Responding to the Needs of Older Children

A Practice Guide for Panel Members

Contents

Introduction

The Children (Care and Justice) (Scotland) Act 2024 proposes a number of considerable changes to the Children's Hearings System, some larger than others.

For Children's Hearings Scotland and the Panel Members it supports, the main impact of the Act is changing the definition of 'child' in a number of pieces of legislation and most notably, the Children's Hearings (Scotland) Act 2011. The result of this is to increase the age of new referrals into the Children's Hearings System from 16 to 18. In this context, any person under the age of 18 would be considered to be a child, and could therefore be referred to a hearing on welfare or offence grounds.

It is clear that in law, policy and practice, there are inconsistent definitions of what constitutes a 'child'. Certain laws afford 16- and 17-year-olds the same rights as adults, whilst other laws provide the same protections to this age range as those below the age of 16. The UNCRC defines a child as "every human being below the age of 18 years", and the Children (Care and Justice) (Scotland) Act 2024 goes some way to bringing Scotland in line with this principle, whilst recognising the increasing autonomy of older children.

Currently, there is disparity in the way that 16- and 17-year-olds are dealt with regarding both welfare grounds and offending behaviour in Scotland. At the time of writing, if a child has had no previous involvement with the Children's Hearings System, they may only be referred to the Scottish Children's Reporter Administration (SCRA) in order to arrange a hearing if they are under the age of 16. There is similar disparities in relation to criminal justice. Currently, if a 17-year-old commits a serious offence, their case would likely be dealt with through the criminal justice system. However, if that 17-year-old is subject to a Compulsory Supervision Order (CSO) which was put in place prior to them turning 16, the Reporter and the Procurator Fiscal would have a conversation to decide whether their case should be dealt with via the Children's Hearings System or the criminal justice system. This gives the option to go to a hearing, rather than to court.

The Children (Care and Justice) (Scotland) Act 2024 will change the current position, so that any 16- or 17-year-old could be referred to a children's hearing. The criminal justice system – and in particular, the courts and prison settings – is not an appropriate place for a child to be and can cause long-term damage to a child at a vulnerable time in their lives.

Naturally, this change in law will increase the number of referrals into the hearings system, and the number of hearings each year. It will also likely bring an increase to the number of hearings involving conflict with the law. Whilst this is true, it is important to note that projections conducted by the SCRA show that the majority of new referrals for 16- and 17-years-olds will relate to care and protection needs, rather than conflict with the law.

In anticipation of this legislation, Children's Hearings Scotland consulted with a number of Panel Members to discuss concerns around these changes and to determine where further training and resources could be provided to support the community. These conversations heavily involved offending behaviour and the community identified that further learning and training would be required in this area. However, there are many other areas which will become more relevant in such hearings, such as mental health, children's rights, and social needs such as interpersonal violence and harmful sexual behaviour, which have been included in this guide (amongst other topics) in order to support Panel Members to comprehend the complex needs of 16- and 17-year-olds.

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In this guide, we often refer to 'children'. For the avoidance of doubt, by this, we mean infants, children and young people: all of those under the age of 18.

This guide has been drafted by the Children and Young People's Centre for Justice, in partnership with Children's Hearings Scotland. It is extensive in its content and intended to be used as a reference guide for Panel Members in supporting the needs of 16- and 17-year-olds.

We would like to thank the Children and Young People's Centre for Justice for their hard work and dedication in producing this guide, and for providing an incredibly valuable resource for Panel Members.

The following guide includes some content that some people may find upsetting or triggering. If you would like to speak to a trained counsellor at Health Assured, you can find out more at our Community Hub SharePoint page: Wellbeing Hub.

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Adversity and Trauma

Introduction

This section highlights important issues related to adversities and trauma impacting upon children who need support. It also provides information about the role that resilience plays in their life. More detailed information from CYCJ's Practice Guide can be found here.

Adverse Childhood Experiences

Adverse Childhood Experiences (ACEs) are a group of ten circumstances that have been shown to increase the risk of problems later in life. As this video shows, higher exposure to ACEs amongst the population increase the risk of adverse outcomes such as health problems, involvement in the care and justice system and drug use. Compared to the general population, levels of exposure to ACEs are particularly high amongst those children and young people who go on to be placed within secure care or prison, as well as those in care settings. This report from SCRA highlights that children who come into conflict with the law also face significant adversities.

The impact of each of these ten issues may well contribute to the episodes of harm to and by the child, resulting in referral to the hearings system. Each of them can be particularly damaging and result in physical harm, emotional distress and damage and a detriment to their welfare.

However it is essential to remember that research relating to ACEs originates from very large studies of thousands of people and relates to adverse outcomes within a similarly large scale, and so should not be used to predict the future outcome of a single child. Many children go on to enjoy happy, successful lives despite these earlier experiences. The presence of ACEs does not mean that a child is certain to face negative outcomes later in life, although may mean that the child currently needs help. As Panel Members it is therefore important that decisions are not made based on exposure to these issues alone, and instead should reflect the wider situation including the supports, strengths and protective factors that are present in the child's life at that time. By seeking to secure positive care today, the hearing can increase the likelihood of a positive outcome later in life. Panel Members should look to make decisions that provide the conditions for positive childhood experiences.

Broader Adversities

One criticism of the ACEs approach to understanding this issue is that the approach is too narrow a focus and fails to consider the impact that other contextual factors can play in wellbeing. For example issues such as bullying, child criminal exploitation, mental ill-health of the child, and fleeing war are omitted from the ACEs approach. A diverse range of factors can contribute to the child experiencing adversity, and research has shown that children who come into conflict with the law have often encountered multiple and sustained adversities.

Panel Members should therefore expect to receive a comprehensive assessment of the child and their family which provides a broad picture of their lives. Included within this should be an assessment of how these issues impact upon their ability to lead happy, safe and worthwhile lives and what is required in order to achieve positive outcomes.

Trauma

Trauma is an event, a series of events or set of circumstances that cause significant harm or distress and then results in long term impairment to a person's emotional, mental, physical, or social wellbeing. For example, this could take the form of a road traffic accident which results in the child being fearful of entering a vehicle again or experiencing nightmares and distress at other times. Children may display anger, impulsivity, hyper-arousal and have difficulty in controlling their emotions. Other people may interpret this as violent or aggressive behaviour which can lead to police involvement. However, behaviours such as breach of the peace, vandalism and violence could all be a result of distressed behaviour caused by frightening past events and trauma.

Children who come into contact with the care and justice systems have often faced a range of traumatic experiences, and indeed their contact with those systems may be one such experience. Attending a hearing may also be traumatic for children and their families, and so Panel Members should consider ways in which they can reduce the risk of re-traumatisation. This can be achieved through adopting trauma-informed practice and acting in a way that is more empathic to the needs of the child and their family, including adhering to the five Trauma-Informed Practice principles: Safety, Trust, Choice, Collaboration and Empowerment. Children's Hearings Scotland published a blog about the role such an approach plays during hearings here. NHS Education for Scotland provide a useful video and training on trauma-informed practice which Panel Members complete during their pre-service training, and should be referred back to.

Panel Members should give attention to the history and context of the child appearing at a hearing and take steps not to perpetuate the trauma they have faced. However, as with all issues of this nature it is important to remember that not everyone who has faced adversity will experience trauma. Nevertheless, some simple steps can be taken which will improve the experience of all children attending hearings. These include the following:

- **Use sensitive language**: ensuring that a non-judgemental approach is taken necessitates avoiding stigmatising or blaming language that causes harm or distress. In partnership with Our Hearings, Our Voice (OHOV) and other professionals in the sector, CHS have produced a guide – Language in the Hearing Room – to support Panel Members around language.
- **Provide reassurance**: supporting the child to discuss their circumstances. Panel Members should reassure the child and instil a feeling of safety within the hearing room.
- **Promote agency**: giving the child opportunities to have their voice heard and take control of their situation will increase their sense of empowerment.

Further information about how to take a trauma-informed approach in hearings can be found in the CHS Practice and Procedure Manual here.

Resilience

Whilst everyone involved in supporting children aims to avoid adversity from occurring, this can be an impossible task and regrettably some children will continue to face adverse circumstances. The child is not responsible for addressing this, and instead society must take steps to keep them safe, improve the situation and assist the child to flourish.

To support the child to overcome the difficult situation that they find themselves in, family members, social workers, teachers, Panel Members and others should encourage the development of resilience. This resource similarly highlights

the role of adults in achieving this. As this short video shows, resilience is the ability to overcome challenging situations by developing positive characteristics, skills and personal coping mechanisms that allow the child to manage the difficult situation they find themselves in. Resilience can be developed within various areas of life such as school, home, community and the other settings. In this way, a child who is experiencing a difficult situation at school can benefit from the care afforded to them at home, and so on and so forth.

Resilience within a child – or their immediate environment – can protect them from the impact of adverse circumstances. However determining whether there is sufficient protection is not a simple task, with each child's circumstances being different. This is particularly challenging when working with teenagers as their diverging pace of development makes it is difficult to describe how a 'typical teenager' ought to behave.

It must be stressed however that the absence of resilience is not grounds to have concerns over a child, and rather it is the presence of those risks and vulnerabilities which impact upon the child's wellbeing. As Panel Members you should consider what supports and protective factors are around the child as these are likely to form the basis of a child's plan.

Panel Members can have a role in supporting the resilience of children in the ways they interact with them during hearings. As this guide points out, acts such as permitting them space to learn from mistakes, remaining committed to their welfare and allowing them time to make their own choices all go some way towards achieving this.

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Brain Development

Introduction

Adolescence, the transition period between late childhood and adulthood, is a distinct developmental stage. Adolescents commonly seek new experiences, with tendencies towards sensation-seeking, risk-taking and impulsivity, often with little apparent regard for consequences. They are more prone to disharmony with parents and move to seeking the approval of peers. Rates of offending also peak at age 14-15 and decline steadily through late adolescence, known as the 'age-crime curve', the vast majority not continuing to offend into adulthood.[i] Adolescent brain development helps explain these behaviours.

Brain Development

The brain matures through childhood and into adolescence, now known to be a critical period for development. Brain cells send messages called neurons to each other, allowing us to function. The point where cells connect to transmit neurons is called a synapse. More cells and synapses are produced than we need, and in periods of brain development, 'pruning' takes place where the brain loses many of these connections. At the same time, other connections are newly established. The most commonly used connections are strengthened with a protective coating called myelin, which increases their efficiency and the speed at which information travels. This means that the connections which are most commonly used will be those most likely to be used in the future. This process is more pronounced in the early years but also significant during adolescence, with the suggestion this 'rewiring' of the brain improves efficiency and promotes the establishment of more adult-type patterns.[ii]

These 'pruning' and 'rewiring' processes are referred to collectively as 'neural plasticity'. Neural plasticity is impacted by both developmental and experiential demands as whether connections are used or not, and consequently strengthened or lost, depends on our individual experiences and environments. Neural plasticity occurs in different parts of the brain at different times, which is thought to help explain adolescent typical behaviours, and their differing rates of maturation.[iii]

Impact on Behaviour

The brain is split into multiple areas, each responsible for certain functions. Neural plasticity in the parts of the cortex (the outer covering of the brain governing motor and sensory functions) slows down way before adolescence, whereas the pre-frontal cortex (the area responsible for responses such as empathy, insight, emotional regulation and response flexibility) and the areas relating to further cognitive functioning such as inhibition and judgement continue to develop though adolescence and into early adulthood.

Delays in the maturation of these front areas of the brain are thought to explain why adolescents continue to display developmental immaturities in cognitive control, attentional regulation (maintaining calm whilst receiving and organising information/stimulus before responding), response inhibition (supressing inappropriate reactions), and other cognitive functions.[iv]

Risk-Taking

Adolescent studies on the part of the brain that responds to rewards show an exaggerated response to rewards, and a

much lower level of response to anticipatory rewards or cues for rewards, than both adults and children. This is a characteristic also linked to increased risk-taking behaviours,[v] which can explain why an adolescent may choose a risky path with short-term rewards, rather than a safe path with long-term rewards.

The disparity between the more developed limbic system of the brain, which is responsible for emotional and behavioural responses, and the lesser developed prefrontal control system may also account for risk-taking in adolescence. Teenagers can make rational decisions, but this ability is impaired in more emotional/stressful situations (e.g. in the presence of peers or with the prospect of an immediate reward), when rewards and emotions will have greater influence on behaviours than rational decision-making processes.[vi]

Risk-taking in adolescence can also be attributed to a lesser neuro response to things that could trigger adverse or harmful outcomes, such as threats or consequences than in adults, responses only generated when penalties are particularly high.[vii] This could explain why adolescents appear more motivated by easily attainable rewards (e.g. missing school with friends or substance use) than they are deterred by future penalties, and why they may be unable to appreciate the risks associated with reward behaviours.

Sex also determines how and when areas of the brain develop, related to the timing of puberty, which is earlier for girls than boys, suggesting a role for sex hormones in brain development. These differences may account for the prevalence of specific disorders within each sex associated with areas of the brain where these variations are evident. For example, differences in the basal ganglia (responsible for executive functions and behaviours, motor learning and emotions) may explain higher rates of obsessive-compulsive disorder (OCD) and attention deficit hyperactivity disorder (ADHD) in males, and of major depressive disorder (MDD) in females.[viii]

Adolescent Mindset

Peer acceptance and status are important to adolescents, with popularity shown to be positively related to risky behaviour, indicating peer acceptance influences behaviours. It has been shown that peer observation increases risky decision-making in 16- to 18-year-olds whilst the simple presence of a peer did not.[ix] This age group are more conscious than any other of their reputation amongst peers, linked to increased rewards seeking as activation in this part of the brain peaks in adolescence and reduces up to around age 30.[x]

Studies on the influence of peers and mothers show that whilst peer influence increased risk-taking behaviours, the mothers' presence reduced it,[xi] indicating social influence can also result in more positive decision-making. This has implications for interventions and may involve encouragement of increased time with those who are regarded as positive influences in social/education/family spheres, and targeted work to improve relationships with those positive persons whose acceptance the child desires.

Implications for Practice

Care planning for older children must involve careful consideration of brain development. We must set realistic expectations, recognising failure to follow parental direction, plan-ahead, and think consequentially are not things they have full control over. Equally, threats that don't hold immediate consequences, like future criminal convictions or offence grounds, are unlikely to deter behaviours.

Example: Police approach a group of older children who are drinking. The group run and one child accrues a police assault charge. It may seem logical to impose a month's grounding and expect them not to run from the police or drink again, reinforcing negative consequences as a deterrent. However, a neurodevelopmentally informed response may recognise a few days grounding offers a level of punishment/contemplation time. Within a few weeks of a month's grounding, there will likely be immediate rewards that override adherence to this lengthy sanction. A more informed approach could recognise the pull of peers and the likelihood the child will use alcohol again but look to offer alternate positive uses of time and promote harm reduction techniques (i.e. avoiding spirits/mixing drinks, drinking indoors). It involves talking when the child is calm/rational and recognising that behavioural change and neurodevelopment takes time, the child will likely age out of these behaviours and working to get them through adolescence with as few negative experiences as possible.

Neurodevelopmental Issues

The Scottish Government describes those who have a neurodevelopmental disorder as "those who present with a 'functional' impairment in day to day life due to difference in one or more neurocognitive function which lie at the extreme of, or out with the normal range." Providing further clarity on appropriate language, it also explains the following definitions:

- Neurodiversity is the statistical normal range of a function in a population at a particular age;
- Diversity is a trait of the whole group, not a specific individual;
- Neurotypical describes individuals where a selective neurocognitive function falls within the prevalent societal norm; and
- Neurodivergent describes individuals where a selective neurocognitive function falls out with the prevalent range.

If needs are not identified and met appropriately then longer-term problems can arise, such as mental ill-health and involvement in the care and justice system. Recent research in England and Wales estimates around half of prisoners have neurodevelopmental disorders.[xii]

Assessment and treatment of neurodiverse conditions have traditionally been via CAMHS however distinct neurodiverse pathways are being introduced, with associated Neurodiversity Standards of Care to sit alongside CAMHS National Service Specification. Those common in children in the care and justice systems are discussed below.

Attention Deficit (Hyperactivity) Disorder (ADHD)

ADHD comprises behavioural symptoms broadly characterised by impaired attention, overactivity, and impulsivity, understood to be caused by impairment of executive (cognitive) functioning.[xiii] It can be split into two behavioural categories: inattentiveness (difficulty retaining focus and concentration) and hyperactivity and impulsiveness, though not all display the hyperactivity/impulsiveness, referred to as having ADD.

Research shows that around a quarter of prisoners in England and Wales are thought to have ADHD.[xiv] Certain traits of ADHD may explain the correlation between the diagnosis and criminal activity: for example, impulsivity could override consequential thinking and the development of a negative self-view, or sensitivity to perceived rejection could become a trigger for violent reactions.

Diagnosis requires symptoms having begun before age 6 and to exist across different domains such as home and school. ADHD can co-occur with a Conduct Disorder (CD), dyslexia, depression, or anxiety. Problems with learning, sleep, self-esteem, and school achievement often become apparent as the child develops. Rejection Sensitivity Disorder (RSD) is common with ADHD, characterised with fear of rejection. Adolescents with ADHD are overly reactive and perceiving of social rejection cues and more likely to miss positive social cues.[xv]

Where there are indicators of childhood maltreatment along with ADHD traits, both ADHD and traumatic stress should be considered in assessment. Symptoms can be similar, but treatment very different. Professional assessment of neurodivergence should be sought but may take time, or a child may not consent, therefore, as recommended by the Scottish Government: "Understanding of support needs can be enhanced by diagnosis but should not wait for diagnosis."

Evidence-based interventions for ADHD generally include high-intensity school interventions, parent training, education, and medication. Studies have shown earlier drug treatment of ADHD to have more effective long-term positive behavioural change.[xvi]

Autism Spectrum Disorder (ASD)

ASD is life-long condition, and though often diagnosed in early childhood, can also go undiagnosed. For diagnosis, substantial impairment must be seen across three domains: social, language/communication, and thought/behaviour. Difficulties with social communication, recognising and expressing emotions, repetitive and restricted range of behaviours and over- or under-sensitivities to sensory stimuli are common traits of those with ASD.

Level of impairment varies significantly. ASD was traditionally differentiated into either Autism or Asperger's Syndrome, those with Asperger's sharing the clinical features of ASD but possessing better language skills and no intellectual impairment. The clinical features of ASD are grouped into interpersonal, affect, behaviour, language, cognition, physical and sensory.[xvii]

Those with ASD often have difficulty reading other people, take things very literally, and may spend time alone and find it hard to make friends. This does not mean they lack empathy: recent research conducted by the National Autistic Society (NAS) showed that there were diverse experiences of empathy within participants, which does not support prior thinking that there is an inherent 'empathy deficit' in those with autism.

ASD impacts upon all aspects of a child's life and it is crucial to understanding their risks and needs. Some features of ASD, for example difficulty with regulating emotions or seeing other perspectives, are shared by complex trauma responses, so it is important to differentiate between traumatic stress and ASD, and on rarer occasions emerging personality traits.

Displays of violence in those with ASD may occur when they are denied access to their special interest, in the context of change, or in response to sensory overload/feelings of being overwhelmed. See the NAS's Meltdowns - a guide for all audiences for advice on how best to respond. Understanding the relevance of ASD for the individual is crucial, particularly in relation to legal issues, as ASD may undermine a child's ability to understand and engage whilst in a children's hearing. Panel Members should consider carefully what practical modifications and additional support can be provided to ensure the young person can participate effectively, such as a lay representative to support them or an advocate.

Behavioural interventions in response to specific concerns associated with ASD, such as anxiety, sleep difficulties, or communication problems, may be beneficial. Most interventions in response to ASD will likely be undertaken by parents/carers, or by implementing systemic or environmental changes. For Panel Members, this could mean changing the room layout or carefully considering the number of professionals participating in a child's hearing.

Panel Members can read further about supporting children with ASD in hearings in CHS's Practice and Procedure Manual here.

Acquired Brain Injury (ABI)

An ABI is any injury to the brain post birth, falling into two categories. A Traumatic Brain Injury (TBI) is caused by a traumatic external incident injuring the brain, such as causes during sports, road accidents, falls or through violence. A Non-Traumatic Brain Injury (Non-TBI) comes from internal disease processes such as a stroke, infection, abnormal growth (such as a tumour), or lack of oxygen to the brain.[xviii] Around half the prison population in England and Wales are estimated to have an ABI, higher amongst women linked to experiences of domestic violence.[xix] ABIs can cause damage to the area of the brain impacted, which can affect brain functions of the affected area(s).

ABIs are more prevalent in males and younger people in poverty, with alcohol use one of the biggest risk factors. It follows that the children in the Children's Hearings System who are involved in alcohol use and/or violence are at increased risk of brain injury.

TBIs include concussion (which can be mild to severe), skull fractures, a brain bruise or bleed, and penetrating brain injuries - often caused by assaults. Impairment to the functions of the brain affected is common and can also lead to further internal damage such as swelling or infections, again impairing function. ABI impact is extremely varied, given the complexities of the brain. TBIs are a leading cause of death and disability for children and adolescents.[xx] They can cause seizures, hearing and vision problems, disorientation, and cognitive impairment, impaired ability to recall words and process information, and often impulsivity and impaired judgement. ABIs impact skill in day-to-day functioning, and in turn, this can impact a child's self-esteem.

If a child is known to have experienced an ABI, or is involved in alcohol use and violence, good practice is to inquire as to lasting impact or prevalence of any of the above symptoms to establish if an ABI could be impacting behaviours or ability to communicate/engage. Medical treatments and care management are varied, though levels of pre-ABI family functioning are linked to recovery so consideration of family work to improve functioning and relationships should be given.

