels of Post-Traumatic Stress Disorder (PTSD) compared to states where women have few reproductive rights (McLaughlin *et al.*, 2011). Whether reproductive rights are a direct influence or are a proxy marker reflecting wider entrenched gender biases remains to be seen; nonetheless, they illustrate the impact of gender on one area of trauma.

However, exploring female experiences of trauma provides only part of the equation in understanding *gendered* trauma needs. The *different* experiences of trauma by males further illustrates the need for a gendered approach to care. Exposure to trauma is typically cited as being less prevalent in males, who more commonly occupy the role of perpetrator within trauma literature. Nevertheless, traumas experienced by males are underreported in

childhood and adulthood (Romano & De Luca, 2001), and underreporting is likely to reflect that males are less likely to recognise situations as abusive and less likely to disclose abuse (Okur *et al.*, 2017), especially if the perpetrator is female (Cook-Daniels, 2009). Difficulties have also been found in defining and characterising male experiences of abuse and males tend to perceive their own abuse experiences as being less severe compared to females (de Jonge, 2013). Accordingly, the actual prevalence of abuse in the male population is likely to be greater than currently considered (Pereda *et al.*, 2009).

Moreover, the comparatively lower levels of trauma males experience masks significant variations in trauma figures when sexuality, ethnicity, refugee status, age and wider socio-economic statuses are considered (Fleurant, 2019). Within male gay or sexual minority communities, the risk of experiencing violent trauma and discrimination is significantly increased compared to heterosexual populations (Paquette *et al.*, 2019). Similarly, exposure to trauma in young black males eclipses that of white young people (Roberts *et al.*, 2011). Older men are also particularly conspicuous in their absence from the trauma literature (Schnurr *et al.*, 2004), in the context of higher levels of social isolation compared to females (Devine *et al.*, 2019).

Transgender populations, while heterogeneous, also experience high levels of childhood (Giovanardi *et al.*, 2018) and adult trauma compared to cisgender⁷ populations, often related to their trans status and perpetrated both by their social networks and by statutory agencies (McKinnish *et al.*, 2019). They are also more likely to experience additional intersections, such as homelessness, that further increase the risk of exposure to trauma (McKinnish *et al.*, 2019). Non-binary populations, who also remain significantly under-researched, may also present with additional risk of exposure to trauma compared to binary trans male and trans female populations, including increased risk of homelessness (Reisner & Hugtto, 2019).

Furthermore, differential gendered patterns are also apparent in the constellation of responses to trauma, further strengthening the need for gendered approaches to service and treatment models (Fleurant, 2019). At a diagnostic level, reviews of evidence suggest key gender differences in trauma-related psychiatric diagnoses, such as PTSD and personality disorder, and in the symptom patterns in these diagnoses.

Females are more likely to be diagnosed with PTSD (Chapman *et al.*, 2012; Wade *et al.*, 2016) and complex PTSD (Lunn & Morris, 2020) than males, particularly following specific incidents, including disasters, accidents, and chronic diseases (Ditlevsen & Elkliit, 2012) and as a result of their professional roles (Baum, 2016). Trans female status is also associated with significantly higher levels of PTSD compared to cisgender populations (Reisner *et al.*, 2016). While PTSD appears to be a valid construct for males, females and trans females, females also present with greater severity and differential patterns of PTSD symptoms (Galovski *et al.*, 2013; Kimerling *et al.*, 2018). For example, females are more likely

1. Where the terms male and female are used in this essay, this is in reference to cisgender males and females (those whose gender identity matches the gender assigned to them at birth). This approach has been taken to ensure that the needs of all across the gender spectrum are acknowledged, and to facilitate ease of reading.

2. Non-binary is a term used to describe a self-identified gender that doesn't fall into being either male or female. This may reflect that a person identifies with a gender that includes elements of being a male or a female. It may also reflect a self-identified gender identity that doesn't identify with male or female genders.

3. Developed by the Council of Europe (CoE) (2020), World Health Organization (2020), United Nations (2020) and Stonewall (2020).

4. A non-binary identity reflects a spectrum of gender identities that are neither exclusively male nor female. 'Gender fluid' is an example of such an identity and describes an individual for whom their gender identity varies over time.

5. Within the UK it is noted that approaches to gender inequalities have long noted and incorporated consideration for wider intersections including ethnicity, disability and socio-economic variables (CoE, 2020).

6. Secure services are specialist mental health hospitals that work with service users who engage in aggressive/challenging behaviours that make them a risk to themselves or others. Many people in secure services have been convicted of a crime that is linked to their mental health problems.

7. Cisgender is defined as a person who identifies with the gender assigned to them at birth.

to present with dissociative symptoms and a more intense sense of threat compared to males (Irish *et al.*, 2011). Such differences have not been explored within gender minority populations. Currently, gendered patterns in trauma symptoms are not reflected in guidance for the assessment for PTSD. Such omissions provide a key clinical example demonstrating the need for a gendered approach to trauma care.

Gendered patterns in diagnoses and symptoms are not exclusive to PTSD but also emerge in Borderline Personality Disorder (BPD), a diagnosis synonymous with the experience of childhood trauma. Unsurprisingly, females are significantly more likely than males to be diagnosed with BPD. While gender biases in diagnostic processes may account for some differences in BPD prevalence (Sansone & Sansone, 2011), males with trauma histories do present with differential behavioral responses to trauma, such as recklessness and differences in their core BPD symptom patterns (Sharp *et al.*, 2014), with their trauma needs often remaining undetected until they enter the criminal justice system for offending behaviour.

Males with BPD, and with a history of trauma, are also significantly more likely than females to present with comorbid substance use (Almuneef *et al.*, 2018) and anti-social personality disorder needs (Robitaille *et al.*, 2017), which are not reflected in current dominant treatment models for trauma. Trauma research, in particular research exploring complex PTSD, typically excludes people with substance use needs from samples (Lunn & Morris, 2020), which also contributes to our lack of understanding of male trauma-related treatment needs. As such, gender may also impact on the number and type of secondary referrals that people require in the treatment of their trauma needs (for example, substance use teams and criminal justice support). Moreover, males with BPD are also less likely to be offered treatment, indicating that trauma needs remain unmet (Stanley, 2010). Such evidence suggests that training for healthcare professionals should incorporate awareness of and vigilance to recognising differential (gendered) signs and potential treatment needs of populations, though without enforcing rigid stereotypes, to allow for individualised approaches to treatment.

Males also experience greater difficulties in accessing mental health services (Men's Health Forum, 2008) though this is an inequality faced by those with trauma histories across the gender spectrum (McChesney *et al.*, 2015). Additionally, compared to white males, men from ethnic minority groups present with greater difficulty accessing therapy and are more likely to discontinue psychotherapy for trauma-related needs. Male sexual assault victims are also less likely to access trauma support services (Pereira *et al.*, 2020) and when accessed, they are used less frequently (Turchik *et al.*, 2014). Higher levels of alexithymia (inability to recognise one's own emotions), stigma-related concerns, and same sex preferences for therapists and therapy groups have been identified as barriers to males seeking help (Levant *et al.*, 2009).

Outside of veterans services, men are woefully underrepresented in samples exploring the efficacy of trauma treatments, most notably in Dialectical Behaviour Therapy⁸ (Wupperman & Edwards, 2017). The number of randomised controlled trials for psychological therapies for trauma with male samples is minimal. It is therefore unsurprising that a recent meta-analysis demonstrated that females experience greater PTSD symptom reduction than males following psychological treatment, suggesting current treatments are less efficacious for males (Wade *et al.*, 2016). Commentators have also reflected on the feminisation of trauma treatment models, including group exercises and the coping strategies offered, making them less accessible to males (Røberg *et al.*, 2018). In sum, the experience of males in accessing and having their holistic treatment needs met by trauma therapies is comparatively poorer compared to females.

Further evidence demonstrating the importance of adopting a gendered and integrated approach to trauma care comes from studies exploring the proliferating physical health impacts of trauma. At present, TIC is overwhelmingly focused on psychological outcomes. Yet, exposure to trauma has been linked to most communicable and non-communicable physical health conditions, and premature mortality for males and females (Hughes *et al.*, 2017). While the need to establish parity of esteem between psychological and physical health outcomes is a part of a broader debate within trauma circles, this debate also has important gendered aspects. A small and growing evidence base suggests many physical health impacts have a gendered pattern, indicating differential priorities for prevention, early intervention and management approaches to trauma that are currently not being met.

At a neurological level, evidence suggests that exposure to early prolonged trauma can result in differential impacts for males and females. Greater adverse brain maturation effects have been noted in males, even when age of onset, and duration and type of abuse are controlled for (De Bellis *et al.*, 2011). Similarly, genetic studies also suggest gendered patterns. For example, evidence has found the MAOA genotype, which is associated with impulsive and aggressive behaviour, to be shortened in males with a history of neglect who latterly present with dissociative behaviour (De Bellis *et al.*, 2011); yet this pattern is not evident in females. This suggests novel pharmacological treatments for trauma need to consider differential gender responses at a biological level in order to more effectively address the varying presentations of trauma across different populations.

Further gender differences have also been observed in physical health outcomes, including obesity and smoking. For example, in males, emotional abuse has been found to increase risk for obesity, while physical neglect is associated with being underweight (Ernst *et al.*, 2019). However, the overall risk of developing obesity and smoking following childhood trauma is stronger for females (Fuller-Thomson *et al.*, 2013). Gendered needs relating to gynaecological and obstetric health are also comparatively well documented, with those who experience severe physical or sexual abuse in childhood presenting with a significant risk for endometriosis (Harris *et al.*, 2018). Yet these needs are

not routinely assessed or managed with previous trauma in mind. Interestingly, the corresponding urology and gastroenterology needs of male survivors remain unexplored.

The elevated risk of developing a range of cancers following trauma exposure has also been reported for both genders (Hughes *et al.*, 2017). The exact mechanisms that account for this relationship are not well understood, though poor attendance at preventative cervical cancer screening for female (Gesink & Nattel, 2015) and gender minority (Kiran, 2019) sexual abuse survivors has been documented as a contributory factor. Additionally, women with trauma histories report significantly higher levels of anxiety during intimate medical examinations when the physician is male (Lee *et al.*, 2007), although trauma needs are not typically recognised or accommodated in physical health settings. By contrast the impact of abuse on male engagement in self-assessment for testicular cancer or screening for prostate cancer is unknown. The effects of trauma on engagement with preventative health services and outcomes have not been quantified either.

Accumulatively, the evidence outlined above suggests differential gender patterns in exposure to trauma, risk of presenting with enduring pathology, as well as patterns of psychological symptoms and needs, suggesting that a 'one size fits all' approach to gendered trauma care will not meet holistic treatment needs. Simplistically, while females may require greater access to trauma services through increased PTSD, complex PTSD and BPD needs that reflect early, repeated, and typically interpersonal trauma experiences, male service users need greater support to recognise and report trauma, to access services and to be offered treatment programmes that reflect male patterns of trauma symptoms and needs. This need increases in males from ethnic minority groups. Additionally, much of the trauma treatment needs of gender minority groups remain unquantified.

Collectively, across the gender spectrum, evidence suggests broad physical health needs that trauma-informed approaches could arguably improve outcomes for. Yet, despite wide recognition of the need for a personalised approach to trauma, which considers gender as one of many intersections shaping treatment needs, a number of shortcomings are apparent. These shortcomings reflect the ongoing fracture between academic knowledge and understanding of trauma, and implementation into clinical practice.

Part 2: A critique of current approaches to trauma care

Given the high prevalence of trauma and presenting symptoms in people accessing mental health services, trauma-informed care (TIC) has been a much needed and welcomed development. Unlike 'trauma-specific' services, which are specialist services for individuals presenting with traumatic stress, 'trauma-informed care' encapsulates a culture of safety and trust; it is not just *what* care is given, but also *how* it is given. A number of trauma-informed models focusing on psychological needs have been developed, typically grounded in the

principles of safety, trustworthiness and transparency, peer support, co-production, empowerment and choice, and understanding of cultural, historical and gender issues (SAMHSA, 2014; Sweeney *et al.*, 2016).

The importance of gender is embedded in the theoretical frameworks of TIC, although its presence in shaping services is hugely variable. This in part reflects a broader lack of commonly agreed definitions, structures, standards or governance for TIC services. As such, benchmarking and assessing the quality of services remains subject to inconsistencies, rendering clinicians and service leads with limited guidance to meet the needs of heterogeneous and complex populations. The absence of broader governance of TIC magnifies challenges of fully embedding gendered approaches. Additionally, limitations of the wholly psychological focus of TIC models and the invisibility of marginalised groups are intensified when viewing TIC through a gender-lens. The next section explores these issues.

The need for a consensus about what constitutes 'gender-responsive' trauma-informed care

A trauma-informed service is one that is 'gender-responsive' (SAMHSA, 2014), responding to the needs of service users in the context of their gender. Yet, in the absence of standards around defining and operationalising gendered approaches to care, initiatives are typically developed at the user-end, rather than in commissioning. As such, considerations of gender in the remit, design and budgeting of trauma-informed services largely manifest as an add-on, rather than being central to care modelling (Morgan *et al.*, 2018). In addition, where treatment programmes labelled as 'gender-responsive' have been evaluated, there is inconsistency in the criteria for assessing their effectiveness (Purtle *et al.*, 2018), typically reflecting the needs of cisgender females only.

Despite this, there is recognition of the need to invest in gendered TIC services at a commissioning level, including for women in the criminal justice system. For example, the 'Women's Secure Blended Service' project (NHS England, 2016) is a specially commissioned service to meet the trauma needs of females in medium- and low-secure forensic care within a single service. This approach emphasises the importance of relational security, namely staff's knowledge and understanding of service users and the importance of relationships between staff and service users, as a therapeutic intervention working with women. However, such approaches are the exception and illustrate the gender 'specific' rather than gender 'sensitive' approach taken in TIC, reflecting the needs of a single gendered group rather than all service users across the gender spectrum.

The absence of nationally agreed, inclusive standards for gendered TIC, carried through into governance and evaluation structures surrounding TIC, remains a concern. Without such structures, the accessibility and efficacy of these approaches for *all* gendered groups cannot be adequately demonstrated. Furthermore, the narrow definition of gender adopted within current TIC models arguably contributes to the invisibility of non-female trauma populations and their differential mental and physical health needs.

8. Dialectical Behaviour Therapy (DBT) is a psychotherapeutic approach developed primarily for the treatment of BPD. This treatment approach is comprised of the following four key modules: mindfulness, distress tolerance, emotion regulation and interpersonal effectiveness. It emphasises developing adaptive skills to manage emotions and to improve interpersonal relationships.

The cost of non-inclusive gendered services: the invisibility of marginalised groups

Perhaps the greatest cost of non-inclusive approaches to gendered care is the perpetuation of invisibility for certain populations. Currently, mental health providers largely operate under policies and practices that respond to neither male nor transgender needs (Walton & Baker, 2019; Wilkins & Pollard, 2014). Yet, arguably, gender-responsivity is defined by the incorporation of gendered needs for *all* service users. The limitations in sectors operating within a 'trauma-informed' framework call for gendered needs to be embedded in the groundworks of care. Failure to do so raises particular concern for males, especially those from ethnic and gender minority populations, who, as outlined previously, present with high levels of trauma exposure in the context of significant barriers to service engagement. Male trauma needs, as voiced through veteran services, may be an exception to the poorer discourse surrounding male trauma experiences. Nevertheless, the focus on 'war' trauma perpetuates the cultural machoism around what is socially 'acceptable' male trauma. Outside of war or service-related trauma, the differential needs of males remain invisible within TIC approaches. Outcomes for males and gender minority groups are unlikely to improve in gender neutral or gender 'specific' (female-informed) services.

Additionally, the potential for re-traumatisation in models that fail to consider nuances in clinical needs reflects a cost paid by *all* users of gender-blind or narrowly defined services. Re-traumatisation, which refers to the re-experiencing of an adverse event often triggered by cues in the environment, is a key barrier to accessing mental and physical health support (Garg *et al.*, 2020). Given that trauma experiences are prevalent amongst users of mental health services (Mauritz *et al.*, 2013), and those in the criminal justice system (Baranyi *et al.*, 2018), re-traumatisation is a key consideration in such settings, the risk of which could arguably be mitigated through gender-inclusive approaches to TIC.

The gender-blind approach to trauma adopted within current systems may provoke the re-experiencing of past adversities. For example, prisons overwhelmingly reflect a male-orientated establishment and power dynamics may act as a trigger for female offenders (Jewkes *et al.*, 2019). Though cultural shifts have been initiated, practices such as strip searches and the use of 'safe clothes' remain potential triggers. Given the various disparities faced by males, females and gender minority groups in healthcare services and the criminal justice system, the gender-lens must be widened. Adopting a more inclusive approach would mean that the needs of *all* populations are reflected at the level of budgeting, service design, and policy development, as well as at a service delivery level, through the implementation of appropriate staffing, resources, and treatment approaches.

Reducing fragmentation and increasing holistic gendered care

Recovery from psychological trauma symptoms provides only part of the recovery process, yet, consistent with traditional mental health frameworks, TIC models are overwhelmingly psychologically focused and sit exclusively

within mental health services. This position is echoed at the policy level, with no consideration for physical trauma impacts in clinical PTSD guidance (NICE, 2018). Yet, establishing equivalence in mental and physical health is a priority in the five-year UK health strategy. (Public Health England, 2019). Additionally, the fragmentation and lack of integration of different mental health services needed by trauma survivors *within* mental health services further illustrates the current challenges in meeting gendered needs. For example, the lack of joined-up working between substance disorder and mental health teams has a greater impact on male survivors of trauma, as current treatment approaches do not reflect common patterns of clinical need in this gendered group, but rather traditional models reflecting clinician expertise.

While negative physical outcomes are problematic for *all* exposed to trauma, physical health morbidities magnify gendered needs. Evidence outlined in section one of this essay demonstrates that differential physical health needs stemming from trauma require gendered solutions. This is especially clear in the case of cancer screening, urology and obstetric care. Clinicians must be alert to differential 'red flags' for trauma, in the context of gender, to improve the health outcomes of trauma survivors and avoid further exacerbating pre-existing health inequalities. This is not to suggest that TIC models should assume responsibility for all aspects of physical healthcare, but arguably they do have a role in the psychoeducation of survivors and healthcare professionals about physical health sequelae, and in reducing the barriers to engagement with physical health services.

Collectively, current practice intensifies the false fragmentation within and between psychological and physical wellbeing which negatively, albeit differentially, impacts across the gender spectrum. In doing so, service provision mirrors the fragmented internal worlds of trauma survivors. As such, the failure to recognise and respond to the additional health needs of individuals with experiences of adversity within a gender-responsive framework reflects a major shortcoming in current trauma-informed services and policies. To improve outcomes and reduce the invisibility of marginalised groups, a top-down approach characterising major budgetary and cultural shifts is needed to facilitate the implementation of *true* gender-responsive TIC. Specialist trauma 'hubs' that offer integrated, holistic mental health services and support physical health needs are required.

Gender as an anchor to integrate needs and as a platform for holistic care: an inclusive gender mainstream approach to trauma

Arguably, a gendered approach is required at all levels of trauma care. Despite attempts to achieve gender equality, approaches have largely failed to make substantial reductions to social inequalities (CoE, 2020). In response, 'gender mainstreaming' has long been advocated by leading international bodies such as the United Nations (UN) and CoE. Gender mainstreaming focuses heavily on policy processes, stakeholder consultations, impact analyses, and typically involves reorganisation of budgets, commissioning processes, governance structures and

significant cultural shifts. It is a 'top-down' approach that requires commitment from national policy, budgetary and commissioning decision-makers, and front line staff. Developing 'mainstreamed' services involves integrating gendered needs at all stages of decision-making around policy development, project programming, budgetary allocation, workforce planning and service models (CoE, UN, WHO). It is positioned as being the model to ensure that the needs of *all* service users are met, and to drive the next generation of health systems.

Initial attempts to introduce gender mainstreaming into healthcare in the UK produced notable policy documents including *Women's Mental Health into the Mainstream* (Department of Health, 2002) and the appointment of national leads and programmes for equality in women's mental health, responding to the specific service needs of women. Although these stalled early into the millennium (Newbigging, 2017), recent evidence of attempts to re-integrate these approaches are apparent in isolated areas of practice, such as the 'Women's Secure Blended Service' project (NHS, 2016).⁹

That said, overall, attempts to embed gender mainstream approaches in healthcare policies in the UK typically excel at acknowledging gender inequalities but fall short on translation into transformative practices within both physical and mental healthcare services. Additionally, despite its aims to reduce gender inequalities, the framework, toolkits and rhetoric of gender mainstreaming are exclusively focused on cisgender female needs. Thus, a more inclusive definition of gender mainstreaming is necessary to highlight needs across the gender spectrum. A number of opportunities for development exist to support the transition to an all-encompassing gender mainstreamed approach.

Recommendations

This essay invites a call to action, an opportunity to re-think trauma services in a way that can substantially reduce inequalities (Kuhlmann, 2009). We recommend approaching gender as an inclusive concept, broadening the scope of TIC approaches and further embedding gender mainstreaming, and thinking more carefully about gender within research and evaluations of service innovations.

1. Approaching gender as an inclusive concept

- At present, TIC largely reflects cisgender female-defined needs. To address the invisibility of male and gender minority groups, approaches to gender should be formulated and operationalised as an inclusive construct.
- To reduce the invisibility of key intersections, including gender, sexuality and race, and to recognise the needs of marginalised populations, current TIC guidance documents should be reviewed, including trauma-related NHS and NICE guidelines.

2. Service structure and configuration

- To ensure that gendered care is embedded within trauma services and TIC models, the adoption of 'gender mainstreaming', in the broad and inclusive sense of the term, is recommended. Gender-responsive budgeting by ministries, healthcare commissioners and workforce planning and training will be crucial to ensuring that services, policies and frameworks are responsive to all gender-based needs.
- Assessing policies against an established standard measure of what constitutes gendered TIC would be essential to ensure consistency in the evaluation and labelling of services as 'gender-responsive'. Public commissioning bodies should too consider *gendered* trauma-informed policies and practices when evaluating performance, including acknowledging further the impact of geographic diversities, such as denser populations and greater economic inequalities in some areas.
- Embedding gendered physical health needs within trauma models is a clinical imperative to promote holistic recovery. At a service-commissioning end, this could manifest in services that reflect both physical and mental health specialities. At a user end, this would include giving parity of esteem to needs at all stages of assessment, formulation, psychoeducation and intervention.

3. Research and innovation recommendations

- The invisibility of marginalised gendered groups warrants greater understanding of their needs. Gender analysis must be embedded at all stages of the research cycle; existing toolkits, such as that from GARCIA (2015), provide a useful checklist of considerations.
- Results should be reported by gender so as not to generalise findings across the population. Conclusions should be drawn in respect to the varying gender identities and intersections existing within the sample.
- Gender impact assessments should be embedded as standard practice to evaluate whether a research programme is reducing, maintaining or increasing gender inequalities.
- Males and gender minorities, especially those from older and ethnic minority groups, are minimally present in the trauma literature, especially relating to the efficacy of psychological trauma interventions. A comprehensive programme to develop and evaluate interventions that reflect their differential treatment needs is warranted.

9. Of note is that gender mainstreaming in the UK has an established tradition of incorporating additional intersections of inequality into this context, an approach that is embedded in anti-discrimination legislation and policies that aim to reach all social inequalities that contribute additional dynamics to gender-based inequalities.

Conclusion

Despite growth in the recognition of *gendered* trauma experiences, translation into policy and practice is inconspicuous. The next generation of health systems faces the considerable challenge of reducing multiple inequalities in the context of competing budgetary demands. The complexities and interdependent nature of relationships between socio-demographic variables such as age and ethnicity are such that any approach to embedding gendered care needs to include wider intersections in its analyses of gendered needs, to ensure equitable outcomes.