Brain Development and Neurodiversity

Neuroscience studies into the adolescent brain over the last 25 years show that the pre-frontal cortex, the part of the brain responsible of executive function (the set of mental skills that include working memory, flexible thinking, and self-control) continues to mature and be impacted by experiences into a person's 30's.[xxi] The adolescent brain is not mature, still reliant on external influences, which impacts responsibility.

The Committee on the Rights of the Child observe that children may lack criminal responsibility on account of neurodevelopmental issues: "Children with developmental delays or neurodevelopmental disorders or disabilities (for

example, autism spectrum disorders, foetal alcohol spectrum disorders or acquired brain injuries) should not be in the child justice system at all, even if they have reached the minimum age of criminal responsibility. If not automatically excluded, such children should be individually assessed."

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Mental Health

Introduction

The needs of children entering the Children's Hearings System can be complex. By adolescence, mental health and behaviours which lead to conflict with the law or a breakdown of family relationships may be a significant concern.

Development of insecure attachment styles and responses to childhood adversity and trauma can lead to the development of mental health disorders, and manifest as distress behaviours, which can bring children into conflict with the law, regardless of whether they were originally referred on welfare or offence grounds. UK population-based studies have shown the prevalence of mental health problems in children and young people to be between 10-20%, but significantly higher for those in conflict with the law, rising to estimates of 25-81%, and up to 95% for the prison population. Children and young people in conflict with the law also have higher rates of neurodevelopmental issues than would be expected from rates evident in the general population.

These experiences and circumstances, along with certain responses from systems and agencies, can lead to the development of further mental health difficulties in later childhood or adulthood.[xxii] Depression in adolescence has also been linked to depression and anxiety in adulthood.

Adolescence brings further challenges that can be detrimental to children, as noted in the Scottish Government's Mental Health and Wellbeing Strategy:

"Periods of transition often put extra stress on children and young people's pre-existing resilience and coping strategies. The late teenage years are a point when mental wellbeing can decline… and can also be the point of onset of serious mental illness. Teenage years are also a stage in life where the increased use of online communities and social media can impact mental health, especially for young women. Experiences of bullying, harassment and abusive behaviour put young people at higher risk of poor mental health."

There is also growing awareness of the impact of external factors such as poverty, homelessness and inequality on mental health and wellbeing, issues that many 16- and 17-year-olds in the Children's Hearings System have experience of.

The Scottish Parliament's 2022 review of Children and young people's mental health in Scotland concluded there had been a decline in the mental wellbeing of children and adolescents in the past decade. Groups at an increased risk were:

- Those from deprived areas;
- Care experienced children and young people;
- Lesbian, gay, bisexual, transgender and intersex (LGBTQI+) individuals; and
- Adolescent girls.

National data is not available specifically for 16–17-year-olds, though Scotland's Health Survey 2022 offers data on 16–24-year-olds, which is relevant given the Children's Hearings System's role in meeting the needs of children at the start of this age group (more recent data is available, although the statistics provided have changed to provide less detailed mental health data). More 16–24-year-olds than any other age range had: two of more symptoms of depression (16%, adult average 13%); two or more symptoms of anxiety (25-26%, adult average 17%); ever self-harmed (29%, adult average

10%); attempted suicide (10-11%, adult average 7%). All rates of these key indicators are above average for this age group, with depression, anxiety, suicide attempts and instances of self-harm also more common in the most deprived areas.

Those working with and making decisions for children require an awareness of how mental health and neurodevelopmental issues impact children's experiences, behaviours, and communication, and respond in ways which are sensitive to recognised mental health issues in order to minimise further trauma.

Policy Context

Policy and guidance in relation to good health and mental health for children in Scotland is rights-based. The UNCRC sets out the civil, political, economic and social rights of every child under the age of 18. Relevant to health:

- Article 24 (health and services) states every child has the right to the best possible health, with state governments required to provide conditions to promote this; and
- Article 39 (recovery from trauma and reintegration) states children who have experienced neglect, abuse, exploitation, torture or who are victims of war must receive special support to help them recover their health, dignity, self-respect, and social life.

The Scottish Government's Mental Health and Wellbeing Strategy highlights the need for a stronger focus on prevention, early intervention and supporting person-centred and whole family approaches, all of which the Children's Hearings System is well-placed to promote. A key principle is the 'whole person' approach, defined as "looking at a person and their wider circumstances (like housing, relationships, physical health, employment etc.), not just their mental health". These principles mirror those of Getting it Right for Every Child (GIRFEC), the rights-based policy approach that governs all practice with children and young people in Scotland. Mental health and wellbeing indicators are incorporated into the holistic assessment tools within GIRFEC's National Practice Model, comprising the Risk/Resilience Matrix, SHANARRI Wellbeing Wheel and My World Triangle, which Panel Members will be familiar with from child assessment and care plans.

A notable strategic priority in the government's Mental Health and Wellbeing Strategy is to "Reduce the risk of poor mental health and wellbeing in adult life by promoting the importance of good relationships and trauma-informed approaches from the earliest years of life, taking account where relevant adverse childhood experiences".

To support the workforce, a Mental Health Improvement and Suicide Prevention Framework has been produced by NHS Education for Scotland and NHS Health Scotland which defines the knowledge and skills specific to roles and responsibilities in relation to mental health improvement and the prevention of self-harm or suicide. Learning resources have also been developed across the four identified levels (informed, skilled, enhanced and specialist) to support improvement. A similar package of resources has been developed by NHS Education for Scotland in relation to trauma-informed practice. In February 2021, the Scottish Government published the Community Mental Health and Wellbeing Supports and Services Framework which sets out the support that children should be able to access for their mental health and emotional wellbeing within their community.

As an integral part of a system which supports Scotland's most vulnerable children, Panel Members must have a good awareness of prevalent mental health issues amongst older children and their impact, and adopting an individualised,

trauma-informed, whole-person approach to ensure the way in which hearings are conducted are the most appropriate to meet the needs of the child.

Common Mental Health Presentations

Below is an overview of the mental health disorders/conditions experienced most frequently by children and young people, and signposts to further information in relation to best practice.

Anxiety

Anxiety is "a feeling of unease, like worry or fear, that can be mild or severe". Anxiety is normal for everyone at times, such as before an exam, but for some it affects their daily lives. There are different types of anxiety, and it can also be a symptom of other disorders.

Separation anxiety: Normal in younger children, this is characterised by clinginess and crying when a main carer leaves. Most children grow out of this, but it can signify insecure attachment in later years. The main carer relationship in early childhood becomes the model for all future relationships, and the child who has not experienced a predictable, loving, and secure attachment relationship can become anxious about what the people in their life and the world around them will bring. It follows that adolescents who have insecure attachment styles are more likely to have difficulties with emotional regulation, engage in risky behaviours, and display behavioural problems, which can bring them into the care and justice system. Working on development of positive relationships and emotional regulation can help address early childhood experiences. It is also important to involve children in planning for their future, giving them an element of control where possible and time to plan for change to suit their needs, minimising further anxieties.

Social anxiety (social phobia): An overwhelming fear of social situations, which is common in and usually starts in the teenage years. It affects everyday activities, self-confidence, relationships, and education/employment and can lead to avoidance of everyday activities like speaking/eating in front of people, avoiding eye contact, feeling sick, and panic attacks. Children may avoid school or avoid asking for help, or become frequently upset or angry. Symptoms could raise concerns with regards to truanting and negative labelling which could exacerbate symptoms, so it is important to understand a child's behaviours before looking for solutions or imposing consequences. Those with social anxiety are encouraged to better understand their own anxieties through learning about anxiety and self-reflection, working on overcoming small barriers, and practicing relaxation and breathing techniques. Adults can help children to regulate by acknowledging their feelings and using calming techniques with them. Panel Members should carefully consider the specific needs of children with social anxiety when attending a hearing, and consider whether alternative means of participating could provide a more trauma-informed approach, whilst still obtaining their views. Such alternative means may be providing their views via a trusted person or advocate, or participating online.

Generalised Anxiety Disorder (GAD): Sufferers feel anxious about many things, a new anxiety arising as another is alleviated, and may never feel calm. It can impact thoughts, feelings and behaviours and symptoms are wide-ranging, including feeling on edge, restlessness, difficulty concentrating, irritability, and physical pains. Symptoms may cause people to withdraw from social contact to avoid such feelings. Public Health Scotland commissioned a 2022 National Survey on the health of school aged children, which showed that, at age 15, 19% of boys and 49% of girls were classed as having moderate or severe anxiety, which equates to 1 in 3 children in Scotland.

A combination of factors may play a role in the development of GAD, such as:

- Overactivity in areas of the brain involved in emotions and behaviour;
- An imbalance of the brain chemicals serotonin and noradrenaline, which are involved in the control and regulation of mood;
- Genetics – a person is 5 times more likely to develop GAD if a close relative has it (this could also be linked to modelling/learned behaviour);
- A history of stressful or traumatic experiences, like domestic violence, child abuse or bullying;
- Having a painful long-term health condition; and
- Having a history of drug or alcohol misuse.

Specialist mental health supports may be required if anxiety persists, however NHS Inform offer online mental health self-help guides based on Talking Therapies to help people with anxiety and other mental health issues, as well as specific Anxiety self-help guide.

Daylight is a digital programme to improve anxiety based on Cognitive Behavioural Therapy (CBT). It is clinically proven to help people improve their anxiety symptoms by using it for just a few minutes each day and can be accessed via a smartphone.

Disruptive/Conduct Disorders (CD)

All children display behavioural problems at times. However, if issues such as defiance and poor emotional regulation continue for lengthy periods, and/or behaviours are out of the ordinary and repeatedly break the established rules in their environment, then a Conduct Disorder may be present.[xxiii] CD is known as Oppositional Defiance Order (ODD) in younger children. To meet the criteria for CD, a child's behaviour must be significantly outwith what would be expected of their age and/or stage of development. Examples of such behaviours include initiating fights, bullying, cruelty to others or animals, destructive behaviour, stealing/robbery, fire-setting, severe disobedience/defiance and weapon use.[xxiv] They may also lie or steal without apparent remorse, abscond, truant, and take risks with their own personal safety, find it hard to make friends and feel worthless/unsure about how to change, despite outward displays of anger and blaming others for their difficulties.[xxv]

There is no one cause of conduct disorders, though the following signs make development more likely:

- The presence of certain genes leading to antisocial behaviour (more common in boys than girls);
- Difficulties learning good social and acceptable behaviours;
- Learning or reading difficulties (they may struggle/get bored/feel stupid/misbehave);
- Having been bullied or abused;
- 'Hyperactivity' (due to difficulties with self-control, paying attention and following rules);
- Parenting factors, including discipline issues and family disorganisation: little attention to good behaviour, quick to criticise, too flexible regards rules, poor supervision;
- Involvement with other difficult young people and drug abuse; or
- Depression.[xxvi]

Studies have shown around 5% of 5- to 16-year-olds have a CD, rising to almost 40% for children who had been looked after, abused, or who are on the child protection register, with a much higher prevalence rate also noted in the lowest income households. A child showing signs of CD at an early age is more likely to be male and may experience neurodevelopmental disorders such as ADHD. The Royal College of Psychiatrists state that the earlier the onset, the higher the risk of the child becoming involved in violence/conflict with the law, though this could be related to environmental factors such as peer groups and substance use.

Getting the right interventions for CD in teenagers is complex as there is a strong focus on parenting and family led interventions, though interventions should also be within the child's wider social systems, have a de-escalation focus and involve the child.[xxvii] Good assessment is key, and this may be required by a specialist service as it is important to acknowledge/assess for other disorders which may co-exist. It is also important to focus on strengths, praising good behaviour, and supporting the child to increase positive behaviours.[xxviii]

Depressive Disorders

Depression symptoms in children often include persistent sadness/low mood, being irritable or grumpy, losing interest in things they used to enjoy, feeling tired/exhausted, and possible self-harm and/or thoughts of suicide. Depression is more common in adolescents than in younger children, and may occur alongside other difficulties such as CD, anxiety, ADHD, or as part of a traumatic stress reaction. A 2022 study revealed that at age 15, 24% of boys and 31% of girls had low mood, with a further 8% of boys and 25% of girls at risk of depression.

Depression can arise for a number of reasons, such as life events like bereavement or a home/school move, or by longer term issues such as persistent poverty, bullying, abuse, or family history. Early intervention in children and young people is vital to promote more positive long-term outcomes and avoid recurrent episodes. There are a range of treatments accessed via CAMHS services, and there may be alternatives in the community for mild to moderate cases. These include CBT, family therapies, and Interpersonal Therapy (IPT) in adolescence.

To get the right support the child must have someone they trust to talk to, to reassure them their feelings is normal, and things can get better. It can also be helpful to talk to friends or others experiencing depression, learning what helps them and that they are not alone.

Tips are available from the NHS on Talking to Teenagers whilst The Mix offers supportive online chats and groups for 13- to 25-year-olds.

Trauma and Stressor Related Disorders

Post Traumatic Stress Disorder (PTSD) can develop following traumatic events and falls into two categories. Type 1 is traumatic stress that emerges following the experience of a catastrophe or threat to life, such as a physical or sexual assault, a car accident, separation from their family or the death of a loved one. Difficulties relate to reliving the traumatic event, or trying to avoid reminders which prompt anxiety and emotional arousal. Common symptoms include intrusive thoughts, flashbacks, intense distress in response to reminders, hypervigilance, emotional numbing, avoidance of reminders, sleep difficulties, relationship problems, anger outbursts, irritability, difficulty concentrating, and isolation. These are considered normal in the immediate aftermath of a traumatic experience, though for sufferers of PTSD,

symptoms persist in the longer-term. In terms of treatment, PTSD (Type 1) has been shown to respond well to CBT tailored towards the specific trauma and the person's developmental stage.

Type 2 is known as complex (or developmental) trauma/PTSD, associated with experiences of multiple and chronic or recurring traumatic events over time, often by someone close to the person who may have been in a position of trust. Trauma at a young age is associated with complex trauma and causes can include childhood abuse or neglect, domestic violence, and trafficking.

Symptoms of complex PTSD can be similar to Type 1 or may be wider in scope. The National Child Traumatic Stress Network described Type 2 sufferers as having symptoms across the following domains:

- Interpersonal (e.g. problems with boundaries, distrust and suspiciousness);
- Affect (e.g. difficulty with emotional self-regulation, difficulty knowing and describing internal states);
- Cognition (e.g. problems processing new information, difficulty planning and anticipating);
- Learning (e.g. problems with language development, problems with orientation in time and space);
- Behaviour (e.g. self-destructive behaviour, oppositional behaviour);
- Physical (e.g. hypersensitivity to physical contact, somatic (relating to the body, distinct from the mind) complaints);
- Dissociation (e.g. amnesia, depersonalisation and derealisation); and
- Identity (e.g. disturbances of body image, shame and guilt).[xxix]

Children in the care and justice system often have significant histories of maltreatment, associated with the development of complex trauma. It is notable that maltreated children can present with difficulties which attract diagnoses of ADHD, ASD, CD (or ODD), anxiety, depression or self-harm, many signs of which overlap with complex trauma characteristics, or could be indicative of poor attachment. Diagnosis can therefore be a challenge for clinicians when considering a child with multiple presenting concerns and a history of abuse and/or neglect. Responding to trauma will not start with exploration of the trauma itself, this may be a longer-term therapeutic task, with some not addressing it directly until adulthood, if at all.

A phase-based approach to complex trauma is recommended, a sequential approach where, commonly, feelings of safety are established first, followed by emotional regulation and anything else required, such as providing advocacy, building confidence and stability in other areas, before the child is in a place to contemplate more direct trauma work. Individual treatment plans of this nature may involve work in several areas, with the holistic, multi-agency approach of GIRFEC. Models specific to the treatment of complex trauma in adolescence stress the importance of the therapeutic relationship (positive and effective relationships with responsible professionals) in intervention effectiveness, as well as focus on redressing attachment-based difficulties, and continued re-assessment, reviewing the treatment plan as things change over time.[xxx] It is important that the child understands why interventions are recommended and has a say in them, participating in their care plan.

Most children in the Children's Hearings System will have experienced some level of trauma. As objective supportive adults, Panel Members can have a role in pointing out the benefits of certain plans/interventions from an objective stance. It is also important to be mindful of the theory of change: forcing changes on a child will likely not work. There are stages

to go through to achieve change, not least acceptance that something needs to change. If the child isn't of this mindset, safety/crises planning may be the best course of action at that time.

The experience of childhood trauma may influence risk of violence, for example by modelling of violence, denying safety and the development of self-regulation capacities, or by teaching the child that the world is unsafe and they must be vigilant and protect oneself. Trauma by nature is complex and the impact of and response to trauma should be considered on a case-by-case basis.

As noted above NHS Education for Scotland (NES) has developed a National Trauma Training Programme. This Government commissioned initiative has also resulted in Transforming psychological trauma: A skills and knowledge framework for the Scottish workforce which was published in May 2017 and the publication of the Scottish Psychological Trauma Training Plan in 2019.

Schizophrenia/Psychotic Disorders

Psychosis refers to the group of psychotic disorders, which includes schizophrenia. It is when thoughts and emotions are disturbed to the point people lose contact with reality. The Royal College of Psychiatrists note three main symptoms:

- Hallucinations: Seeing, hearing, feeling or even smelling things that don't exist outside their mind but feel very real, like hearing voices;
- Delusions: Strong belief in something that isn't true or views that are not shared, like believing someone is conspiring to harm them; and
- Disordered thinking and speaking: Thoughts and ideas come very quickly which can make speech fast and confusing.

The experience of symptoms above is referred to as a psychotic episode. The first episode usually occurs in the late teens or early adulthood. This is normally preceded by psychological symptoms like mood swings, confusion, anxiety, depression, social isolation, reckless or disinhibited behaviour, and loss of concentration, and potentially low frequency or intense delusional beliefs or hallucinations. Many of these symptoms are not uncommon in teenagers and could also be representative of other issues/disorders. If behaviours become more pronounced or concerning, then medical advice should be sought. Early interventions such as talking therapies and stress management can prevent escalations of psychotic episodes.

Psychosis can be triggered by a traumatic experience, substance use, a head injury, childbirth (post-partum psychosis) or following a serious mental illness like severe depression or bipolar disorder. Psychosis does not always signal the development of a psychotic disorder, with some people only ever experiencing one psychotic episode in their lifetime.

Early identification and intervention in response to the first episode of psychosis has a significant and positive impact on longer-term outcomes. Urgent referral to mental health services is recommended. Cognitive Behavioural Therapy and family interventions often accompany antipsychotic medication.

It is rare for children and adolescents to be diagnosed with psychotic disorders, with the prevalence of psychotic-like experiences higher than diagnosis both in adults and adolescents. Review of studies has shown the median prevalence of

psychotic symptoms to be 17% among children aged 9 to 12 years and 7.5% among adolescents aged 13 to 18 years.[xxxi] Most children will recover from psychotic episodes with medical and therapeutic interventions.

Non-Suicidal Self-Injury (Self-harm)

Recent data shows 25% of 16–24-year-olds have self-harmed. Children and young people who are 'looked after' (LA) and 'looked after and accommodated' (LAAC), have been identified as being especially at risk of self-harm. An anonymous self-reported Scottish study of 12-17-year-olds found that 32% of the LA/LAAC children had self-harmed and/or thought about harming themselves. This group were noted to identify significantly fewer reasons for living and to be more self-critical than their non-LA/LAAC peers, with self-hatred particularly important in predicting self-harm.[xxxii]

Self-harm is any act where injury is purposely inflicted on the self, in the absence of suicidal ideation or intention. Self-harm commonly occurs in the context of other mental health difficulties and/or adverse life experiences. Adolescents who engage in self-harming behaviour often have difficulties with regulating their emotions, solving problems, and engaging with supports. When there is no suicidal function associated with self-harming behaviour, other functions need to be considered so that interventions can be put in place. Common functions, observed clinically, include:

- Punishment: Self-harm is driven by a sense of deserving punishment or guilty feelings. This is often associated with a severely negative self-view;
- Distraction: When emotional pain is unbearable, self-harming behaviour may serve as a distraction and may be viewed as a positive alternative to emotional distress;
- Relief: Individuals who report self-harming often cite a sense of associated relief or release;
- Control: Self-harm may give children a sense of power or control over themselves when things around them are overwhelming or seem outwith their ability to change; and/or
- Communication: Self-harming may serve as a vehicle to communicate great distress.

Children may self-harm for more than one of the above reasons and differing functions may apply to different instances of harm over time.

It is important for trained professionals to establish what function the self-harm is fulfilling for the child for interventions to be effective. It is perhaps unlikely that a child will disclose this in a hearing, though Panel Members will want to be satisfied that the child has someone they can talk to, and their needs assessment is comprehensive, evaluating potential reasons for self-harm and appropriate interventions. It is likely that a variety of interventions geared towards improving self-worth, purpose, positive emotional regulation and promoting engagement in positive relationships will have some success in reducing self-harm. Safety plans should also be in place for children who self-harm, which should include ways to minimise accidental severe injury/infection.

Young Minds have a comprehensive section for professionals responding to self-harm in children and young people.

Guidance on How Best to Support Children and Young People Experiencing Mental Health Difficulties

Acknowledgement that a child's needs differ from those of adults, as well as those experiencing structural inequalities and with protected characteristics is important.

Children must be supported to develop resilience to cope with life's ups and downs, with positive relationships essential in promoting this, as well as being a protective factor for good mental health. Supportive networks, including having trusted adults, have been found to be an important protective factor for children and adolescents in having resilience against the impacts of adverse childhood experiences and trauma.

The Promise highlights that for children, safety means relationships that are real, loving, and consistent, and that planning for children may require a shift towards balancing the risk of harm with the risk of not maintaining these relationships. 16- and 17-year-olds know who makes them feel loved and safe and who has been there for them. We must listen to what they tell us, both verbally and behaviourally, when making decisions about their lives. The sense of belonging and togetherness offered by friendships and peer networks are extremely important in adolescence, as can be the pull towards birth family as children try and make sense of their past in forging adult identity. Supporting children to manage relationships that may not appear the most positive is a crucial part of care-planning for children at this age.

Helping children to identify what role relationships can safely have for them is key. This can be done by seeking to understand the value relationships hold for children whilst also supporting them to identify any areas of risk/concern, through reflection on past events and decision-making:

- A parent may not be able to meet all of a child's emotional needs, but still provide them with love and have them to stay a weekend each month;
- Siblings (whether biological or not) can provide a child with a positive link to their earlier childhood, especially for children who are no longer living with their parents;
- It may be the same friend that the child is with when they come into conflict with the law, but maybe they met this friend in care, and they are only person they feel understands them.

No relationship is perfect, though we must support children to navigate them as best they can and make sure their needs are met, even if not by the people we may choose.

Those who are disadvantaged experience greater risk to their mental health, particularly those who are care experienced, affected by substance use, experiencing abuse or homelessness or in contact with the care and justice system, with poverty and social isolation carrying a high risk of suicide. These are all sadly issues that are particularly prevalent among children in the Children's Hearings System, and we must work to minimise further marginalisation.

Importance of Thorough Assessment

Children's behaviours can have varied and multiple drivers. Signs and symptoms of mental health disorders can be indicative of one of several disorders, trauma, or attachment behaviours. Mental health and neurodevelopmental disorders can also be symptomatic of early childhood trauma and/or poor attachment relationships. Some, such as mood swings, strong emotions, anxiety, anger, and lethargy could also be hormonal. Behaviours or strong displays of emotion could also be purposeful, learned behaviour.

It is crucial that the child's emotions and behaviours are fully assessed on a multi-disciplinary level to understand what they are trying to communicate and begin to address the issue. It is not the role of a Panel Member to undertake formal assessments of a child, but it is important to be aware of common issues affecting children in the hearings system. As Panel Members, you can ask for more information if you don't feel satisfied with available assessments, or able to make

decisions due to missing information. It is hoped this section will better prepare you to evaluate care plans and assessments and notice any gaps.

Where there are gaps in knowing what support can be put in place for a child (and without this information, the panel could not reach a substantive decision), Panel Members may wish to request an independent report. An independent report is one written by an expert in a particular field which may be requested by a panel if they have questions in relation to a child's needs or the support. More information is available in this section of the Practice and Procedure Manual.

Mental Health Support Services

The following are national resources, though it is important to establish what is available locally (resources can vary, even from school to school).

NHS Inform offers advice and guidance on all health issues.

Anxiety UK (specific section on children and young people): https://www.anxietyuk.org.uk/

Daylight Anxiety Treatment Programme: https://onboarding.trydaylight.com/daylight/nhsinform/332#1/1

NHS Inform Anxiety Self-help Guide: https://www.nhsinform.scot/illnesses-and-conditions/mental-health/mental-health-self-help-guides/anxiety-self-help-guide/

Scottish Action for Mental Health (SAMH) provides support for young people including what to expect from CAMHS: https://www.samh.org.uk/about-mental-health/children-and-young-people

Young Minds: https://www.youngminds.org.uk/

Psychological Aspects of Conflict with the Law

Introduction

Understanding the presentation of a child, and the mental factors that contribute to certain behaviours can be challenging. Adolescence is a period of emotional and psychological change with the brain developing rapidly and identity forming. This video and this video each provide a comprehensive summary of the psychosocial stages of development experienced by adolescents, and indeed adults. Added to this, the period of adolescence is one during which the brain undergoes significant development and can also have an impact on children coming into conflict with the law or taking a variety of risks.

By understanding this process, Panel Members will be better positioned to make decisions about the lives of children who attend hearings who have come into conflict with the law.

As this video shows, children who cause harm to themselves or others have often faced a wide range of disadvantages which impact upon their behaviour during adolescence, and upon their psychological functioning. In some instances, this develops into mental illness which can increase the likelihood of adverse outcomes for children, with children within secure care facing significant levels of mental illness.

The most prevalent mental health challenges for both the general population and children in the care and justice system involve conduct, emotional, attention, and substance misuse disorders. This encompasses a broad spectrum of emotional, social, and behavioural difficulties. Children in the care and justice system face increased complexities, linked to the higher frequency and greater severity of difficulties, along with the presence of more than one problem.

Understanding and responding to individual mental health needs is further complicated by significant levels of undiagnosed conditions. Moreover, children often exhibit symptoms than fall below the threshold for a formal diagnosis but continue to face challenges on a daily basis. Lastly, the intricate relationship between mental health difficulties and risk-taking behaviours, if indeed there is one, introduces additional complexity. Panel Members must therefore remember that the relationship between mental ill-health and negative outcomes is not direct nor certain.

To further complicate matters, a range of neurological factors are linked to episodes of risk and adversity, and can contribute – if not cause – a child to be referred to the hearings system. To assist Panel Members in considering how best to support children in the hearings system, this section seeks to provide information about how various psychological, mental health or neurological conditions affect some children who attend hearings. Further reading can be found in this CYCJ report and this practice guide.

Peer Pressure

Peer influence can play a significant role in shaping a child's behaviour. As the child enters adolescence, they naturally begin to loosen their ties to family and seek greater connection with peers. Receiving rejection or isolation from peers increases the likelihood of them seeking acceptance from other people who can pose a risk to their physical or emotional wellbeing. Peer pressure can influence children to engage in harmful behaviours, as the child may feel compelled to conform in order to achieve acceptance.

Peer pressure extends beyond mere association. Delinquent peer groups often provide a context where antisocial norms and values can be reinforced. Children may adopt these norms, viewing them as acceptable or even desirable. This process of socialisation can contribute to the development and escalation of risk-taking behaviour. Panel Members must therefore consider the role that diversionary supports could play in the life of the child, offering them spaces within which to participate in prosocial activities, whilst acknowledging that pushing boundaries is a normal and natural stage of life. For those children who cause the most serious levels of harm, support could be targeted at addressing any attitudes or values that develop as a consequence of peer pressure and association, with a view to encouraging positive and safer choices.

Self-Esteem

Whilst unlikely to be the primary reason that a child attend a hearing, low self-esteem may impact upon the child's situation. This may stem from familial abuse, lack of confidence during adolescence or bullying. Children in the care and justice system often experience low self-esteem, leading them to seek validation and acceptance by engaging in harmful behaviours. Those supporting children should therefore consider ways to develop positive self-esteem. It is also the case that being in the Children's Hearings System can have a detrimental impact on a child's self-esteem and this is something that Panel Members should keep in mind whilst in hearings.

Some studies suggest that developing high self-esteem without also addressing pro-criminal attitudes may in fact lead to an increase in risk of offending, as the child may take pride in their status as an 'offender'. Those working with children therefore need to strike a fine balance in how to respond to this issue, and if relevant should articulate this within their assessments.

Depression

Depression relates to a state of low mood which can lead to irritability, sadness and tiredness amongst a range of other symptoms. This guide from the NHS provides further information on its impact of the condition and how to treat it.

Depression could be related to a wide variety of matters including interfamilial challenges, school issues, safeguarding concerns or self-esteem. It may also be linked to biological family traits. Depression is a risk factor for acts of self-harm and development of suicidal thoughts, however this is by no means a certainty to occur.

Depression and its symptoms can contribute to a child experiencing risk or causing harm to others, through avoiding social situations or responding in an angry manner. Some children may use alcohol and drugs to ease the mental pain they experience. Like all mental health issues, Panel Members should discuss this subject in a sensitive manner, ensuring that the child does not feel blamed for their condition.

Anxiety

Anxiety is a common problem amongst children and can manifest itself in different ways including through thoughts, feelings, physical symptoms, and actions. It can occur when the child is scared of something such as needles or medical interventions, being away from caregivers, bullying or of taking part in an activity. It may also relate to previous adverse experiences.

Anxiety can lead to intense reactions such as panic attacks, avoiding leaving the home, avoiding certain places and experiencing a loss of control over their thoughts and behaviours. In some cases this could contribute to self-harm, with this resource providing further information. This video also provides a simple explanation of adolescent anxiety.

Autism or Autistic Spectrum Disorder

The specific characteristics of people who have Autism or Autistic Spectrum Disorder (ASD), and how this interacts with their disproportionate contact with the criminal justice system, has been outlined here. Such children may encounter additional challenges in communicating with others, interpreting social situations, and coping with sensory overloads. These, in turn, could contribute to adverse situations for the child or those around them, with this information sheet highlighting how this can lead to justice involvement. This video provides further information that helps understand the condition.

Young people who have Autism or ASD report that their experiences of support are hindered by the lack of understanding by those professionals they come into contact with. Panel Members can avoid this by enhancing their own knowledge through accessing this video, whilst this guide from the National Autistic Society adds to considerations for Panel Members to think about when supporting children with ASD who have come into conflict with the law. At a most basic level, consideration should be given as to how the hearing takes place, including the language (both verbal and body language) used by Panel Members.

Foetal Alcohol Spectrum Disorder

Foetal Alcohol Spectrum Disorder (FASD) is a life-lasting neurological condition that stems from maternal alcohol use during pregnancy. This manifests itself in the child displaying impulsivity, difficulty in making decisions, poor memory, and difficulties in interacting with others within social settings. Health Improvement Scotland's guidance explores these – and many other – factors in greater detail. Each of these features could contribute to children coming to a hearing, where they would benefit from additional considerations of the environment and way in which the hearing is run. This guide provides further details of the challenges faced by children with FASD, and what adults can do to help them. More information is also available from FASD Hub Scotland and in CYCJ's Practice Guide here.

Attention Deficit/Hyperactivity Disorder

Attention Deficit/Hyperactivity Disorder (ADHD) is a collection of behavioural symptoms broadly characterised by impaired attention, overactivity, and impulsivity. As this guide from the NHS shows, this can manifest itself in a variety of forms and in certain circumstances could result in the child coming into conflict with the law or being exposed to adverse circumstances. This video similarly explains how children and adults may experience the condition.

ADHD may contribute to a child behaving in a manner that is impulsive, with this impacting consequential thinking. ADHD may also contribute to a negative self-view or sensitivity to perceived rejection, which may become a trigger for violent or harmful reactions. Most children with ADHD do not cause harm to others however, and Panel Members must be careful not to attribute causation to ADHD (or any other condition).

Brain Development

Coinciding alongside all of the above factors is the teenage brain which will continue to grow until the child has reached their mid 20's. This report highlights the impact that a still developing brain has upon children who come into conflict with the law, whilst this report makes similar arguments. This is also reflected in the Scottish Sentencing Council's Sentencing guidelines on sentencing young people. Much of this relates to adolescent brains not yet reaching full maturity, leading to increased risk of the child making irrational or dangerous decisions. More information about this can be found here and here. Panel Members should therefore reflect on the additional barriers that children face when they make decisions; barriers that most adults do not need to overcome.

Final Considerations

Whilst the conditions and factors highlighted within this section may contribute to the reasons why a child might be referred to the hearings system or why they may come into conflict with the law, there are of course several other factors that may be relevant and should be considered. Nevertheless, all Child's Plans must take into consideration the psychological, neurological and mental health of the child and propose a plan that reflects the particular risks, needs, vulnerabilities and strengths of the child.

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Speech, Language and Communication Needs

Introduction

Communication is an exchange of information by speaking, writing or other means. Language is the dominant mode of human communication, where meaning is conveyed via spoken or written word. This involves vocabulary, basic grammar, use/comprehension of more complex grammatical structures. Spoken communication is also impacted by things like tone and volume, and non-verbal communication including body language and gestures.

What we convey and interpret from one another's language, actions and gestures provides additional meaning and our abilities in this vary and depend on factors such as developmental age and stage, maturity, neurocognitive functioning, IQ and any learning disabilities or difficulties, temperament, and stressors/life events occupying our mental capacity.

The sections in this guide on Adversity and Trauma, Mental Health, and Brain Development provide further details on communication in relation to those affected by specific issues/conditions.

Speech, Language and Communication Needs (SLCN)

SLCN refers to those who have difficulties with or conditions affecting aspects of their communication. These difficulties could be caused by a speech impairment due to physical or neurological factors, learning disabilities, neurocognitive conditions or as a result of another condition. Individuals with SLCN may require specific, bespoke methods of communication in line with individual needs.

Neurocognitive Functioning and SLCN

Neurocognitive functions are selective aspects of brain functions - the ability to learn and use language, the ability to regulate attention, emotions, impulses (including movements and spontaneous utterances), social behaviours, and process sensory stimuli (like light, sound, or touch). These functions contribute to how we communicate with and are perceived by others. Like physical attributes, these traits can be significantly genetically influenced, and are present from birth. The normal range of functions change with age and the societal norm for a selective neurocognitive function is defined by the general population.[xxxiii]

The statistical normal range of brain function is called 'neurodiversity'. A person is said to have a 'neurodevelopmental disorder' if they present with a functional impairment outwith the normal societal range of behaviours. This may also be referred to as a 'neurodevelopmental condition'. As stated by the Scottish Government's National Autism Implementation Team, the term 'neurodivergent' is used to describe those who have a neurocognitive function which falls outwith the normal range. See the Brain Development section of this guide and CYCJ's Mental Health Practice Guide Chapter for more details on neurodevelopmental conditions. The NHS provides information on Aphasia (speech or language difficulties) and Dysarthria (difficulty speaking), both generally as a result of neurological impairment.

A 'learning disability' is defined by the Scottish Government in their Keys to Life Strategy as "a significant, lifelong, condition that started before adulthood, which affected their development and which means they need help to: understand information; learn new skills; and cope independently". Those under this definition will have SLCN. The strategy details how a person who has a learning disability should be supported.

Communications of individuals with neurodevelopmental conditions will not always meet recognised developmental milestones. Early deviation from developmental norms is an important sign of possible SLCN.[xxxiv] In addition to typical adolescent brain development inconsistencies, neurodiversity and neuro-divergency also impact communication development and performance. The child may or may not be aware of, or disclose, neuro-divergency, and may or may not respond well to certain interventions.

Possible Indicators of SLCN

There are recognised signs and symptoms which may indicate SLCN that Panel Members should be aware of, both when reading reports about children and when interacting with them, to help identify SLCN and inform how best to support and communicate with children. CYCJ's SLCN Chapter of their practice guide offers an in-depth discussion on SLCN and expands on the below examples of the types of issues which could indicate SLCN:

Social Interaction Skills:

- Being loud and overbearing, poor turn-taking skills;
- Being quiet and letting others take the lead in interactions;
- Overreacting to or misunderstanding jokes or sarcasm; and
- Avoiding situations requiring communication, using distraction, disengagement or failing to attend.

Language Skills:

- Showing non-verbal indications of agreement or following what is being said but being unable to respond appropriately;
- Often saying they 'can't remember' or 'don't know';
- Appearing unable or unwilling to follow instructions, or only following part of an instruction;
- Appearing obstructive, bored, or oppositional due to failure to adhere to the rules and social expectations of conversation; and
- Copying what they see others doing or copying chunks of spoken language.

Numerical and organisational skills:

- Getting dates and appointments mixed up;
- Not appearing to complete tasks, often with no apparent reason;
- Repeatedly asking the time or what is happening next; and
- Seeming disengaged or staring into space.

Speech:

- Speech being slurred, indistinct or otherwise difficult to understand; and
- Stammering, or having fast, 'crowded' speech.

Literacy

- Avoiding reading and writing tasks, for example, perhaps by criticising the task;
- Reading very slowly and/or out loud; and
- Managing basic literacy tasks such as texts or social media posts with some effort, but struggling with more lengthy, abstract/complex information, like letters and reports.

Sensory issues

- Being particularly sensitive to touch, noise, bright lights, or textures;
- Eating a very restricted diet or seeming very sensitive to food textures or combinations; and
- Having difficulty relaxing or having 'down time'.

Background information

- Having family members with learning difficulties or disabilities; and
- Having existing or suspected diagnosis/history of: ASD, ADHD, dyspraxia, dyslexia, ODD, OCD, Speech Language Impairment, stammering, learning disability, learning difficulties, brain injury, anxiety, depression, selective mutism, anger, abuse or neglect, disrupted early relationships, care experience, school refusal, suspension or expulsion.

Disrupted early relationships are a key marker for SLCN in those without an underlying condition affecting communication. Consistent and positive care giver responses are critical in supporting neurological development which allows for the development and refinement of communication skills.[xxxv] Those who have experienced disrupted attachments may develop basic language skills but lack the consistency of care and experiences required to allow them to develop a nuanced understanding of communication, link emotions with language, and accurately interpret the communications of others.

Children need and value consistency, reliability, honesty, and warmth from those around them. Consistency and openness are key to gaining their trust and developing ways to best support them to communicate and participate. Panel Members should be mindful of this when reviewing child's plans with multiple changes of social worker and consider continuity of Panel Members to best support children with SLCN.

Further information regarding continuity of Panel Members can be found in CHS's Practice and Procedure Manual here.

Communication, SLCN and Children's Hearings

Children's hearings are potentially emotional and distressing experiences for children. 16- and 17-year-olds may have significant experiences of attending hearings and/or having panels making life-changing decisions for them or may have grown up in a family where being honest with Panel Members and professionals was not encouraged. They may be afraid of the consequences of communicating what they think and feel. Basic skills to enhance discussions (eye contact, reassuring nods, smiling, relaxed tones, empathy, inviting views) are encouraged but still may not result in a child's active communication.

Article 12 of the UNCRC states children have the right to actively participate but also the right not to, which must be respected. They must be reassured this is ok, not reprimanded or told they must contribute. Children should be encouraged to submit views via other means (see Children's Rights and Participation section for further details). Panel Members must be conscious of their own non-verbal communication, remaining calm, encouraging, and respectful of the child's choices and careful not to show any signs of frustration, disapproval or unhappiness with the child or anything they say or do – they may not do things consciously or understand how they might be interpreted.

A child may appear disinterested, dismissive, or even disrespectful. It is important to avoid initial judgement and be aware of the possible underlying reasons for this. Children could be employing protective coping mechanisms, masking fear or lack of comprehension, or have additional SLCN impacting their presentation.

Examples:

- Lack of eye contact could be indicative of anxiety or low self-esteem rather than dismissiveness;
- Interrupting or fidgeting could be a sign of ADHD, not disrespect; or
- Shrugging shoulders or not answering a question, or shouting and making off-hand remarks, could be because they didn't understand what was being asked of them.

The Promise noted many children in the Children's Hearings System have a known speech, language or communication issues and that children with additional support needs are over-represented. Even more are undiagnosed.

SLCN and Children in the Care and Justice System

Not all SLCN result in or require specialist input or diagnosis, and as such prevalence rates are difficult to establish. SLCN are overrepresented in children in conflict with the law and those in the care system, and that presence and the severity of SLCN appears to have associations with offending severity. The Royal College of Speech and Language Therapists report 60% of young people in justice settings have SLCN. Whilst relatively common with children in conflict with the law, SLCN are particularly common amongst more severe and violent offenders.[xxxvi]

Fairer Justice for All: A Report about Young People with Learning Disabilities and Autism in the Criminal Justice System highlighted the views of professionals working with children in the justice system who reported that an increase in the numbers of neurodivergent children in conflict with the law was a result of improved assessment and diagnosis. It also asserted that a lack of appropriate assessment and/or poor support following assessment can increase the potential for children to come into conflict with the law. This research may be interest to Panel Members, offering an easy read on the prevalence of neurodiversity in children in conflict with the law, attitudes towards them and views of professionals as to good practice.

Justice for Children and Young People – A Rights-Respecting Approach: Vision and Priorities – Action Plan states as an outcome aim that speech, language and communication needs for all children and young people are taken into consideration both when assessing individual needs and adapting information and communication used in formal processes. All children need to be communicated with in a way they can understand, and Panel Members will gain information from reports, and interactions with the child, family, and professionals to inform this.

How to Communicate with Older Children

As described in the Brain Development section, areas of the teenage brain mature at different rates. Adolescents may have competent verbal communication skills but be impulsive and lack consequential thinking. They may understand hearing proceedings fully but not have the confidence to respond effectively or the maturity to accept responsibility for their actions. In a hearing room, some 16–17-year-olds will be very articulate, confident in sharing views and challenging assertions, whereas others will say very little and stare at the floor. There is no one way to ensure good reciprocal communication, however, it is Scotland's responsibility under Article 12 of the UNCRC to ensure that children have the right to express their views, feelings and wishes in all matters affecting them, and, under Article 13, to receive information that allows them to express their views. For these rights to be upheld in the Children's Hearings System, children must be provided with the information they need to form their views in a way they understand. Fundamental to this is using language they understand.

Whilst most older children have a better command of language than younger children, this should not be assumed. These basic communication tips are recommended to optimising understanding for children of all ages:

- Where possible use simple language. If you need to use a legal term which is not easily understood, explain what it means;
- Use clear, succinct communication, using fewer words if possible;
- Avoid long speeches, break down information to smaller points then check comprehension;
- When checking comprehension, avoid where possible using closed (yes/no) questions. Ask if they need more information or if there is anything they need help to understand;
- Lead by example: say when you have not understood what has been said;
- Give an overview first. Summarise where necessary, before and after you go into detail;
- Highlight key information: "It's important you remember xxxx from what I am about to tell you";
- Repeat important information and reframe if possible – repetition helps with retention;
- If the child has asked about something specific, answer them. If you don't know the answer or cannot provide it, say this directly;
- Give extra time for the child/young person to listen and process. This will help them to understand what you have said;
- Speak slightly more slowly than you would normally do to assist listening and understanding;
- Do not repeatedly ask a child the same thing if they can't or won't answer;
- Give positive feedback but be sensitive as some children find praise difficult to accept;
- If you are concerned about a child's comprehension, consider specifying someone who will follow up with the child to explore this; and
- Make sure that the child is aware of, and is offered, access to independent advocacy services.