Within TIC approaches, positive and much needed strides have been made in promoting the needs of females.

Women are undeniably the main recipients of TIC and, as such, it is important that their differential needs be addressed. Nonetheless, the differential experiences of trauma and mental health services by male and gender minority populations demand tailored approaches to meet their treatment needs, which are not currently met by gender-sensitive or female-informed approaches. Gender mainstreaming, formulated in a more inclusive definition, offers one such approach to navigating this process. It is not the role nor goal of gendered approaches to elevate the status of one gender, but rather to use gender as an inclusive anchor to ensure that all have access to resources, decision-making and healthcare that facilitates whole recovery from trauma.

The differential and holistic needs of males, females and gender minority groups renders clinicians with an impossible task of supporting recovery in gender neutral or female-informed services, particularly if models of care focus on fragmented psychological needs only. Moving forward, it is imperative that the mainstreaming of an inclusive approach to gender be embedded throughout the design of policies and practices, from the offset. By doing so, services will be better placed to address the life-limiting impacts of trauma and reduce structural inequalities.

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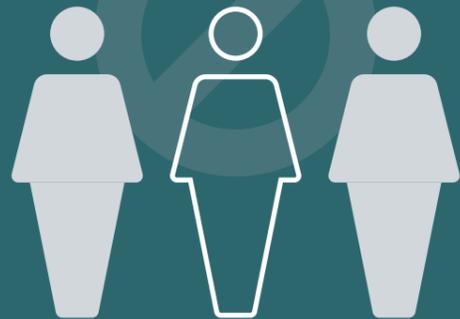
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Essay four

The central role of racism in shaping the life experiences of ethnic minority people in the UK



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Summary

Introduction

Policy, public and academic understandings of race/ethnic inequalities in economic, social and health outcomes are typically shaped by everyday, common-sense understandings of what ethnicity represents – genetic and cultural difference and the seemingly natural, and neutral, identification of groups as ‘other’. This leads to a focus on explanations that draw on factors that are perceived to be inherent to ethnicity and ethnic difference.

Rather than an approach rooted in such common-sense understandings of ethnicity, we need a conceptually robust and thorough analysis of the role of various inter-related dimensions of racism in race/ethnic inequalities and policy and practice responses to them.

A novel approach

To address this, this paper summarises a novel approach to theorising inter-related dimensions of racism – classified along the dimensions of structural, interpersonal and institutional. It details how these dimensions of racism operate, how they overlap, how they are inter-dependent and how they shape inequalities.

Conclusion

The paper concludes by identifying the failure of policy in the UK to address race/ethnic inequalities. It also argues that institutions, as the sites where structural and inter-personal racisms are enacted and mediated, could also be the sites where processes of racism are disrupted.

Introduction

At the time of writing (July 2020), a series of events have centred the issue of ethnic inequalities and racism in the UK in the minds of the public, media, NGOs, and those involved in shaping and responding to policy. These events include the stark race/ethnic inequalities in the impact of the coronavirus pandemic, alongside the police killing of George Floyd and the subsequent resurgence of the Black Lives Matter movement.

These events have raised questions across the full range of social, public and private institutions in the UK. Questions are being asked about everything from deaths in custody, unequal health outcomes and failures of education systems, to the ways in which histories of colonisation, slavery and empire are embedded in our cultures and celebrated by our monuments and in the commemorations of our history.

Although these events have led to public statements from a large proportion of private, public and governmental organisations in support of race equality, it is important both to note and question why they did not themselves raise concerns about these recent illustrations of race/ethnic inequalities. Rather it was the public, public activism, and media reflections of and engagement in this activism that forced public and private bodies to pay some, perhaps passing, attention to these issues. For example, ethnic inequalities were pushed onto the coronavirus agenda by a growing public and media recognition that a large proportion of the NHS and care staff who were dying were not white.¹ This led public health bodies, academics and political leaders to collect and analyse data, to comment on the issue, and to set up short-term, and perhaps superficial, investigations into these inequalities.

In part this might be because political and policy leaders consider economic, social and health crises to impact on all segments of a population. For example, the coronavirus pandemic was described as a 'great leveller', particularly when the UK's Prime Minister, Boris Johnson, became ill. However, individuals from marginalised or disadvantaged groups, who are already experiencing poorer social, economic and health outcomes, are almost certainly disproportionately affected by crises, because of their more precarious situation. But, because we have not focused sufficiently on underlying patterns of inequality and risk, when it becomes apparent that there are additional inequalities both in the outcomes of a crisis and the policies put in place to manage it, we typically do not have the tools to fully understand why this is happening. This then leaves us drawing on common-sense, everyday notions to find explanation.

We can see this in much of the research, and almost all of the policy work on inequalities in relation to race/ethnicity. Such work typically treats race/ethnic groups as uncomplicatedly real, already established entities. Attention is not paid to the historical and contemporary contexts within which race/ethnic groups are constructed and given meaning and the implications of these processes for understanding documented inequalities.

Instead, race/ethnic groups are considered to have properties associated with everyday understandings of what factors determine ethnic difference, be they genetic, cultural or social (where the identification of groups of people as 'other', and how this shapes relationships, is somehow seen to reflect natural differences). Such factors then become the source of explanation for race/ethnic inequalities in outcomes. Indeed, even where the focus is on the social and economic disadvantage associated with race/ethnicity, including personal experiences of discrimination or racism, attention is very rarely paid to the processes that lead to this disadvantage. This includes how disadvantage is shaped by the devaluation of race/ethnic identities and how this then shapes life chances, interpersonal interactions, and encounters with institutions. Rather, these inequalities are seen to reflect inherent differences between groups that are not only reflected in genetic and cultural risk, but also in how groups of people relate to each other.

Such an approach allows for the avoidance of a thorough consideration of racism and instead encourages a focus on superficial, individualised explanations for inequalities. So, the patterning of the risk of adverse outcomes across groups is explained by individual differences in things such as economic position, housing, geographical context, and education, as well as culture and genetics. And the focus on such immediate risk factors means that insufficient attention is paid to the ways in which they, and institutional responses to them, are shaped by processes related to racism.

This is well illustrated by contemporary discussions of the factors that might lie behind the increased risk of Covid-19-related mortality experienced by ethnic minority groups in the UK. Central to such discussions has been the possibility that ethnic minority people were more likely to be in locations where they were exposed to risk of infection. This included living in urban, densely populated areas with a higher risk of virus transmission, or being more likely to be employed in sectors that increase the risk of exposure to the virus (transport and delivery, security, cleaning, health care assistants, social care, and nursing and medicine), and potentially being less likely to have access to protective equipment as a result of discrimination.

In addition, it is argued that, once infected, ethnic minority people may be at more risk of having adverse clinical outcomes as a result of the underlying socio-economic inequalities they experience. That is, most ethnic minority groups are both more at risk of catching and have a poorer prognosis from, Covid-19 infection. This is because they are more likely to: have poorly paid and insecure employment; live in overcrowded housing; and live in deprived neighbourhoods with high rates of concentrated poverty and pollution (Byrne *et al.*, 2020). And such socio-economic inequalities are also linked to ethnic minority people being more likely to have the underlying health conditions that have been linked to increased risk of Covid-19 complications and mortality, such as diabetes, high blood pressure, and coronary heart disease (Nazroo, 2001).

Also argued to be important are the high rates of obesity among ethnic minority people, which then becomes related to individual, or cultural, factors, and low levels of vitamin D, which becomes related to cultural and genetic factors. We are left with a confusing, 'complex' list of all possible explanations derived from our common-sense speculation of what race/ethnicity represents (Nazroo, 1998).

An alternative approach to generating an understanding of race/ethnic inequalities in risk is to recognise that the processes identified in such lists of explanations do not operate in isolation. They occur together and operate to sequentially lead to deepening inequalities in many areas across a person's life course, and are transmitted from one generation to the next (Gee *et al.*, 2012; Bécares *et al.*, 2015). However, developing an understanding of the dynamic inter-relationships between these processes and using this to develop appropriate policy analysis is not straightforward. It requires a consideration of the ways in which various dimensions of inequality interact to amplify risks of adverse health, social and economic outcomes. It also requires a move beyond a focus on the perceived innate and immediate drivers of inequalities to an understanding of how these are shaped by broader processes related to racism.

Centring racism

So, behind the apparent complexity of the processes that lead to the social and economic inequalities ethnic minority people face is the way in which these inequalities are driven by entrenched structural and institutional racism, and interpersonal experiences of racism and racial discrimination (Nazroo *et al.*, 2019). An explanation of ethnic inequalities that doesn't acknowledge the underpinning role of racism is limited in its ability to generate a robust understanding of the processes that lead to such inequalities and solutions for addressing them.

Racism draws on an ideology where physical difference is linked to cultural and social difference. This allows race/ethnic groups to be identified, to be given meaning and value, and to be placed on a hierarchal scale – a process described as racialisation (Hughey & Jackson, 2017). This then allows for the subordination, marginalisation and exclusion of those considered to be inferior (Golash-Boza, 2016; Emirbayer & Desmond, 2015). Consequent inequalities then, do not arise from the inherent properties of race/ethnic groupings, rather they are a result of the historically and politically shaped meanings ascribed to race/ethnic identities.

According to Omi and Winant (1994), such ideas of and categorisation by race are central to the organisation and regulation of modern societies. Indeed, Emirbayer and Desmond (2015) have argued that we need to consider how race/ethnic groups are configured within social spaces and how this reflects access to economic, cultural, legal, political and symbolic resources that shape how identities are perceived, valued, mobilised and interacted with. They argue that it is additionally important to consider how shared emotions attached to symbolic resources shape the practices of individuals and institutions. Take, for example,

the shared emotions around risk, danger, fear and disgust that are attached to different ethnic minority identities and how they provide resources for and shape the practices of discrimination and racism. This, then, has direct impacts on economic, social and health outcomes. So, although race and ethnic identities might be social constructions, the meanings they contain do have real impacts on people's lives.

To achieve an adequate understanding of race/ethnic inequalities we need then to understand the ways in which identities are racialised and the consequent substantial impacts this has on the lives of ethnic minority people. To do this, it is useful to consider three closely related ways in which racism operates in our lives. First, how structural racism leads to disadvantage in accessing key economic, physical and social resources. Second, how interpersonal racism, from everyday slights, through to discrimination in a range of settings, to verbal and physical aggression, emphasises the devalued and risky social status of both those who are directly targeted and those who have similarly racialised identities. Third, how these processes are embedded within institutions and shape their processes and practices and, consequently, encounters within them.

Each of these dimensions of racism, and their consequences, are detailed further below. However, it should be noted that this approach to the classification of racism is designed to provide the analytical tools necessary to understand how racism operates and to inform decision-making, while at the same time acknowledging that these forms of racism are closely related, mutually supportive and operate together. It draws on and develops existing approaches to understanding racism (see, for example, Hughey and Jackson, 2017; Hicken *et al.*, 2018; and Phillips, 2010 for related approaches) in order to provide a fundamental explanation for race/ethnic inequalities across a range of economic, social and health areas.

Structural racism

Any consideration of racism must include the structural, overarching (macro) level. Operating alongside and in interaction with other areas of inequality, such as class and gender (Byrne, 2015; Golash-Boza, 2016; Phillips, 2010; Song, 2014), race/ethnicity remains a key determinant of social location, status and power. Here, the legacies of historical regimes of colonialism, race-based slavery and apartheid interact with current processes of globalisation, migration and governance to shape inequalities in accessing key economic, physical and social resources (Bailey *et al.*, 2017; Phillips, 2010).

Processes related to racism and discrimination both directly and indirectly result in inequalities in accessing economic, physical and social resources, and consequent inequalities across a range of related outcomes. For example, discrimination in relation to seeking accommodation will have a direct impact on inequalities in relation to housing quality and overcrowding, but may also indirectly impact on employment opportunities.

1. Ethnic minorities dying of Covid-19 at higher rate, analysis shows. The Guardian, 22 April 2020. Available at: <https://www.theguardian.com/world/2020/apr/22/racial-inequality-in-britain-found-a-risk-factor-for-covid-19>; and Afua Hirsch 'If coronavirus doesn't discriminate, how come black people are bearing the brunt?' The Guardian, 8 April 2020. Available at: <https://www.theguardian.com/commentisfree/2020/apr/08/coronavirus-black-people-ethnic-minority-deaths-pandemic-inequality-afua-hirsch>

Figure 1 – Persisting ethnic inequalities in employment in the UK (source: Kapadia et al., 2015)

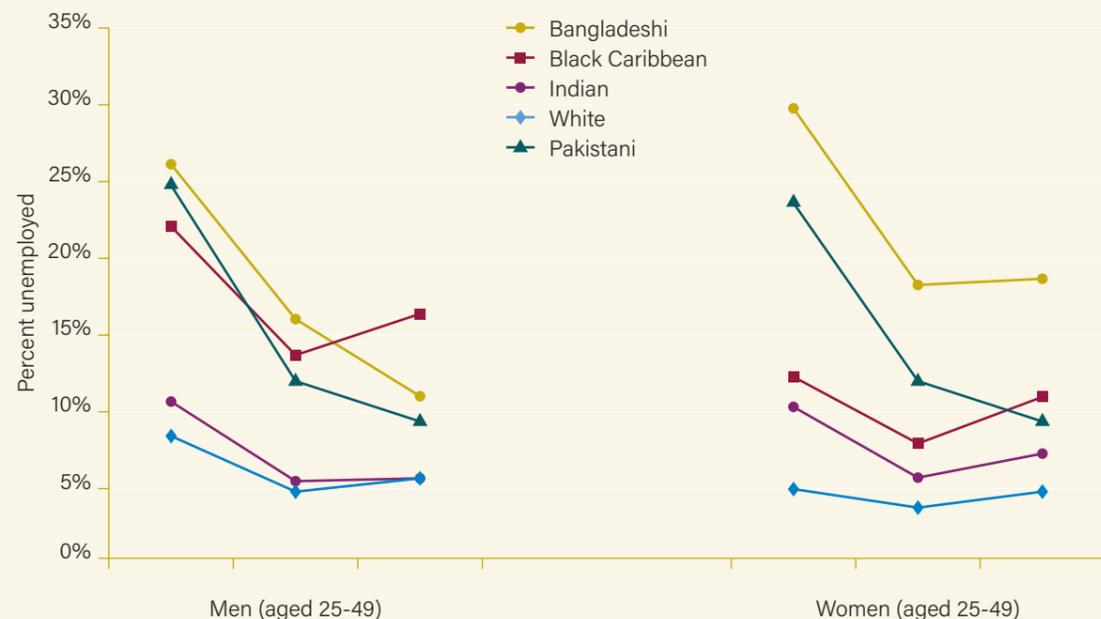
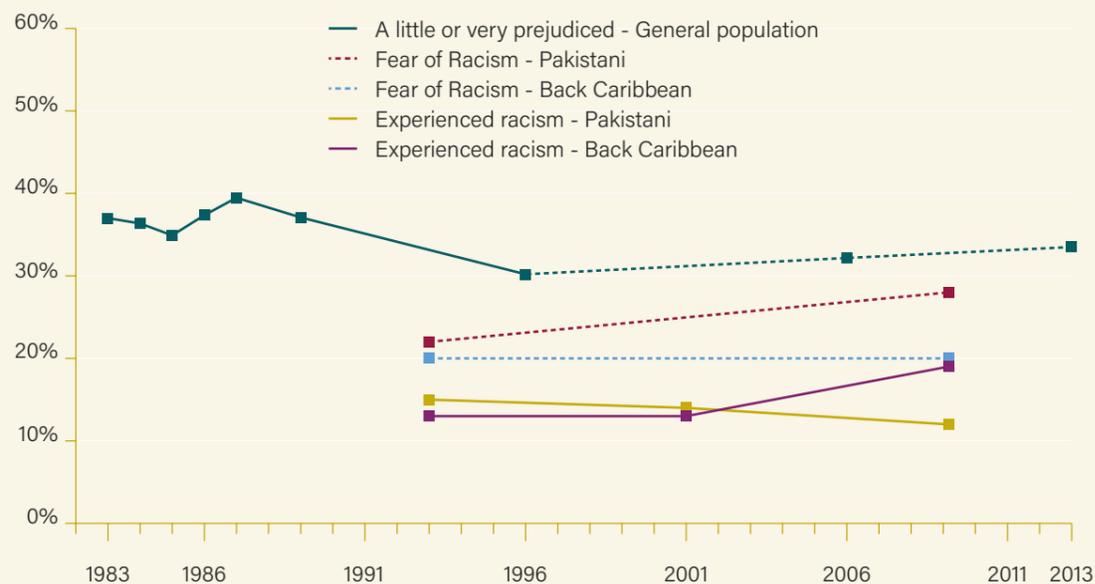


Figure 2 – Trends in levels of prejudice and racism over time (sources: Kelley et al., 2017; Karlsen and Nazroo, 2014; Virdee, 1997)



Importantly, structural racism consists of not just material outcomes, such as in income and housing, but also has cultural and ideological dimensions (Essed, 1991). The circulation of ideas and representations that produce race and ethnic groups as different, but also as threatening and inferior, serve to rationalise and inform an uneven distribution of resources. So material inequality carries with it associated denigration. They are inextricably linked. Although some commentators have argued for a distinction between the structural and cultural domains of racism (Hicken *et al.*, 2018), it is crucial to identify the significance of the 'collective-emotional' dimensions of social structures. That is, how "racial life" is "suffused with shared passions, imageries and fantasies" that inform modes of "attachment, defence, solidarity or struggle" within society (Emirbayer & Desmond 2015). These emotional responses guide political action at the structural level, but also individual, group and institutional actions. This is because such practices are laden with racialised meaning and associated emotional content. So, culture and associated emotion provides a context for social action, including at economic and political levels.

What are the material consequences of this? Within the UK there are deep and persisting ethnic inequalities across almost all socio-economic dimensions – income, employment, residential location, housing and education (Byrne *et al.*, 2020; Jivraj & Simpson, 2015; Modood *et al.*, 1997). For example, the persistence of race/ethnic inequalities in risk of unemployment is revealed by an examination of Census data over the periods 1991, 2001 and 2011, which provide the most robust and comprehensive assessment of unemployment rates over this 20-year period. As illustrated by Figure 1, Census data show that Black Caribbean men and women have had persistently high levels of unemployment, more than twice as high as the White rate (Kapadia *et al.*, 2015). And while Pakistani and Bangladeshi men and women have seen large falls in unemployment over the period 1991 to 2011, they continue to have much higher unemployment rates than White men and women, and any fall is mainly a result of a large rise in part-time work (Kapadia *et al.*, 2015). For example, for Bangladeshi men the part-time employment rate has risen from just over 3% in 1991 to 35% in 2011, a figure that is coupled with a fall, rather than a rise, in full-time employment rates. This part-time employment rate is seven times higher than that for White men (Kapadia *et al.*, 2015).

The persistence across generations and over time of such employment inequalities within the UK might be unexpected, as for a number of reasons it should have diminished over time. For example, more recent periods have ethnic minority populations with a large proportion of second and third generation people. They would be both more fluent in English and would have passed through the UK education system. They should therefore be less disadvantaged in the employment market. As well as this the introduction of equality legislation, which has been in place in the UK for more than 50 years, might be expected to have diminished the negative outcomes of discrimination.

Interestingly, unlike unemployment there is some suggestion of improvements in outcomes in more recent periods for education. Here the improvements in educational attainment that occurred in the UK for all ethnic groups over the period

1991 to 2011 were smallest for the White group, leading to a narrowing of ethnic inequalities. For example, the proportion of White people with a degree-level qualification increased from 13% in 1991 to 26% in 2011, while that for Indian people increased from 15% to 42%, and for Black Caribbean people from 9% to 26% (Lymperepoulou & Parameshwaran, 2015).

However, such an improvement is not the case across other, included related, outcomes (Byrne *et al.*, 2020; Jivraj & Simpson, 2015). Particularly worrying is that the data on employment, described above, indicate that these relative improvements in educational attainment for ethnic minority people have not translated into equivalent improvements in employment outcomes. This emphasises the depth and persistence of structural inequalities in relation to race/ethnicity and the difficulties in changing relevant processes. Improvements in some outcomes (in this case educational attainment) do not necessarily translate into improvements elsewhere (in this case employment, but also housing and the probability of living in a deprived area), despite the implementation of a range of legislative and equal opportunities processes. These include the Race Relations Act of 1968, which sought to tackle institutional racism in housing, employment and public services, the Race Relations Amendment Act of 2000, and the proliferation of race equality policies and practices across institutions ranging from the BBC and Arts Council, through higher education and the NHS, to politics and the trades unions.

Interpersonal racism

If structural racism accounts for the more abstract workings of culture, economy and society, a focus on interpersonal racism examines the more routine, everyday expressions of racism, which prey upon and accentuate marginal racialised identities. Indeed, it is through interpersonal actions that the structural, cultural and collective-emotional aspects of racialised identities come into being (Emirbayer & Desmond, 2015). As Knowles (2003) argues, "people are the motor of race making" as "racial orders are in fact composed of myriad and ordinary everyday social processes and mechanisms with which people interface".

Similarly, forms of interpersonal racism operate within collectives, such as families, neighbourhoods or institutions, providing them with a structural character (Phillips, 2010). In this sense, structural racism operates through the interpersonal, not outside of it. Structural racism shapes the context of everyday racialised and racist interactions, but it is itself also an outcome of cumulative patterns of everyday racism. Consequently, structural and interpersonal racism are interdependent.

A range of studies have acutely demonstrated that interpersonal experiences of racism and discrimination are central to the everyday lives of ethnic minority people (for example, Funnell, 2015; Stevens *et al.*, 2012; Virdee, 1995; Virdee, 1997). However, given the diverse and often very subtle forms that interpersonal racism takes, it is extremely difficult to quantify the level of risk faced by ethnic minority people (Karlsen & Nazroo, 2006). In

addition, assessments that quantify risk typically focus on individual experiences at a single point in time and so fail to capture how experiences of racism and discrimination operate across, and impact on, the life courses of connected individuals. Nevertheless, such assessments do show high levels of risk within the UK and levels that have not changed meaningfully over the past 20 years.

This lack of meaningful change in exposure to racism over time is illustrated by Figure 2 (see page 44), which uses data from surveys, selected because they have similar approaches to measurement so can be meaningfully compared. Figure 2 shows that 15% of Black Caribbean people reported experiencing racist abuse, assault or vandalism in 1993/1994, compared with 14% in 2000, and 12% in 2008/2009 (Karlsen and Nazroo, 2014; Virdee, 1997). Similarly, 20 per cent of Black Caribbean people were very, or fairly, worried about being a victim of a racist attack in both 1993/1994 and 2008/2009 (Karlsen & Nazroo, 2014; Virdee, 1997). Over the same period Pakistani people have experienced an increased risk of experiencing racism, and increased levels of being worried about being a victim of a racist attack, while over a shorter period Irish people have experienced a reduction in their risk of experiencing racism (Karlsen & Nazroo, 2014; Virdee, 1997). The differences in the changes in experience for Pakistani and Irish people indicates changing processes of racialisation, with a rise in Islamophobia (Elahi & Khan, 2017), and a possible decline in anti-Irish sentiment. Importantly, underlying these experiences is a worrying continuation of prejudice in the majority population within the UK. As Figure 2 (see page 44) shows, this has remained at a consistently high level over the past 30 years with between 30% and 40% of people saying that they are a little or very prejudiced against ethnic minority people (Kelley *et al.*, 2017).

It is important to note that interpersonal incidents of racism are an attack on communities rather than just on individuals (Virdee, 1997). Racism need not have been experienced personally for it to produce a sense of threat (Karlsen & Nazroo, 2004). As Oakley (1996) points out: "the distinguishing feature of racial violence and harassment is not simply that it involves members of different racial groups or ethnic groups; it is that the action is racially motivated... Racially motivated behavior, therefore, is not an attack aimed at a person purely as an individual, but an attack on a member of a category or group". Indeed, acts of racism are reflections of historical legacies of racial orders and domination, so their psychological impacts are to reinforce the disempowerment and lack of security of those whose identities have been negatively racialised (Funnell, 2015).

Institutional racism

Understanding race/ethnic inequalities also requires attention to be paid to the role of institutional racism. First coined by Carmichael and Hamilton (1967) the term 'institutional racism' was used to highlight how racialised inequalities were not naturally occurring, but a function of actions operating within institutions. Institutions,

located as they are at the level between the structural and the interpersonal, have a particularly important role. Institutional settings provide a context within which the concentration and amplification of structural forms of disadvantage and interpersonal racism can occur (Bailey *et al.*, 2017; Emirbayer & Desmond, 2015; Phillips, 2010).

Conceptually, institutional racism has been beset by the challenge of attributing racism to institutions, rather than to individuals (Bradby, 2010). However, by locating institutional racism within a wider framework involving both structural and interpersonal processes we can see how institutional practices are produced both via "agential overt and unwitting practices of individuals" and "interacting causal structural conditions" (Phillips, 2010). Indeed, the idea that institutional racism is really a problem of conscious, or unconscious, interpersonal racism ignores the ways in which "institutional and interpersonal racism interpenetrate and support one another" (Emirbayer & Desmond, 2015).

Recognising this interplay allows us to avoid the detachment of institutional practices from the actions of individuals. So, we can consider how the systems of operation in institutions relate to and reproduce both structural and interpersonal racism, and how this is reflected in routine activities, local knowledge, and the collective-emotional structuring of relationships and institutional cultures. All of this results in discriminatory policies and practices that impact on both staff and the users of services.

The outcomes of institutional racism can be seen in the greater likelihood of ethnic minority people having more negative pathways through care, poorer access to effective services and interventions, and poorer outcomes. This is present in any institution we may care to examine, including education (Alexander & Shankley, 2020), health and social care (Chouhan & Nazroo, 2020), housing (Shankley & Finney, 2020), arts and culture (Malik & Shankley, 2020), politics (Sobolewska & Shankley, 2020), but is perhaps most striking in those institutions that have a regulatory, or disciplinary, function, such as criminal justice (Shankley & Williams, 2020) and mental health (Nazroo *et al.*, 2020). Given the very visible nature of the striking race/ethnic inequalities in the practices of these institutions, it is puzzling that they continue with minimal attempts to address institutional racism within them.

How do those who commission and provide services tolerate such negative circumstances and outcomes? At a minimum, such tolerance requires those involved to distance themselves from those receiving negative outcomes from services. This is something that is easier in the context of service provision to members of a group that is racialised. The 'othering' and denigration of such groups enables the necessary distance to be achieved. This also leaves space for unequal outcomes to be wrongly considered to be a consequence of general structural conditions where race/ethnic inequalities are treated as the norm and beyond the control of commissioners and practitioners. They are consequently more easily accepted.

Concluding comments

Despite the evidence summarised above and the stark reminders of ethnic inequality resulting from the coronavirus pandemic, the killing of George Floyd and the Black Lives Matter movement, there has been little policy development to specifically address ethnic inequalities. However, there is not a policy 'vacuum'. Rather there is a continuous series of policies around culture, community, segregation and migration that are populist and that disregard the evidence base. This policy context undermines the citizenship claims and the social status of ethnic minority people and communities, and reinforces processes of racialisation. This has been clearly evidenced by the ongoing Windrush Scandal,² named after the ship that in 1948 carried the 'first' group of post-World War Two labour migrants from Jamaica to the UK. The scandal itself involved the victimisation and deportation of members of the generation of immigrants who arrived between 1948 and 1971 as children, but whose records were never appropriately recorded and who then had their citizenship rights questioned and fell foul of the Home Office's 2012 'hostile environment' initiative for illegal immigrants. It is also clearly evidenced by the use of medical, housing, employment and social services for border control. Careful scrutiny is needed of the evidence base for such policies, and their likely negative impact on the situation of race/ethnic minority people and the communities within which they live. Indeed, rather than this hostile approach, we need policies that promote equitable life chances and that address the underlying racism and marginalisation faced by ethnic minority people.

However, a central challenge is to move beyond simply establishing the existence and/or extent of racism and race/ethnic inequalities to instead "better understand the structures and processes of racial inequality" (Emirbayer & Desmond, 2015). Here there is a need for a more comprehensive, fully integrated understanding of various dimensions of racism and racialised inequality, and the ways in which they shape people's lives and life chances (Emirbayer & Desmond, 2015; Phillips, 2010; Song, 2014). This leads to the pragmatic classification presented here of structural, institutional and interpersonal racism.

Indeed, much of the theoretical and empirical work investigating race and ethnicity and racialised inequalities has focused on specific dimensions of racism, and particularly on institutional racism. There has been a tendency to neglect the inter-relations between the different dimensions of racism. However, institutional racism is not somehow distinct from structural and interpersonal racism. Rather institutions are crucially both situated in and shaped by wider forms of structural racism and inequality, and are spaces within which forms of interpersonal racism operate and can acquire greater salience precisely through their institutionalisation. This then shapes discriminatory policies and practices, and the actions of individuals, resulting in inequalities in the experiences of those with racialised identities.

Also important is to understand the crucial role of the cultural denigration of racialised groups within social and economic structures and how this is played out in both institutional practices and interpersonal interactions.

The central place of institutions in bringing together structural and interpersonal racism, then, leads to the need for a policy agenda focused on disrupting the ways in which particular, and inter-related, institutions produce and reproduce racial/ethnic orders and consequent inequalities. This requires a focus on how such inequalities operate within institutional structures, for example in their employment practices, and on how institutional racism shapes the provision of services and the experiences of clients.

There is also a need to focus on the contexts and functions of institutions – how an institution relates to broader social structures and operates in particular contexts. Part of this is to recognise that institutions do not operate in isolation from one another. So, it is crucially important to understand how institutions and their functions relate to one another, how the boundaries between institutions operate, and the consequences of this for race/ethnic inequalities and the opportunities this provides to disrupt these inequalities.

Finally it is important to note that the pursuit of an agenda to reform the operation of institutions to address race/ethnic inequalities, rather than to reproduce them, must involve partnership between the clients and the leadership of institutions.

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Essay five

Trauma-informed or trauma-inducing? The criminal justice system as an active player in the perpetration of trauma



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Summary

Introduction

Across the UK, criminal justice policy and practice has increasingly focused on the role of trauma in people's pathways into the criminal justice system (CJS), leading to a number of pilots of 'trauma-informed' approaches within the CJS. While recognition that people in the CJS have often experienced significant harm is welcome, this essay argues that the dominant narrative, which portrays trauma as something that happens outside of the system bringing people into it, obscures the role the youth/adult justice systems play as perpetrators of harm.

Describing violence and loss as a result of police contact and imprisonment

Reviewing existing literature, primarily from the UK, this essay describes violence and loss that people and communities in England, Wales and Scotland experience as a result of police contact and imprisonment. It argues that these experiences can be highly distressing, and may result in significant and ongoing psychosocial consequences.

Interactions with past trauma

This essay also argues that these experiences should be understood in interaction with past trauma. It suggests that current criminal justice responses can be understood as denying people's lived experience of harm, and in so doing inflicting further trauma.

Conclusion

The essay concludes by exploring what recognition of the traumatising effect of police contact and imprisonment could mean for criminal justice policy and practice in the UK.

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Introduction

There is a growing narrative that trauma, particularly in childhood, leads to poor outcomes, including involvement in the criminal justice system (CJS). This narrative is evident in the UK Government's 2018 Serious Violence Strategy and in debates on related topics such as knife crime and youth violence. When the Labour MP Vicky Foxcroft raised the issue in the House of Commons, the then Leader of the House, Andrea Leadsom MP, welcomed a proposed debate on the issue, acknowledging "the very serious issue of the impact of appalling early experiences on young people who then find themselves on the conveyor belt into a life of crime"(HC, 28 Jun 2018). This narrative also underpins the Scottish Government's 2017-20 Justice Strategy, with adverse childhood experiences (ACEs) identified as a key challenge. In the different jurisdictions of the UK, this has led to pilots of 'trauma-informed' approaches, building on the idea that practice should be sensitive to trauma, and avoid re-traumatisation (Vaswani and Paul, 2019).

While recognition that people in the CJS have often experienced significant harm is welcome, the focus on trauma as a pathway into the youth/adult justice systems detracts scrutiny from the CJS's contribution to trauma. This essay reviews research literature, primarily from the UK, on experiences of violence and loss arising from police contact or imprisonment. While my interest arose from my research with mainly white men in England and Scotland, I wrote this essay around the time of the high profile deaths of two black Americans, Breonna Taylor and George Floyd. Police shot Taylor dead in her bed at home, on a warrant that has been argued to be illegal (Balko, 2020). Floyd died after a police officer's extended use of neck restraint, which continued despite Floyd's pleas for help and subsequent unconsciousness (New York Times, 2020b). The resulting worldwide protests about police violence against people of colour emphasise the links between trauma from contact with the CJS and racial (in)justice. These links are explored throughout this essay.

Whether violence and loss are traumatic depends on the psychological responses to those events. In psychiatry, trauma refers to a psychological injury (Thompson and Walsh, 2010), or rather, from stressful events that give rise to such an injury (Briere and Scott, 2006). Post-traumatic stress disorder (PTSD) is one injury arising from exposure to stressful events. Its symptoms include alterations in arousal (for example, hypervigilance), avoidance of thoughts or reminders of trauma, intrusion, and changes in thought/cognition (American Psychiatric Association, 2013). Traumas include single or repeated events but it has been argued that a new diagnosis, complex PTSD/trauma, would better capture the experience of repeated or prolonged exposure, particularly to early-life interpersonal events (Herman, 1992).

For a PTSD diagnosis, traumas are narrowly conceived as events resulting in "actual or threatened death, serious injury, or sexual violence", but exclude health conditions such as cancer (American Psychiatric Association, 2013). In terms of violence and loss, this definition includes sexual violence, serious physical violence, and bereavement through traumatic means, for example homicide.

Others have challenged this narrow conceptualisation. Briere and Scott (2006) suggest that "an event is traumatic if it is extremely upsetting and at least temporarily overwhelms the individual's internal resources" (p.4), which might include major losses/separations, and degradation or humiliation. In such approaches, what is important is how people experience these events. Thompson and Walsh (2010) have argued that trauma is better understood as an existential, rather than psychological, injury: by destabilising or destroying the "linking thread of meaning that connects past to future" (p.380), traumatic events jeopardise "our very sense of who we are and where we fit in the world" (p.379). Similarly, constructivist approaches to trauma suggest that traumatic events are those that we can't accommodate into our core beliefs about ourselves, other people and the world (McCann and Pearlman, 1992). This impacts on core psychological needs of safety, trust, esteem (from/towards others), independence, power or control over others, and intimacy and connectedness.

Following these broader conceptualisations of trauma, this essay will detail a range of other losses and 'pains of imprisonment', beyond physical and sexual violence. Since not all uses of force and losses arising from police contact or imprisonment are traumatic, wherever possible the review discusses evidence of how these events are subjectively experienced, and their psychological impact. This discussion focuses primarily on the person experiencing police contact or imprisonment, but also touches on the broader impact on families and communities, particularly of people of colour. This essay then explores the interactions of experiences within the CJS with previous experiences of trauma. Having outlined some of the ways in which the CJS is a perpetrator of trauma, the essay ends by briefly discussing the implications for UK criminal justice policy and practice.

Violence and loss in the CJS Interactions with the police

Writing this essay in spring 2020, protests against police violence are spreading across the US, and throughout the world. While the deaths of Floyd and Taylor in the US prompted UK protests, similar events have occurred this side of the Atlantic. To name a few: the coroner's juries were critical of police use of excessive restraint in the deaths of Sean Rigg in 2008, and Darren Cumberbatch in 2017 – both black men experiencing mental health crises (Baker, 2016; Inquest, 2019). The Scottish Government have ordered an inquiry into the death of Sheku Bayoh in 2015 following use of restraint by the police, and the subsequent decision not to charge the officers involved (Yousaf, 2019). Protests in London followed the fatal shooting of Mark Duggan in 2011 (Newburn *et al.*, 2018) and an inquiry into the shooting of Anthony Grainger in 2012 concluded that Greater Manchester Police were to blame for his death (Teague, 2019).

In 2018/19 in England and Wales there were three fatal police shootings, 16 deaths in or following police custody, 42 road traffic fatalities involving the police, and 152

other deaths following contact with the police that were investigated by the Independent Office for Police Conduct (IOPC, 2019). In Scotland, in the year from April 2018, the Police Investigations and Review Commissioner (PIRC) were referred four deaths in custody, and 17 deaths following contact with the police (PIRC, 2019). These provide some insight into the most adverse outcomes of police contact, although not all of these deaths involved police use of force, or factors under police control.

Deaths are a rare outcome of police use of force in the UK, and so these figures represent merely the tip of the iceberg in relation to adverse or traumatic contact with the police. From April 2018 to March 2019, in England and Wales, 25,000 (6%) of the 428,000 recorded police use of force incidents were noted as having resulted in injuries, of which 610 (2%) were severe (Home Office, 2019). In Scotland, over the same period, there were 104 serious injuries following police contact that were referred to the PIRC (2019), of which they decided to investigate 13. Problems with recording and monitoring practices surrounding use of force incidents have been identified in both England and Wales (HMICFRS, 2019) and Scotland (HMICS, 2018). A 2018 visit by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT, 2019) to Scottish prisons reported that nearly a third of prisoners interviewed alleged that police officers had used excessive force in apprehending them.

Other police practices may also be experienced as distressing, degrading or abusive, including strip-searching, especially where intimate parts are exposed, and the use of spit hoods (Kennedy *et al.*, 2019; Skinnis and Wooff, 2020). It is particularly concerning that these practices are used on children (CRAE, 2018; Lightowler, 2020; Metropolitan Police, 2014; Metropolitan Police, 2018).

Another concern is racial disparities in potentially harmful policing practices. Casework by Inquest suggests that the proportion of black and minority ethnic (BAME) deaths in custody where use of force/restraint is a feature is over two times greater than for other deaths in custody (Inquest, 2020). More generally, Home Office (2019) statistics suggest police force is used disproportionately against people of colour in England and Wales, with people identified as black by the officer particularly over-represented amongst firearms and non-lethal weapons use. In Scotland, the role racialisation plays is being explored within the inquiry into the death of Sheku Bayoh (Yousaf, 2019). Long and Joseph-Salisbury (2019; see also Long, 2018) argue that: "Stereotypes of black masculinity which construct black men as threatening, lead to aggressive policing in response to the imagined threat." (2019: p.208). This over-policing of communities of colour, and its sometimes disastrous consequences, has a long history in the UK (Palmer, 2012).

While the power to use force is often regarded as constituting the core of the police role (Bittner, 1970), some commentators distinguish between the use of force by police, and police violence, in which the use of force is excessive or unjustified (Milani *et al.*, 2017). It has been argued that what constitutes police violence is relative and subjective, with attitudes towards police use of force shaped by factors such as legitimacy and a sense of shared social

identity (i.e. group membership) with the police (Milani *et al.*, 2017; Bradford *et al.*, 2017). Research in the US has identified inconsistencies between the accounts of police officers and suspects (Alpert and Dunham, 2004; Smith *et al.*, 2010), for example regarding whether the force was considered excessive and whether it continued beyond the point at which the suspect was under control.

Not enough is known about how those on the receiving end experience the police's use of force. Some young people sampled from an inner-city youth offending service in England experienced the police as aggressively harassing and violent (Paton *et al.*, 2009), while research with people from black (Long, 2018), black mixed-race (Long and Joseph-Salisbury, 2019), and different ethnic minority communities in the UK has found experiences of aggressive policing (Sharp and Atherton, 2007). In particular, there is insufficient knowledge about the long-term consequences.

Research from the US suggests a trauma lens may help understand the impact of police contact and violence on those subject to it (Root *et al.*, 2013; Meade *et al.*, 2017), their family members and wider communities, and especially for people of colour, in particular Black Americans. Geller *et al.* (2014) asked young men, few of whom reported involvement in criminalised activity, about their experiences of being stopped by the police. They found a relationship between police contact, especially intrusive contact, and PTSD and anxiety symptoms, with this relationship also affected by perceptions of procedural justice. The young men interviewed by Smith Lee and Robinson (2019) from an economically disadvantaged area of Baltimore had witnessed and experienced police violence, resulting in distrust of the police. Where people had lost loved ones in this way, they experienced fear and hypervigilance around the police, and a sense of injustice.

Researching the experiences of families of those who died following police contact, Baker and Norris (2020) found that such deaths can affect family beliefs in procedural justice, trust, police legitimacy, the justice system and their sense of a just world. Baker *et al.* (2019) suggest that these deaths may result in a sense of disenfranchised grief – the term given for grief following a loss which "is not or cannot be openly acknowledged, socially sanctioned or publicly mourned" (Doka, 1989: p.4). Other US-based research suggests that the negative psychological impact of the killing of unarmed black Americans extends beyond immediate communities to other black Americans, who may only have witnessed the killing through the media (Bor *et al.*, 2018; Lipscomb *et al.*, 2019). Bryant-Davis *et al.* (2017) concluded that, directed at people of colour, police violence should be understood as a race-based trauma, which could be transmitted intergenerationally.

The ubiquity of armed police and the comparatively high number of deaths in the US of people of colour following police contact (see Bureau of Justice Statistics, 2016) may contribute to a pervasive sense of hypervigilance among people of colour in the US. It is important to note, however, that social, cultural and historical differences mean that US evidence on police violence cannot simply be imported and applied uncritically in a UK context. Nevertheless, findings on the traumatic impact of police contact have some relevance

for overly-policed communities in the UK. Researching accountability processes following deaths after police contact in England and Wales, Baker argues that those who die after contact with the police “leave behind families and friends who are grief stricken because of the death, and often doubly traumatised because the accountability process does not construct legitimate outcomes” (Baker, 2016: p.205). Long and Joseph-Salisbury (2019) highlight ways in which black-mixed race men in England are affected by the experiences of other black people they know, high profile cases and their own prior experiences, resulting in fear, heightened awareness of police presence and attempts to avoid police encounters – all emotional, sensory and behavioural responses with links to trauma. Awareness of police violence and the resulting fear and hypervigilance are likely to shape how people experience subsequent contact with the police.

Imprisonment and youth custody

Violent incidents appear to be increasing in prisons in both England and Wales (HMIP, 2019) and in Scotland (HMIPS, 2019). The 2019 CPT inspection concluded that none of the male establishments visited in England and Wales could be considered safe (CPT, 2020). The CPT visit found that inter-prisoner violence, prisoner-on-staff assaults and staff-on-prisoner violence in the adult male prisons they visited had all reached “record highs” (p.5), while HMIP (2019) reported that use of force by prison officers had increased in 28 prisons and that governance remained weak at many establishments. The CPT (2020) reported a disturbing practice of staff punching compliant prisoners who were deemed a potential threat in the future, in what were known as “preventive strikes”(p.6). In Scotland, the CPT (2019) heard reports of excessive use of force and unnecessary infliction of pain by prison officers during control and restraint operations.

Exposure to such violence is particularly harmful during childhood (Cook *et al.*, 2005; Hillis *et al.*, 2017), and yet despite ratification of the United Nation’s Convention on the Rights of the Child, Goldson (2009: p.87) argues that: “violence against children remains legal, state-authorised and socially approved” within custodial institutions for children in the UK. Restraint techniques that deliberately inflict pain on children remain legal (CPT, 2020). Accounts of periods in custody from young people attending an English inner-city youth offending service depicted “a violent institutional culture [...] where authority figures did not protect young people from violence” (Paton *et al.*, 2009: p.49). In 2017, Her Majesty’s Chief Inspector of Prisons wrote to the then Justice Minister declaring that none of the facilities that they had inspected across England and Wales were safe to hold children, while in 2019 they found that, despite improvements in safety in children’s custody, levels of violence remained high and bullying was a constant concern (HMIP, 2019). A survey of children in secure training centres and young offender institutions in England and Wales

found that more than one-third (35%) had felt unsafe in the establishment at some point, and just under half (48%) had experienced bullying. 42% of children reported experiencing victimisation by staff (HMIP, 2020). There were 1,070 reported incidents of alleged sexual abuse against children held in custodial institutions in England and Wales between 2009 and 2017, mostly by staff, which were often alleged to have taken place during restraint or body searches, and which in some settings were rarely investigated (Independent Inquiry Child Sexual Abuse, 2019).

As with police contact, disparities in experiences of victimisation and use of force are cause for concern. In the HMIP (2020) survey, children from traveller communities were more likely to report having felt unsafe or experienced bullying. Although children from BAME backgrounds were less likely to report victimisation from other children, they were significantly more likely than children from white backgrounds to report being verbally abused or threatened/intimidated by staff. Use of force incidents in English and Welsh prisons disproportionately involve prisoners from BAME groups, especially younger black males, as well as prisoners of Muslim faith (HM Prison & Probation Service, 2017; Jolliffe and Haque, 2017). This should be understood in the context that certain groups are over-represented in the prison population, including black people, and people from gypsy, roma or traveller communities (Lammy, 2017; Scottish Government, 2020b).

As well as restraint techniques, other routine practices such as use of isolation and strip-searching can also be construed and experienced as abusive or distressing (Goldson, 2009; McCulloch and George, 2009; Armstrong and McGhee, 2019). Commentators and researchers have also noted other ‘pains of imprisonment’. Crewe (2011) argues that pains of imprisonment arising from deliberate abuses and derelictions of duty, although still present, have been supplemented by a more prominent set of pains: pains that are the consequences of systemic policies and institutional practices, and the micro-aggressions and humiliations within these. For example, Crewe suggests that psychological assessment practices can overwrite prisoners’ own personal identities with negative labels. The concept of institutional trauma has been used to describe “the profound distress that can be caused through the overlapping effects of the physical qualities, daily routines and typical events, organisational culture and prevailing (or constrained) social dynamics of institutions themselves” (Armstrong and McGhee, 2019: p.33).

Loss seems inherent to the prison experience. The ‘pains of imprisonment’ famously identified by Sykes (1958) can all be understood as losses: loss of liberty, deprivation of goods and services, frustration of sexual desire, deprivation of autonomy and deprivation of security. In a contemporary UK context, certain losses appear particularly pertinent to certain groups. Crewe *et al.* (2017) suggest that prison is particularly painful for women, in particular the losses of autonomy and relationships, as well as loss of physical and emotional privacy. Writing about young people in custody in Scotland, Vaswani (2015; 2018) identifies a ‘catalogue of losses’ experienced in custody, including loss of relationships, and status, and so autonomy in terms of

control over one’s own life. Her participants talked about the loss of future, such as the loss of opportunities and diminishment of their prospects as a result of their actions or imprisonment. Despite mostly being on short sentences, her participants still saw prison as placing substantial barriers on their realisation of a desired future. She highlights that late adolescence is a crucial period for the development of self-concept, meaning that the impact of incarceration is likely to be particularly significant at this age.

Loss of relationships is a commonly noted loss of imprisonment. Our relationships with others are intimately tied up with our sense of self (Haney, 2003), with disempowerment and disconnection core features of psychological trauma (Herman, 1998). For mothers, the imposed powerlessness of imprisonment presents substantial barriers to maintaining relationships with children and performing maternal identities (Couvrette *et al.*, 2016; Crewe *et al.*, 2017; Easterling *et al.*, 2019), even where children were not in their custody prior to imprisonment. Some women may be able to modify their conception of motherhood to reflect a new way of being a mother in prison, but others are unable to do this (Easterling *et al.*, 2019). Some women on long sentences will be denied the opportunity to have children altogether, resulting in feelings of grief and loss for an unrealised identity (Jewkes, 2005).