Speech & Language Therapy Services: Speech and Language Therapists

Children may benefit from specialist supports for communication. Speech and Language Therapists (SLTs) are health professionals who are responsible for both working with individuals with SLCN and providing guidance and support to other professionals. The Royal College of Speech and Language Therapy provides an overview: What is Speech and

Language Therapy? SLT services are provided at universal, targeted and specialist levels. They also describe difficulties experienced by children and young people with SLCN in the justice system and how best to support them.

Speech and Language UK offers advice and support for families and those working with children with SLCN to aid them with communication. They detail possible signs and symptoms for speech and language challenges, also providing an Ages and Stages Guide describing typical development. This covers what is typical and what may indicate difficulties for 14–17-year-olds.

The Children's Neurodevelopmental Pathway – Practice Framework offers guidance on the development of neurodevelopmental referral pathways and what individuals should expect when referred for neurodevelopmental assessment, though rollout varies nationally.

In Scotland, SLT and neurodevelopmental service provision for children, and specifically children in conflict with the law, varies across the country. Panel Members may wish to explore referral pathways available in their area.

Poverty

Introduction

Poverty has a significant impact on Scotland's overall well-being, disproportionately impacting on children who are at greater risk of experiencing poverty than adults due to their limited potential to earn money and being reliant upon adults to meet their needs. The Poverty Alliance estimate that some 250,000 children across Scotland experience poverty, fuelled by a combination of factors.

Recent research has pointed to some 10% of children accessing foodbanks in the past year, 40% of homes facing unaffordable energy costs and increasing rent and mortgage payments. Meanwhile, the real terms value of government support has fallen, despite the introduction of the Scottish Child Payment for eligible families. Data published in January 2025 shows that rates of child poverty have steadily risen over the past 20 years, with 'deep poverty' now more prominent than other financial pressures.

One such factor is in-work poverty, with over 10% of Scottish workers facing persistent low pay, and a majority of them (72%) being women. Given the inequalities experienced in parenting, this often impacts upon the welfare of children. Certain groups face disproportionately high levels of poverty with women, disabled people, single parents (the vast majority of whom are women), and people from minoritised ethnic groups particularly impacted. Being a member of more than one of these groups increases a person's risk of facing poverty. As this report highlights, however, even those enjoying significant salaries are in a precarious position and at risk of facing financial difficulties in the short term due to the volatile nature of the economy.

Large volumes of research and studies have stressed the need to address such high rates of poverty due to the interconnected nature of poverty, ACEs, trauma, and poor outcomes for children in later life and through childhood. The impact of COVID-19 has added to the financial turmoil experienced by the United Kingdom since 2008, with children from the most economically deprived homes disproportionately suffering.

Impact

The impact of poverty on children is wide ranging, including contributing to mental ill-health, housing insecurity, receiving adequate nutrition, levels of physical activity and related health issues. This leaves parents and carers with a higher risk of anxiety and depression, with the Poverty Alliance finding that nearly half (49%) of Scottish adults reported a negative impact on their mental health due to the cost of living crisis. Allied to this, the stigma of poverty further affects mental health, makes it harder to access help, hampers educational attainment, and results in isolation from peer groups. Living in poverty can contribute to a range of social, health and economic challenges, and individuals in such situations may be more prone to taking risks or coming into conflict with the law.

Research from SCRA shows that those children who come into conflict with the law are more likely than their peers to experience poverty, whilst rates of poverty amongst children who enter care are significant. The levels of poverty experienced by children in the hearings system is significantly higher than the general population, and particularly so for those who are placed in secure accommodation. One study suggests that 80% of children in secure care experience relative poverty, compared with approximately 23% of children amongst the general population. However, it's important to note that poverty alone does not directly drive a child to criminal behaviour or experience harmful circumstances. The

relationship between poverty, crime and harm is a complex one influenced by various factors including social, economic, and environmental conditions.

SCRA research also demonstrates that care experienced children face 'digital poverty', meaning that they are unable to participate in the online groups and communities that are often part of everyday life for teenagers. This in turn can stigmatise the child, exclude them from friendships and impact their self-esteem, and may result in them losing out on the opportunities to engage in activities.

Poverty may also impact upon the child through the environmental factors which surround them. Communities facing greater levels of deprivation – a much wider range of factors including poverty – may have fewer leisure and recreation opportunities for children. In turn, lack of such opportunities to socialise safely may lead to children engaging in risky behaviours including episodes which bring them in to conflict with the law, or displaying anti-social behaviour that causes community friction. More broadly, communities experiencing high levels of deprivation may lack the local resources that a child and their family require including transport routes, health resources, successful schools and employment opportunities. The cost of the school day similarly adds to the financial pressure experienced by families, having a number of consequences for children within school as this video demonstrates.

Responding to the Needs of Children in Poverty

Restoring the economy and closing the gross income gaps is – of course – outwith the powers of a children's hearing but Panel Members should be aware of the impact of poverty on the children and families that they have contact with. It is essential that Panel Members recognise that while poverty may be a risk factor, most individuals living in poverty do not turn to crime and many factors contribute to criminal behaviour.

Panel Members will inevitably encounter children and families living in poverty in a hearing room. Deciding what is neglect and what is simply poverty is a difficult task which Panel Members will encounter.

Research and policy indicate that poverty can be mitigated through social and economic interventions, providing education and employment opportunities, and improving community resources. Panel Members should therefore consider what steps they can make through the hearing to put in place the support, advice and assistance that can mitigate the negative impacts for families living in poverty.

Further information on poverty in the Children's Hearings System can be accessed in CHS's Practice and Procedure Manual here.

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Housing

Introduction

Lack of stable accommodation is a significant issue for children who come into contact with the Children's Hearings System and often remains so as the child makes their transition into adulthood. Scotland's Independent Care Review highlighted the adverse impact it can have upon the health and wellbeing of children and families within its final report The Promise, which Panel Members should be familiar with. This short guide refers to housing insecurity – using that term to include various types of issues relating to housing including rough sleeping, temporary accommodation, 'sofa surfing' and living in overcrowded housing. This guide from Shelter Scotland provides further details.

Housing in Scotland

The United Nations Special Rapporteur on adequate housing highlighted several concerns over the availability of appropriate housing provision in the UK, describing it as a 'critical situation' that required immediate attention during their visit in 2013. Since then, rates of homelessness have increased, with Scottish Government data showing that over 33,000 households – each potentially consisting of several people – were assessed as being homeless in 2023/24. An update of these statistics, covering the period from April to September 2024, shows an increase in the number of households assessed as being homeless.

This increase is partly due to money. Housing charities have since estimated that by 2026, some 202,000 households will lack stable accommodation across the UK, with rates within Scotland increasing by one third.

Those aged between 16 and 24 account for 22% of all homeless households in Scotland, despite equating to just 13% of the population. Over 8,000 homelessness applications were made by young people aged 16-24 in 2022/23, with an 11% increase in homeless applications from young people experiencing mental ill-health. Research undertaken in England found that those from minority ethnic groups with care and justice experience face greater exposure to this issue. Young people who are LGBTQI+ similarly face heightened rates of housing insecurity, with this cohort facing particular challenges that may place them at increased risk. In addition to this, households with families wait longer to obtain accommodation when they reach crisis.

Impact of Housing Insecurity

The relationship between housing insecurity and adverse circumstances is extensive. It has been linked to increased involvement in crime, to complex mental health problems and repeat offending, and to substance abuse. It has been shown to increase the risk of children being exposed to four or more Adverse Childhood Experiences, whilst 10% of children within secure care have experienced homelessness of one kind or another. Young people with recent experience of the custody/secure care are at increased risk of experiencing homelessness. Indeed, recent research has highlighted that lack of suitable accommodation is often the most significant factor in unsatisfactory transitions from custody to community, whilst a variety of other challenges have been highlighted. As Panel Members, satisfying yourself that a robust care plan is in place that provides stable accommodation is therefore essential when making decisions about the lives of children leaving secure accommodation or at other stages of their lives. Housing can also impact upon the overall welfare of the child. The complex mix of unstable housing, addiction, involvement in the justice system, mental ill-health

and other vulnerabilities also contribute to the lives of parents and carers, and are often factors in the placement of children in alternative accommodation.

Amongst the 16-24 age group, housing charities report that common reasons for housing insecurity include: friends or family no longer willing or able to accommodate; domestic abuse; eviction from a private, social, or supported housing tenancy; landlords selling the property; and an end to a partnership or relationship. The pathways into and risks associated with homelessness are factors that Panel Members will consider during hearings.

Care Experienced Housing Insecurity

Housing insecurity plays a role in driving children and young people into precarious situations. It is particularly prevalent amongst those with care experience, leading to the creation of a dedicated policy for this group of young people. Local authorities and state bodies have corporate parenting responsibilities and powers – as outlined within the Children and Young People (Scotland) Act 2014 – which they must meet for those who qualify. This includes provision of suitable accommodation, with the Care Leavers Covenant settings out a range of supports that should be offered, including exploring housing options.

Panel Members should be aware of the entitlements that children who are leaving care may have in relation to housing insecurity, as outlined below.

Continuing Care

Continuing care is a young person's right to remain living in the place where they are settled and with people who they have existing relationships with. It applies to children and young people subject to Compulsory Supervision Orders with a measure of residence away from home in kinship, foster or residential care. Continuing care means the local authority is legally obliged to continue to provide the placement and other assistance that was being provided to a care leaver immediately before their Compulsory Supervision Order was terminated until the age of 21 years. There are limited exceptions to this, such as where this is not in the best interests of the child; where the child resides in secure accommodation; or where the carer/provider of a placement cannot or will not continue to provide the placement.

Research tells us that positively delaying the age of leaving care is a critical factor in improving outcomes for care leavers. When considering whether to terminate a Compulsory Supervision Order with a measure of residence, Panel Members should explore whether continuing care in the child's existing placement would be in the child's best interests, and if not, what alternative arrangements are in place or being considered.

You can read more about continuing care here, which is a guidance note prepared by CELCIS, Clan Childlaw and the Care Inspectorate.

After Care

'Aftercare' is the term used to describe support services provided to a child or young person by a local authority to help them to make a successful transition into adulthood after leaving care. It is defined as "advice, guidance and assistance" and may include supported accommodation, help to find accommodation, financial support, educational support such as literacy and numeracy courses or employment support, such as help with job applications or interviews. A local authority is legally required to provide aftercare support to young people who have left care on or after their 16th birthday until

their 19th birthday, unless they are satisfied that the child or young person's welfare does not require it. Young people aged between 19 and 26 are also potentially eligible to receive aftercare support from their local authority. More information can be found here from the Scottish Government.

Aftercare support is available to a child or young person who is on a Compulsory Supervision Order (whether accommodated at home or by the Local Authority) on or after their 16th birthday. If a Compulsory Supervision Order is terminated before a child's 16th birthday, the child will have no entitlements to aftercare support. In a hearing, if the local authority's recommendation is to end a child's Compulsory Supervision Order before the child's 16th birthday, it is very important for the panel to consider the longer-term repercussions of this.

If a child is in receipt of aftercare support, they will receive assistance from a pathway coordinator who will work with the child by conducting a pathway assessment. This will determine what advice, guidance and assistance it would be appropriate for the local authority to provide when the young person is no longer looked after. This will involve taking the views of the child, and important people in their lives, and making a sustainable plan for what the child or young person might need going forward, called a pathway plan. This will go some way to ensuring the child's rights to support are maintained and they are helped to develop and make a positive transition into adulthood.

Conclusion

Panel Members should expect a comprehensive assessment of, and attention to, the factors driving housing insecurity, and a proposed care plan that addresses – as best as possible – the underlying factors that affect the child and their family. For those children approaching the natural end of their time within the hearing system, Panel Members may wish to consider the plans to secure stable accommodation for the child as well as ensuring that they are aware of their legal rights.

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Alcohol, Drugs and Substance Use

Introduction

Experimenting with alcohol, drugs or other substances are common experiences of a child's life as they develop and 'break away' from their immediate families and begin to test boundaries. In some cases this behaviour can lead to adverse outcomes in the short or longer term. The impact of each of these can often lower inhibitions, leading to the child engaging in behaviours that they otherwise would not have undertaken. This can place both the child themselves or others at risk, and could subsequently bring them to the attention of the Children's Hearings System. Of those children who are involved in the hearings system, research has shown that substantial numbers have engaged in behaviour such as this, and thus it is an area that Panel Members must be aware of.

Adolescence is a period marked by significant physical and behavioural changes, making adolescents more susceptible to the lasting impact of drug exposure. Excessive consumption of alcohol, drugs or other substances, either individually or in combination, can have enduring effects on the brain and body.

Moreover, use of one form of substance increases the likelihood of other substance use, i.e. those who drink alcohol and more likely to also use drugs. Given the teenage brain's attraction to thrill-seeking, Panel Members are likely to consider the needs of children who experiment with a variety of substances. Peer pressure often contributes to children engaging in behaviours such as this, with social pressures pushing them towards conforming with the actions of their friends. In an attempt to 'fit in' and to belong to a crowd, children may choose to experiment or use these substances at a level that they would have otherwise avoided.

Children who have experience of care often experience problems in this part of their life. As research shows, there is a significant overlap in the number of children experiencing care, using one or more substances, and experiencing poor mental health. By comparison, children within the general population are less likely to use alcohol, drugs or substances.

This section therefore begins to highlight some information that Panel Members should consider when deciding how best to support children who experience risk of harm as a result of alcohol, drug or substance use.

Culture

Behaviours such as drug, alcohol and substance use must be viewed within the cultural norms of Scotland and – if relevant – the nation from which the child has heritage. Whilst not condoning or supporting such actions, Panel Members should bear in mind that Scotland is a nation which has a relaxed attitude to alcohol, with drinking alcohol viewed as a rite of passage by many. This contributes to alcohol use by children being particularly commonplace, occurring far more regularly than drug abuse. Panel Members should also consider the cultural background of the child in question, as that may have an impact on the dynamics within the family. Some cultures take a strictly prohibitive view towards alcohol, drugs and substances and this may therefore influence the response taken by family members.

Alcohol

The effects of using alcohol can be significant, with this video from the World Health Organisation highlighting just some of the risks associated with alcohol. In the short term this can lead to intoxication and a feeling of being more relaxed, less

anxious and more confident. Alcohol affects the part of the brain that controls inhibition, and could lead to adverse consequences for the developing brain. This process can also have adverse effects upon the child's ability to make rational choices, affecting the brain and impairing the decision-making process, as well as leading to negative feelings such as anger, depression or anxiety, whilst slowing down the pace at which the brain processes information. This then makes it more difficult for the child to consider the consequences of their actions, understand their feelings and to think logically.

The child's physical health can – in cases of excess – be jeopardised. Alcohol contributes to 15% of all deaths amongst 16- to 24-year-olds, and over the medium to long term, there are a range of risks to both physical and mental health. These conditions may develop over time, and whilst there is no certainty that alcohol use will lead to such outcomes, it does increase the likelihood.

Alcohol use can contribute to children coming into conflict with the law, and in some instances may be used by those who wish to exploit children. Amongst those children who enter the secure estate, some 73% have engaged in alcohol abuse prior to being placed there.

Drug Use

As this blog outlines, teenagers naturally seek out novel, thrill-producing activities with drug use often providing one such experience. Drug use leads to complex reactions within the brain – as this video demonstrates – which then has a physical, chemical or neurological reaction upon the child. Physical reactions can include increased heart rate, increased temperature and pain relief, whilst long term use can lead to dependency, organ damage and respiratory problems. However each drug will have unique effects: this guide provides more details.

Like alcohol, drug use can lower inhibitions and lead to children behaving in a manner that they otherwise would not. In some cases this results in risk taking behaviours including coming into conflict with the law or other thrill seeking activities. In turn, this may bring the child to the attention of the Children's Hearings System. Amongst the secure care population, 74% have used drugs prior to being placed there.

Substance use is commonly a factor in youth offending with 45% of prisoners surveyed in 2019 self-reporting being under the influence of drugs at the time of their offence.[xxxvii] Local authorities will have their own substance misuse services, often with ones specific to children and young people.

Novel Psychoactive Substances

New or Novel Psychoactive Substances (NPS) – often known as 'legal highs' – have become more common over the past decade, although less common than alcohol or drug use. Their use stemmed from the exploitation of legal loopholes which initially allowed their sale. NPS have considerable negative effects upon those using them, and in some instances could contribute to danger to their immediate health or even death. There are a range of factors that children need to be aware of, including the unpredictable nature of NPS which can result in diverse effects depending on which brand of NPS are used. NPS and other substance use has featured in the lives of many children who enter the secure estate, with three in ten using NPS and 42% using other substances, such as prescription drugs or substances intended for other purposes.

Supporting Children

Given the information above, Panel Members have a difficult task in deciding what action – if any – should be taken to respond to a child's use of these substances. To aid in that task, Panel Members should reflect on the risk assessment undertaken by the child's social worker and health professionals and try to understand what factors are instigating, perpetuating or increasing the risk experienced by the child. A plan should be proposed that either directly or indirectly addresses these risk factors.

Children require education regarding the risks of alcohol, drugs and substance use: a 'just say no' approach has been shown to be counter effective and lack the desired results. Child's plans should therefore promote approaches which involve educating the child about the risks involved, whilst for some children, specific consideration of the immediate risks posed by their use should be considered.

Some children may use alcohol, drugs or other substances due to underlying trauma or adversity. Social work assessments – or that of others involved in the care of the child – should attempt to identify what factors contribute to this and deliver the support that is required to overcome the trauma in question. For others, their use may be more sporadic and linked to unstructured free time. The need for specialist intervention may therefore be less urgent, and instead plans should identify safe opportunities for the child to spend time with friends and engage in activities.

Additional Reading

Panel Members considering how best to support children who have engaged in alcohol, drugs or substance use can seek more information and knowledge from a number of resources:

The Scottish Drugs Forum provides a range of materials that help understand the impact of drug use across a variety of different domains.

This website from the Scottish Drug Deaths Taskforce similarly provides relevant information.

This resource from Young Minds provides a range of background information that may enable Panel Members to better understand the issues.

This NSPCC resource provides further considerations for those concerned about the safety of children.

Interpersonal Violence

Introduction

The impact of interpersonal violence can be wide-reaching and many children within the Children's Hearings System are victims, perpetrators, witnesses, or a mixture of all or some of these at varying points.

"Interpersonal violence involves the intentional use of physical force or power against other persons by an individual or small group of individuals. It may be physical, sexual, or psychological (also called emotional violence), and it may involve deprivation and neglect. Acts of interpersonal violence can be further divided into family or partner violence and community violence:

- *Family* or *partner violence* refers to violence within the family or between intimate partners. It includes child maltreatment, dating and Intimate Partner Violence (IPV) and elder maltreatment.
- *Community violence* occurs among individuals who are not related by family ties but who may know each other. It includes youth violence, bullying, assault, rape or sexual assault by acquaintances or strangers, and violence that occurs in institutional settings such as schools, workplaces, and prisons."[xxxviii]

This section will focus on partner violence, with further sections of the training exploring other aspects of the definition. See sections of this guide: Adversity and Trauma, Psychological Aspects of Conflict with the Law, Brain Development and Harmful Sexual Behaviour for further information regarding child maltreatment and youth/community violence.

Family and partner violence is usually hidden, and it is often difficult for victims to tell someone they have been abused. Self-reported abuse rates are significantly higher than official statistics: child sex abuse more than 30 times higher and physical abuse more than 75 times higher.[xxxix] Official data on offences of violence committed against 16–17-year-olds in Scotland is not available, however data for 2024-2025 shows 820 sexual assaults against 13–15-year-olds, and 2,573 crimes under the Domestic Abuse (Scotland) Act 2018, of which 94% were perpetrated against females. Extrapolating this data using the prevalence rates above provides some idea of the scale of IPV nationally.

We have seen that adolescents are susceptible to peer pressure, risk-taking and impulsivity, and are more motivated to seek instant rewards than they are to work towards longer-term ones, or to modify behaviours by considering deterrents or levels of risk. This combination can put them at increased risk of causing or being the victim of harm, including interpersonal violence, particularly given adolescence is a time when peer, partner and sexual relationships gain prominence.

Types of Interpersonal Violence, Impact and Possible Causes

Intimate Partner Violence/Domestic Abuse

The World Health Organisation defines IPV as "behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviours" and is mostly perpetrated by men against women. In Scotland this is generally referred to as domestic abuse.

The definition of domestic abuse used by Police Scotland and the Crown Office and Procurator Fiscal Service (COPFS) is "any form of physical, verbal, sexual, psychological or financial abuse which might amount to criminal conduct and which takes place within the context of a relationship. The relationship will be between partners (married, cohabiting, civil partnership or otherwise) or ex-partners. The abuse can be committed in the home or elsewhere including online."

Violence Against Women

Violence against women is the most prevalent form of domestic abuse. The United Nations defines it as "any act of gender-based violence that results in, or is likely to result in, physical, sexual, or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.". Police Scotland recognise that domestic abuse is a form of gender-based violence predominantly perpetrated by men against women, however its definition of domestic abuse covers abuse of persons of any gender by persons of any gender.

The World Health Organisation reports that 30% of women worldwide have experienced physical and/or sexual intimate partner violence or non-partner sexual violence. This is mostly intimate partner violence, with 27% of women aged 15-49 worldwide who have been in a relationship reporting some sort of physical or sexual violence by an intimate partner, the estimate for high-income countries and Europe being 22%.

Sexual Violence

Sexual violence is "any sexual act, attempt to obtain a sexual act, or other act directed against a person's sexuality using coercion, by any person, in any setting. It includes rape…attempted rape, unwanted sexual touching and other non-contact forms". 6% of women globally report having been raped by someone other than their partner.

Key Legislation and Legal Process

The key pieces of legislation covering interpersonal violence and domestic abuse in Scotland are the Domestic Abuse (Scotland) Act 2018; Abusive Behaviour and Sexual Harm (Scotland) Act 2016; the Domestic Abuse Protection (Scotland) Act 2021; and the Sexual Offences (Scotland) Act 2009.

Any offences under these acts, as with other offences, may be dealt with by the Children's Hearings System if the person suspected of or charged with committing the offence is under 18.

Domestic Abuse (Scotland) Act 2018

Recognising that domestic abuse often takes the form of a sustained pattern of varying behaviours over time, the Domestic Abuse (Scotland) Act 2018 introduced as an offence "engaging in a course of abusive behaviour". This is defined under s.1 as a course of abusive behaviours towards a "partner or ex-partner" and the following further conditions under s.1(2) are met:

(a) that a reasonable person would consider the course of behaviour to be likely to cause B to suffer physical or psychological harm,
(b) that either—
    (i) A intends by the course of behaviour to cause B to suffer physical or psychological harm, or

(ii) A is reckless as to whether the course of behaviour causes B to suffer physical or psychological harm (including fear, alarm and distress).

S.2 extends the definition of abusive behaviour to recognise varying types of abuse. This includes under s.2(2) behaviour that is violent, threatening or intimidating and also that which is controlling and coercive, covering any behaviour directed towards a partner or ex-partner, their child, or another person that intends to result in or would be considered by a reasonable person to result in any of the below under s.2(3):

a) Making B dependent on, or subordinate to, A;
b) Isolating B from friends, relatives or other sources of support;
c) Controlling, regulating or monitoring B's day-to-day activities;
d) Depriving B of, or restricting B's, freedom of action; or
e) Frightening, humiliating, degrading or punishing B.

The Act's Explanatory Notes explain each section in easier to read terms and provides basic examples of abusive behaviours linked to the above effects, though further discussion highlights the complexity of what constitutes abuse.

Nature of Domestic Abuse Behaviour

Domestic abuse can be subtle, not always obvious initially or in isolation, or more noticeable when considered in a wider behavioural context. Controlling behaviour may occur under the guise of care or love. A partner might genuinely ask where their partner is, when they will be back, or who they are with because they care or want to know their partner is safe. If, however, requests for information about their whereabouts etc. become incessant, overwhelming, or demanding, or there are unpleasant consequences if they do not provide the desired information, then it is abusive, controlling behaviour.

Example 1: When Jane goes out with friends, her partner insists she posts her location on social media/send photos showing where she is and who she is with. Jane's partner calls often when they aren't together and if she doesn't answer his calls immediately, he messages repeatedly and continues to call. She has learned if she doesn't answer straight away, he will be angry with her, shout at her and call her names when she sees him. Sometimes he gets so angry he punches walls or slaps Jane. Jane stops enjoying seeing friends and family and even going to college as she is pre-occupied looking at her phone in case she misses a call, so she starts staying home more. She falls behind at college and drops out. This is controlling, violent behaviour.

Example 2: Jill's partner expresses negative opinions about who she spends time with and how she dresses, belittling her and her choices. She starts to question how she looks and her friends' motives and soon she is dressing down and only seeing the few people her partner approves of, mainly him and his family. She struggles to make choices without his help, and her life looks very different to before she met him. This is coercive behaviour.

Coercive, controlling, and violent behaviours are often justified by the person saying things like; "You're lucky I care so much"; "I don't think that person is a good friend, you deserve better"; "I worry about you when I'm not with you, call me so I know you're ok"; "I miss you, I bet you look great, send me a photo". These comments in isolation are not necessarily controlling, but if a partner expresses anger or unhappiness to the extent that a person is afraid of what they may do if their demands are not adhered to, then this is emotional abuse. Physical abuse may factor in too, however these

examples highlight how abusive behaviours can escalate and co-occur in many forms, not always accompanied by physical abuse, though the threat of it may be real.

Recognising the role of and impact on children in cases of domestic abuse, the 2018 Act also introduced as an aggravation of an offence in relation to a child, under Part 1, s.5. This can be used where the person carrying out domestic abuse directs behaviour at or makes use of the child of their (ex)partner in this behaviour, and also if the child sees, hears or is present during the behaviours, or if the course of abusive behaviour, or an incident of this course, is such that a reasonable person would consider it to adversely impact a child usually residing with the victim or person carrying out the abuse.

Scottish Women's Aid is a leading national charity supporting women who are or think they may be experiencing domestic abuse. Their website provides further advice and information about forms of abuse and what supports they offer both nationally and locally. Men's Advice Line UK is a charity dedicated to supporting male victims of domestic abuse and offer support to male victims via a free phone service, email or webchat. Their website Local Support Near You also contains a Scotland section.

Under Scottish Women's Aid's Information and Support page there are various sections including What is domestic abuse? which provides a guide on how to recognise if you or someone you know is a victim of domestic abuse and examples of different types of abuse:

Emotional/Verbal Abuse:

- Calling you names and putting you down
- Refusing to trust you and acting jealously or accusing you of cheating
- Trying to stop you from seeing family or friends
- Demanding that you tell him where you go, who you call and who you spend time with
- Putting rules in place about how you do things, for example how long you have to answer calls or texts
- Trapping you in your home and stopping you from leaving
- Making threats to hurt you, your children, or others you care about including pets
- Giving you the silent treatment
- Blaming you for the way he behaves or saying that you are making it up
- Cheating on you
- Telling you what to wear, whether you can wear makeup or not
- Telling you that you can't do anything right
- Threatening that he will have the children taken from you if you leave
- Telling you that you have no rights because of your immigration status and that you will be deported
- Making you feel like a bad parent, telling the children not to listen to you
- Threatening to hurt himself

Physical Abuse:

- Pulling your hair, punching, slapping, kicking, biting, or choking you
- Stopping you from sleeping
- Controlling what you eat

- Hurting you with objects or weapons; for example, throwing the remote control at you or threatening you with scissors
- Forcing you to use drugs or alcohol
- Harming your children, family, or pets

Financial Abuse:

- Giving you money and making you tell him how you have spent it
- Not letting you have any access to the bank account or money
- Stopping you from working
- Taking out debt in your name or making you take on debt for him
- Not giving you money towards household bills when he lives with you
- Not paying maintenance for children when the relationship has ended

Sexual Abuse and Coercion:

- Calling you a slut, whore, or other names
- Pressuring you into having sex or performing sexual acts
- Making you feel guilty or like you owe him sex through threats or force
- Hurting you with objects during sex
- Involving other people in sexual activities with you without your consent
- Ignoring you if you say you don't want to have sex
- Forcing you to watch pornography or to participate in the making of it
- Withholding or controlling your access to contraception and protection
- Threatening to share intimate images of you with your friends, family, community or online – also a specific offence under the Abusive Behaviour and Sexual Harm (Scotland) Act 2016.

Digital Abuse:

- Watching your social media accounts i.e. keeping track of who likes your posts, who messages you
- Sending you negative or insulting messages
- Using technology to track your movements and activities.
- Constantly texting you and making you feel you can't be separated from your phone.
- Insisting that you give them your passwords to your email or your social media accounts.
- Sending you explicit pictures without your consent and demanding you send them in return.
- Threatening to share intimate images of you with your friends, family, community or online – also a specific offence under the Abusive Behaviour and Sexual Harm (Scotland) Act 2016.

The above lists of examples are not exhaustive but aim to illustrate the breadth of abusive behaviours.

A visual representation of the range of abusive behaviours can be seen in the Duluth Power and Control Wheel. Created in the 1980's in America, it is a prominent tool used to demonstrate the most common abusive behaviours and tactics used

to control, coerce, and instil fear in victims in relationships characterised by IPV. Conversely the Duluth Equality Wheel highlights the qualities and behaviours to be promoted in healthy relationships, such as negotiation, mutual respect, support, and accountability and can be a useful tool in promoting recovery.

Abusive Behaviour and Sexual Harm (Scotland) Act 2016

Aggravators enhance the severity of an offence and the accompanying sentence. An aggravator of 'domestic' can be added to offences under s.1 of the Abusive Behaviour and Sexual Harm (Scotland) Act 2016 if in committing the offence:

a) The person intends to cause the partner or ex-partner to suffer physical or psychological harm, or
b) In the case only of an offence committed against the partner or ex-partner, the person is reckless as to causing the partner or ex-partner to suffer physical or psychological harm.

Common examples where this is applied include breach of the peace, threatening or abusive behaviour and assault.

Domestic Abuse Protection (Scotland) Act 2021

The Domestic Abuse (Protection) (Scotland) Act 2021 introduced additional, more immediate protection for victims of domestic abuse, particularly those who live with their abuser, by way of Domestic Abuse Protection Notices (DAPNs) and Domestic Abuse Protection Orders (DAPOs). These are short term measures which can be granted, DAPNs by Police and DAPOs by the court, without the establishment of a criminal offence if it appears certain criteria are fulfilled. A DAPN can precede a DAPO as an immediate measure if required. A DAPO lasts up to two months with the option of a one month extension, giving the victim time to plan their next moves to safety. It is an offence if any of the prohibitions or requirements of the measure are breached. A DAPN/DAPO may only be taken out against someone who is 18 or over, though they can be taken out to protect victims aged 16 and over.

Sexual Offences (Scotland) Act 2009

The Sexual Offences (Scotland) Act 2009 provides the statutory framework for sexual offences in Scotland. Part 1 of the Act defines the range of sexual offences including rape, sexual assault, sexual coercion and communicating indecently. A key focus of the Act, under Part 2, is establishing whether sexual conduct constitutes a sexual offence is based on whether the act takes place with consent, which is defined under s.12 as "free agreement". S.13 contains a non-exhaustive list of circumstances when free agreement, i.e. consent, is not present. This includes where the victim is intoxicated, or the sexual activity is agreed to due to violence or the threat of violence being used against them.

The Act also creates "protective offences" which criminalise sexual activity with those who do not have capacity or full capacity to consent on account of their age or mental disorder. There is a distinction between "protective offences" relating to sexual activity with younger children (under age 13) and older children (aged 13-15).

Working with children who cause sexual harm to others, including that which constitutes harm under this section are covered under the Harmful Sexual Behaviour section of this guide.

Rape Crisis Scotland are a national charity who provide support to victims of sexual violence, their website featuring a helpline and links to find local support. They also have a resource section with support for survivors (a term often

preferred by victims), friends and families, and specifically for young people, including a fact sheet on how to keep safe from sexual violence online.

Legal Processes

When investigating an incident of domestic abuse or otherwise, and sufficient evidence of a crime being committed is established, the police will charge the suspect and report the circumstances to the Crown Office and Procurator Fiscal Service (COPFS), who will consider prosecution. As seen, often incidents of domestic abuse are not reported to the police, and others do not progress to reporting to COPFS due to lack of evidence. Incidents may also not be progressed by the police to COPFS or by COPFS for prosecution if alternatives are deemed more suitable.

Under the Scottish Government's Whole System Approach to Youth Offending, offence behaviours of under 18s can be dealt with via Early and Effective Intervention (EEI) and Diversion from Prosecution (DfP) where the child accused is supported by relevant services to address reasons for offending behaviours. This aims to avoid prosecution and prevent further offending. See CYCJ's Practice Guide chapters, updated annually, on Early and Effective Intervention and Diversion from Prosecution for fuller details on both, and this section of CHS's Practice and Procedure Manual for hearings-specific information. Incidents may also be diverted to the Children's Hearings System to be dealt with under current measures, if the child is already subject to a CSO, or under a new ground (s.67(2)(j) of the Children's Hearings (Scotland) Act 2011) 'the child has committed an offence'. Under s.49 of the Criminal Procedure (Scotland) Act 1995 the court may also remit the case of a child not subject to a CSO to the Children's Hearings System for disposal where it feels this is the most appropriate course of action.

In summary, Panel Members will be supporting children known to have displayed, are suspected of displaying, or have been legally found to have committed harmful behaviours towards others. Regardless of the legal status of the behaviour or how the behaviour or offence is being dealt with procedurally, it is the responsibility of Panel Members to ensure the welfare and best interests of the child responsible remains paramount throughout their involvement in the Children's Hearings System. This involves having a good understanding of factors contributing to domestic abuse and violence, and how best to respond to meet the needs of that child whilst reducing the risk of future harm to themselves and others.

Contributory Factors for IPV/Domestic Abuse

It can be hard to attribute reasons to harm causation given the complexities of individuals and their experiences, though there are some notable links. Of significance is that victims of harm and those who harm are often one and the same, meaning labelling individuals with these terms can be misleading.

In recognition of this, the 2019 Scottish Prison Survey introduced inquiries regarding prisoner exposure to Adverse Childhood Experiences (ACEs) (more recent data is available, although measuring different metrics here). It revealed: 40% came from childhood homes where adult(s) physically hurt each other (slapped, kicked, punched, beat up); 47% had themselves been physically hurt by adult(s) in their home (hit, beat, kicked, physically hurt them); 58% had been sworn at, insulted, put down or humiliated by an adult in their home, and 62% had been bullied at school or elsewhere. Whilst not every child who has been harmed goes on to harm others, those who are involved in harm and offending are more likely to have been harmed as children.

The WHO Violence Against Women Factsheet highlights risk factors for both those who carry out and those who experience intimate partner violence. Notably lower education levels, and a history of exposure to child maltreatment and witnessing family violence are risk factors for intimate partner and sexual violence, with difficulty in communicating and male controlling behaviours associated with IPV. Awareness of risk factors can highlight concerns and provide scope for early intervention and education and is something Panel Members should be alert to when supporting children where risk factors are evident, even if they have not yet displayed or been known to display harmful behaviours or IPV.

We have seen that children who grow up experiencing ACEs including poverty, trauma and abuse have a higher prevalence of mental health and attachment difficulties, contributing to poor emotional regulation, and can result in impulsivity and violence, potentially compounded by neurodivergence. We have also seen that the brain cements connections in adolescence based on the responses/behaviours it most often experiences, forming the basis of future patterns of behaviours and responses. It is therefore crucial that interventions in response to any experiences of interpersonal violence in adolescence work to address emotional and behavioural responses, enhancing interpersonal skills and views of self and feelings of safety, promoting positive behavioural change.

Responses

GIRFEC should be used when care planning for all children. Its holistic, needs-focused approach is designed to inform assessment, care planning and risk management, with the option to incorporate local Care and Risk Management (CARM) processes if required. See the Risk section of this guide and CYCJ's Practice Guide Chapter on Managing Risk of Serious Harm for further details.

Plans for children whose behaviour has harmed others should involve specific education and guidance on the behaviours displayed; where behaviours sit in relation to the law; what it is acceptable, what is not and why; and explore victim experiences with a view to developing victim empathy. It is likely assessment will identify a need for trauma informed therapeutic and practical work to address unmet needs of the child responsible for the harmful behaviour, with improved relationships, development of interpersonal skills and self-worth often required. In promoting these, work on healthy relationships, parenting work/team around the child interventions, scenario planning, development of positive coping mechanisms, support with substance misuse and/or mental health issues (assessment and intervention), positive use of time, and goal setting.

The Equally Safe at School | A whole school approach to preventing gender based violence programme for secondary schools helps schools work towards Curriculum for Excellence outcomes, GIRFEC, and the Equally Safe Strategy 2023 which aims to eradicate sexual violence for women and girls. The website offers links that schools can access.

The national Relationships, Sexual Health and Parenthood resource for children and young people provides a breadth of resources designed for use in schools and colleges, with community-based learning resources, linking in with the Curriculum for Excellence. They have a variety of resources freely available at different levels, including those designed for use with children with additional support needs and resources for parents and carers. Although consent and relationships are taught in schools many children do not attend school regularly or require additional one to one support to embed and reinforce learning, making this resource useful for all.

Rape Crisis run the Scottish Government funded National Sexual Violence Prevention Programme which provides to children education on consent, gender equality and healthy relationships, key to promoting lasting cultural change. Resources for this are available online.

Where there has been harm caused to another child or person there will be a focus also on reducing the risk of future harm, and safety planning must be part of the child's plan. See the Risk section of this guide and CYCJ's annual practice guide on Managing Risk of Serious Harm in relation to Safety Planning and Risk Management.

Impact

Interpersonal violence can be fatal and commonly incurs a range of other consequences. Intimate partner and sexual violence cause serious short- and long-term physical, mental, sexual, and reproductive health problems for women and impact children's health and wellbeing, as explained in previous sections of this guide (see sections on Brain Development and Mental Health). The impact of domestic abuse is far-reaching and enduring. Victims often do not feel safe in their relationships or homes, experience restrictions on their freedom, losing autonomy and becoming socially isolated, as well as experiencing physical and psychological symptoms which can impact all areas of their lives.

Victim Support under the Children's Hearings System and the Children (Care and Justice) (Scotland) Act 2024

Victims of offences which are dealt with via the Children's Hearings System due to harm being caused by a child retain their victim status and associated rights. For child victims, this includes protection under Article 39 of the UNCRC of their right to supports which promote physical and psychological recovery from neglect, exploitation and abuse, and social reintegration. Care should be taken to ensure the child has the support they require. There are differences however in outcomes for the child who caused harm and what associated details can be shared with the victim depending on whether offences are dealt with via the courts or the Children's Hearings System.

The increase in referral age to the Children's Hearings System which will be implemented by the Children (Care and Justice) (Scotland) Act 2024 has generated discussion on the experiences of victims of offences dealt with via the Children's Hearings System. Whilst there will be an increase in the number of children aged 16 and 17 referred on offence grounds, there are a number of 16- and 17-year-olds already in the Children's Hearings System where the child is placed on a CSO prior to their 16th birthday.

Part 1 of the Act extends the list of measures which can be attached to a CSO, adding two new prohibitions. The first prohibits the child from entering a specified place, such as an address or area, and could be used to protect someone deemed at risk of harm or harassment by the child. The second prohibits the child from approaching, communicating with, or attempting to approach or communicate with a specified person or class of persons either directly or indirectly, again designed to prevent harm, intimidation, or harassment of another by the child. Failure to adhere to these measures could incur further restrictions on liberty such as a Movement Restriction Condition (MRC) (covered in the Interventions section of this guide). Whilst not equitable to the consequences for adult offenders, this is required to promote children's right to a separate justice system responsive to their specific needs under Article 40 of the UNCRC.

Similarly, there are differences in the information on outcomes provided to victims when the child is referred to the Children's Hearings System (rather than the criminal justice system). Children in conflict with the law have the right to re-integration under Article 40 of the UNCRC and to privacy under Article 16 of the UNCRC and Article 8 of the European

Convention on Human Rights. As such, children cannot and should not be subject to the victim notification schemes in place for adult offenders. Under section 179A of the Children's Hearings (Scotland) Act 2011, certain persons are entitled to request information about actions taken by the Children's Reporter and the children's hearing in relation to a child over 12 (the age of criminal responsibility) when an offence ground (s.67(2)(j)) is being considered, or under 12 whose behaviour was physically or sexually violent, sexually coercive, dangerous, threatening or abusive and which caused harm to another person. Those who can request information are those affected by or harmed by the child, or where that person harmed is a child, a Relevant Person for that child. The information which can be requested and provided to these persons is covered in section 179B of the 2011 Act and relate to the decision made by the Principal Reporter as to whether a hearing requires to be arranged, the reasons for this, and the outcome of any subsequent hearing (whether a CSO was made, terminated, continued or varied). Currently the Reporter may comply with information requests only if doing so would not be detrimental to the child who proceedings related to, or any other child, and that sharing information is appropriate. This allows sharing of information that would impact safety planning for victims.

The Children (Care and Justice) (Scotland) Act 2024 will implement changes to these provisions, placing a duty on Reporters (as far as reasonably practicable) to inform those entitled to request information under s179A of that right unless the Reporter is satisfied that applying it would be detrimental to any child involved. The Act also increases the level of information that may be provided to victims:

- Whether a CSO has been made, terminated, varied or continued;
- Whether one of the new prohibitions or an Movement Restriction Condition has been included which stops the child from contacting the child victim, or whether such a measure is removed or changed;
- Whether a secure accommodation authorisation has been made; and
- Other information necessary to the safety planning of the child victim.

Whilst proposals under the Children (Care and Justice) (Scotland) Act 2024 go some way to enhancing protections for victims, it is recognised that the experiences of victims within court processes also require improvement. Research carried out into the experiences of victims and witnesses of domestic abuse attending court since the Domestic Abuse (Scotland) Act 2018 came into force highlighted that safety was not consistently ensured before, during or post proceedings, contrary to their expectations that abuse would cease upon reporting. Non-harassment orders (NHOs) offered some protection and reassurance for victims, the principles of which the above prohibitions that will be implemented by the Children (Care and Justice) (Scotland) Act 2024 seek to provide for those harmed by children where appropriate. This research suggests that continued involvement of the police and courts proceedings does not ensure safety or minimise trauma for victims. Advocacy and support were reported as the most significant factors in minimising trauma and enhancing feelings of safety and are already available to victims of offences that are dealt with via the Children's Hearings System. National victim support services are discussed below, however arrangements for advocacy and support do also vary locally so it would be prudent for Panel Members to familiarise themselves with what is available in their area.

The proposed Victims, Witnesses, and Justice Reform (Scotland) Bill (currently being considered in the Scottish Parliament) also aims to improve the experiences of victims and witnesses within Scotland's justice system, in particular the victims of sexual harm, though this generally applies to those attending court.

Currently under section 3D of the Victims and Witnesses (Scotland) Act 2014 Police Scotland have a duty to provide victims of crime with access to appropriate support from victim support services, either by referring a victim to victim support services at their request, or by providing sufficient information to a victim to allow them to self-refer.