Whether these losses are experienced as traumatic may depend on what comes next. For example, if future identities as a good mother are realised then imprisonment may be subsequently interpreted as offering an opportunity to draw good from the bad (a form of ‘post-traumatic growth’). But where losses are permanent, then it is likely stories of imprisonment may assume a tragic form. My own research (Anderson, 2019) suggests that, for some men, the losses imposed by their experiences of criminalisation and punishment are still experienced acutely after imprisonment, in some cases many years later. In fact, the experience of release and the failure to realise desired goals can only embed this experience of loss (Nugent and Schinkel, 2016).

The impact of these losses can be linked with trauma in a number of ways. To start with, these losses are often associated with societal stigma and lack of recognition from others, resulting in disenfranchised grief (Vaswani, 2018). In addition, the process of coping with these losses may result in permanent changes to one’s identity. While some prisoners may be able to create positive new identities and so construe some aspects of their prison experience as meaningful (Maruna *et al.*, 2006; van Ginneken, 2016), the required identity transformations can also be damaging. Hulley *et al.* (2015) suggested that: “The everyday pains of imprisonment are ‘felt’ less sharply, because, in some senses, they have been internalized into the prisoner’s being, and have made him or her become a different person” (p.788).

Particularly following lengthy imprisonment there is evidence of psychological consequences extending beyond release. Following their U.S. based research with released life prisoners, Liem and Kunst (2013) propose the existence of a specific “post-incarceration syndrome” (PICS) as a sub-set of PTSD, but with additional features including institutionalized personality traits, social-sensory disorientation, and alienation. Hulley *et al.* (2015) identify traits of PTSD/Post-

Incarceration Syndrome (PICS) in the narratives of English life-prisoners, especially ‘emotional numbing’, distrust in others and difficulties in social interaction. These long-term impacts need exploring with other populations, especially repeated short-term prisoners who have been said to effectively experience a life sentence ‘by instalments’ (Armstrong and Weaver, 2013).

Interactions with past trauma and adversity

How violence and loss within the CJS are experienced should be understood in the context of past trauma. Traumatizing past experiences have been identified in research with multiple groups in the CJS, including women (Segrave and Carlton, 2010; Crewe *et al.*, 2017), people with histories of problematic drug and alcohol use (Hammersley *et al.*, 2016) or multiple disadvantage (Anderson, 2019), violent men (Ellis *et al.*, 2017), and young people (Vaswani, 2014; Paton *et al.*, 2009).

For people who have experienced past trauma, “events or circumstances that echo the violation and lack of control of an earlier trauma can be re-traumatizing”, with the impact of these events being cumulative and additive (multiple occurrences and multiple types of event are both associated with greater negative impacts) (Kammerer and Mazelis, 2006: p.11). Institutions and the practices within these present particular risks of re-traumatisation through practices discussed above such as restraint, strip-searching (see McCulloch and George, 2009; Hutchison, 2020) or the use of spit hoods, but also through the broader loss of control that institutionalisation presents. In their research with women life-prisoners, Crewe *et al.* (2017) draw attention to the ways in which imprisonment “interacts with and compounds the forms of trauma and degradation that almost all of the women in our study had suffered prior to their sentence” (p.1375), reproducing feelings of low self-worth and shame from previous abuse, and powerlessness from their lives outside prison. Additionally, researchers have drawn attention to environmental factors within the prison, for example bars on windows, corridors with poor sightlines, and even sounds, which can recreate or trigger memories of previous abusive experiences (Jewkes *et al.*, 2019). Jewkes and Laws (2020) research with women in prison in Scotland and England described how prison designs such as those enabling officers to see women in the shower or in their cells, presented a “constant threat of exposure and intrusion [which] resulted in many participants experiencing a diminished sense of self” (p.5).

Violence, loss and other traumatic events outside of the CJS are likely to impact on the way that stories of violence, loss and trauma within the CJS are narrated. Vaswani (2015) found that the “catalogue of losses” experienced by young people in the CJS preceded their time in custody. She found that “for some of the young men, their experiences meant that a sense of being predestined for prison was embedded in their self-concept from a young age, signalling a chronic

loss of hope and ambition for the future" (Vaswani, 2015: 30). However, incarceration is still likely to play an active role here, reinforcing a sense of disconnection and confirming and embedding this way of viewing themselves and their lives.

My research with adult men who had faced multiple disadvantage found that, in at least some cases, the accumulation of multiple violent events appears to have resulted in acclimatisation to a culture of violence (Anderson, 2019). For example, police violence could be recognised as an injustice but one that had come to be expected as part and parcel of everyday life and the purposeless cruelty of the CJS. Violence within custodial institutions could be accepted as an improvement on violent home environments they had left behind. Yet this does not mean that this violence did not play a role in how the person saw themselves and their relation to the world, their trust in others and so their relationships, and their sense of safety. This complex relationship between experiences within and outside of prison is also captured in Segrave and Carlton's (2010) research with women imprisoned in Australia. For some of their interviewees "prison is not a safe haven but a safer place" (p.295, emphasis in original) yet as one memorably says, "the system becomes the abusive partner when you get to prison" (p.296).

Processing someone as an offender through criminal justice institutions has considerable symbolic power. It serves to erase the harms that they have experienced in the eyes of others, constructing them as a perpetrator of harm to others (Anderson, 2019). This exposes them to further harm by rendering their pain legitimate in the eyes of others, and so allowing us to do nothing to rectify these harms. As Angela Davis has powerfully argued: "This is the ideological work that the prison performs; it relieves us of the responsibility of seriously engaging with the problems of our society, especially those produced by racism, and, increasingly, global capitalism" (Davis, 2003: p.16).

Stauffer (2015: p.5) has argued that "being abandoned by those who have the power to help produces a loneliness more profound than simple isolation". In denying the men's experiences of harm, prior to and within the CJS, this system 'turns away' from them and silences their story. It denies their lived experience, and so their humanity, inflicting further trauma (Anderson, 2016). Scott (2015: p.19) argues that "not hearing the voice of the estranged Other, failing to respond to a cry of pain, matters enormously to those who are not heard because the sense of abandonment impacts upon how the past resonates in the present and how they face the future". Writing about trauma survivors, Laub (1992: p.68) argues that the absence of an empathetic listener to affirm and recognise the realness of their memories annihilates their story – and with it inflicts further harm, annihilating the self (see Anderson, 2016). It is arguably this aspect of the CJS that is most harmful, yet the most intractable.

What does this mean for the CJS?

This essay has described violence and loss as traumatising features of the UK criminal justice system, focusing on police contact and incarceration in custodial institutions, specifically prisons and young offender institutions. This discussion is partial, excluding other potential sites of harm such as community supervision and the court, as well as interactions with the CJS as a victim of crime. The focus has been on people in direct contact with the CJS, but the essay has also explored ripple effects extending outwards to families and communities, particularly communities of colour (Baker *et al.*, 2019; Lipscomb *et al.*, 2019; Minson, 2019).

The central question then is whether police forces and prisons/young offender institutions can be transformed so that they no longer contain these traumatising features. Without space to fully explore this question here, the discussion suggests some reasons to be pessimistic. Use of force is a core part of the police role (Bittner, 1970), and yet whether that force is excessive appears to be partly subjective and based on previous trauma experiences. Consequently, reforms based on eliminating unjustified use of force may still not change the harmful nature of this experience for those subject to it. And while reduction of violent assaults within a prison may be possible, the prison is designed around loss – it separates people from the community, severing relationships; it de-individualises and dehumanises.

2020 has seen arguments around 'defunding the police' featured prominently in US and UK media (e.g. Bakar, 2020; The New York Times, 2020a; The Times, 2020), suggesting some public appetite to engage with abolitionist critiques and consider new solutions. Nevertheless, while accepting that policing practices and prison can be harmful, many readers will remain wedded to their use, regarding these as a necessary evil, for their perceived role in preventing crime, and the perceived lack of alternatives.

When we feel resigned that there are no alternatives, it is worth reminding ourselves that much conflict resolution in our lives already happens outside the CJS, and that, in effect, public police and prisons already play a highly limited role in preventing and responding to many types of crime. In the UK, this includes crimes as diverse and serious as rape, due to low reporting and conviction rates (Daly and Bouhours, 2010; Office for National Statistics, 2018); safety crimes in workplaces, which may fall under the purview of regulatory bodies and which may be dealt with through other forms of enforcement action (Tombs and Whyte, 2008); and the policing of the internet, which is instead governed by "a complex assemblage of networked nodes of security" (Wall, 2007: p.189 references omitted). Researchers have also increasingly identified ways in which actions by criminal justice agencies actually impede people's pathways away from crime (Hart, 2017; Wright, 2017; Schinkel *et al.*, 2018).

Those searching for alternatives remain committed to accountability and safety, but do not view the CJS as the vehicle by which to achieve this. Some prefer community interventions (Kim, 2011; Schenwar, 2014; Sered, 2019),

while others suggest we make greater use of civil, rather than criminal, law (Scott, 2013). Examples that have been developed show glimmers of promise, but make clear the challenges of enacting such approaches. Yet it is not surprising that our alternatives remain underdeveloped when policy and practice commitment to developing solutions outside the CJS have paled in significance to the energy invested in unsuccessful reform efforts.

At a minimum, taking seriously the traumatising nature of policing practices and imprisonment requires us to think very carefully about their use. This means avoiding reforms that inadvertently give the police greater power, resources or reach (Vitale, 2017). It means limiting police powers, such as stop and search or possession of weapons, and their reach through decriminalisation. It also means diversion of people from prison – ideally from the CJS altogether – wherever possible, and a commitment to decarceration and halting prison building (Scott, 2013). It means getting people out of prison as soon as possible, so reversing the upward drift of sentence lengths and time served in prison both sides of the border (House of Commons Justice Committee, 2019; The Scottish Government, 2020a). Brangan (2019) describes how penal policy in the Republic of Ireland in the 1970s, while non-abolitionist, operated "with a deep scepticism of the prison and an awareness of the harms it causes" (p.2). This manifested in significant use of temporary release, and supportive interventions designed to address "the problems of the prison, not the problems of the prisoner" (p.14), helping the person cope with the pains of imprisonment.

The traumatising effect of criminal justice institutions, and the interaction with past trauma, should preclude the use of these institutions to address trauma and its effects. Across the UK, pilots have been established in trauma-informed policing, trauma-informed youth justice, trauma-related training of professionals across criminal justice agencies, and other related initiatives. While recognition that people who have offended may require sensitivity to and support for trauma is welcome, there is a danger that the availability of support through criminal justice routes inadvertently makes calling the police or sentencing someone to prison more appealing, so exposing people to the risks of further trauma outlined here.

Wherever possible, work to address trauma should happen in the community. As Baroness Corston argued in her report on women in prison: "The practice of sending a woman to prison as a 'place of safety' or 'for her own good' is appalling and must stop. Nor should sentencers use prison as a means of accessing services" (Corston, 2007: p.9). This argument should be extended to men, and especially children and young people. We should ask if the significant amount of public money poured into policing and prisons (notwithstanding the substantial cuts to justice services in England and Wales over the post-2010 era of austerity) could be invested into areas better suited to supporting people who have experienced trauma – such as mental health, substance use, domestic/sexual violence, and anti-poverty services. It has been proposed that our responses to offending should concentrate resources on the victims of this offending, rather than the perpetrators (Scott, 2013).

Reinvesting criminal justice funds outside the CJS can also reduce social inequalities that the CJS reproduces. We should consider who it is that gets labelled, with social injustices around race and class embedded within and exacerbated by the system. Some commentators and researchers have argued that the violence and loss this system imposes are not unhappy accidents – but are core to its function. These arguments are not only based on failed attempts at reform, but on the racial and class disparities in those subject to the CJS, and historical analysis of the origins and functions of policing and prisons. These origins and functions can be linked to maintaining the conditions for capital accumulation (for example, through the protection of property and the suppression of industrial action, protest and riots) and to preserving a racial order (Alexander, 2010; McDowell and Fernandez, 2018; Vitale, 2017). These "traumatizing, historical injustices", embedded within the CJS, are left untouched by attempts to provide "trauma-informed" approaches within it (Whalley and Hackett, 2017: p.456).

There is a rich abolitionist literature and this essay is not speaking to those voices who have articulated the problem far better and for far longer than I have (Ruth Wilson Gilmore, Angela Davis, Alex Vitale, David Scott, Joe Sim, Vincenzo Ruggiero to name just a few). This essay seeks to ensure that – in a collection about trauma, poverty and multiple disadvantage – trauma is not viewed as something that happens 'out there' bringing people into these systems. Rather the system is recognised as an active player in trauma, so redirecting our search for solutions away from this system. Reflecting on Jewkes *et al.*'s (2019) insights as to the extent of the changes needed in creating a trauma-informed prison, Armstrong and McGhee (2019) question whether what would be left could still be considered a prison at all. Instead, these insights could lead us to the conclusion that "overcoming fundamental dynamics of carceral institutions means avoiding their use altogether" (p.36). Rather than tweaking existing systems, being truly trauma-informed in our responses to harm requires a need to engage with more radical solutions and imagine very different ways of enacting justice.

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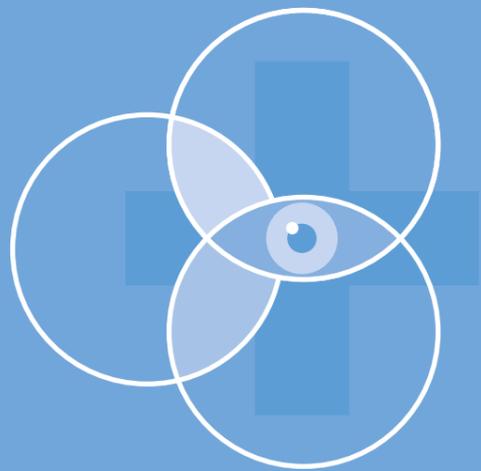
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Essay six

Adversity and injustice: Reframing and claiming our responsibilities



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Summary

Introduction

The experience of trauma, poverty and adversity causes persistent harm, distress and ill-health for many people. But current epidemiological and biomedical models don't fully account for these malign effects at a population level. Economist Amartya Sen's Capabilities approach, with its emphasis on human dignity, diversity and choice, offers a useful reframing of the impact of poverty, trauma and multiple disadvantage on public health.

Capabilities and childhood adversity

The Capabilities approach allows us to consider the causes and impact of trauma and adversity in a broader frame. Although Adverse Childhood Experiences (ACEs) are associated with biological changes, and may predispose someone to physical and mental illness, the Capabilities approach also brings a perspective which emphasises the relationship between ACEs, dignity and rights – which may apply at both an individual and community level.

Reframing inequality and adversity

Considering adversity and disadvantage in Capabilities terms emphasises the importance of harmful experiences as a marker of disempowerment, humiliation and disrespect, and their relevance for both individuals and communities. When considering poverty and trauma from a Capabilities perspective, *dignity*, *affiliation* and *control* are particularly important.

Causes of adversity and impaired capabilities: recognising our responsibilities

Young's Social Connection Model (2006) emphasises a collective responsibility for these large-scale effects, rather than attributing liability or fault to the conscious choices of a few individuals with malign intent. Scholarship in the fields of social justice, including racialisation and gender equality, can complement a biomedical understanding of trauma and adversity by turning our attention towards societal attitudes and structures as well as biological markers of change in the bodies of those affected.

Conclusion

The important signal generated by ACEs in relation to health inequalities needs to be reconsidered in a new conceptual frame based on social justice, human connectedness and rights and freedoms.

Conceptualising these issues in a Capabilities framework, with its attention to emotions, affiliations, senses, imagination and thought, can bring a fresh perspective on the connections between poverty, adversity, trauma and multiple disadvantage. But moving from a biomedical to a Capabilities frame requires a significant shift for all – including the social attitudes and defences of researchers, practitioners and policy-makers themselves. We offer five practical suggestions for change.

Introduction

This essay investigates the theoretical underpinnings of a daunting practical question: how can we improve population mental and physical health? Although progress has been made over recent decades, poor health and inequality still persist. Since such inequalities are not inevitable, we need to consider that the problem may not just be one of delivery (reaching enough people in the right way), but perhaps also a failure of concept. If we were to rethink and reframe our approach, what might that look like?

The conventional approach has been to identify certain problems amongst certain groups and implement a programme of 'interventions' to address them. But these issues are hard to measure, and even harder to change. Those difficulties will be particularly pronounced if our framing of the problem is misconceived.

Working as a psychiatrist (MS) and a public health practitioner (KH), we know from experience that three elements have a critical influence on health and wellbeing: poverty, injustice and childhood adversity. This much is uncontroversial – but converting these principles into practice is both complex and contested.

The Scottish Government set out a commitment to preventing and mitigating Adverse Childhood Experiences (ACEs) in its 2017/18 Programme for Government, and that work continues. But to be effective, an approach to ACEs needs to integrate decades of work on human rights, poverty and inequality across the life course (Hetherington, 2020). That kind of consolidation requires a sound intellectual foundation.

"Social justice," asserts the World Health Organization (WHO), "is a matter of life and death. It affects the way people live, their consequent chance of illness, and their risk of premature death" (Commission on Social Determinants of Health, 2008). Yet conventional public health metrics have struggled to capture and understand social justice and its constituent parts, including social connectedness, relationships, and the dynamics of work and family life.

Poverty is clearly a fundamental cause of health inequality. But considering poverty alone can't fully account for variation in health status between places and over time. This gap in understanding is known as 'excess mortality' – deaths which can't be accounted for by considering poverty and demographic factors alone. Excess mortality has commonly been observed around the world at times of political upheaval or socio-economic adversity. Most of that mortality is caused by increased deaths from suicide, violence and substance misuse, a pattern of morbidity that has variously been described as 'the Glasgow effect' in the UK, 'dying unneeded' in Russia (Parsons, 2014) or 'deaths of despair' in the USA (Case & Deaton, 2015). This profile echoes the poor health associated with discrimination and disempowerment experienced by indigenous and racialised people (Smith, 2018; Williams *et al.*, 2019).

Not surprisingly, each situation is different: in Russia, excess mortality occurred almost entirely amongst men rather than women; and in the USA, the 'deaths of

despair' predominately affected the white population, rather than people of colour. Detailed work in Scotland describes a complex influence of deindustrialisation, poverty, social selection, impaired social capital and a democratic deficit (Walsh *et al.*, 2016).

The challenges are to find a frame or model sufficiently broad to include individual as well as population effects; to consider poverty as only one of a range of different adversities; to be aware of the impact of adversity on adults as well as children; to extend our understanding of 'trauma' beyond overt neglect and abuse and consider more subtle or pervasive forms of harm; and to think about the consequences of such harm in social and relational terms as well as its impact on health.

In this essay, we approach these challenges by returning to a deceptively simple question the economist Amartya Sen asked more than 30 years ago: "equality of what?" (Sen, 1987).

This paper opens with an exploration of the strengths and weaknesses of our understanding of adversity in childhood, and the use of the Adverse Childhood Experiences (ACEs) tool as a window into those issues.

It continues with a consideration of Sen's Capabilities approach – which aims to place economic disadvantage into a much broader conceptual frame. We propose that ACEs act not only as risk factors for future health problems, but also as a marker of infringement of rights and freedoms, and an important limitation on capabilities.

We conclude by bringing a third dimension into play: the influential but often unexamined dynamic by which society chooses to either acknowledge and turn towards these problems, or to deny that they exist.

Adverse Childhood Experiences: a measure in need of context

Childhood development is an important determinant of health, and evidence shows that secure attachment and support in the early years has the potential to reduce health inequalities as well as protect children's rights. The WHO recognises child maltreatment (physical, sexual, emotional abuse and neglect) as a severe public health concern, and studies investigating the impact of ACEs since the late 1990s have repeatedly confirmed strong links between harmful experiences occurring up to adolescence and a range of health and social outcomes in adulthood.

In 1998, researchers doing a study into ACEs chose to ask about 10 forms of adversity experienced within the household before the age of 18. These included exposure to physical, sexual and emotional abuse; physical and emotional neglect; and five kinds of 'household dysfunction' (parents separated or divorced, domestic violence, substance misuse, mental illness and incarceration). Studies showed not only that ACEs were common (two-thirds of the original sample had experienced at

least one adversity), but also that ACEs correlated with health and social outcomes in later life in proportion to the adversity experienced (Felitti *et al.*, 1998).

ACEs are associated with an increased risk of heart disease and cancer, but have a particularly strong impact on mental health: exposure to ACEs strongly influences rates of depression, substance misuse and suicide. Overall, experiencing six or more of these adversities is associated with a reduction in life expectancy of 20 years (Felitti and Anda, 2014). Subsequent studies and meta-analyses have confirmed both the strength and scope of the effect (Hughes *et al.*, 2017).

Models seeking to explain the mechanisms connecting ACEs with poor health and social outcomes have plausibly related experience of childhood adversity with neurobiological pathways relating to chronic stress, health-harming behaviours, and social determinants of health such as access to education and income (Allen & Donkin, 2015). Such models are typically linear in form: certain exposures are associated with certain outcomes, and the changes are largely posited to take place within the individual who is affected. The 'social determinants' are not explicit and are largely considered as static, external factors (McEwen & Gregerson, 2019; McEwen & McEwen, 2017a).

In Scotland, as in other parts of the UK, there has been a policy focus on the importance of early years for decades. The possibility that ACEs might have an effect at a population level led to investigation of possible correlations between childhood adversity and excess mortality in Scotland. No clear effect has been found (Smith *et al.*, 2016), though the potential confounding effect of socio-economic factors on ACEs is significant (Taylor-Robinson *et al.*, 2018; Walsh *et al.*, 2019).

Nonetheless, the publication of a Scottish Public Health Network report on ACEs in 2016 (Couper & Mackie, 2016) provided a renewed opportunity to bring attention to the importance of early life, not only as a children's rights and health issue, but also as one with implications for adult health and a range of social issues. ACEs research "provided an important bridge between professions in gaining a shared language about how early life can impact on later social, health and economic life outcomes" (Spratt *et al.*, 2019). ACEs are now recognised in Scottish Government policy and understood as a public health issue (Hetherington, 2020). But they are also the source of significant contention and debate, which is perhaps to be expected given the diversity of perspectives and experiences that ACEs-related responses seek to encompass.

Clinicians and epidemiologists conducted the initial ACEs studies, and subsequent research, interpretation and popularisation of ACEs thinking has remained firmly rooted in biomedical models.

While there is broad support for the principle of a compassionate response for people affected by trauma and adversity, critics point out that ACEs do not arise in a vacuum, but are profoundly influenced by socio-economic and other structural factors. A reductionist

biomedical model, and well-intentioned but simplistic approaches to expert 'care' for the 'vulnerable' risk entrenching, rather than improving, existing inequalities.

Critics have argued that ACEs:

- are excessively reductive and decontextualised, neglecting wider structural influences such as poverty, gender equality and the role of power in society; and that they medicalise issues that are essentially social and political (Gupta, 2017).
- are too deterministic and potentially stigmatising – the 'risk' associated with childhood adversity has been misrepresented (Eaton, 2017).
- use definitions and measures which are ill-defined, retrospective, variable and subjective, and overall represent a well-intentioned but faddish bandwagon motivated in part by professional self-interest (Kelly-Irving and Delpierre, 2019).
- do not include the voices of people affected by adversity, and blame the very people that practitioners purport to help (Sweeney and Taggart, 2018; Treanor, 2019).
- Are based on a 'deficit' model, which limits inclusion of people in decision-making about their own priorities.