S.3D(5) of the Act defines "victim support services" as:

(a) Information, advice and support to victims including information on compensation for criminal injuries, and the participation of victims in criminal proceedings;
(b) Information about any relevant specialist support services in place;
(c) Emotional and, where available, psychological support;
(d) Advice relating to financial and practical issues arising from the crime;
(e) Advice relating to the risk and prevention of:
    (i) Secondary and repeat victimisation;
    (ii) Intimidation; and
    (iii) Retaliation; and
(f) Such other services as a competent authority considers appropriate to the needs of victims.

The 'competent authority' defined under section 32 of the Act includes the Lord Advocate, the Scottish Ministers, the chief constable of the Police Service of Scotland, the Scottish Courts and Tribunals Service, and the Parole Board for Scotland.

Victim Support Scotland are the main service providing emotional support, practical help and essential information to victims, witnesses and others affected by crime in Scotland with information regarding this support available to review on their website. The government webpage Get support as a victim or witness of crime has links to supports available to victims under specific crime categories including Domestic Abuse, Rape and Sexual Assault and Youth Crime, viewing of which is recommended to see the variety of specialised supports available. There is also a Young Victims of Crime support page.

Sections 179A-179C of the Children's Hearings (Scotland) Act 2011 provides that victims of crime committed by children under 16 and by 16- and 17-year-olds on CSOs are entitled to support from the SCRA Victim Information Service. The Children (Care and Justice) (Scotland) Act 2024 will make this support available for victims of crime committed by all children (under the age of 18). SCRA's website provides links to their Victim Information Leaflet, Easy Read Victims of Youth Crime Guide and SCRA's service to victims of youth crime information page which provides contact details for victims to access more information.

The Children (Care and Justice) (Scotland) Act 2024 also provides for further regulations to be made by the Scottish Ministers to provide enhanced support services for victims of a child's behaviour, including providing a single point of contact for victims when they have been harmed by a child who has been referred to a hearing. The full details of this service are not yet known at the time of writing of this guide.

The Scottish Government and key partners' most recent Standards of Service for Victims and Witnesses sets out what supports victims are entitled to at every step of the process, including a helpful flow-chart illustrating the process. Standards are reviewed annually and aim to help victims feel supported, safe and informed in what is recognised to be a frustrating process.

Harmful Sexual Behaviour

Introduction

The Scottish Government defines Harmful Sexual Behaviour (HSB) as "developmentally inappropriate sexual behaviour by children and young people which is harmful or abusive".

HSB is indicated if the behaviour meets any or all of the following criteria:

- It occurs at a frequency greater than would be developmentally expected;
- It interferes with the child's development;
- It occurs in a context of coercion, intimidation or force;
- It is associated with emotional distress;
- It occurs between children of divergent ages or abilities; or
- It repeatedly recurs in secrecy after intervention by caregivers.[xl]

Behaviours will vary in degree of harm caused, intent, sexual arousal, use of force and context. They can occur in person or online and may bring the child in conflict with the law. Stop It Now have designed a tool for parents and carers to understand if a child's sexual behaviour is age appropriate.

HSB occurs in a variety of settings including peer relationships, exploitative relationships, intrafamilial abuse and online coercion/grooming, and like other types of interpersonal violence, it is under-reported. The majority of children who display HSB do not continue these behaviours into adulthood.

Policy/Legal Approaches

In 2017 there was a 5% increase in recorded sexual offending in Scotland, linked to a growth in online sexual offending and offending involving younger children, with a large proportion of harmful sexual behaviour towards children carried out by children. This saw the formation of an Expert Group who in 2020 produced guidance on Prevention of and Responses to Harmful Sexual Behaviour by Children and Young People.

The Equally Safe Strategy which addresses violence against women and girls, also promotes accountability and behavioural change for boys and young men who perpetrate HSB and violence against women and girls.

HSB carried out by children can be addressed via Early and Effective Intervention (EEI) processes, the Children's Hearings System either via current measures or new grounds or through referral to the Crown Office and Procurator Fiscal Services for consideration for court proceedings (if such behaviour constitutes an offence). Welfare-based approaches such as those taken in the Children's Hearings System and EEI are promoted by experts in HSB, providing more scope for timely prevention and early intervention, compared to justice system responses which can label and stigmatise children who carry out HSB, impacting their self-esteem, mental health, and access to education.

Pathways into HSB

Although profiles are individual, a significant proportion of children with HSB come from families facing complex challenges, experiencing parental discord and with multiple disadvantages and adversities in childhood.[xli] Research also shows that children with learning disabilities and ASD are over-represented. Adolescents who commit HSB have commonly been victims of childhood sexual abuse, research showing this applies to 26-92%, with high prevalence of physical abuse, emotional abuse, neglect, and exposure to violence also found.[xlii]

The vast majority of HSB is by boys against girls with the average onset of HSB for boys aged 13 to 14, coinciding with the onset of puberty, when increased prominence of sexualised feelings and behaviours can trigger the sexualisation of general behaviours and interpersonal problems. Extensive research from different perspectives attributes the overwhelming prevalence of male against female HSB, over 90% in every study, to historic cultured gender inequalities, which continues to promote male dominance and feelings of sexual entitlement.

Sexual exploration and experimentation are normal parts of adolescent development, important in shaping sexual identity and understanding of how to conduct healthy and appropriate relationships. Some children have less experience and understanding of their own and others' sexuality and sexual boundaries than others, and keeping all children safe whilst they grow is the responsibility of all adults in Scotland under GIRFEC.

Technology Assisted Harmful Sexual Behaviour (TA-HSB)

Technology Assisted Harmful Sexual Behaviour (TA-HSB) involves using technology to engage in sexual activity that may be harmful to themselves or others, including inappropriate/problematic behaviours as well as exploitation, abuse, and victimisation. Children lead extensive lives online which can lead to bullying or exploitation, and accessing inappropriate sexual content, which can impact their expectation of sexual norms and lead to TA-HSB.

One NSPCC study noted 46% of referrals for its HSB programme involved TA-HSB. However, it is rare for children to engage in TA-HSB without also being involved in offline HSB. In this study, the most prevalent type of TA-HSB amongst boys was developmentally inappropriate use of pornography, followed by making, taking and distributing indecent images of children and 'sexting'.

The Glasgow-based Risk of Online Sexual Abuse (ROSA) Project piloted early TA-HSB specific interventions. Girls made up a third of referrals and were significantly more likely to be reported for sharing images of under 18s, although in 86% of cases this concerned pictures of themselves, with upwards of a third of these coerced by peers or adults.[xliii] Reasons for referrals and behaviours, including welfare concerns were notably complex. See the Risk of Online Sexual Abuse (ROSA) Project for informative discussion around examples of TA-HSB.

Exploitation

Sexual exploitation involves a person of any age using a power imbalance to force or entice a child into engaging in sexual activity in return for something. Children may have been the victim of grooming by the person of power and may not be aware they are being exploited. As made clear by the Scottish Government, the presence of perceived consent does not constitute consent when the child has been subject to an abuse of power. Adolescents may or may not be aware of power

dynamics within relationships which could lead to unconscious HSB including exploitation. Education is key to ensuring children are aware of power dynamics within relationships and recognise the signs of grooming and exploitation.

The Scottish Government's Child Exploitation - Definition and Summary provides information identifying and responding to Child Sexual Exploitation (CSE). CSE is explored along with Child Criminal Exploitation (CCE), the growth of online personas and social media impacting the trajectories and prevalence of multiple forms of exploitation and crime.

Child Sexual Exploitation is covered in further detail in the below section Trafficking and Exploitation.

Prevention and Intervention

Hackett's Continuum of Sexualised Behaviours has been identified as useful to aid understanding of developmental appropriateness of sexual behaviours, incorporated into the Harmful sexual behaviour framework: an evidence-informed operational framework for children and young people displaying harmful sexual behaviours. This provides guidance on 5 domains: Responses, Prevention, Assessment, Intervention and Development.

Government Policy Guidance follows the framework on levels of preventative interventions, designed at three levels (but with overlap):

- Primary prevention: community or population-wide initiatives such as education, aimed at prevention;
- Secondary prevention: interventions, prior to abuse with higher risk and/or need, aimed at individuals and families addressing problematic behaviours/attitudes; and
- Tertiary prevention: post-abuse interventions to help victims and perpetrators recover and to reduce their risk of repeating more serious levels of HSB.

Interventions do not solely focus on sexual behaviours and are multi-faceted depending on the individual's assessed needs and risks. Children with HSB rate being equipped with skills as well as knowledge in the success of interventions; building skills in managing HSB by developing their social competency, self-esteem and self-efficacy; and learning skills in identifying and managing triggers to their HSB and the ability to put these into practice in different contexts as critical.[xliv] Integrated assessment looking at TA- HSB and offline HSB is required as well as specific interventions required to address TA-HSB.

Children who display HSB and who are harmed by HSB (often the same children) hold rights under the UNCRC and the European Convention on Human Rights, which guide policy and practice in Scotland, including GIRFEC and National Guidance for Child Protection in Scotland which provide a national framework to promote the wellbeing and safety of all children. A collaborative response and holistic care plans are required to support children who commit HSB, as well as victims.

Specialist risk assessment and intervention can be incorporated as required, and are suggested when tertiary levels of prevention are reached. Risk assessment tools for children and young people engaged in HSB and TA-HSB can be found under the Risk Management Authority's Risk Assessment Tools Evaluation Directory (RATED). Different kinds of risk assessments are used in response to different kinds of risk (see Risk section of this guide). Where there are concerns that a child's behaviour is or could be significantly harmful, the Framework for Risk Assessment and Evaluation (FRAME) for children aged 12-17 should be followed, which includes guidance on following local Care and Risk Management (CARM)

Processes. This guidance allows for safety planning to protect victims whilst also addressing the needs of the child who has carried out HSB, with clear distinctions from the management of adult offenders on account of children's unique needs and rights.

Child Protection Guidance emphasises that children with HSB are likely to have additional needs relating to their behaviour or the impact of their behaviour: "While the police and statutory services will take action to protect the safety of those involved in the situation and attend to the needs of victims, all investigative and planning activity triggered by a child's harmful behaviour must have regard for the child's wellbeing as a primary consideration." This echoes the principle of the Children's Hearings System that the child's welfare is paramount.

Research shows that poor parent-child attachment, particularly anxious attachment, is a factor in HSB, and that placing these children in stable home environments with nurturing, consistent carers can be effective in addressing the HSB,[xlv] suggesting scope for interventions aimed at improving attachment relationships and family functioning: meeting the child's unmet needs. Children with HSB value the role of parents/carers in recovery, with improved skills in anger management, self-esteem, personal responsibility, and communicating were felt by them and parents/carers to lead to improved relationships with family members and peers, further increasing self-esteem.[xlvi]

Relationships and Consent

Older children may exhibit HSB within the context of a relationship with a child of similar age, perhaps children who have lacked appropriate boundaries and were potentially sexualised at an early age, who may commence relationships without the maturity to manage these safely and with consent.

Children need to be educated on and aspire to be in healthy, respectful relationships where both people feel comfortable. How this is done is key to getting through to the child, with the roles of practitioner and parents, and ability to communicate honestly valued by children in HSB interventions.

The Scottish Government's Healthy relationships and consent: key messages for young people offers practitioners a comprehensive guide covering relationships, consent, the law, and safe sex. Children should be educated on consent at all stages of intervention, and encouraged to verbalise consent, and be mindful of body language and other communication. Comprehension should be confirmed repeatedly and scenario planning should encourage children to prepare for real life situations, promoting internalisation of learning. The NHS Awkward Moments website aims to help adolescents communicate consent, and includes videos created with children and young people showing different scenarios and how they can respond.

Sexual offences are defined under the Sexual Offences Scotland Act 2009, with accompanying Explanatory Notes explaining these in more detail to inform them of what is not acceptable behaviour. Consent should be sought for all sexual activities. Using encouragement or coercion to engage in a sexual act will constitute an offence.

Rape Crisis Scotland offers in person and online support for victims, and has a For Young People section including a factsheet on how to stay safe online.

The Lucy Faithfull Foundation's Stop It Now project offers support for anyone with concerns about child sexual abuse and its prevention.

Trafficking and Exploitation

Introduction

Exploitation and/or human trafficking may be areas Panel Members are familiar with. However given the higher prevalence amongst older children, these topics may become more common within the Children's Hearings System with the anticipated increase in 16- and 17-year-olds referred due to the Children (Care and Justice) (Scotland) Act 2024. Trafficking and exploitation are complex, but simply put they are the commodification and abuse of people for another person(s) gain. This section explores forms of exploitation and trafficking and how they are linked, which is important for Panel Members to be aware of for the purposes of ensuring that children subject to such exploitation receive appropriate supports.

Exploitation, Power and Serious Organised Crime (SOC)

Exploitation involves an imbalance of power, with children particularly vulnerable to this due to their age. Those who exploit children will identify things they need or want, (material and non-material goods such as clothes, gifts, alcohol, accommodation, status, or protection), and use these to entice the child to perform criminal tasks or sexual acts in exchange. These enticements, or grooming tactics, may decrease or cease once the child is 'recruited', the child is then under control of the individual or group, and violence and threats may be used to maintain this.[xlvii]

Power, and therefore power imbalance, present in different ways. Power could be in relation to protected characteristics covered by the Equality Act 2010 such as age, gender, or disability. However, as the Scottish Government's National Guidance for Child Protection in Scotland makes clear, it can also relate to socio-economic status, such as those within a position of professional or social authority, a high level of disposable income, highly regarded/feared members of a gang or a popular older peer group, those with superior intellect, physical strength, or economic superiority. The type of power wielded may influence the enticement.

Two forms of abuse Panel Members may come across are Child Criminal Exploitation (CCE) and Child Sexual Exploitation (CSE). These will be discussed separately below, though are often interlinked, and are both forms of child abuse. Children can be exploited by individuals, most often external to family, or by groups of individuals, which is regarded as Serious Organised Crime (SOC).

SOC is defined under section 28 of Part 2 of the Criminal Justice and Licensing (Scotland) Act 2010 as a crime involving two or more persons acting together to commit or conspiring to commit a serious offence or series of offences. A "serious" offence is an indictable or solemn offence (one where a trial will take place before a jury) committed with the intention of obtaining a material benefit for any person, or an act of violence or threat carried out with the aim of obtaining such a benefit.

The Scottish Government's Serious Organised Crime Strategy provides further context and examples, highlighting the majority of Serious Organised Crime Groups (SOCGs) in Scotland are involved in drug trafficking, though are commonly involved in multiple crime types, such as drugs, violence, money laundering, fraud and human trafficking. Threats posed to society by SOCGs include drugs, violence, child criminal exploitation, child sexual exploitation, and human trafficking.

Legal Interpretations of Human Trafficking and Exploitation

Exploitation may occur during or due to being a victim of human trafficking. In Scotland 'human trafficking' is an offence under section 1 of Part 1 of the Human Trafficking and Exploitation (Scotland) Act 2015. It occurs when a person takes a "relevant action" with a view to another person being exploited, meaning the person either intends to exploit the person during or after the action, or they know (or ought to know) that another person will do so. Relevant actions are recruiting, transporting, harbouring, receiving, exchanging or transferring control over another person, or arranging or facilitating of any of these actions.

Explanations of what actions constitute exploitation for the purposes of human trafficking are defined under section 3 of the Act. They include slavery, servitude and forced or compulsory labour, and securing services or benefits for another. Child Criminal Exploitation is not specifically defined in law but can be prosecuted under these categories.

Child Sexual Exploitation occurs when a person is pushed into prostitution by another or involved by another in the making or production of obscene or indecent materials of children or is a victim of certain offences, including those under Part 1 (Rape etc.), Part 4 (Children) and Part 5 (Abuse of a Position of Trust) of the Sexual Offences (Scotland) Act 2009. Exploitation of a child (rather than an adult) under any of these categories is considered to be an aggravating factor to the crime, and will therefore attract a more severe sentence.

Trafficking often involves the transfer of children across national borders, but also happens within Scotland, and does not need to involve any movement of the child at all. 'Harbouring' involves the hiding or concealing of a person, which would fall under the definition of human trafficking in Scotland. Children who have absconded/are spending time in a place, whether they have been encouraged to or otherwise, where they are sheltered or concealed (and whilst exploited as explained above) would also be considered to be trafficking.

Responding to Exploitation and Trafficking

The Scottish Government's Trafficking and Exploitation Strategy provides an overview and sets out what must be done to tackle and eliminate trafficking in Scotland. Promoting greater understanding and awareness of the crimes involved and their impact is key; its first area of action being to identify victims and support them to safety and recovery. The strategy is recommended reading for Panel Members, who may be supporting child trafficking and exploitation victims, with Section 4 highlighting the strategy specific to children and their varying needs. It highlights that children are inherently more vulnerable to exploitation due to their dependency on others to care for them, and that child victims should be supported and protected through the National Guidance for Child Protection in Scotland procedures, with local authorities responsible for coordinating services for child victims.

Part 2 of the Human Trafficking and Exploitation (Scotland) Act 2015 covers the protection of victims of trafficking and exploitation. Support and assistance for adult victims should be referred to when a child victim is approaching 18 to ensure provisions are in place as required. Support and assistance for child victims provides that where no one in the UK has parental rights and responsibilities for a child, and that child is (or may be) a victim of trafficking, or is vulnerable to being so, the child will be assisted by an Independent Child Trafficking Guardian. Aberlour's Guardianship Scotland:

National Child Trafficking Support Service provides this statutory service. Their report On your side, by your side highlights their impact through stories of young adults supported as children.

The Lord Advocate's instructions for non-prosecution of victims of human trafficking notes a strong presumption against prosecution of a child victim of human trafficking or exploitation if the offence took place in the course of, or as a consequence of, their being a victim of such, and is also applicable to adults if there is evidence that they were compelled to commit the offence. This highlights the importance of Panel Member awareness of what constitutes trafficking and exploitation, and being vigilant to signs of it in reports or during hearings. It is noted that offences committed because of trafficking or exploitation commonly include those relating to drug production, supply, and distribution, commercial sexual exploitation, shoplifting and crimes of violence and dishonesty to escape circumstances, so Panel Members should be alert to circumstances around these offences which could indicate exploitation or trafficking.

Any suggestion that the child, and at 16/17 soon to be adult, is or has been a victim of trafficking or exploitation could have significant influence over how any current or future criminal charges against them are dealt with and should be recorded and shared with those working with the child on an ongoing basis.

Migration Scotland, an online Convention of Scottish Local Authorities (COSLA) platform dedicated to supporting migrants, provides Human Trafficking & Exploitation Guidance to support local authorities and their staff to develop good practice in referring and supporting victims of human trafficking and exploitation. Part 5 covers support for victims, highlighting that support for child victims should be underpinned by GIRFEC. Pages 19 and 20 provide 'Best practice in supporting victims of human trafficking' and a 'Flowchart overview of referral and support process'.

The National Referral Mechanism (NRM) is a UK Government framework for identifying and referring potential victims of trafficking and slavery, servitude and forced labour. The NRM Toolkit provides an overview of referral and support processes for first responders, designed to improve identification and protection outcomes for victims.

Risk Factors to Exploitation

Common vulnerabilities to exploitation include poverty and destitution, as well as homelessness, insecure immigration status and fleeing other forms of violence, with females more vulnerable to sexual exploitation and males to criminal exploitation.

Barnardo's Child Exploitation: A Hidden Crisis discusses types of child exploitation, vulnerabilities, and prevalence throughout the UK. It highlights the needs children have which make them vulnerable to exploitation, identifying economic hardship and isolation as particular vulnerabilities, exploring concerns these are being compounded by the current cost of living crisis. It also raises concerns that increased time online for children increases the risks of being exploited. Common exploitation vulnerabilities for children include anything which increases their reliance on adults, such as physical or learning difficulties, and separation from protective factors such as friends or family, and lack of shared language.

Non- or reduced school attendance and lack of meaningful use of time is a potential impact of exploitation, though research also indicates that children who are not in full time education may be vulnerable to exploitation due to boredom and lack of appropriate adult supervision, as well as highlighting that the effects of exploitation may also lead to behaviours that may see them marginalised or excluded by education.[xlviii] Panel Members should be alert to these risk

factors and how best to mitigate them when supporting children who have disengaged from education and there are unknowns as to how they spend their time.

Prevalence and Impact

Children who are being exploited may often go missing from home, become isolated from family or friends, and disengage from education. They will likely have little control over their actions and be subject to physical, emotional, or sexual abuse, and serious violence or the threat of such, particularly when involved with SOCGs. They must be safeguarded and treated as victims, not criminalised. Whilst prosecutions for child trafficking and exploitation are low throughout the UK, it is very important that victims are not treated as criminals.

The Scottish Government's current approach to children's justice, A Rights-Respecting Approach to Justice for Children and Young People: Scotland's Vision and Priorities, has 'victims' as a priority area, highlighting that all children at risk of CCE or CSE must be supported through increased understanding of the nature, scale and extent of the issue and awareness raising with practitioners and communities.

Related Rights

Whilst many rights may be neglected when a child is a victim of trafficking or exploitation, certain UNCRC articles place specific responsibilities on state parties to prevent against this:

- Article 19 protects children from all forms of violence, abuse or neglect, including exploitation;
- Article 34 protects children from all forms of sexual abuse and exploitation;
- Article 35 protects children from sale and trafficking; and
- Article 26 protects children from all other forms of exploitation.

The SOC Strategy highlights that human trafficking for labour exploitation and sexual exploitation occurs throughout Scotland. All cases of trafficking and exploitation should be dealt with via child protection procedures, with sections on each included in the National Guidance for Child Protection in Scotland.

The below sections highlight some of the nuances between CCE and CSE, whilst also considering overlaps.