The tone of this debate has been intense, with some authors alleging that "the ACE movement fervour" has been misled by a "chaotic concept" which serves to distract or obscure the influence of structural factors: "the irrefutable and long-recognised relationship between child poverty, poor health, lower educational attainment and reduced life expectancy is concealed by alleged ACE pathways", with poverty "reframed as a symptom of a damaged brain and body" (White *et al.*, 2019). This zero-sum argument (either ACEs or poverty, but not both) has generated a lot of heat, with White *et al.* (2019) attributing "a eugenic logic of predicting and preventing abnormality", asserting that ACEs "authoritatively... locate the seeds of dysfunction in the brains and bodies of children".

We take a different stance in this essay. Firstly, we argue that poverty and ACEs are both important, and that while they frequently overlap, they also represent distinct forms of adversity, including material deprivation, losses within the family and disrupted family dynamics (Rod *et al.*, 2020).

The interaction between health conditions and health inequality caused by poverty, stigmatisation, stress, and structural violence is a well-recognised feature of 'syndemic' health problems (Singer *et al.*, 2017).

Secondly, although the original 10 ACEs items chose to focus on 'household dysfunction', subsequent research clearly shows that domestic ACEs have their equivalents in 'community' adversity, such as neighbourhood violence, racism, poverty and insecurity (Cronholm *et al.*, 2015).

Even the so-called 'household' ACEs such as family breakdown, incarceration, mental illness and addiction problems do not arise in a vacuum – they are strongly influenced by political choices. For example, the UK has the highest level of child and adult imprisonment in Western Europe, and tens of thousands of children have a parent in

prison. Regressive individual and corporate taxation, labour market policies designed to reduce employee protections, and a welfare system which does not provide adequate income for healthy living each correlate with increased inequality and rising levels of child poverty. A falling price of alcohol relative to other goods, and advertising of unhealthy food and alcohol contribute to high rates of obesity and alcohol and drug misuse in the UK (Beeston *et al.*, 2013).

Thirdly, we now know that the presence of an 'always available adult' – someone a child can always trust to provide support if needed – can mitigate much of the harm associated with ACEs (Bellis *et al.*, 2017). Youth work, family support, sport, community groups and public services all provide important places to develop safe, trusting relationships for children, young people and adults (Whitehead *et al.*, 2019).

In summary, the original ACEs measure has two big limitations:

1. It is too restricted in scope, and should include a much wider perspective on adversity, disadvantage and trauma, especially including the impact of structural factors such as poverty and discrimination.
2. It is too focused on measuring the impact of trauma and adversity on victims and survivors; a structural perspective requires action on the causes of harm, and not only on action to mitigate their effects.

We need to take care not to think of ACEs as an outcome, or a stigmatised indicator of deficit and damage. Notwithstanding its limitations as a narrow, reductive proxy, an ACE score in practice can often provide a useful and important signal of potential harm. Being able to hear and attend to that signal requires us to listen carefully to the language we use when talking about ACEs. We need to think carefully about the assumptions and implications of metaphors and concepts such as 'vulnerability', 'resilience', 'adversity', 'complex trauma', 'deprivation' and 'disadvantage'. Just as important – given the prevalence of ACEs in all parts of society – who is the 'we' that is talking about 'these people' with ACEs?

We turn next to Sen's Capabilities approach, which offers an alternative way to understand adversity, development and poverty.

Sen's Capabilities approach

Amartya Sen and the philosopher Martha Nussbaum developed the 'Capabilities approach' as a 'necessary counter-theory' to existing approaches to social justice and public policy.

Sen argued for a shift in focus from considering material resources – the "means of living" – to the "actual opportunities a person has". This emphasis on the 'functionings and capabilities' available to someone, rather than the income they have, addresses shortcomings in conventional economic indicators. For example, measuring

a person's income (or a nation's gross domestic product) overlooks aspects of quality of life which are not monetised, such as physical security, environmental quality and leisure time. They also fail to account for the diversity of human needs: a nominally equal resource may still be inadequate for some people. Furthermore, disadvantage is multi-faceted, and redistribution of money can't in itself end oppressive social structures (Wolff & de Shalit, 2007, p.5).

Nussbaum proposed a list of 10 'central human capabilities', which represent not only the minimum requirement for each of us to live a life with dignity, but also constitute a minimum guarantee which any just society must make for its citizens. The 10 capabilities are summarised in figure 1 on page 67 (Nussbaum, 2011).

Nussbaum's formulation is broad in scope, and acknowledges the subjective nature of people's choices. People need to make their own decisions, and will choose different things; they will often need to prioritise between choices in conflict.

Nonetheless, if these Capabilities are available and secure, people can transform them into the things they value in life, and can actually do or be as part of that life. These 'functionings' may be basic, such as being in good health and having enough to eat. Others are much more complex and socially embedded, for example, "achieving self-respect, being socially integrated, being happy, taking part in the life of the community, and appearing in public without shame" (Sen, 1993).

The transformation of 'capabilities' into 'functionings' is achieved through 'conversion factors'. For example, the opportunity for *movement* would be a capability, the actual moving would be a functioning, and that movement could be enabled by a conversion factor such as a bike, a wheelchair or a bus, depending on one's needs and preferences. Sen and others recognise that poverty is an important limitation on conversion factors, but also retain a focus on non-material limitations on capabilities. Discrimination on the grounds of sexuality or gender, for example, will limit functioning even for people with money.

Conversion factors can be considered in three groups (Brunner, 2015, p.76):

1. Personal – attributes of the individual, such as their physical health, gender or cognitive abilities.
2. Social – the attitudes, norms and values in society in relation to gender, race and class which may encourage or prevent functionings.
3. Environmental – including not only climate and pollution, but the availability of housing and transportation.

Societies are generally able to recognise and implement most of Nussbaum's 'central' capabilities: citizens have access to education, health care, protection from assault, green spaces and so on. Although these are recognised as 'social determinants' in public health models, they typically place less emphasis on *dignity* as a key theme across capabilities, and especially to the importance of *affiliation* and *control*.

Figure 1 – Nussbaum proposed a list of 10 'central human capabilities' (Nussbaum, 2011)



Integrating ACEs with Capabilities

ACEs such as neglect or abuse are important in their own right as a direct cause of physical and emotional distress during childhood and as an abuse of children's rights. But in Capabilities terms, ACEs also impair the 'functionings' required to achieve our full potential. For example, children who grow up in a violent household, with the fear of an unpredictable parent, may find it much harder to laugh, play and learn. Children who are forced to endure abuse and violence are exposed to severe disempowerment, humiliation and disrespect. Bullying, discrimination and threat experienced outside the home will similarly harm the dignity, control and affiliation that Capabilities suggests are important. The protective effect of loving, supportive relationships also makes sense in a Capabilities context. We should extend to adults the same sense of love, compassion and understanding as we do for children experiencing abuse and neglect (Hardcastle *et al.*, 2020).

We therefore propose that ACEs-related harm is mediated through its impact on fundamental human Capabilities. ACEs act not only as risk factors for future health problems, but also as a marker of infringement of rights and freedoms.

That shift in paradigm opens new avenues of thinking. Firstly, it aligns population health more closely with social justice movements, and the activism and scholarship they embody. For example, although racism, poverty and ACEs all evoke a measurable stress response and damage the health of both individuals and populations (McEwen & McEwen, 2017b; Williams *et al.*, 2019), we do not seek to understand or counteract discrimination at a cellular level – to do so would be absurd. In Capabilities terms, 'social conversion factors' would include public policies and laws, social norms, discriminating practices, societal hierarchies and power relations (Brunner, 2015).

Secondly, many people who have experienced trauma and its consequences may need care and treatment, but to think of trauma as solely an illness located within the individual would

be inappropriate. Using a Capabilities approach in this context helps to incorporate both social and biomedical models, and attend to the economic, environmental and cultural barriers faced by children and families (Featherstone *et al.*, 2018).

Thirdly, using a Capabilities approach therefore reinforces the importance of service user participation in decision-making about care, including choices about what kinds of care are offered, and how population needs should be identified and responded to.

Causes of adversity and impaired capabilities: recognising our responsibilities

A perplexing feature of the ACEs landscape is to ask why it should be necessary to intervene in this way to prevent injustice. Harming children is morally repugnant, developmentally consequential, personally painful, economically costly and socially corrupting. Why then should childhood adversity be so prevalent?

Shifting the focus away from the neurobiology of stress to a social justice perspective allows us to tackle this question in a more meaningful way. In her Social Connection Model of Responsibility (SCM), Young emphasised that the “obligations of justice” do not arise only in a moral-legal model of liability, in which blame or fault can be attributed to malign actions. “Structural injustice” could instead emerge:

... as a consequence of many individuals and institutions acting in pursuit of their particular goals and interests, within given institutional rules and accepted norms. All the persons who participate by their actions in the ongoing schemes of cooperation that constitute these structures are responsible for them, in the sense that they are part of the process that causes them. They are not responsible, however, in the sense of having directed the process or intended its outcomes. (Young, 2006, p.114)

In fact, well-intentioned people “habitually following the accepted and expected rules and conventions” is typical of a system dynamic which serves to hold structural injustice in place (Applebaum, 2012). Writing half a century ago about “the lies we tell ourselves about race, poverty and the poor” in America, William Ryan described a system of denial constructed by the best-intentioned of people. Even actions designed expressly to counter injustice could instead entrench it:

As we might expect, the logical outcome of analysing social problems in terms of the deficiencies of the victim is the development of programs aimed at correcting those deficiencies. The formula for action becomes extraordinarily simple: change the victim.

All of this happens so smoothly that it seems downright rational. First, identify a social problem. Second, study those affected by the problem and discover in what ways they are different from the rest of us as a consequence of

deprivation and injustice. Third, define the differences as the cause of the social problem itself. Finally, of course, assign a government bureaucrat to invent a humanitarian action program to correct the differences. (Ryan, 1976)

The same processes continue today – though are typically not captured by epidemiological methodologies. If ACEs act not only as risk factors for future health problems, but also as a marker of infringement of rights and freedoms, then the examination of discrimination and injustice in other fields is instructive. In her investigation of the roots of misogyny, philosopher Kate Manne argues that misogyny does not arise because women are hated. Instead, she asserts that:

Misogyny is something that women face, rather than something that predominately men feel. So I think of misogyny as primarily a property of social systems or environments as a whole... I try to understand misogyny throughout from the inside, not primarily as a psychological matter – but rather as a social-political phenomenon with psychological, structural and institutional manifestations. (Manne, 2017)

Academic enquiry into the nature of racism makes a similar point. Karen and Barbara Fields describe how the practice of racism, like misogyny, is typically not rooted in hatred, but is instead a social practice:

Racism is not an emotion or state of mind, such as intolerance, bigotry, hatred, or malevolence. If it were that, it would be easily be overwhelmed; most people mean well, most of the time, and in any case are busy pursuing other purposes. Racism is first and foremost a social practice, which means that it is an action and a rationale for action, or both at once.

Importantly, the concept of race is assumed to exist, independently of the process of racialisation:

Racism always takes for granted the objective reality of race, as just defined, so it is important to register their distinctness. The shorthand transforms racism, something an aggressor does, to race, something the target is in a sleight of hand that is easy to miss. (Fields and Fields, 2014)

We can draw a similar analogy in our understanding of trauma and adversity. Parenting practices exist on a continuum, and “child maltreatment involves a range of severity that reaches far into the ‘normal’ population. Maltreatment is not inflicted only by unimaginably vicious or neglectful parents but occurs as part of a spectrum of parenting behaviour ranging from optimal to severely abusive” (Gilbert *et al.*, 2012).

A focus on ‘troubled families,’ ‘vulnerable people’ and ‘disadvantaged groups’ serves to characterise their differences and deficits from mainstream groups, thereby diverting attention away from the *causes* of that vulnerability and disadvantage (Featherstone *et al.*, 2018). These linguistic and professional dislocations have a long history (Lambert, 2019; Welshman, 2013), and serve a purpose.

The extensive and rapidly growing literature on ACEs is part of that dynamic. Framing children’s needs in terms of neurophysiological deficits and epidemiological risks diverts attention away from structural factors. The acts of impoverishment or neglecting become the *status* of ‘poverty’ or ‘neglect.’

For example, the UK Government abolished its target to eliminate child poverty by 2020 in order to move away from ‘income-based indicators’ to factors related to ‘family breakdown, debt and addiction’ – a victim-blaming reversal which neatly avoids responsibility for the causes of poverty by claiming concern for its consequences (Wickham *et al.*, 2016).

In this context, we would want to stress that none of this requires policy-makers to dislike children, or to want to cause them harm. In fact, what is particularly striking is the way in which such political choices are electorally popular, despite the harm that they create. This isn’t an odd artefact or oversight. Without a form of denial of this kind, the status quo could not be tolerated.

The forms that such avoidance and denial take include subtle forms of victim-blaming (“we must do all we can to help vulnerable people”), projection (“discrimination exists, but bad people are responsible for it”) and denial (“other people need to make a change”).

The original harm caused by ACEs and other forms of trauma is important. But these forms of distorted thinking generate a new chain reaction of social and relational consequences of ACEs. Such responses may endure long past the initial trauma, and are one of the factors that perpetuate ACEs-related harm through the lifespan.

Conclusion

This paper seeks to avoid a zero-sum debate about whether ACEs or poverty are most responsible for disadvantage by arguing that both are important, but need to be reframed within a social justice context.

The original 10-item ACEs concept has some value as a narrow marker of past household adversity, but should be extended to include a range of social and structural factors. The biology and psychology of chronic stress is an important field of study, and has yielded useful therapeutic insights. But we should be wary of locating both the problem and its response within the bodies of those affected. The Capabilities approach reinforces the importance of tackling causes through social justice means, with an emphasis on human dignity, participation and control. The subjective and pluralistic approach Capabilities uses can help the ‘subjects’ of enquiry gain some control over what gets measured and counted, and what kinds of assistance are offered.

‘Adversity’ and ‘poverty’ are not immutable ways of being to which ‘vulnerable’ and ‘disadvantaged’ people are particularly prone, but instead the direct and predictable consequences of the conceptual framing, psychological awareness and political choices for which we are all responsible, and all complicit in.

The societal task is to offer care and mutual aid to those who need it, while acting against the social and psychological systems that allow these problems to endure. Ultimately, the creation of a just social environment requires a healthy civic culture and ‘social climate’ of regeneration through empowerment, participation and social cohesion (Belkin, 2020). Professionals have a special

responsibility to avoid ‘blaming the victim,’ and become aware of the ways in which their well-meaning actions may not only be underestimating the strengths of patients and clients, but also constraining their capacity to act.

In the words of campaigner Sherrilyn Ifill, we need to decide “what we are prepared to dismantle, and what we are prepared to build” (Ifill, 2020). Here are five suggestions:

1. ACEs should be considered primarily within a human rights and social justice frame, rather than as a health issue. Professionals working in this field need to ensure that ‘ACEs awareness’ is focused on the causes as well as the effects of trauma and adversity.
2. We should stop celebrating ‘resilience’ and exceptional stories of rescue and survival when they divert attention away from the factors that made them necessary. Dignity should not be accorded only to those who have managed to survive structural violence.
3. We should accept that any discussion of ACEs is necessarily and properly a political one, and furthermore that such expression of political affiliation and control is an important value in its own right.
4. We need to accept a collective, civic responsibility for interrupting the chain reaction that ACEs set in motion, and recognise our own complicity with structures that meet our own needs at others’ expense. That means we should be wary of ‘awareness-raising’ and ‘education’ for other people: we should humbly ensure our own house is in order before lecturing others.
5. We need to focus on preventing discriminatory actions, rather than measuring the harm they cause. As a first step, we should reconsider our terminology: ‘diseases of despair’ are in fact *diseases of neglect and disempowerment*. Just as exclusion, manipulation, gaslighting and mendacity are abusive in personal relationships, we should recognise and name *political abuse* and *socio-political neglect* when we see it.

The Covid-19 pandemic has suddenly placed us in an historic bio-socio-ecological crisis, with the effects of climate change already tangible. The need for human dignity, affiliation and control as part of a ‘social climate’ for change has never been greater.

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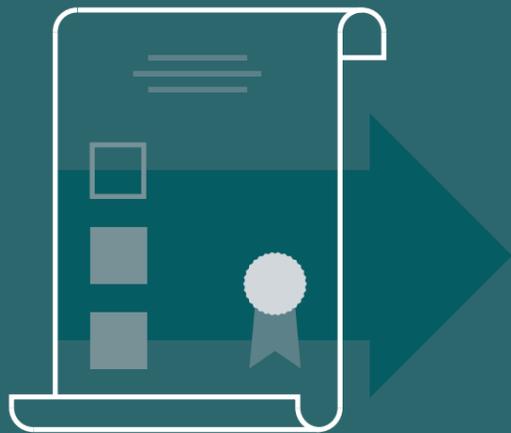
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Essay seven

Towards a human rights approach to multiple disadvantage



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Summary

Introduction

This paper explores how a moral human rights approach, based on the Universal Declaration of Human Rights 1948 and Amartya Sen's Capabilities theory (1992), can provide a useful lens for understanding how the rights of people facing multiple disadvantage can be upheld. The paper contributes to the literature on multiple disadvantage by exploring how practitioners and policy-makers working with people who face multiple disadvantage can apply these theoretical approaches. It makes suggestions about policy and practice, including ideas about the use of human rights impact assessments, flexibility in operational practice, the importance of training and awareness, and co-producing services alongside those who face multiple disadvantage.

Literature review

The first section of the paper reviews the multiple disadvantage literature. It considers an understanding of trauma as a way to enhance opportunity for people facing multiple disadvantage, and encourages co-production as a central practical approach.

Theoretical basis

The theoretical basis of the paper, the Universal Declaration of Human Rights 1948 and Amartya Sen's Capabilities approach, are next examined, considering more recent modifications of the Capabilities approach by Wolff and De-Shalit (2007) to focus on genuine opportunity.

Focus groups

Three focus groups, held with staff from the Fulfilling Lives Lambeth, Southwark and Lewisham programme, form the empirical basis of the paper. The focus groups considered the programme's experiences of three case studies of people facing multiple disadvantage to explore the interconnectedness of poverty, trauma and multiple disadvantage, and to explore how a human rights and Capabilities lens could impact upon the ways practitioners and policy-makers respond to these interconnections.

The discussion offers suggestions as to how an expanded human rights approach, informed by the Capabilities theory and expanded on by Wolff and De-Shalit (2007) to focus on genuine opportunity, can be incorporated into policy and practice to support a better response to people facing multiple disadvantage.

Conclusion

Overall, the paper's contribution builds on more theoretical discussions to explore how practitioners and policy-makers can take these forward in practice to support more effective responses in systems supporting people facing multiple disadvantage.

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Introduction

The UN's Special Rapporteur on extreme poverty and human rights recently declared that "British compassion has been replaced by a punitive, mean-spirited and often callous approach apparently designed to impose a rigid order on the lives of those least capable of coping" (Alston, 2018, p.5). This hard-hitting conclusion was based on his analysis of how human rights are upheld for different groups in the UK, including older people, asylum seekers and people with disabilities.

People facing multiple disadvantage – defined in this paper as experiencing three or more of using drugs and/or alcohol, mental ill health, homelessness, and involvement in the criminal justice system – were not included as part of the UN Special Rapporteur's analysis. This is unsurprising: human rights as a concept has not been widely applied to the field of multiple disadvantage, either in theory or in practice.

However, recent work between Crisis and the FrameWorks Institute found that using the moral value of human rights is one of the key ways through which to engage the public and policy-makers with issues around homelessness and to in turn drive policy change (Crisis, 2018). This paper builds on these recent suggestions and debates in the sector by using theoretical thinking about human rights to explore the practice response for practitioners and policy-makers. It uses the Capabilities theory, with a specific focus on Wolff and De-Shalit's (2007) view of genuine opportunity, and explores how this theoretical thinking can be put into practice.

The paper is based on research with Fulfilling Lives Lambeth, Southwark and Lewisham (Fulfilling Lives LSL), which is part of the national Fulfilling Lives initiative funded by The National Lottery Community Fund. The initiative tests new ways of ensuring people facing multiple disadvantage receive joined-up and person-centred services.

The paper first discusses the concept of multiple disadvantage, considering an understanding of trauma as a way to enhance opportunity for people facing multiple disadvantage, and co-production as a central practical approach that promotes capabilities and the human rights value of all people being equal. The theoretical basis of the paper, the Universal Declaration of Human Rights 1948 and Amartya Sen's Capabilities approach, are next examined, considering more recent modifications of the Capabilities approach by Wolff and De-Shalit (2007) to focus on genuine opportunity.

The paper then moves on to its empirical contribution – focus groups that explore three case studies from Fulfilling Lives LSL. The purpose of the focus groups was firstly to explore the interconnectedness of poverty, trauma and multiple disadvantage highlighted in the case studies, and secondly, to explore how a human rights and Capabilities lens could impact upon the ways practitioners and policy-makers respond to these interconnections. The focus groups were conducted with people who have lived experience of multiple disadvantage who work for Fulfilling Lives LSL,

connecting the empirical section to the theoretical basis of the paper in which co-production is put forward as a way to implement the paper's suggestions for policy and practice.

Finally, the essay concludes that human rights and the Capabilities approach offer a dual lens through which to promote policy and practice that better supports people facing multiple disadvantage.

Multiple disadvantage

The concept of 'multiple disadvantage' highlights the challenges people with intersecting areas of need in their lives face. A 2015 study by a funder, Lankelly Chase, with Heriot-Watt University, developed the understanding of this concept and its prevalence in England, drawing together data about people whose substance use was problematic, who were homeless, and who had interactions with the criminal justice system. It estimated that 58,000 people were facing multiple disadvantage in England by this definition, with poverty and mental illness also being common factors amongst those facing multiple disadvantage (Bramley *et al.*, 2015). Other work that has explored multiple disadvantage also highlights these interconnected factors (Cooper & Bailey, 2019; Fisher, 2015; Fitzpatrick *et al.*, 2013; Fitzpatrick *et al.*; 2011). The approach to understanding these interlinking issues is important: in recognising that these issues often go hand-in-hand, yet are treated separately by services and systems, the concept of multiple disadvantage questions "whether single issue systems and services are any longer the most effective response" (Bramley *et al.*, 2015, p.4). The way that services and systems currently respond to single issues is explored further in the paper.

Bramley *et al.* (2015) also considered the root causes of multiple disadvantage, finding that a background of poverty, difficult family relationships and poor educational attainment were common experiences. Policy-makers have also sought to both understand and to tackle combinations of factors from childhood that contribute to challenges in adult life. This includes the Social Exclusion Taskforce's (2006) consideration of a 'lifetime approach', looking particularly at intervention in the first two years of life to try to break cycles of disadvantage. Similarly, the Marmot Review into health inequalities (2010) emphasised the social determinants of health, including housing, poverty and employment, finding that "disadvantage starts before birth and accumulates throughout life" (2010, p.14).

Another common experience of people facing multiple disadvantage is trauma, "an inescapably stressful event that overwhelms people's coping mechanisms" (Van der Kolk & Fisler, 1995, p.505). Trauma can have an ongoing impact, affecting behaviours, emotions and physical health. For example, more traumatic experiences in childhood have been shown to be associated with negative impacts on physical health, mental health and wellbeing (Anda *et al.*, 2010), and challenges in coping with trauma can lead to substance use and difficulty forming healthy attachments and relationships (Van der Kolk, 2014). Everitt and Kaur (2019) found that 85% of people facing

multiple disadvantage had experienced childhood trauma, and the role of trauma is explored further in the paper.

This paper draws on experiences from the Fulfilling Lives LSL programme. The definition of multiple disadvantage the programme adopted is the combination of using drugs or alcohol, having mental ill health, being homeless or at risk of homelessness and being involved in the criminal justice system. The programme aims to influence system change to improve the way that systems respond to and work with and for people facing multiple disadvantage.