Child Criminal Exploitation (CCE)

Definition

As stated in the National Guidance for Child Protection in Scotland, "Criminal exploitation refers to the action of an individual or group using an imbalance of power to coerce, control, manipulate or deceive a child or young person under the age of 18 into any criminal activity in exchange for something the victim needs or wants, or for the financial or other advantage of the perpetrator or facilitator. Violence or the threat of violence may feature."

The Scottish Government's Practitioner Guidance on Criminal Exploitation offers a fuller discussion on CCE, highlighting that a victim may have been criminally exploited even if they appear to consent to the activity, or have received something they wanted in exchange for the criminal activity, with children more vulnerable to CCE due to the power imbalance of age.

Types of CCE

Victims of CCE are often involved in the transportation and dealing of drugs, cannabis cultivation, and acquisitive crimes such as shoplifting, theft, begging and burglary, though drug related crimes across 'county lines' feature heavily in CCE in Scotland.

The term 'county lines' is more common in England, and use has been criticised for not emphasising the exploitation element,[xlix] though it is useful for Panel Members to know what the term means and that it is related to drug movement and supply. The National Crime Agency's County Lines Briefing discusses this, signs to look out for and how to respond. 'County lines' is a term used to describe drug gangs in large cities expanding their reach to small towns, often across Police and local authority boundaries. Mobile phone 'lines' are used to communicate drug orders, with the 'county line' being the mobile phone used to take the drug order.

The Home Office's From Harm to Hope: A 10-year drugs plan to cut crime and save lives discusses the intricacies of drug crime and prevention in more detail. It highlights how organised crime gangs will target and exploit children and vulnerable individuals to transport substances, coercing their involvement as 'runners' moving drugs and money, or selling drugs to peers. They will then struggle to get out of the arrangement due to threats of violence or their own drug debts.

Dixon's scoping report Understanding Child Criminal Exploitation in Scotland discusses this type of CCE in more detail, and the prevalence of drug dealing and transportation along 'county lines' in Scotland. It notes some do run from England into Scotland, disproportionately to the North of the country. Though the nature of lines differ, they also rely on the recruitment of children as 'runners'.

Data and Impact

The National Referral Mechanism is a UK Government framework for identifying and referring potential victims of trafficking and slavery, servitude and forced labour. This is the most reliable source of data on CCE, albeit there is likely a significant under-estimation due to the overall hidden and often misidentified nature of CCE. The Home Office's National Referral Mechanism Statistics (2024) show the majority of children referred were UK male nationals and the most common reason for referral was CCE (45% of cases). There have been increases in referrals in recent years, which is attributed to improved identification of 'county lines' cases.

The SOC Strategy notes Scotland has seen an increase in CCE and online CSE. SOC has a disproportionate impact on communities where there are higher levels of social and economic deprivation, with children and young people particularly at risk of exploitation.

Barnardo's report Exploited and Criminalised discusses CCE and the importance of improving identification of CCE victims and co-ordinated multi-agency responses to victims.

Indicators of CCE

The Scottish Government's Practitioner Guidance on Criminal Exploitation provides an extensive list of possible CCE indicators. This includes missing episodes, checking their phone frequently, physical injuries, having more than one phone, new items/money, signs of drug dealing, anti-social behaviour and fighting. It also highlights signs of 'cuckooing',

where others take over or 'nest' in the home of another (usually vulnerable) person's property, using threats of violence, and often using the property to hold drugs. This may be relevant to 16- and 17-year-olds who have their own tenancy, and this could be indicated by the occupant appearing anxious or distressed or avoiding/being less visible at their own address.

The NSPCC Criminal Exploitation and Gangs section of their website has easy-read sections on Signs and Dangers of Criminal Exploitation. Signs to look out for include frequently absconding or doing badly in school, committing petty crimes like shoplifting, unexplained injuries and refusal to seek medical help, carrying weapons, being angry, aggressive or violent, self-harming, and going missing or staying out late. It also discusses the recruitment of children, highlighting the use of other children who may have been exploited themselves, with peer pressure of wanting to fit in with friends cited as a potential reason.

Child Sexual Exploitation (CSE)

Definition

As defined in the Scottish Government's Practitioner Briefing Paper on Child Sexual Exploitation, CSE is "a form of child sexual abuse in which a person or persons of any age take advantage of a power imbalance to force or entice a child into engaging in sexual activity, in return for something received by the child and/or those perpetrating or facilitating the abuse. As with other forms of child sexual abuse, the presence of perceived consent does not excuse or mitigate the abusive nature of the act." For these purposes, a child is anyone under the age of 18.

This is the definition used in the current National Guidance for Child Protection in Scotland, which defines sexual abuse as any act that involves the child in activity for the sexual gratification of another, which clearly encompasses CSE.

The key factor distinguishing CSE from other forms of sexual abuse is the "additional requirement for some form of exchange". This involves sexual gratification on the part of the person carrying out the abuse, whilst the 'gain' for the child may be 'rewards' such as money, drugs, material items like gifts or clothes, status, perceived love/affection, a place to stay, a sense of belonging, or the prevention of something negative like violence or harm to a loved one.

CSE Specific Power Imbalances

Sexual abuse typically involves an imbalance of power between the child and abuser and can involve coercion or compliance by enticement, or under threat. It is still abuse even if it is claimed the child consented if they were not of an age they could legally do so, and/or in situations where there was not 'free agreement'. Consent and free agreement are defined under Part 2 of the Sexual Offences (Scotland) Act 2009, along with examples of circumstances where there can be no free agreement. These include when a person is under the influence of a substance, under threat of violence, or deceived in some way by the person carrying out the abuse.

Examples of CSE with varying power dynamics and exchanges:

- A 17-year-old boy with no permanent home is enticed by the prospect of staying with a 30-year-old acquaintance for 'free'. They enter a sexual relationship. He could leave, but has nowhere to go.

- A 16-year-old girl living in care with fractured family relations feels a sense of belonging and being loved because a 19-year-old man she is seeing buys her expensive clothes and takes her out. They often have sex. She sometimes doesn't want to, but he reminds her of all he has done for her, and he's in a gang so it's safer to do what he wants.
- A shy 16-year-old with a learning disability is flattered by the attention of older peers who encourage them to drink alcohol and use drugs which they provide initially, but later want paid for them. As the child has no money, their debt is cancelled if they perform sexual acts for the person providing the substances.

Pages 3-4 of the Scottish Government's CSE Practitioner Briefing details a variety of further examples.

Culture of CSE

Situations involving CSE, like in the above examples, may or may not involve sexual relations initially. Sexual contact is often sought, gained, and encouraged by the abuser after a period of 'grooming', during which the child has been provided with what they desire or need by the abuser, who is taking advantage of this deficit, but building physical/material/emotional dependency. Grooming is defined as "targeting, befriending and establishing an emotional link with a child in order to manipulate, exploit, traffick or otherwise abuse them".

The NSPCC's Grooming information page information page provides more information on grooming, how to spot it, and where to turn for help if concerns arise around grooming, and is useful for Panel Members to be aware of.

A child may understand the nature of the exchange which constitutes the CSE and decide to continue the arrangement. This may make them feel like they are in control of the situation and giving consent, though this remains exploitation as the other person is taking advantage of them, i.e. exploiting the child's need deficit, or desire, to get what they want. The child's need might be a vulnerability, such as poverty or lack of parental love and supervision, perpetuating the power imbalance and leaving them vulnerable to exploitation. Children may or may not understand what they are experiencing is exploitation. In either situation it can be hard to disclose what is happening for varying reasons, such as lack of understanding, shame, guilt or fear.

Possible Indicators of CSE

Those working with children must therefore be alert to possible signs of CSE. The NSPCC has a user friendly Sexual Exploitation information page detailing how to identify and respond to concerns in children, with the National Guidance for Child Protection in Scotland also including a comprehensive list of vulnerabilities to and indicators of CSE.

As these resources indicate, possible indicators of CSE include:

- Being secretive;
- Sudden changes in mood or character;
- Changes in relationships/friendship groups, hanging out with older people;
- Multiple callers/picked up in unknown vehicles;
- Having money or possessions they can't or won't explain;
- Increased alcohol or drug use;
- Depression/self-harm; and
- Staying out late/going missing.

Possible impacts of CSE are noted as:

- Becoming isolated from family/friends;
- Substance misuse;
- Struggling to understand healthy relationships/boundaries;
- Dropping out of education/unemployment; and
- Pregnancy.

These indicators and impacts may have other causes and are not all atypical during adolescence, so robust holistic assessment should be carried out to identify any other possible causes for behaviours, with consideration of CSE given where relevant concerns arise.

CSE Specific Responses

It can be hard to spot exploitation when children are older and regarded as having a high level of autonomy, in particular 16- and 17-year-olds who can legally consent to sex. It is crucial however that all children, regardless of age, who are suspected to be or at risk of being sexually exploited are supported to understand consent and free agreement and what constitutes abuse and exploitation. It is also crucial that the guidance and protection children still require as children (who are not fully autonomous) is provided. This is their right and the responsibility of the state, acting through relevant agencies such as the Children's Hearings System, under Article 34 of the UNCRC, the child's right to protection against sexual exploitation. This covers specifically the inducement or coercion of a child to engage in any unlawful sexual activity, the exploitative use of children in prostitution and pornographic performances or materials.

All behaviours surrounding CSE must be seen in the context of a wider GIRFEC approach to allow interventions to be appropriate for the child and to identify what approach other agencies may require with the person carrying out the abuse.

Strong holistic assessment with use of the National Practice Model tools is crucial in identifying and managing risks to the child, as well as any needs leading the child to be vulnerable to exploitation that could be met in other ways.

The trauma of sexual abuse and sexual exploitation leaves victims in need of specialist accredited services, with capacity noted to be lacking in many areas.[i] Panel Members are encouraged to explore what specialist provisions and bespoke supports are available in their areas generally and in response to the individual needs of victims of CSE.

CCE and CSE Crossover

As previously referred to, Understanding Child Criminal Exploitation in Scotland highlights the crossovers between CSE and CCE, and potentially different pathways into it both by girls and boys.

Referencing examples from several studies (references are available in the full report), it states that of the girls who are being criminally exploited, it is unknown whether this is the primary form of exploitation or whether this is secondary to sexual exploitation. For example, it has been noted that females may become criminally exploited through initially being groomed into relationships with gang and members of organised crime groups. Similarly in a study examining county lines in Scotland, an example was given of a drug dealer grooming a young girl into a relationship before forcing her to store

illegal items in her home, including drugs and money. Another study noted that some drug dealers sexually exploited girls by forcing them to engage in sexual activity with others, particularly where they had a drug debt. Other accounts from professionals note that girls being criminally exploited are frequently subject to severe sexual threats and assault. These examples highlight the overlap between CCE and CSE. This report is recommended reading for an in-depth and up to date overview of exploitation in Scotland.

As Barnardo's state: "Although victims of CSE and CCE experience abuse and coercion, they are often still blamed and criminalised for their 'behaviour' and 'risky actions', rather than appropriately safeguarded. This is because of a lack of understanding of what exploitation is, its complexities, and the level of control exploiters have over children. When children are criminalised rather than recognised as victims and safeguarded, they can get stuck in the criminal justice system."[li] Panel Members should be mindful of this when supporting older children. They should seek to fully explore any 'risky' or 'criminal' behaviours when there are potential signs of exploitation and look through these behaviours, and back to the potential drivers for them.

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Education

Introduction

Meaningful use of time is often a key factor in the care planning for older children within the Children's Hearings System. This section discusses the legal right to access and the duty to provide education and the options for 16- and 17-year-olds.

Statutory Responsibilities

All children in Scotland have the right to education under Article 28 of the UNCRC, and this should also include the option of technical and vocational training should a child prefer or be better suited to this learning style than academic study.

Children retain this right to education until age 18, even though school attendance is only mandatory until age 16. Though education and training options are more varied post 16, this provision is a statutory obligation.

Relevant provisions of the Education (Scotland) Act 1980:

- S.1(1) states it is "the duty of every education authority to secure that there is made for their area adequate and efficient provision of school education and further education";
- S.1(4) states that "The facilities for further education that may be provided by an education authority shall include facilities for vocational and industrial training";
- S.(1)(5)(a) states "school education" means progressive education appropriate to the requirements of pupils… regard being had to the age, ability and aptitude of such pupils, and includes provision for special educational needs. Further education includes voluntary part-time and full-time courses of instruction for persons over school age and social, cultural and recreative activities and physical education and training, either as voluntary organised activities to promote educational development, or as formal courses leading to a recognised qualification.

Local education authorities therefore have a responsibility to provide education and training through school and beyond, but to do so in a way that meets differing educational needs and preferences.

The Education (Scotland) Act 2016 placed new duties on education authorities to reduce outcome inequalities in relation to school attainment, particularly those due to socio-economic disadvantage. It also introduced the National Improvement Framework (NIF) setting out strategic priorities to achieve this. These resonate with improving outcomes for children in the Children's Hearings System.

Key priorities of the National Improvement Framework:

- Placing the human rights and needs of every child and young person at the centre of education;
- Improvement in children and young people's health and wellbeing;
- Closing the attainment gap between the most and least disadvantaged children and young people;
- Improvement in skills and sustained, positive school-leaver destinations for all young people; and
- Improvement in attainment, particularly in literacy and numeracy.

Trauma, Adversity, and Inequality

Children who have experiences trauma or adversity are impacted in a variety of ways which affect their ability to attain academically. They may have had gaps in education, changes of school/home, have neurological, attachment or mental health issues, as well as continued exposure to trauma and disadvantage. 16- and 17-year-olds may already be living independently, often in temporary accommodation without access to supportive household learning environments. It is no surprise attendance and attainment in education is often negatively impacted in these circumstances.

NIF reporting includes the Annual Participation Measure: the percentage of 16–19-year-olds participating in education, training, or employment. In 2024, 88.4% from the 20% most deprived areas in Scotland were 'participating', of which 65% were in education, compared to 96.6% of the 20% least deprived, of which 81.6% were in education.

Research by the Poverty Alliance showed that in 2018-19 just over 2 in 5 young people living in the most deprived areas in Scotland had achieved one or more Higher upon leaving school (43.5%) compared to almost 4 in 5 young people living in the least deprived areas (79.3%). Year on year the number of children entered for Higher qualifications in the least deprived areas is more than double that of the most deprived and decreases as the level of deprivation rises, with numbers achieving A to C grades also increasing as deprivation levels fall, as reported by the Scottish Qualifications Authority.

Reporting in 2023 shows attainment of at least 1 qualification at SCQF Level 6 (equivalent to a Higher) were as follows:

- Looked after for part of the year – 15.8%;
- Looked after since turning 12 – 16.5%;
- Looked after since turning 5 – 17.4%; and
- All school leavers – 57.9%.

These children need support to access and maintain education or training suited to their needs, wants and capabilities and improve education outcomes, which are positively related to lower unemployment, higher earnings, and better physical and mental health in later life.[lii]

In 2022-2023, 65.6% of care experienced children remained in school after S4 compared to 85.6% of all school leavers. For children to experience school positively we must understand the child's specific needs and circumstances. This involves not exacerbating trauma by using restrictive and punitive consequences that may be humiliating for children, such as seclusion, shouting, or reward-based systems, as reported by the Independent Care Review. As seen children who have experienced trauma or have mental health or neurodiverse conditions may not be able to work to these systems and be further traumatised or stigmatised and avoid school.

Children must not be excluded from education or have their timetable reduced to such that it denies their right to education. Nurturing, supportive, and reciprocal relationships with staff and peers at school can be invaluable for children who experience instability and adversity at home. The child may need increased time with key staff or in smaller groups to promote relationship growth and learning.

Research and statistics for care experienced children provide stark evidence of attainment gaps, however it is important to remember many contributory factors also apply to children who have been looked after at home or in kinship placements.

Following the implementation of the Children (Care and Justice) (Scotland) Act 2024, children may have their first contact with the Children's Hearings System at age 16 or 17, their history unknown. They may possess traits or display behaviours indicative of trauma or adversity, or not, but still retain the same right to education suited to their needs.

Because of difficulties with focus and cognition, negative experiences of school, or due to specific areas of interest, many children leave high school to attend college or other vocational studies. Often these can be incorporated into school timetables (hybrid timetables) allowing them a supportive, gradual transition to further education. This can be positive, but it should not be assumed that this is the best outcome due to lack of attainment: entry into the care system has been seen to improve educational outcomes, though achievements may take longer, with focus on progress (not exclusively attainment) encouraged,[liii] and the educational attainment levels for children leaving care remain significantly lower than their peers.

There are factors which can mitigate the impact of poverty on education such as strong family relationships and supportive parenting, positive social environments within schools, high quality home environments, confidence gained through sports and hobbies, and the desire to earn money.[liv] These are all areas that holistic care planning within the Children's Hearings System can help to address.

Education/Training Opportunities

There are a variety of positive destinations for school leavers including college/university courses, apprenticeships and employment. There are also a number of short-term employability courses available that can give children and young people a taste of what it is like to work in different sectors whilst also building employability skills like confidence, timekeeping, social skills and independent travel, as well practical supports like building a CV and completing job applications and are a good option to prepare children and young people for longer term commitments.

Third sector course providers and provision vary area to area. However, Skills Development Scotland (SDS) are contracted to support children and young people after leaving school. Their Skills Development Scotland Careers Service works within every state high school in Scotland to prepare pupils for life after school and all young people will be allocated an SDS employability worker upon leaving school to support them on their career journey. This is someone the child or young person can always return to, and this should be encouraged as evidence suggests careers education and guidance, tutoring and mentoring positively impact educational outcomes for disadvantaged children and young people.[lv]

Additional Resources

The My World of Work website gives careers information and advice to children in school and beyond to explore strengths, skills and interests; find suitable jobs, modern apprenticeships and industries; and think about further learning and training.

The Young Person's Guarantee's School Leavers Toolkit gives information on practical things they might find useful as they leave school.

The Jobcentre Plus helps people who are unemployed look for jobs and claiming benefits. Jobseekers Allowance eligibility starts at 18, though there can be exceptions. Children approaching 18 and not in employment should link in with their Jobcentre Plus in advance as claims can take a while to process.

16–19-year-olds in education may also be entitled to Education Maintenance Allowance to help with the cost of studying. Financial assistance has been found to be one of the most effective supports to allow disadvantaged children to fully participate in education and further education.[lvi]

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Equality and Diversity

Introduction

Factors such as race, religion, sexuality, gender identity, and others play a key role in shaping children's experiences of the care and justice system in Scotland. It is important for Panel Members to understand the unique challenges faced by children from different backgrounds in order to best respond to their needs. More reading can be found within the CYCJ practice guide.

Race and Ethnicity

Children of Black, Asian and Minority Ethnic (BAME) heritage account for around 5% of the Scottish population. They are very often exposed to discrimination in various forms and Panel Members should be mindful of this when considering how best to support to them. This may or may not have been a factor in the grounds for referral but will almost certainly have been a feature of the child's life. Migration into Scotland may have been a factor in the life of the child too.

Language

In some cases it may be necessary to use an interpreter during a hearing, which can be organised by staff in SCRA. This role is highly skilled and requires Panel Members to carefully consider how they communicate with those present. Avoiding idioms, metaphors and other colloquialisms may be necessary in order to avoid confusion. This guide by Iriss highlights a range of issues that may be helpful for Panel Members to consider.

Supporting Children from Diverse Backgrounds

Panel Members should avoid a 'colour-blind' approach that can result in generic and non-specific support being delivered. Instead, supporting children from BAME heritage requires different approaches, recognising that achieving equity may necessitate diverse strategies.

Sexual Orientation and Gender Identity

LGBTQI+ refers to lesbian, gay, bisexual, transgender, queer, questioning and intersex people, and more (LGBTQI+). A helpful list of terms with descriptions can be found from Stonewall here.

There is limited research to explain why children who are LGBTQI+ come into conflict with the law, leading some academics to describe the LGBTQI+ population as 'invisible'.[lvii] Panel Members will almost certainly have come into contact with children who are LGBTQI+ however may not have been aware of this at the time. Factors including bullying and parental rejection often prompt them to keep their sexual and gender identity private.

For LGBTQI+ children who have come into contact with the Children's Hearings System, it should not be assumed that gender or sexual identity played a role in them doing so; their lives may involve intersecting dynamics of race, ethnicity, religion, (dis)ability, and numerous other factors. Panel Members must exercise caution, refraining from attributing specific circumstances in an individual's life solely to a particular attribute or identity.

Despite the lack of research in this field, certain conceptual frameworks can shed light on their journey through these experiences. Knight and Wilson (2016) introduced the concept of a 'school-to-prison pipeline',[lviii] proposing a sequence wherein tumultuous home environments, disrupted education, and discrimination can collectively propel young individuals away from school. This disruption negatively impacts employment prospects and contributes to mental health challenges. Family discord may force individuals out of their homes, with substance abuse emerging as a coping mechanism, culminating in legal conflicts driven by financial desperation or mental health issues. While not exclusive to the LGBTQI+ community, this narrative appears plausible considering the difficult circumstances faced by many of these young people.

Dennis (2014) argues that this pathway can lead into conflict with the law, emphasising power imbalances between dominant groups, primarily white, cisgender (a person whose gender identity aligns with the sex they were assigned at birth) heterosexual males, and marginalised groups like LGBTQI+ youth.[lix] The heightened surveillance and stricter law enforcement targeting 'deviant' groups foster conflict with the legal system. The ensuing rise in crime is not inherent to an individual's sexual orientation or gender identity but reflects cultural biases embedded in societal structures, organisations, and individuals.

Research has shown that rates of mental ill-health amongst this cohort are particularly high and thus Panel Members should bear this in mind when attending hearings. To better understand the lives of children who are LGBTQI+, the LGBT Youth Scotland resource directory will be of benefit.