The Fulfilling Lives LSL programme advocates for services and systems that are structured around an understanding of the impacts of trauma on people facing multiple disadvantage. The programme focuses on individuals' strengths, both in terms of coping with past trauma and of reaching their future goals. This gives a holistic view of the whole person rather than focusing purely on a negative past. The recognition of the genuine opportunity that people have to be and do different things in their lives is a key part of the Capabilities theory, which is explored further as the theoretical basis of the paper.

Finally, the national Fulfilling Lives programme takes a co-production approach. People facing multiple disadvantage are often thought of as those who use services. Co-production involves people who use services in producing, designing and delivering their own services. It essentially turns people from passive recipients into active contributors to services to ensure that they better meet their needs (Cahn, 2000). It has been shown to have positive outcomes in social care settings, including health benefits, development of practical skills, and value for money (Needham & Carr, 2009), and positive contributions to physical and mental health, including through development of social networks (Boyle *et al.*, 2006). The paper considers how the practice of co-production when working with people facing multiple disadvantage upholds a human rights approach, as it emphasises the value of every person being equal. It also contributes to people's capabilities by giving them the opportunity to be more than a user of a service but to be valued for their contributions to the design and delivery of services and systems.

This section has defined multiple disadvantage and has considered how different areas of people's support needs can interact with wider issues, such as poverty and trauma. The paper will return to these themes in the empirical section. The paper now goes on to introduce the dual lens of human rights and the Capabilities approach as its theoretical basis.

Human rights

The United Nations adopted the Universal Declaration of Human Rights in 1948, representing a global commitment to its 30 articles that detail the inherent rights of each and every human being.

Article 22 of the Universal Declaration of Human Rights states: "Everyone, as a member of society, has the right to

social security and is entitled to realization, through national effort and international co-operation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality."

Economic and social rights can be seen as the rights most fundamental to people's development and wellbeing (as argued by scholars such as Nolan, 2017). These include rights specified in more detail in Article 25: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control."

These rights relate directly to the living conditions of people facing multiple disadvantage, who may be homeless or in unstable, poor quality accommodation, reliant on social welfare systems and in poor health. Additionally, there are a number of international treaties that support the declaration, such as the International Covenant on Economic, Social and Cultural Rights (ICESCR), which the UK agreed to in 1976.

Both the Universal Declaration and ICESCR are international agreements that the UK has obligations to uphold, although the rights contained within them are not automatically enshrined in domestic law. However, as the UK is a signatory to these agreements, the upholding of these rights in practice is monitored by a public body called the Equality and Human Rights Commission (EHRC).

This Commission uses the Capabilities approach as the underlying theory behind its monitoring, calling it "the most compelling theoretical underpinning for equality and human rights" (EHRC, 2017, p.38). Amartya Sen is the philosopher and economist who introduced the Capabilities theory. Sen (1992) defines 'capabilities' as the freedoms that an individual has to make choices that allow them to do and be what they want, and 'functionings' as the actual achievements or the things that people do or are, based on their capabilities. It is important to note that capabilities are not the same as human rights, but Sen sees that human rights can be interpreted as rights to particular capabilities and that, in turn, the two concepts can work together (Sen, 2005).

For people facing multiple disadvantage, different capabilities and functionings can be interlinked with each other, and people in challenging circumstances can prioritise – whether consciously or not – some functionings that may put other functionings at risk (Wolff & De-Shalit, 2007). For example, in order to have the capability of financial stability, one might rely on the functioning of budgeting and the functioning of receiving benefits. However, receiving benefits may require capability in digital literacy, to access a Universal Credit (the programme for delivering welfare benefits in the UK) account online. Adhering to a budget may require a calm mindset, and if someone is in mental distress and copes with this by taking drugs, they may be easing their distress, while at the same time, putting their capability of financial stability at risk. As Wolff and De-Shalit point out, "in order to secure what they see as most immediately urgent, a person may sacrifice another functioning" (2007, p.71).

The Capability approach provides a theoretical approach for considering multiple disadvantage based on essential equality of all human beings. This perspective is important because it removes any potential questions about whether people should have rights, or are seen as being 'deserving' or 'undeserving', a long-lasting distinction that has featured within British social policy as a way to provide services to some people and not others (Romano, 2015). The Universal Declaration is clear that human rights "are not a reward for good behaviour" (UN, 2015, p.v). Instead, this perspective focuses on the fact that human rights are inherent to everyone, and therefore everyone's capabilities should be nurtured.

Wolff and De-Shalit (2007) add to Sen's original Capability theory, arguing that it is "too vague" (p.74) in its presumption that individual action leads to that person enjoying certain functionings that arise from their capabilities. They highlight the importance of considering "the real world, where people are choosing against the background of inequality" (2007, p.78). Instead, they put forward the central idea of "genuine opportunities for secure functioning" – that is, taking into account not solely the hypothetical functioning, such as reducing drug use, but whether or not it is reasonable to expect that the person takes the steps towards this functioning, and whether or not they have the genuine opportunity to do so.

Understanding the impacts of trauma here is critical: for example, it may appear reasonable to expect a woman to engage with a drug service, but if the only way to engage with that service is to wait a long time in a waiting room predominantly of men, and the woman has a history of being abused by men and feels terrified in that waiting room, the expectation may not be so reasonable after all. Robeyns (2017) points out that "in practice, it is often impossible to know what the causal factors were that led someone to make decisions that lowered her achieved wellbeing, and hence it is difficult or even impossible to know whether the causal factors are those for which one could be held morally responsible or not" (p.110). Thus, establishing whether someone has a genuine opportunity to secure a certain functioning is challenging and it can be problematic to assume that an opportunity is, in fact, genuine.

The discussion in the next section highlights how a holistic view of a person experiencing multiple disadvantage, trauma and poverty can help practitioners and policy-makers to consider how their services respond to and promote genuine opportunity to uphold people's human rights and capabilities.

Having explored the contributions that a dual lens of human rights and Capabilities theory can make, the paper now moves on to its empirical section, to consider how practitioners can take forward this dual lens, and the implications these theories may have for the practice response.

Applying this theoretical thinking in practice

To ground this paper in lived experiences of multiple disadvantage, small groups of staff from Fulfilling Lives LSL discussed three case studies from the programme in focus groups. Most of the participants had their own lived experience of multiple disadvantage, addressing Ignatieff's (2000) concern that human rights advocates can be removed from the very people they seek to defend.

The focus groups explored the interconnectedness of poverty, trauma and multiple disadvantage in the three case studies, and the contributions an expanded human rights approach, using Wolff and De-Shalit's (2007) theory of genuine opportunity, could make to better respond to these interconnections at a practice level. The case studies were chosen to highlight how systems sometimes fail to respond adequately to those who face multiple disadvantage.

The interconnections between poverty, trauma and multiple disadvantage

The focus groups began by exploring how poverty, trauma and multiple disadvantage had played significant and interconnecting roles in the lives of each of the three anonymised cases from the programme.

The three case studies used were:

- Henry, a man who has a history of using various drugs. He has no qualifications and is in a relationship with a woman where domestic violence was occurring. He has a long history of being in and out of housing, sleeping on the streets, and prison. His prison sentences were often short, for acquisitive crimes used to fund his drug and alcohol use. Henry does not have a formal mental health diagnosis and has untreated physical health issues. He is funny, well-known and popular, and likes listening to music.
- Silver, a woman who was removed from her parents' care as a child due to abuse, and spent her childhood moving between different care homes. She has been using substances for many years and occasionally funds this through prostitution. It is not known if she has ever had a formal mental health diagnosis but she presents with behaviours consistent with abuse and trauma, and she reports having made suicide attempts earlier in life. Silver has given birth to several children, who have all been removed from her care. Silver is bubbly, has a great sense of humour, and enjoys arts and crafts.
- Victor, a man whose mother used substances and who spent time in local authority care as a child. He has experienced neglect and abuse throughout his life. He finds it difficult to regulate his emotions and has difficulty in understanding complex information and executing daily tasks. He also uses substances. Victor loves singing, writing poetry and doing sudoku.

In all three case studies, trauma has played a significant part in each person's life. Each person spent time in

local authority care, and all have experienced both childhood trauma (such as abuse, living with caregivers who used substances, and growing up feeling unloved) and trauma in adulthood. For example, Henry suffered many attacks as an adult when living on the streets, through owing people money, which added to the challenges he faced while homeless. Silver, too, has experienced numerous incidences of sexual and physical violence as an adult. One staff member commented on her history: "It looks like battle after battle".

Trauma interacts with and exacerbates poverty and multiple disadvantage. For example, all three people have spent most of their lives living from the welfare benefits system, with Silver also making money through prostitution. Through sex-working, she has also experienced further sexual violence and trauma. Following Victor's traumatic experiences in his childhood and a lack of secure relationships in his life, his ongoing seeking of friendships has led him to stay with people who give him drugs and this has put his own accommodation at risk, further fuelling his drug use and homelessness. Trauma can have an ongoing effect on mental health and behaviours, and substances can be used as a coping mechanism (Van der Kolk, 2014; Holly, 2013). This ongoing exacerbation of disadvantage through the interplay of poverty and trauma is also evident in Henry's life – he acknowledged to his worker that his substance use was a mechanism to cover up difficult feelings and emotions. Living in poverty and having frequent problems with his benefits claims, he often committed offences to fund his drug use, bringing him into a revolving door cycle in and out of prison, exacerbating his experiences of multiple disadvantage and homelessness.

Staff members discussing the case studies felt that services and systems often focus predominantly on an immediate presenting need: "It's more 'you are the problem, these are the problems you present with', instead of [looking at] the causes." Victor himself picked up on this, recognising that services were often afraid of him, but telling his worker that his behaviour was his response to the abuse he had suffered all his life. The causes of a person's circumstances can be systemic and structural, whereas services are generally set up to tackle individual immediate issues, often not engaging with people whose behaviour they may find challenging. The way services respond to people facing multiple disadvantage is examined further in this paper, highlighting how a Capabilities approach that recognises the interconnected nature of multiple disadvantage can structure more effective and appropriate responses to people facing multiple disadvantage.

Staff members felt that, in addition to understanding how experiences of trauma have shaped a person, it is also important to see beyond their traumatic experiences to have a holistic view of the whole person. As one staff member eloquently put it: "Yes, it [trauma] makes an impact but it's an experience, it's not who you are, it's what happened to you." This view, recognising the significance of trauma in one's life but not solely defining someone by those experiences, is in keeping with the Capabilities approach, with its focus on the real opportunities and choices that a person has in front of them.

This section highlighted the interplay between trauma, poverty and multiple disadvantage in the lives of three people. It has shown how trauma has affected them since childhood and the ongoing effects this has had on them into adulthood, which, when combined with poverty, created multiple layers of disadvantage. Additionally, the discussions from the focus groups illustrated, from a practitioner's perspective, how systems do not always recognise and respond appropriately to these complex interplays. The paper now moves on to discuss how a dual human rights and Capabilities lens can support practitioners and services to respond more appropriately.

Discussion: the contribution of a human rights approach to responding to multiple disadvantage in practice

The following section highlights themes that emerged from the focus group discussions about the contribution of a dual human rights and Capabilities approach and how this theoretical work could structure a more appropriate response to people who face multiple disadvantage in practice.

Taking a holistic view

Many different professionals have worked with Henry, Silver and Victor, and they have all been the subject of various multi-disciplinary, multi-agency meetings that bring different professionals together to create coordinated plans and responses.

One issue that can arise when someone faces multiple disadvantage is that, while they have certain needs, they do not meet the thresholds to access support from particular services and these thresholds may not take into account the cumulative effects from multiple disadvantage. Victor's cognitive function did not meet the thresholds required for learning disability team support, but he still had difficulty understanding and executing certain day-to-day tasks and was having difficulty keeping himself safe. The EHRC's monitoring framework lists a pragmatic set of capabilities they define as "central and valuable freedoms and opportunities". For example, in the area of living standards, the capability defined is for "enjoying an adequate and secure standard of living, including nutrition, clothing, housing, warmth, social security, social services and utilities" (EHRC, 2017, p.95). This implies the need to look at issues such as mental health and substance use not on their own but as a combination, examining how they affect whether or not someone has the capability to enjoy an adequate standard of living. In Victor's case, while his cognitive function may not meet the thresholds required for learning disability team support, the reality is that his flat, frequently without a secure door, gas or electricity, is not a safe and secure standard of living.

Undoubtedly, many organisations and services provide holistic support. However staff members felt that while the current system is designed to meet the person's needs, its structure can enable a silo approach to working and it is possible for someone with high levels of overall need to fall between the remits of different services, ending up with little support. People who have dual diagnosis – both substance use and mental health needs – often falling between drug and alcohol and mental health services is well-documented (CFE Research and University of Sheffield, 2020). Henry experienced this – he was told he needed to stabilise his alcohol use before he could be referred for a psychological assessment when he sought support to address the issues he faced with his mental health.

A human rights lens can be used to consider these issues of siloed service provision within the system's responses. The Capabilities approach can address these issues by focusing on the person as a whole, rather than on individual areas of their life. Sen highlights the importance of the overall *combination* of capabilities that one has, and by not specifying individual capabilities, his Capabilities theory promotes a holistic view of a person's life in its entirety. To put this into practice, services could look beyond their individual remit to consider whether the person's current circumstances mean that they have genuine opportunity to find support elsewhere, or whether the combination of a person's needs means that their situation is likely to deteriorate if they do not receive support now.

On a practice level, one way of operationalising a Capabilities approach to support the whole person could be using human rights impact assessments. These are usually used to help policy-makers consider the wider implications of proposed policy on human rights. A human rights impact assessment tool could be adapted to focus on an individual and could be used at multi-disciplinary meetings or forums to examine the real opportunities that are being offered that person and to consider their capabilities in the current situation. This would enable professionals to consider the person as a whole instead of seeing only one of the person's needs – the one that is their direct responsibility. For people facing multiple disadvantage, this may lead to a more joined-up approach from services to promote their capabilities.

Additionally, on a wider cultural level, decision-makers should address the issues highlighted here about service thresholds and the way people can be passed between services without receiving support. Wolff and De-Shalit (2007) describe how we “match disadvantage against agency and leave each agency to attend to the least advantaged in its own sphere” (p.91/92). They call this an “over-simplistic” (p.92) way of working, and the examples shown here demonstrate that a cultural change within support structures to overcome operational silos could provide more genuine opportunity for people facing multiple disadvantage.

Flexibility

Human rights apply equally to everyone: Article 1 of the Universal Declaration states “all human beings are born free and equal in dignity and rights”. The Capabilities approach, however, recognises that people have different needs

and may therefore need different resources or support to have the same capabilities and equal opportunities as others. Staff members acknowledged that the UK has many measures in place to uphold human rights (such as social housing systems, a social security system and the NHS) that are valued and meet the needs of many people. However, sometimes the way services are implemented reflects the needs of the system instead of the needs of the person; there are limits imposed that do not allow for flexibility for dealing with individual needs.

Henry demonstrates this: he experienced being turned away from Job Centres due to having drunk alcohol, even though he was not causing any problems and was alcohol dependent. This led to his benefits claim being stopped, pushing him further into poverty and petty crime, and further fuelling his alcohol use. At various points when Henry had problems with his benefits, he ended up stealing and falling into debt, perpetuating a cycle that included multiple arrests and assaults. Silver provides another example: she was referred to a pathway of accommodation for vulnerable adults that would understand and respond to her needs, but then became pregnant. Consequently, she was moved into general needs accommodation that did not have accompanying specialist support, and her patterns of risky behaviour continued. Other scenarios that staff members had experienced in their work included someone ‘running out’ of chances for substance treatment due to not having been successful previously, and someone experiencing an indefinite ban from all accommodation in a supported housing pathway due to an episode of violence, meaning that there were no supported housing options for them and they remained homeless.

These illustrations demonstrate systems acting in a way that does not acknowledge individual need, nor promotes individuals' capabilities. There are, however, great examples of individual flexibility by practitioners that help to ensure people's rights are upheld. For example, when Henry was banned from a substance use service, his worker liaised with the pharmacy and together they found a different way for him to be able to get his prescription for an opioid substitute. Another example was when Victor was banned from a service's offices but his worker still agreed to meet him at a cafe. This flexibility is not always built into the system, but these examples show that flexibility and using creative ways to reach people can keep them engaged in a service, and in turn ensure they receive the support that helps them realise their capabilities.

Genuine opportunity is about the reasonable expectation that someone can achieve functionings, but service structures can limit people's engagement, meaning they will not be able to achieve functionings. This is often due to incidents involving challenging behaviour or risk. However, as Robeyns points out, “many of our choices are the result of the impulsive, unreflective, habit-driven part of our brain rather than the deliberative and reflective part” (2017, p.109). This describes how trauma responses can work – learned behaviours are not always conscious choices, yet when actions by people facing multiple disadvantage who have experienced trauma are treated as logical choices and then services are taken away, this both removes the genuine opportunity for the person to fulfil their capabilities and reduces the efficacy of the service.

In practice, supporting genuine opportunity for capabilities through flexibility could entail better understanding by practitioners of the impact of trauma to recognise how a person's behaviour is influenced and informs their communication. Victor has been interpreted as being aggressive when he shouts in certain situations when he is actually feeling upset and worried. Workers who understand him are able to reassure him and build a relationship with him, without threatening to ban him, which could upset him further. This thereby minimises the risk of his behaviour escalating, and the risks that come from him being banned and not receiving a service at all.

People who fund, design and operate services should ensure that their design takes into account the needs and experiences of those who face poverty, trauma and multiple disadvantage. This includes allowing flexibility, understanding barriers that people using services face, and actively attempting to remove those barriers. For these types of changes to make the most impact, they should be adopted at commissioning and cultural levels, rather than solely confined to individual practitioners acting differently.

Awareness of human rights

To implement or embed any of the suggestions or approaches in this paper, or even to consider multiple disadvantage further through a human rights lens, practitioners and policy-makers need to have an awareness of human rights. However, while staff members in the focus groups are aware of the concepts of human rights and feel they promote the principles in their work, they had not primarily viewed their work as being about upholding people's human rights, nor had their experience found that a rights framework is used as common discourse in external forums or multi-disciplinary meetings.

Staff members expressed interest and curiosity in the idea of thinking about how human rights can apply to their work:

“It would be good to have... something really comprehensive where we could look at it and say ‘this is what this country has agreed to’, in a way that’s not for academics, and then be able to, kind of, have that as part of our service, have policies around that, use that as a benchmark when we go to other services.”

An exploratory programme of training for people working with those facing multiple disadvantage – including frontline staff, commissioners and policy-makers – to understand the conceptual frameworks of human rights and how they apply to their work and the services in the sector would be a good starting point. This could support some of the more fundamental shifts in service design and delivery suggested here, as well as enabling a more widespread cultural change to focus on upholding human rights and promoting capabilities in services and systems.

This could add to existing work with people facing multiple disadvantage on several levels: increasing effective advocacy, changing the perception of the quality of life of people being supported by services, and ultimately contributing to changing the way systems are designed in line with the human rights principles that the UK has agreed to.

Co-production

The paper has so far discussed how a human rights lens using the Capabilities approach can improve the way services and systems see people holistically, rather than reducing them to their individual problems and traumatic experiences, and how these approaches can uphold human rights and genuine opportunity by promoting flexibility within services and systems. The focus groups highlighted how co-production has a key role to play in supporting practitioners to implement these approaches.

The first article of the Universal Declaration says that everyone is born equal, and this is the basis for the universality of human rights. However, it was highlighted during focus groups that power in society is distributed unequally. Acceptable standards and conditions of living, as well as access to services, are defined and controlled by people working in services and people who commission services for those facing multiple disadvantage, leaving those who face multiple disadvantage with very little power. Additionally, decision-makers may have limited understanding of the people their services and systems are working to support. This may make it harder to build the trusting, positive relationships that are so crucial for promoting engagement with services (Robinson, 2017), and to know how to respond to certain situations with flexibility, as discussed earlier. To tackle this, one staff member suggested: *“Every public facing service, even ones that aren’t about multiple disadvantage, like the DWP, Job Centre, GP... any person front facing should undergo training around understanding... poverty, trauma, multiple disadvantage.”*

Training alone, however, does not redress the issues that can arise from power imbalances. Another staff member in the focus groups suggested a further step:

“Say people with lived experience [were] in those commissioning meetings where they make the decision[s] – what if they were armed with human rights knowledge? To be able to go in there at that level and talk about that, how would that affect the process? Because they’d be held accountable, wouldn’t they, by people with lived experience.”

This highlights the importance not only of the presence of people with lived experience in certain forums but the opportunity they have to use their knowledge and experiences to affect processes and decision-making.

Many groups and organisations are working on embedding co-production in service design and delivery, including the national Fulfilling Lives programmes across England, and organisations such as Groundswell, Expert Link and Revolving Doors Agency. This suggestion from the focus groups considers how training and support in understanding and using human rights could increase people's capability to contribute to society, and improve the efficacy of co-production efforts. Co-production underpinning the suggestions made in this paper also ensures that the first article in the UN Declaration of Human Rights is lived out – that people facing multiple disadvantage are seen as valued equals.

Conclusion

This paper has considered how practitioners and policy-makers can use a human rights lens, strengthened by a Capabilities approach, to better support people facing multiple disadvantage. Wolff and De-Shalit's concept of genuine opportunity (2007) has been central to exploring how practitioners can use these theoretical approaches to provide more tailored and effective services.

Focus group discussions of three case studies were explored to illustrate the interconnectedness of poverty, trauma and multiple disadvantage and how systems, as they are currently designed, work well and are effective for the majority of people, but have often not responded well to the needs that result from these interconnections for people facing multiple disadvantage.

The paper makes several suggestions, including the consideration of a holistic view of the cumulative effects of multiple disadvantage on an individual; how increased flexibility in services can better support engagement and genuine opportunity; and how training in and awareness of human rights approaches can support the sector in more appropriately responding to the needs of people facing multiple disadvantage. Co-production is encouraged as a central practical approach to underpin these changes in service delivery, promoting capabilities and the human rights value of all people being equal. The paper also acknowledges the more challenging cultural shifts that some of the suggestions may require to make a real difference at a systemic level.

A dual lens of a human rights and Capabilities approach is presented as a way to support a better response. The paper shows how these can be used in practice, thereby contributing to a society that "recognises people's different needs, situations and goals and removes the barriers that limit what people can do and can be" (HMSO, 2007, p.16). It thus makes a step towards bringing human rights to the practice of supporting people facing multiple disadvantage more effectively, contributing to the ongoing building of a rights culture in the UK.

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Essay eight

Child trauma as a source of lifetime inequality – the impacts on mental health and violent behaviour



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Summary

Introduction

Childhood trauma, in the form of neglect or abuse, is a major source of vulnerability in later life for a range of physical and psychological disorders, as well as criminal behaviours. This paper explores approaches to better understand such trauma, including a socio-ecological model of material disadvantage, an attachment model of psychological damage and a genetic model for biological impacts. It also addresses how to better respond to such trauma in policy and practice.

Models of trauma

Childhood neglect and abuse increase the risk of lifetime disadvantage through poverty, stress and stigma. This invokes a socio-ecological model. An attachment model also indicates that children with experience of abuse develop negative beliefs about the outside world which become fixed as insecure, anxious, avoidant or disorganised attachment styles. This results in lack of close relationships and 'social capital' in times of crisis, and impeded emotional development. Biological approaches consider the impacts of childhood adversity on neurophysiological risk and resilience.

Assessment issues

The social and attachment approach is illustrated through a body of research using the Childhood Experience of Care and Abuse (CECA) and Attachment Style (ASI) interview. Practice partnerships are described which use these tools to help assess and understand adolescents in residential care.

Policy implications

Understanding life trajectories leading to deprivation is important in developing policy, not only around health inequality but also in the social care and criminal justice sectors. In addition, resolving historical abuse through recognition and interventions can prevent recurrence. Ethical concerns should be paramount, and the rights of the child should be respected in stopping neglect and abuse and preventing long-term misery for our young people and children.

Introduction

Child abuse is common, affecting one in five people in the UK (Radford *et al.*, 2011). While current child protection services in the UK are seeing some reduction of cases,¹ our society is also dealing with the large burden of historical abuse which affects prior generations, and the transmission of risk to offspring (Bifulco *et al.*, 2002). Therefore, as a society we are in a position of having to manage the damaging impacts of both ongoing and past childhood abuse (Davidson & Bifulco, 2018). To tackle this, as a society we seek to increase our interventions and preventative work for children. Current mental health policy for children seeks to address this in terms of universal services, including in the school context. For example, the UK's Department for Education (2018) has a 'Five Year Forward View' strategy to improve child access to therapies and interventions, seeking to allay some of the impacts of childhood trauma.²

This paper seeks to examine the consequences of child abuse using social, psychological and biological models, with particular reference to an attachment approach. It also seeks to illustrate how research can be translated into practice, with reference to work undertaken in partnership with foster and residential services. Underpinning this, of course, are ethical issues and the human rights of the child, which are both contravened by the abuse itself.

Childhood maltreatment is a complex topic, invoking psychological issues of traumatisation of children with long-term effects for mental health (Bifulco & Moran, 1998) and criminal behaviour (Widom & Ames, 1994). It also involves disadvantaged environments where children of stressed families experience further disadvantage, poverty and exclusion in later life. Thus, the topic requires multidisciplinary research input, as well as multiagency working in intervention. It also has a biological aspect, with implications for neuroscientists and geneticists (McCrary *et al.*, 2017). It is a complex mix, but one now acknowledged as a central health threat to our society (Conrad-Hiebner & Scanlon, 2015).

Some child maltreatment is at the hands of organised criminals who prey on vulnerable children. For example, multiple coordinated sexual abuse rings were identified in Rochdale, Oxfordshire, Derby and Rotherham between 2010 and 2016. In one case alone (Derby, Operation Retriever 2011³) there were 30 teenage girls victimised, all systematically groomed, given alcohol or drugs and forced to have sex in cars, rented houses or hotels. Of the 13 men who were charged, nine were convicted of 70 offences ranging from rape to false imprisonment. The perpetrators deliberately targeted girls who were vulnerable. While the victims were not all in care, almost all were known to social services. This police operation was followed by the Kern Review, related to yet another

organised sexual abuse ring against vulnerable children occurring just two years later in 2013 in the same Derby area, with a further 14 young girls abused and 11 convictions upheld.⁴ This, together with other similar case reviews across England, implied the wide-scale, coordinated (although possibly with opportunistic elements) sexual abuse of teenage girls in care or known to social services.

The Independent Inquiry into Child Sexual Abuse has a remit⁵ to investigate organised sexual abuse, including historical abuse. It was set up in the wake of the the Savile case and the subsequent police Yewtree investigation (Giving Victims a Voice)⁶ and BBC investigation.⁷ It has examined a range of institutions, including both the Anglican and Roman Catholic Church, and recently reported on issues of sexual abuse in residential care (Roberts *et al.*, 2020). These investigations indicate the breadth of child abuse when it occurs on an organised basis, and also the lack of public awareness of such abuse in previous years.

However, most neglect and abuse cases which reach social services' attention occur in the domestic arena, with parents and substitute parents the perpetrators of maltreatment. Such incidents are highly widespread, but with only sibling groups affected in each instance. Thus, a comprehensive approach to child abuse needs to identify abuse in the home, abuse from coordinated perpetrators outside the home, and historical abuse to gain complete coverage.

Models of childhood trauma

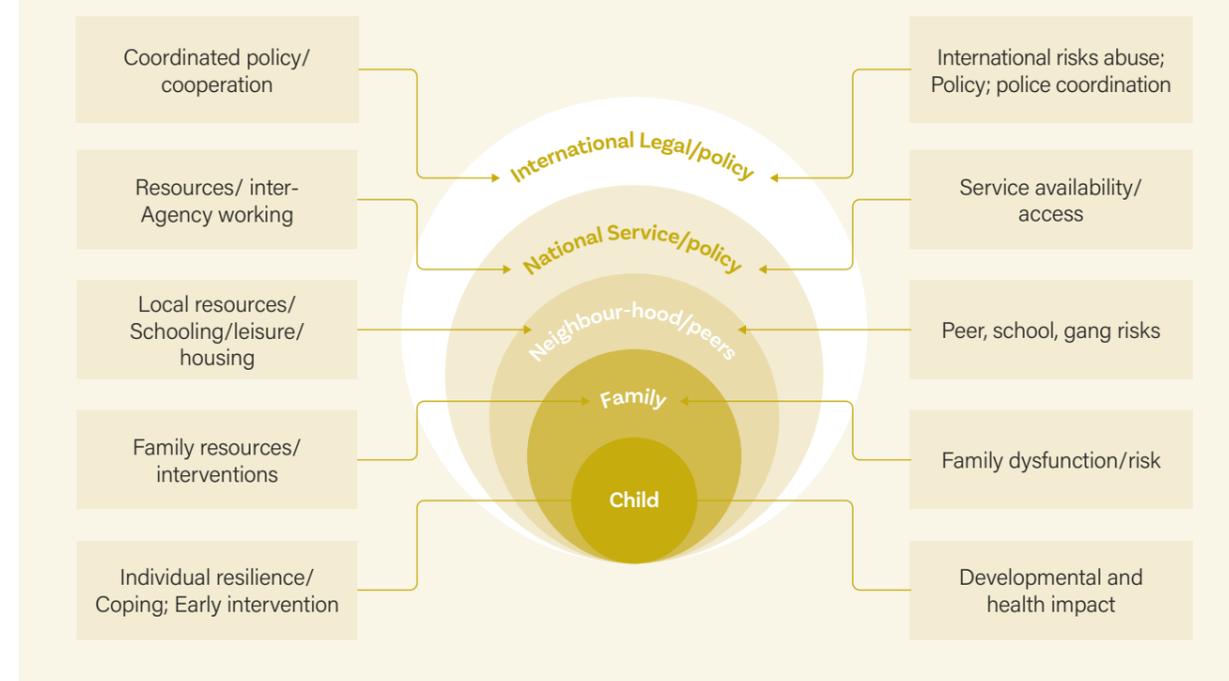
This essay will examine three models of childhood trauma, representing social, psychological and biological impacts that affect adult functioning and life chances.

Socio-ecological theory

A socio-ecological model of social deprivation is based on Bronfenbrenner's (1995) model which illustrates the impact on the child of factors at different societal levels. These factors range from the immediate environment of family, through to neighbourhood and peers, to institutional impacts nationally, and policy internationally. Figure 1 shows a graphical representation of Bronfenbrenner's model, adding elements of risks to the child and interventions and resources available to support the child (Davidson & Bifulco, 2018).

This socio-ecological approach to adversity shows how the different levels of influence can work to confer disadvantage not only on individuals, but also on groups or populations. This highlights the external nature of much adversity – as opposed to that deemed to be created by the individual through their vulnerable or antisocial actions

Figure 1 – Bronfenbrenner's model applied to childhood adversity



(Harris, 1998; Plomin, 2001). This model does not show the impact over time or the life course, but these influences do persist and can create life trajectories with increasing adversity and disadvantage (Elder, 1995; Wachs, 1992). In terms of offending, there is a body of work looking at disadvantage in relation to crime which will be outlined further later in this essay (Farrington, 2006; Widom, 1989).

Childhood adversity is a term which covers both issues of maltreatment and trauma (i.e. neglect, or physical, sexual and emotional abuse) but also issues of family difficulty and disadvantage (for example, parental illness, criminality or family breakdown). Different approaches to childhood adversity use narrower or broader definitions. The models which take a broader approach link childhood adversity to health outcomes and indicate 'dose' effects – a term originally used by pharmacologists concerning the intensity of **effect** produced by a drug as a function of the quantity of drug administered. In the context of child trauma it refers to the greater the multiplicity of adverse childhood experiences, the higher the rate of disorder or illness ensuing in later life (Felitti *et al.*, 1998).

The Adverse Childhood Experiences (ACE)⁸ study has been pivotal in expounding this view in relation to findings in large-scale studies of health. As part of this US investigation, researchers designed a questionnaire with 10 items, five representing types of neglect or abuse to the child and

five representing family context, such as parental illness, criminality and separation from parents.⁹ In their very large sample of US health insurance claimants, people who had experienced four or more (out of 10) categories of childhood exposure, compared to those who had experienced none, had four- to 12-fold increased health risks for alcoholism, drug abuse, depression and suicide attempt. They also had a two- to four-fold increase in smoking, poor self-rated health, sexual intercourse partners and sexually transmitted disease; and a 1.5-fold increase in physical inactivity and severe obesity (Dube *et al.*, 2001). The number of categories of adverse childhood exposures showed a graded relationship to the presence of adult diseases including ischemic heart disease, cancer, chronic lung disease, skeletal fractures and liver disease (Dong *et al.*, 2004). Thus we see adverse childhood experiences are a major public health issue.

These effects have been replicated, but it should be noted that the self-report ACE measure is open to criticism due to its brevity. It has also been shown to be unreliable in relation to childhood documentation provided at the time of the adversity (Reuben *et al.*, 2016). Therefore, in understanding models of the effects of child trauma, it is also necessary to determine the best way to measure key childhood trauma (Bifulco & Schimmenti, 2019). This is discussed later in the essay.

1. <https://learning.nspcc.org.uk/media/1184/child-protection-register-statistics-wales.pdf>

2. <https://commonslibrary.parliament.uk/research-briefings/cbp-7196/>

3. <https://derbynews.org.uk/2015/12/02/child-sex-abuse-unsilencing-the-victims-through-independent-inquiry/>

4. <https://www.ddscp.org.uk/case-reviews/learning-reviews/>

5. <https://www.iicsa.org.uk>

6. <https://www.nspcc.org.uk/globalassets/documents/research-reports/yewtree-report-giving-victims-voice-jimmy-savile.pdf>

7. <https://www.bbc.co.uk/news/uk-35657868>

8. <http://traumadissociation.com/ace>

9. <http://www.theannainstitute.org/Finding%20Your%20ACE%20Score.pdf>

Attachment theory

Other theoretical approaches to understanding childhood trauma invoke psychological damage done to individuals through childhood maltreatment, particularly from parents and carers. Thus attachment theory, devised by John Bowlby (1977), pointed out that attachment, through bonding with a primary carer, was a basic human need and a requirement for healthy development. Damaging parenting behaviour can impede this development, leading to distortions in cognitive (thinking) and affective (emotional) processes, which result in mistrust, fear or anger in relating to others (Bifulco & Thomas, 2012).

Mary Ainsworth, who collaborated with Bowlby, strengthened this model by adding the concept of different attachment styles (secure, insecure anxious-ambivalent or insecure-avoidant) (Ainsworth *et al.*, 1978). 'Disorganised' was a later addition (Crittenden, 1997; Main & Hesse, 1990). These attachment styles outline different profiles of inter-personal behaviour based on three key elements: approach-avoidance (desiring contact versus distancing); autonomy-dependence (needing a high level of help or support versus functioning alone); and fear-anger (fear of rejection or abandonment versus anger at others). Thus, insecure adults vary in their ability to relate closely to others, with anxious style profiles linked to clinging, dependent behaviour and fearing separation; and avoidant styles linked with over-autonomous behaviour and either fear of rejection or angry dismissiveness. Both styles result in a lack of key support when needed with crises (Bifulco & Thomas, 2012).

Disorganised styles have varied interpretations but can combine both anxious and avoidant features and are linked to dissociation, a disconnect between thoughts and feelings, and impulsive aggression, which at the extreme can involve violent behaviour (Fonagy, 1999; van Ijzendoorn, 1997). The model invoked is that of 'mediation' – identifying the factors linking childhood and adult risk through attachment style. For example, childhood neglect or abuse leading to problem attachment styles (the mediator) which in turn leads to mental health problems (Bifulco *et al.*, 2002) or criminal behaviours (van Ijzendoorn, 1997). Here there is no direct impact of childhood experience on adult disorder, apart from where attachment insecurity occurs. Thus, interventions can work to alleviate the attachment insecurity and limit the damage from early maltreatment since the latter cannot be 'undone'. This mediation model is also more specific than the dose model. For example, specific linkages can be shown from neglect to insecure anxious styles, and from abuse to insecure avoidant styles (Bifulco & Thomas, 2012). Single abuses can also be very damaging, particularly when severe and chronic.

There is also increasing study of emotional regulation as a means of coping with stressful environments, with dysregulation associated with a range of clinical outcomes (Aldao, *et al.*, 2010). More dysfunctional coping strategies include those that are suppressing and avoidant. This includes avoidance of thoughts, emotions, sensations, memories and urges, based on avoiding fear, which is linked to avoidant attachment style. It is contrasted with more functional problem-solving and help-seeking strategies.

The other problem of emotional regulation concerns rumination or 'over thinking' the nature and possible causes of the stressor, with this negatively related to problem-solving. Indeed, rumination in the context of distress appears to interfere with good problem-solving and may immobilise individuals with indecisiveness. This is linked to anxious attachment style. The links to attachment theory are through the different attachment-related strategies of emotional control that result from different patterns of interactions with significant others (Mikulincer *et al.*, 2003). This approach looks in detail at how support accessed under stress can serve to modulate emotions and cognitions in the individual. But, inability to access support can lead either to suppression of the relevant emotions, or alternatively rumination and hypervigilance in an attempt to attract attention from potential support givers. Neither of these responses is effective in managing stress.

While attachment theory originally looked at parenting and early child development, it has since extended to adult mental health and offender behaviour. For example, Bowlby's (1944) early work looked at attachment and affectionless character in what he termed 'juvenile delinquents' (those involved with the criminal justice system) who had accumulated multiple separations from carers. More recently, focus has been on violence by adults to others including attachment figures, for example in domestic violence (Fonagy, 1999). Research shows that violent offenders have more insecure disorganised or avoidant attachment styles (Frodi *et al.*, 2001; Renn, 2002; van Ijzendoorn, 1997). This is in turn linked to earlier childhood maltreatment or trauma.

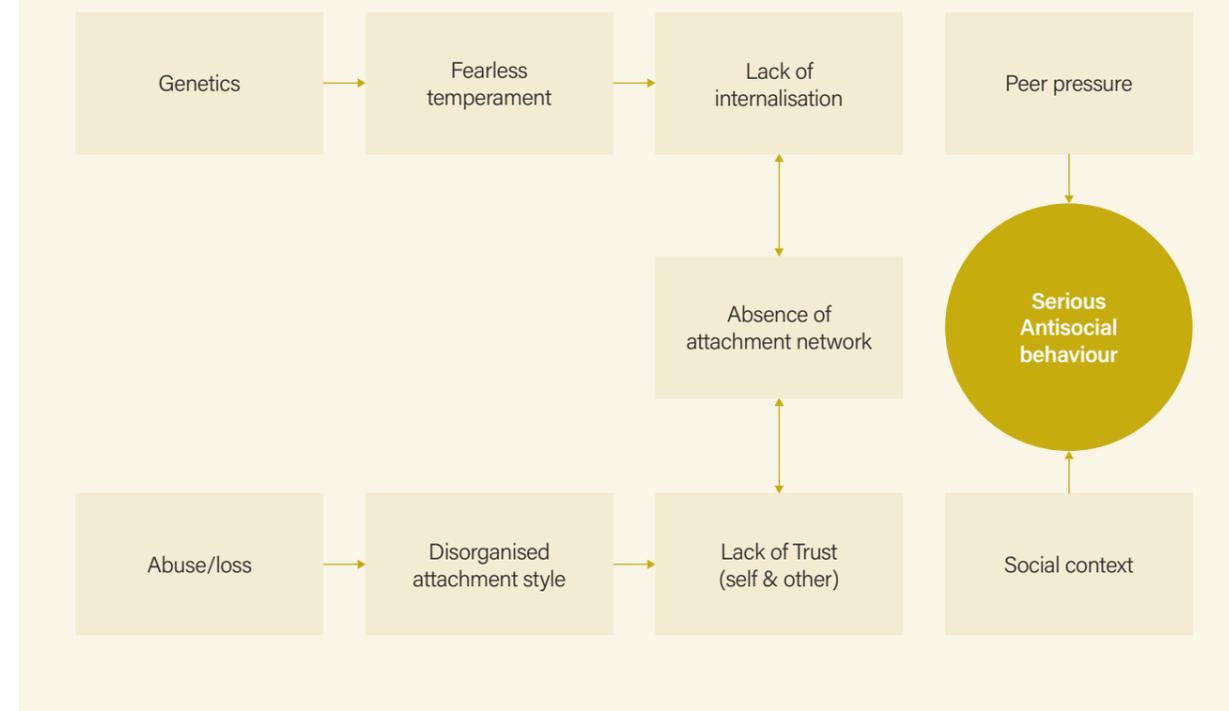
An early conceptual model of how attachment style may relate to antisocial behaviour was developed by van Ijzendoorn (1997) and this is illustrated in Figure 2. This model indicates childhood abuse as relating to disorganised attachment style, together with input from genetic and temperamental sources and peer pressure. This has subsequently been further developed, with emotional dysregulation (lack of emotional control) substituting for 'fearless temperament' in line with the earlier discussion (Aldao *et al.*, 2010).

Biological and genetic models

There is also now a substantial evidence base around the biological damage done to children through sustained maltreatment (McCrary *et al.*, 2017). This evidence extends from highlighting the neuroendocrine system around cortisol (a stress hormone) and its dysregulation in relation to later stress and adversity; to the lack of development of brain functions such as the hippocampus (where memory function is seated) and the corpus collosum and prefrontal cortex (responsible for emotional and behaviour regulation). Another growing area of investigation is that of childhood maltreatment and its genetic impacts. This examines monoamine oxidase A (MAOA), which is an enzyme in the brain that breaks down neurotransmitters such as noradrenaline, adrenaline, serotonin and dopamine. This is linked to the effects of low serotonin (responsible for feelings of wellbeing – the 'happiness hormone'), with resulting lower norepinephrine, which determines alertness and energy, as well as attention, interest in life, motivation and reward (McCrary *et al.*, 2010).

Figure 2 – Attachment model of antisocial behaviour

Models of attachment and serious antisocial behaviour Van Ijzendoorn, 1997



A New Zealand longitudinal study in Dunedin on the effect of childhood maltreatment on violent behaviour in young men found a key interaction with the polymorphism (i.e. individual variation) of the MAOA gene (which affects serotonin levels) (Caspi, 2002). This prospective study found that maltreatment increased risk of later violence perpetrated by males only in individuals with evidence of the polymorphism of the MAOA gene. Young males with only one of the factors (i.e. maltreatment or the polymorphism) had no increased risk.

A second approach is around genetic sensitivity or hardness to adverse experience called 'the differential susceptibility' hypothesis (Belsky & Pluess, 2009). Here, sensitivity to a harsh environment can increase risk of later psychological disorder, but can also increase high functioning in relation to positive environments. The serotonin transporter gene is again implicated. It has two alleles, the short and long alleles. The short 5-HTT promoter region allele is implicated in relation to stress and psychiatric disorder. The analogy is made between sensitive 'orchids' and hardy 'dandelions' – the latter experience lower impact from both negative and positive settings. Thus, children with the short allele in their genetic makeup are more sensitised (orchids) to both negative and supportive environments, with either adverse or positive developmental sequelae to life events, and so-called 'for better or for worse' outcomes (Belsky *et al.*, 2007).

Furthermore, alleles of certain dopamine, serotonin and monoamine oxidase genes also appear to render individuals more susceptible to environmental influences and factors, such as biological reactivity to stress and negative emotional reactivity (Kennedy, 2013). Research on epigenetic effects (how environmental factors can impact on gene expression) provides a revolutionary model of how individual experiences can interface with genetics to alter biological vulnerability due to environmental influences (van Ijzendoorn *et al.*, 2011).

While this paper has a focus on social deprivation and poverty, it needs to be borne in mind that social conditions affect children's biological development. For example, a neglected child may lack key nutrients for development, and a physically abused child may suffer injuries, even brain injuries which lead to enduring developmental problems. This creates an additional level of risk for enduring emotional and behavioural problems. It should also be noted that maltreatment is shown to affect biological change, which can impede a child's development. Here it is argued however that harsh or deprived environments are the primary factors in such damage.

Measurement issues

There are a number of measurement issues that need to be examined in relation to childhood trauma and adult disorder. These include the poor reliability of self-report questionnaires when compared to practitioner records kept at the time (Reuben *et al.*, 2016). The issue with practitioner records is that they do not exist for all children and are not necessarily consistent or comprehensive, and thus may also be flawed. In metanalysis, interviews are observed to be a somewhat better retrospective measure than either approach (Baldwin *et al.*, 2019).

The Childhood Experience of Care and Abuse (CECA) interview, one of the few validated interview measures, has the advantage of being standardised and tested for accurate retrospective measurement. It has compared childhood accounts by independently interviewing 80 pairs of sisters raised together with good agreement achieved (Bifulco *et al.*, 1997). It is also used internationally (e.g. Gianonne *et al.*, 2011) and has the necessary detail and time-based measurement to provide a rich source of information for causal analyses (Bifulco & Schimmenti, 2019). Future studies need to triangulate measurement to ensure the best picture of childhood experience, and researchers should therefore not overlook interviews despite their greater time-resource requirements, as they provide invaluable insights that help us to hear the 'voices' of those victimised.

The following studies using the CECA interview illustrate impacts around childhood trauma and social deprivation on mental health and offender outcomes.

Findings using CECA

The CECA interview is an intensive measure of childhood neglect and abuse which is used retrospectively with adolescents or adults (Bifulco & Moran, 1998). Key indices involve scales of neglect, antipathy, physical abuse, sexual abuse and psychological abuse (see figure 3). These are all measured on four-point scales and for each incident of abuse and care from different parent figures in childhood, up to age 17. Thus, the tool enables an examination of abuse across childhood and can encompass multiple experiences of abuse and care at different ages. As an index of severe neglect or abuse, analysis takes into account the peak score for each type of abuse. In addition, details of family context, such as separation from parent, parental illness, family poverty, conflict and violence are also recorded and considered in analysis (Bifulco & Moran, 1998).

Using this measure and index in community-based samples allows for exploration of the key themes discussed here in relation to negative outcomes and disorders.

Dose effects on disorder

A Medical Research Council-funded study on intergenerational risk of clinical disorder in London community samples (Brown & Bifulco, ending in 2000) was able to study in depth the long-term impacts of childhood neglect or abuse. It involved a two-generation study of mothers and adolescent/young adult offspring. It showed that multiple incidences of abuse related to higher rates of clinical disorder outcomes in both generations – both the adult women and mixed-gendered adolescents. In the adult sample of 303 women, multiples of neglect or abuse were shown to have a dose effect in relation to depression (Bifulco *et al.*, 2003) (see Figure 4A). Thus, there were increased rates of recurrent lifetime clinical depression associated with higher rates of childhood adversity. In the second generation, the adolescent/young adult offspring sample, this also held for behavioural disorder such as conduct disorder and substance abuse (Bifulco *et al.*, 2014) (see Figure 4B).

Figure 3 – Definitions of childhood maltreatment

CECA neglect and abuse definitions (Bifulco & Moran, 1998)

Antipathy

cold or critical parenting. Instances include critical comments, angry hostile interaction, scapegoating and rejection. This is sometimes considered emotional abuse.

Neglect

indifference to the child's physical, material and emotional needs in domains of feeding, clothing, hygiene, medical care, education, friendships and sympathetic support.

Physical abuse

attacks on the child which have the potential for harm. Severity determined by frequency, chronicity and intensity of attack.

Sexual abuse

inappropriate sexual contact or solicitation by adult or older peer, either related or non-related. Severity determined by extent of sexual contact, power exerted and closeness of prior relationship.

Psychological abuse

coercive control exerted through psychological or emotional means to confuse, disorientate and create submissiveness. It covers a range of techniques including dehumanisation, terrorising, emotional blackmail, deprivation of basic needs and valued objects. Severity determined by intensity, chronicity and range of strategies used.

Therefore, the more times children are severely abused, the worse the disorder outcomes are both in adolescence and adulthood. Other types of dose effects were also uncovered. For example, in the adult sample of women, the risk of experiencing domestic violence as an adult could be predicted by the number of times they had been abused as children, as well as the multiples of adversity they faced as adults (Bifulco *et al.*, 2019).

Family context

The ACE studies, explored earlier in this essay, not only included neglect and abuse but also family context factors including parental disorder, criminality, domestic violence and separation from parents. However, the issue of making predictions based on family context factors is that they can differ according to mental health outcomes. For example, for depression in adult women, indices such as loss of a parent or parental conflict had little or no association with later life depression (Bifulco & Moran, 1998). The odds-ratio

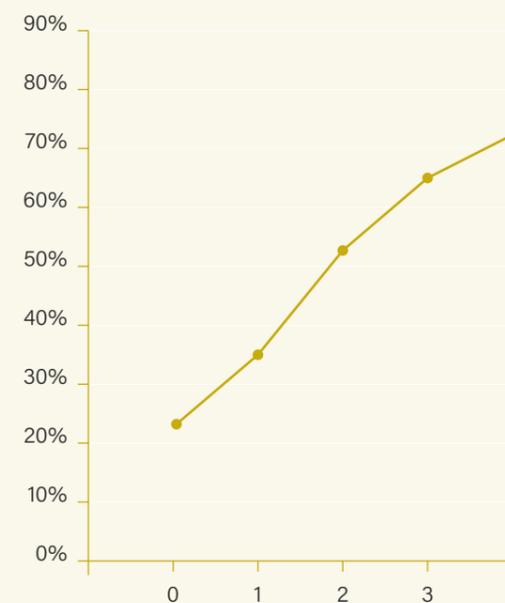
(OR) (the increased likelihood of disorder to occur when the childhood factor was present) for depression were low and non-significant – for example the odds ratios for loss of parent (OR=1.0), parental psychiatric illness (OR=1.2), parental alcoholism (OR=1.1) and parental physical illness (OR=1.3) were all found to be low. These low ratios indicate that the presence of these factors did not increase risk of later disorder. Therefore, neglect or abuse to the child has substantially more impact than the family context aspects in these studies (OR=3.5 for an index of neglect or abuse and adult depression). However, it should be noted that these family context variables (loss of parent, parental alcoholism or illness) were shown to increase the risk of maltreatment (i.e. neglect or abuse) three-fold (Bifulco & Moran, 1998).

With the CECA data, issues relating to the family context tended to have a different role in contributing to externalising (behavioural) disorder in a sample of high-risk adolescents. This included conduct disorder (delinquency) or substance abuse/dependency. Thus, structural equation modelling (SEM) was used as a statistical technique, allowing a set of relationships between one or more independent variables (such as childhood neglect/abuse or domestic violence) and

Figure 4 – Dose effects of maltreatment on disorder outcomes

A. Adult women and lifetime depression

—●— Chronic/recurrent depression



B. Adolescents and behavioural disorder

—●— Substance abuse

—●— Conduct disorder



Multiple abuse < age 17

Severe neglect & physical & sexual abuse & psychological abuse in A only.

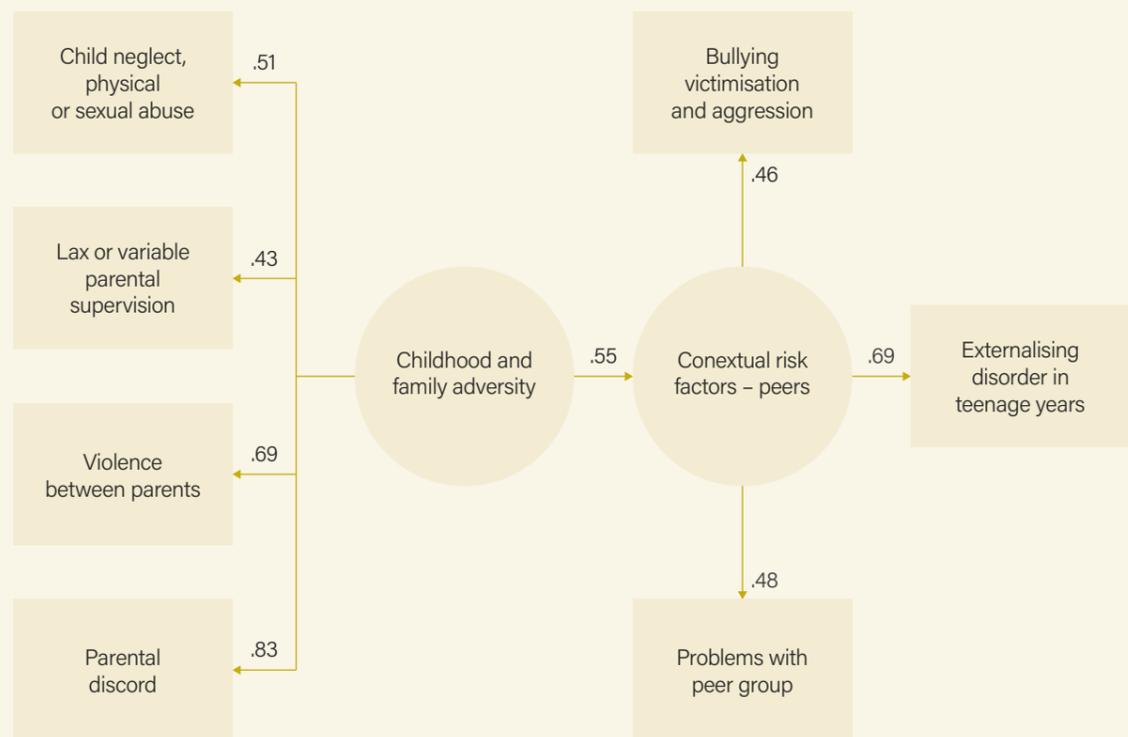
one or more dependent variables (such as problems with peers or behavioural disorder) to be examined in a graphical array. In the adolescent sample, this analysis looked not only at neglect/abuse but other family characteristics and those of peer problems and bullying (victimisation or perpetration) (Bifulco *et al.*, 2014). Here, a mediating or linking role was played by school factors such as problems with peers and being both perpetrator and victim of bullying. This related to externalising (behavioural) disorders (see figure 5).

There is substantial evidence of the impact of parental violence, bullying and peer problems on externalising disorder to support these findings (Olweus, 2004). Bullying is also associated with problematic peer relationships (Kaltiala-Heino *et al.*, 2010), social deprivation and ethnic minority status (Espelage *et al.*, 2000; Striegel-Moore *et al.*, 2002). These also confer disadvantage.

With regards to offenders, the CECA has also been used in the study of psychopathy in criminal populations. This was assessed using the validated PCLR¹⁰ psychopathy checklist instrument by Robert Hare, and studied in the Scottish

prison system (Hare & Neumann, 2006). Marshall and Cooke (1999) assessed serious offenders and established a group of 55 who had high scores on psychopathy and 55 with low scores. These groups were both also interviewed about their experiences of childhood adversity using the CECA interview. They found significantly higher rates of antipathy, neglect, poor supervision and discipline, and psychological abuse in the high psychopathy scoring group. No differences were found for physical or sexual abuse between the two groups. Of the two factors then identified in the psychopathy assessment (callousness versus unstable lifestyle), these maltreatment experiences particularly related to the former – embodying selfish, callous, remorseless behaviour. However, the researchers also found in their analysis that wider adversity was influenced by negative residential care, poor school experience and performance, and problematic social experience involving peers. This related to the psychopathy dimension of unstable or antisocial lifestyle (Marshall & Cooke, 1999). Thus, both maltreatment and its family context of disadvantage have important negative impacts on later functioning in relation to antisocial behaviour.

Figure 5 – SEM model of family context and externalising disorder



10. <https://exploringyourmind.com/the-psychopathy-checklist-by-robert-hare/>

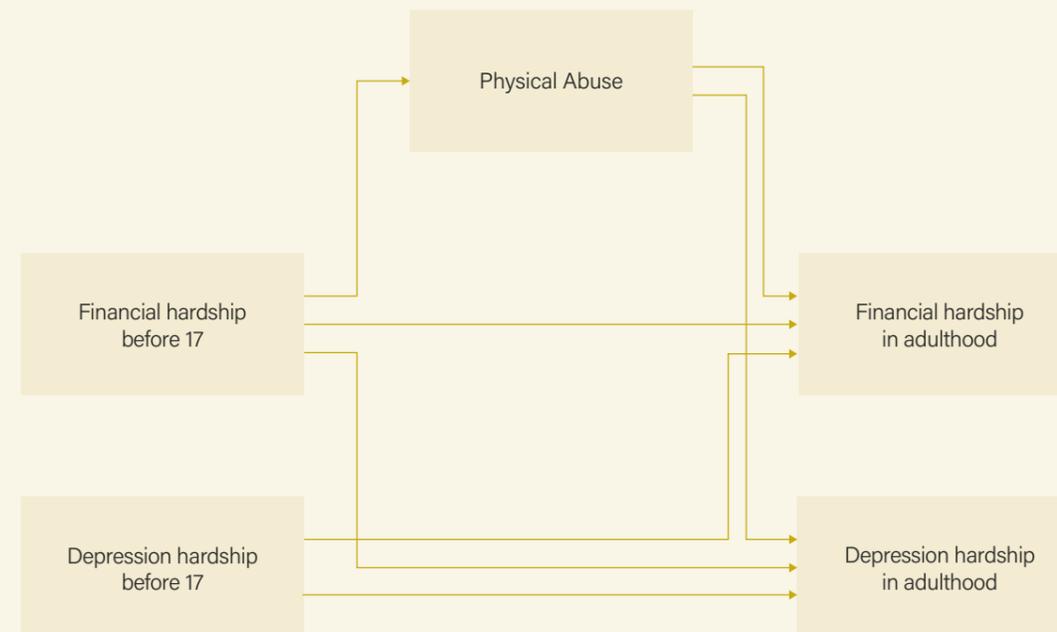
Poverty

Poverty in childhood was measured through the CECA in terms of housing or financial hardship in a sample of adult women. It was examined alongside neglect/abuse in childhood in relation to depression, but also with adult poverty as an outcome (Spence *et al.*, 2019). A simplified version of the SEM model described earlier was used to assess if childhood financial hardship was a predictor of adult financial hardship and depression, to see if these associations were mediated by physical abuse, together with stigma and childhood feelings of shame. Part of this analysis is shown in Figure 6. Early financial hardship before age 17 predicted adult depression and was mediated by physical abuse. Physical abuse also mediated the relationship between childhood and adult financial hardship. The same findings also held for both shame and stigma as mediating factors. This provides an important link between child abuse and poverty, but also with the psychological impact of shame. This analysis indicates

that targeting shameful feelings could be a key focus for interventions supporting families experiencing financial hardship and associated physical abuse of children.

To summarise this section: analyses using the established CECA interview in a range of samples indicate evidence for both socio-ecological and attachment models helping to understand risk and clinical disorder. It is evident that multiple experiences of childhood abuse have stronger effects on mental health in adulthood and that childhood abuse is mediated in a number of ways, including through insecure attachment styles and characteristics such as stigma and shame. Family and peer context can also play a part in mediating children's experiences of abuse. Outcomes of childhood neglect and abuse are also very varied – they encompass depression as well as behavioural disorders such as conduct disorder, substance abuse, violent offending and psychopathy.

Figure 6: Financial hardship, physical abuse and depression (Spence *et al.*, 2019)



Research into practice

It is incumbent on researchers to translate their findings for use by practitioners. Thus, through the Centre for Abuse and Trauma Studies (CATS), I have sought to translate my research on childhood neglect/abuse and attachment style for use by those working in child safeguarding with children in care. CATS has partnered with child protection services to aid with accurate assessment of childhood neglect and emotional abuse. This is particularly around neglect which has proved more difficult in mobilising court action due to its supposed less destructive impact on the child or belief it can be easily alleviated by family support, but for which rates are increasing while others are falling.¹¹ To do so, CATS has provided workshops on child safeguarding for social workers using CECA criteria which have proved effective for improving practice (Bifulco & Jacobs, 2012). Practitioners reported more confidence in their judgement of what constituted neglect or abuse, and in applying thresholds more accurately, leading to different care plans. For example, practitioners recounted how these tools have aided them with challenging decisions about family support versus implementing care proceedings.

Other partnerships have been with agencies managing children in foster and residential care (Bifulco *et al.*, 2017). Here, attachment styles have been examined as part of the risk profile resulting from early abuse experience and separation from parents. This has aided practitioners' recognition of child need and in appropriate care planning. The particular experiences of children in residential care with different attachment profiles is further described below.

Residential care

Around 9% of the 69,540 children and young people looked after by the state in England, as estimated in 2015, were placed in residential care homes and hostels (Department for Education, 2015). In the UK, this more often affects adolescents with complex needs who have experienced other types of arrangements which have been disrupted, with residential care increasingly seen as a last resort (Colton & Hellinckx, 1994). These young people have among the worst outcomes of children in care. For example, half of children in care have emotional and behavioural problems at clinical levels, and the highest rates are found in residential care (Ford *et al.*, 2007). Young people emerging from residential care are more likely to become involved in criminal activity in adulthood (Farrington, 1990) or to be referred to forensic psychiatric services (Department for Children, Schools and Families (DCSF), 2007) and high-security hospitals (Scott, 2004). They are also disadvantaged educationally,¹² and are more likely to be homeless and to become teenage parents (Department for Education, 2015). This has led to the Narey review, described in further detail in the next section of the essay.

Young people who have been in care have difficulties in forming relationships. Recent guidelines published by the National Institute for Health and Care Excellence (NICE) highlight the wide-ranging implications attachment theory has for child-care policy and practice in the UK (NICE, 2016). These sought to develop formal guidance on the attachment and therapeutic needs of looked-after children and those adopted.

The Centre for Abuse and Trauma Studies (CATS) at Middlesex University partnered with a voluntary residential care agency (St Christopher's Fellowship) for a number of years to encourage understanding of attachment theory amongst its staff and to train them in attachment assessment. This took the form of self-report questionnaires (Q packs) completed by the young people and care workers on a regular basis to monitor progress with the social pedagogic intervention.¹³ This humanistic intervention takes a 'head, hands and heart' approach to aiding child development and education, using a holistic approach with a focus on allowing the child to grow rather than exerting strict controls (described in further detail below). To aid in appraising the child, the group introduced the intensive interview assessment (Attachment Style Interview) for more in-depth work (Bifulco *et al.*, 2017; Jacobs *et al.*, 2019). This assessment looked at the quality of the adolescent's close relationships and support as well as ascertaining aspects such as mistrust, fear of rejection or abandonment, anger and autonomy. From this, an accurate attachment profile was deduced giving a theoretical underpinning in working to reduce anxious or avoidant attachment patterns or those with disorganised styles.

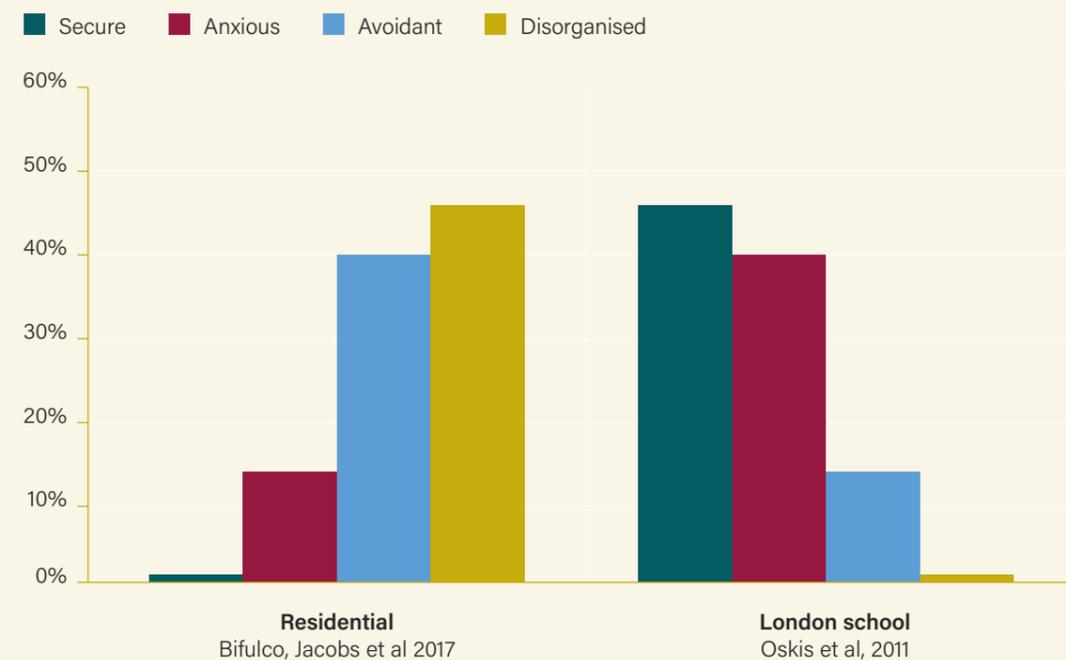
When the prevalence of attachment styles from interview assessment was assessed for 118 young people in residential care, only 1% had a secure attachment style compared with 52% in school adolescents, using the same interview (Oskis *et al.*, 2010). Figure 7, from the same study, also shows how 46% of those in residential care showed the most complex insecure style, that of disorganised, which showed both anxious and angry-dismissive elements with accompanying lack of emotional control. This style was rather rare in the sample of school adolescents, with only 9% having such a style. This style poses particular problems when working with adolescents in care because the levels of dissociation or disconnection between thought and emotion can make the young people very unpredictable. Amongst other insecure styles, avoidant was most common (40%) in residential care with only 11% in the school setting having an avoidant style (Bifulco *et al.*, 2017). Thus, adolescents with this style were more likely to be over-independent, not able to ask for help, and often with angry responses to others. Similar results were shown by use of a self-report of attachment style. These rates of insecure attachment styles replicated those found in other UK (Wallis & Steele, 2010) and European studies (Zegers *et al.*, 2006).

11. <https://learning.nspcc.org.uk/media/1184/child-protection-register-statistics-wales.pdf>

12. <https://www.nao.org.uk/report/children-in-care/>

13. <http://www.thempira.org.uk/social-pedagogy/>

Figure 7 – Attachment style in young people: residential versus school



Showing care workers the rates of different attachment styles in school children compared to those in their care helped them to understand the high level of need expressed by the residential care children. Also, in unpacking concepts of disorganised style they were able to recognise how both anxious and avoidant (particularly angry) attachment styles co-existed. This helped them to recognise the young people's fear around attachment as well as the more observable hostility. As a result, the agency was able to rebalance the care versus the control aspects of working with the young people, using a social pedagogic intervention (Holthoff & Junker Harbo, 2011). This led to improvement over time. Social pedagogy is also relevant as an approach for examining disadvantage and inequality. The ThemPra organisation, which offers training in social pedagogy, states on its website:

Social pedagogy is essentially concerned with well-being, learning and growth. It is underpinned by the idea that each person has inherent potential, is valuable, resourceful and can make a meaningful contribution to their wider community if we find ways of including them. This requires that we also tackle or prevent social problems and inequality.¹⁴

14. <http://www.thempira.org.uk/social-pedagogy/>

Policy issues

As demonstrated throughout this essay, experiences of neglect and abuse have very damaging impacts on children which can last into adolescence and adulthood and have large social consequences. This includes clinical disorder and criminal behaviour, and problematic relationships which can lead to partner separation and domestic violence. These are shown to be at particularly high rates in young people in our care system who subsequently require a high level of service resource in adult life from the health, psychiatric and criminal justice systems.

Early life experience is now recognised as a public health issue in the UK. In his review of public health, Marmot recognised how interventions in the early years could have a significant impact on reducing a high number of mental and physical health issues (Marmot, 2010). As a result of this recognition, a review of residential care in England was undertaken. This was particularly important as the residential care system in England has estimated costs to the country of £12 billion, with a cost of £131,000 per child per year and with a third of children having more than one placement per year (Narey, 2016). This is three times the cost of supporting

a child in foster care. Most of the children in residential care need treatment from Child and Adolescent Mental Health Services (CAMHS) as well as specialised educational help and legal help when they have police contact following delinquent behaviour (Davidson & Bifulco, 2018).

This review into residential care (Narey, 2016) had 34 different recommendations including placement flexibility, being cautious against criminalising children, staying safe by offering ongoing support to residential care leavers age 18 and over, improving staff quality, work conditions and pay, and the need for improved leadership through setting up a Residential Care Leadership Board. He also called for value for money and for more effective inspection. These measures were proposed to improve the quality of life of children in residential care and lessen negative impacts on their health and risk of offending going forward.

Narey also commented on the successful use of social pedagogic approaches in Europe, notably Scandinavia,¹⁵ and their utility for children in care (Berridge *et al.*, 2011; Petrie *et al.*, 2006). He commented:

Berridge describes the pedagogical approach which: "Is said to involve the whole person – head, hands and heart. Relationships between staff and children are central and physical contact may be used for reassurance (Berridge et al., 2011). Pedagogues undertake domestic tasks in developing a comfortable living environment. Activities with children are important, including developing practical and creative skills." For me, that is close to a description of good residential social work in England. As Berridge has said we can be allured by what he calls the 'Nordic Nirvana'. "There is a tendency to believe that children's services in other countries are more successful than ours. However, the large policy transfer literature cautions against introducing social policies from elsewhere into a very different social and historical context." I am not suggesting we cannot learn a great deal from international approaches. (Narey, 2016, p.68)

In relation to all we know about child abuse, it is important not to forget the human costs and the rights of the child (Davidson & Bifulco, 2018). We need to intervene and prevent child abuse not only because of the lasting harms and costs to society, but also on ethical grounds given that children's human rights are being contravened (UNCRC, 1989). The United Nations Convention on the Rights of the Child comprises 54 articles that cover all aspects of a child/young person's life and set out the civil, political, economic, social and cultural rights to which all children everywhere are entitled. These rights apply regardless of gender, ethnicity, religion, language, abilities or any other status. Related to these rights is the principle that the child should have a voice, an aspect emphasised in certain child protection reviews (Munro, 2011), in police investigations such as Yewtree¹⁶ and in relation to abuse more generally (Childs-Smith, 2017).

Conclusion

This paper has sought to integrate a number of research approaches to child abuse using a multi-perspective view. This is often lacking in other reviews which tend towards single disciplinary vantage points. Such a multi-perspective view is important as the area of research is a complex one – abuse itself is a complex phenomenon, encompassing a variety of experiences which can change over childhood and adolescence and be from a range of perpetrators. Impacts too are complex, leading for example to negative cognitive bias (for example, mistrust), emotional dysregulation (impulsive anger), impaired relationship patterns (conflictful and lacking closeness) as well as social disadvantage and problematic mental health. As a result of these complexities, it can be challenging for practitioners working with children who suffer these impairments to understand the bases of the behaviours shown, and how they can intervene to effect positive change.

Child abuse is thus acknowledged to be a major issue in terms of social disadvantage, poor health and criminal behaviour. Understanding it requires encompassing social, psychological and biological models. This essay has argued that using an attachment-informed approach helps to encompass the personal and social consequences of child abuse. Social disadvantage is also a central element of childhood abuse both as a cause and a consequence. As a society we need to eradicate the conditions that allow for such harm to take place against children and seek to ensure a kinder environment to allow them to flourish.

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