Drawing on the work of Knight and Wilson, Gibson summarises key practice principles that could benefit LGBTQI+ children who attend hearings, including:

- Avoid making assumptions about a person's gender or sexuality from their initial presentation or appearance;
- Be aware that, for some people, disclosing their sexuality to a stranger is very difficult;
- Refer to individuals as their self-identified gender, regardless of their appearance or stage of transition;
- In cases of same-sex domestic violence and abuse do not assume that the violence and abuse would be less serious than in heterosexual relationships; and
- Seek to understand LGBTQI+ children's experiences of discrimination and abuse. There is a high probability that they will have experienced incidents that may be linked to their offending behaviour, although this is not always the case.

Further information on gender identity and sexuality in hearings can be found in CHS's Practice and Procedural Manual here.

Risk

Introduction

Risk is an extremely challenging subject, with each person's understanding of it shaped by their own personal, organisational, and cultural values. It is a subjective issue and views on this topic vary widely from person to person. Risk can also be found within various aspects of life including personal risk, financial risk, reputational risk and corporate risk. As a result it is challenging to provide one standard account of what risk is and how it may be addressed. On a basic level however, risk can be understood as the likelihood of an adverse outcome being experienced (i.e. 'he is at risk of injuring himself') or as a way of describing the things that make adverse outcomes more likely (i.e. she is facing multiple risk factors at the moment).

All children face risk on a day to day basis, ranging from short term hazards to life changing – or even life ending – circumstances which are present for extended periods of time. Their status as children makes them both more susceptible to encountering risk and means that they are equipped with fewer material resources to overcome risk. Added to this, the teenage brain is still developing and does not reach full maturity until the mid 20s; this video provides a simple explanation and helps to understand why children engage in risky behaviours. This can lead to adverse outcomes which may result in them coming to a children's hearing, whilst the behaviour of adults may also create adverse outcomes for the child. However, risk should not simply be viewed negatively. Exposure to risk is a natural part of life, and for children it is an opportunity to develop resilience and to reach the various milestones associated with growing maturity and independence, as this video demonstrates. The Promise has also called on Scotland to adopt an approach that is less risk averse, and does not merely focus on the negative outcomes, but considers the negative consequences of making decisions about children that prevent them from enjoying a natural life.

Given the importance of understanding this issue, this chapter seeks to explain the role that risk and risk assessment play in Panel Members' decision-making. More comprehensive information regarding managing risk of harm can be found in this guide from CYCJ, whilst this guide from Iriss highlights the complexities associated with embracing risk.

Risk Assessment

Children coming to a hearing will have had some form of risk assessment included within the hearing papers. The type of assessment used will differ based on the nature of the concern and the level of harm believed to be present.

Many local authorities will adopt the START-AV (Short Term Assessment of Risk and Treatability: Adolescent Version) risk assessment approach when considering the lives of older children. It can be used to provide an assessment of the child's likely involvement in harmful behaviours, risk-taking, exploitation and various other matters. It is an approach which calls on practitioners to draw on knowledge of the child, their family and of wider circumstances, as well as theory and research to come to a professional view as to the risk of harm to and by the child. This has led to an improvement in the quality of assessments which should then influence the decisions made in hearings and the child's plans created. Children who pose a risk of violence to others may be assessed using the SAVRY (Structured Assessment of Violence Risk in Youth) tool. For those who pose a risk of Harmful Sexual Behaviour (regardless of which tool or approach to risk assessment is adopted by practitioners), there are certain measures which should have contributed to their overall assessment, as this resource highlights. Further details regarding the policy framework within which risk practice exists can be found here.

In instances where a child is at risk from others, practitioners will also undertake risk assessments which look at the likelihood of harm being caused, the nature of this harm, the impact that it could have and what protective factors are in place to stop or minimise the harm in question. Signs of Safety is one tool that could be used, but all assessments of children should be informed by the National Practice Model. More information about child protection in Scotland can be found here.

Regardless of the reason for risk assessment taking place, the assessment should explain the following:

- What is the risk?
- How likely is it that this will happen?
- What would be the impact of this adverse outcome occurring?
- How can this risk be reduced?
- What can be done to address the reason the risk is present?

This should lead to a clearer way of understanding the problem and knowing how to overcome the challenges faced by the child. The assessment should also highlight the strengths and protective factors that the child and their caregivers enjoy. These not only point to how adverse outcomes can be avoided, but are likely to be the foundation upon which the child's plan is built. Knowing what strengths and protective factors are present will also play a large role in the discussions amongst Panel Members when considering what decision to reach.

Challenges of Risk Assessment

Balancing the rights of children who are the subject of risk assessment is essential in order to ensure that they are not deprived of their liberty unnecessarily or experience any other unnecessary intrusion. This is of particular importance since the incorporation of the UNCRC into Scots law. An overly cautious approach to risk can mean that those children who have caused the greatest level of harm lose out on opportunities to participate in social activities with friends and family, which can lead to increased risk of harmful behaviours.

Undertaking an assessment of risk is a difficult one. It involves gathering information from multiple sources, determining how accurate or meaningful it is, placing it within the wider context of the child's life and considering what theories and research are relevant to the situation. This video highlights some of the issues that social workers and others face in completing this task, and steps that they take in creating the assessment. Similarly, this NSPCC video provides a summary of signs or indicators of abuse and which would be considered within a risk assessment.

Those undertaking risk assessments, or Panel Members looking to understand their content, should also be mindful of cultural and ethnic diversity which may influence the perceived level of risk and the possible solutions to this issue.

Discussing Risk

Panel Members should expect to have a child's risk assessment explained in clear, simple language which helps the panel come to an understanding of what risks are present, how likely they are to occur, what impact they would have on the child or others, and what steps can be taken to reduce the risk. Ensuring that children and their family have an opportunity to comment on this is essential as there can often be a difference of views on this matter. Holding this conversation requires sensitivity from all involved as the discussion may be upsetting, and indeed many families have

found discussion of risk to be stigmatising and disempowering. As Panel Members, it is also important to reflect on personal attitudes and views of risk and vulnerability, as this blog highlights. This will include considering issues such as domestic violence and its connection to child protection, children who display harmful sexual behaviour and child neglect.

Making Decisions

Panel Members face the difficult task of making decisions about the future of children, many of whom have experienced multiple adversities and risks, a task which often involves consideration of risk. On one hand, Panel Members will consider the risks that children are exposed to and the likelihood of adverse outcomes occurring. They will also be aware of the negative impact that unnecessary contact with social work and other agencies may have, potentially stigmatising the child and disrupting family life. Receiving a clear explanation of the risk assessment – including areas of strengths and protections – will help Panel Members to make decisions leading to more positive outcomes for the child.

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Interventions

Introduction

In deciding how best to meet the needs of a child appearing at a children's hearing, Panel Members will be mindful of the various types and models of interventions that can be used. This section therefore describes some of the approaches used by social work and their partners, and suggests points that should be considered during the panel's deliberations. Interventions can focus on micro level interventions, larger structural and policy based approaches, or both. This video also provides a description of social work theory. More detail on the responses available can be found in two parts of CYCJ's practice guides, here and here.

Which Interventions Work Most Effectively

As has been illustrated by preceding sections, the key to effective interventions is a robust understanding of what drives behaviours and decision-making. They must be informed by a holistic assessment of the child in line with GIRFEC, involving the child and the key people in their lives as far as possible in the assessment and planning. Interventions may need to be timely in certain circumstances, in response to risk or crises, however consideration should always be given as to how to achieve meaningful and lasting positive change.

Interventions must be agreed with (and not done to) a child. There may be occasions when their wishes cannot be fully implemented, but their views must be fully considered and reflected in decision-making. Children in the Children's Hearings System often have multiple complex issues and require a variety of interventions. Care and thought must be given as to how to prioritise these to best effect positive change, which will require patience and acceptance that change takes time, and plans must be individualised. These examples illustrate scenarios that may come to light:

- A 17-year-old using alcohol chaotically and picking up charges whilst living in emergency accommodation likely won't manage a full-time college placement. Support to repair family relationships, promoting a positive sense of self and purpose may be needed before any specific work to reduce alcohol use can begin. Once their home life improves and alcohol use decreases, the stability required to commit to education/training or employment will be more evident.

- A 16-year-old charged with sexual assault for touching a female peer inappropriately will likely require specific offence-focused work on the nature of sexual offences, consent, and healthy relationships. However, if there are doubts over the child's capacity to process information, further assessment on learning ability and speech, language and communication needs is required before this work can be targeted effectively. Key messages can be reinforced whilst doubts over learning ability persist, however a safety plan covering home and school may be required in the short term to protect the child and reduce risk of harm to others.

Movement Restriction Conditions

A Movement Restriction Condition (MRC) can be imposed in a Compulsory Supervision Order when certain criteria is met. At the time of writing, the test for imposing an MRC under s.83 of the Children's Hearings (Scotland) Act 2011 is:

- That this measure is considered to be necessary, and
- One or more of the following conditions apply:
    - That the child has previously absconded and is likely to abscond again and, if the child were to abscond, it is likely that the child's **physical, mental or moral welfare** would be at risk;
    - That the child is likely to **engage in self-harming conduct; and/or**
    - That the child is likely to **cause injury to another person.**

The Children (Care and Justice) (Scotland) Act 2024 will amend this criteria. Following the implementation of the Act in full, the legal test will be:

- That the measure is considered to be necessary, and:
- One or more of the following conditions apply:
    - That the child's **health, safety or development** is at risk; and/or
    - That the child is likely to cause **physical or psychological harm** to another person (which includes causing fear, alarm and distress).

Through the use of an electronic device fitted around the child's ankle, an MRC can place a legal requirement for the child to remain within a particular location for up to 12 hours each day, for up to seven days each week. There is an option to use an MRC more flexibly, such as requiring the child to remain within the home only on specific days, or for shorter time periods.

In deciding which days and times to impose the MRC, the panel should consider how best this restriction will respond to the needs, risks and vulnerabilities of the child. The decision to impose – or not impose – an MRC will therefore be closely related to the risk assessment that is undertaken and which should inform the discussion at the hearing. Panel Members should also be cautious about over-imposing an MRC due to the restriction that this imposes on a child's liberty and thus infringes on their rights. An MRC can also be a stressful experience for the child and those they live with, so consideration of the impact an MRC has on the entire household is important. This report suggests a range of scenarios where an MRC may be suitable.

Further information on Movement Restriction Conditions can be found in the Children's Hearings Scotland Practice and Procedure Manual here.

Secure Care

A secure accommodation authorisation can be imposed in a Compulsory Supervision Order when certain criteria is met. At the time of writing, the test for imposing a secure accommodation authorisation under s.83 of the Children's Hearings (Scotland) Act 2011 is:

- That, having considered the other options available (including a movement restriction condition), this measure is considered to be necessary; and
- One or more of the following conditions apply:
    - That the child has previously absconded and is likely to abscond again and, if the child were to abscond, it is likely that the child's **physical, mental or moral welfare** would be at risk;
    - That the child is likely to **engage in self-harming conduct**; and/or

- That the child is likely to cause **injury** to another person.

The Children (Care and Justice) (Scotland) Act 2024 will amend this criteria. Following the implementation of the Act in full, the legal test will be:

- That, having considered the other options available (including a movement restriction condition), this measure is considered to be necessary; and:
- One or more of the following conditions apply:
  - That:
    - The child has previously absconded and is likely to abscond again unless the child is kept in secure accommodation, and
    - If the child were to abscond, it is likely that the child's **health, safety or development** would be at risk,
  - That the child is likely to engage in self-harming conduct, unless the child is kept in secure accommodation, and/or
  - That the child is likely to cause **physical or psychological harm** to another person unless the child is kept in secure accommodation.

As is currently the position, in addition to the measure requiring the child to remain in a secure accommodation establishment, the hearing must also include details of a non-secure establishment in which the child may reside. If the secure accommodation estate also includes an open residential section, this will need to be stipulated in the Compulsory Supervision Order.

If a child meets the secure care criteria, then the hearing may decide to give the local authority authorisation to place the child within secure care. Secure care is a locked children's house with care staff present all day and education provided on site. Children are unable to leave the accommodation without permission of the staff and visits from family and friends can be restricted. It is therefore a setting which deprives children of their liberty and Panel Members should be mindful of the impact that the use of secure care may have upon a child.

Whilst staying in secure care a number of interventions or support can be put in place. In addition to education, the child can be offered supports such as counselling, various psychological therapies, prosocial modelling and other approaches. Discussion of what these interventions will entail should take place at the hearing so that the panel can be assured that the child's plan incorporates all the supports that are needed in order to respond to the risks, needs and vulnerabilities of the child.

Panel Members should also make themselves familiar with the Secure Care Pathways and Standards which points out what a child can expect before, during and after a period of care within secure.

Being removed from their home and placed in secure accommodation can be very difficult on a child and their family relationships. Cyrenians run a project, 'Keeping Families Together', which supports young people aged 12+ in secure accommodation and their families at the point of admission, and those who are in the process of returning home. One-to-one support from skilled mediators is provided, as well as practical support for each family member, and conflict resolution workshops to help build positive relationships, promote better communication, and reduce the potential for future conflict and its further consequences. Further information can be found here.

Further information on Secure Care can be found in the Children's Hearings Scotland Practice and Procedure Manual here.

Intensive Support

When there are significant risks and concerns surrounding a child, there may be a need to put in place intensive plans, involving a degree of supports and supervision that exceed those normally provided through a CSO and child's plan. These supports should reflect the risks, needs and vulnerabilities highlighted within a risk assessment.

Intensive support could consist of more frequent contact with the child, involvement of specialist services addressing a particularly unique feature of the child's life, or provision of mentoring services during evenings and weekends. In some instances this could include MRCs or the provision of residential care. This will often involve the adults supporting the child meeting on a regular basis (perhaps under the auspices of CARM) to review the child's plan and to respond to any new developments.

More details regarding supports to avoid the use of secure care and custody can be found here.

Risk Management

Risk management strategies should guide the work of those supporting children who pose – and are exposed to – the highest levels of risk. This is essential in those scenarios that result in secure care, MRCs and intensive supports being put in place, but risk management strategies can also be utilised in others too. Although they may have a different name in each local authority, each operates a system that is informed by Care and Risk Management processes.

The Children's Hearings System will seek to create a shared understanding of the risks that children experience and identify what steps can be taken to lower the likelihood of an adverse outcome. This will require regular review and will provide opportunities for child's plans to be adapted as and when required.

Risk management is not an intervention in itself, but rather is associated with the coordination of various interventions and strategies. It may also lead to decisions being made to limit or restrict a child's liberty. More information about risk management can be found in this guide from CYCJ.

Restorative Justice

Some areas of Scotland offer Restorative Justice (RJ) services to children who have caused harm to others. Restorative justice is defined by the Scottish Government as: "a process of independent, facilitated contact, which supports constructive dialogue between a victim and a person who has harmed (whether this be an adult, a child, a young person or a representative of a corporate or other body) arising from an offence or alleged offence." RJ practices can take various forms, such as victim-offender conferences, circles, and community conferences. These approaches are often applied in schools or can take place within the community. RJ seeks to provide the person who has caused harm the opportunity to hear from the person who has been harmed, and for both parties to engage in discussions that might repair and rebuild damaged relationships. It allows the person who has been harmed to explain the impact on their life, potentially achieving a sense of closure. For those who have harmed, it personalises the impact of their actions, prompting them to take responsibility, aiming to reduce the likelihood of repeated harmful behaviour.

The Scottish Government's Guidance for the Delivery of Restorative Justice in Scotland offers an overview and key RJ principles, as well as a guide to the process, including suitability assessment. It highlights that whilst in theory RJ can be used for any behaviours, use in cases where there has been a deliberate course of harmful conduct or coercion over time, such as in cases involving domestic abuse, sexually harmful behaviour, or exploitation is not generally promoted.

Research has shown that this approach is more effective than punitive responses. It highlights that whilst use is prevalent for dealing with lower tariff behaviours, research shows it to be more helpful for those harmed by more serious offences, with reduced post-traumatic stress symptoms and fear of further harm experienced by those who have been harmed.

A key suitability requirement is for the person who has caused the harm to express some level of accountability for their actions, either through full acknowledgement of the harm caused, expression of remorse or guilt, and/or a willingness to address/repair the harm caused. RJ must be mediated by an independent facilitator trained in RJ practice. Both parties must be willing participants and the facilitator must carry out a risk assessment prior to the process to reduce the risk of further harm and to ensure both parties understand expectations and potential impacts. Individuals trained in RJ may work for a RJ service or within organisations such as the police, education, social work or the third sector.

More information can be found in this video or this guide from CYCJ.

Asset-Based Approaches

Asset-based approaches to practice and intervention are akin to strengths-based practice. They focus on harnessing the positive skills, attributes and resources people have, essentially what they can do, as opposed to what they can't do, which is more akin to traditional deficit-based approaches.

The approach for individuals who lack things we all need to thrive, such as nurture, purpose, or a comfortable and safe home, and the interventions to meet these needs must be carefully considered. Interventions that are viewed through a deficiency lens can result in negative stereotyping and view of self for the individual, creating further oppression and feelings of hopelessness. This is apparent when children and young people are labelled as 'not in education', disadvantaged, homeless, or as a 'youth offender'. These labels serve to place responsibility on the individual for their situation and can result in interventions being done to the child to 'fix' the problem with professional expertise and resources rather than building on individual strengths and optimising potential.

Asset based interventions which build on children's strengths and evolving capacities are aligned with participation and rights-based practice, and the holistic nature of GIRFEC. Getting to know the child is key to identifying strengths. Whilst this will be difficult for Panel Members in the limited time with the child, there will be time to ask the child and those who know them best about their strengths and explore ways to harness them. Finding out what they are good at and what qualities others value in them and why will be key to planning successful interventions and solutions.

Commonly, asset-based work involves families and communities, promoted in the Promise as one of the ten family support principles.

Family Interventions

Often children's behaviours reflect experiences of their wider environment which, though nearing adulthood, 16- and 17-year-olds often retain little control over, due to not yet being versed with the full functioning and reasoning of the adult

brain, nor having economic autonomy and/or independence from adults. As with younger children, interventions often need to be 'whole family', or 'whole support network', and involve those closest to and with responsibility and love for the child, statutory or otherwise.

As the Scottish Government's Staying Put guidance highlighted, even if a child leaves home, they continue to require support, care and guidance into adulthood and family work should still be considered where safe and appropriate if a child is aged 16-17. Families with experience of the Children's Hearings System are often in need of more support than others, and work on repairing relationships, supporting children and their parents/carers to better understand each other, mediation, emotional literacy, and developing and strengthening parenting capacities will still be beneficial at this age. It may be pivotal for children who have been on the edges of care and are not entitled to continuing and aftercare support under the Children and Young People (Scotland) Act 2014.

It may involve wider family and should be considered where there is a sense of fractured relationships or family breakdown. Children who have been cared for outwith the home may also be reconnecting with family at this age and require support in navigating these and learning expectations and limitations of parents, and vice versa. Consideration should be given as to who is best placed to carry out this work, based on the views of the child and quality of existing therapeutic relationships. Some areas will have specific family support services or specific programmes/interventions, such as Family Group Decision Making or Functional Family Therapy.

Children's Rights & Participation

Introduction

Rights govern all areas of life and is referenced throughout this training. This section provides an overview of children's rights, rights legislation in Scotland, guidance on upholding children's rights, and where to seek guidance/signpost children if their rights are not being upheld.

Human Rights Definition

As defined by UNICEF, "Human rights are standards that recognize and protect the dignity of all human beings. Human rights govern how individual human beings live in society and with each other, as well as their relationship with the State and the obligations that the State have towards them."

As stated by the Office of the High Commissioner of Human Rights, there are four key concepts relating to human rights. All human rights are:

- **Universal**: Everyone is equally entitled to all human rights.
- **Inalienable**: Human rights cannot be taken away. There are some exceptions, but these are very specific and must follow due process.
- **Indivisible**: Human rights cannot be separated from one another or placed in order of importance: they are all essential and should have equal consideration.
- **Interdependent**: Rights depend on each other to be realised, often one cannot be enjoyed fully without the others.

Children's Rights as Human Rights

Children hold universal human rights but also child specific rights, in recognition that their needs differ from adults. Whilst children's rights are therefore defined separately in law, they complement and expand upon children's basic human rights.

Legislation

Rights are defined in national and international law, with key rights instruments detailed below.

Universal Declaration of Human Rights

The Universal Declaration of Human Rights (UDHR), adopted by the United Nations in 1948, was the first international human rights legislation, the fundamentals of which all future legislation has been built upon. It recognised under Article 25 that childhood is a period requiring special care and that all children must have equal social protections.

European Convention on Human Rights (ECHR)

Introduced in 1953 and since amended and supplemented by various protocols, the European Convention on Human Rights is a regional commitment to and expansion of the UDHR principles.

Key articles for consideration by Panel Members when making decisions about 16- and 17-year-olds are as follows.

Article 5: Right to liberty and security:

"Everyone has the right to liberty and security of person." One exception is noted in relation to children: "in relation to minors: no unlawful detention of a minor except for lawful order for the purpose of educational supervision or for the purpose of bringing him before the competent legal authority." The basic right to liberty should be a paramount consideration when there is mention of depriving a child of any aspect of their liberty, including measures limiting where they can go or communicate with (as will be introduced by the new prohibitions included in the Children (Care and Justice) (Scotland) Act 2024), movement restriction conditions, and secure care.

Article 8: Right to respect for private and family life:

"Everyone has the right to respect for his private and family life, his home, and his correspondence." Public authorities should not interfere with this except for in stated circumstances, which include for the prevention of crime, protection of health, and the protection of the rights of others.

Older children in the Children's Hearings System may have had restrictions on time spent with their family, but regardless of the motives for this, they are entitled to family time if they wish. It is important to remember that when they turn 18, they will have full autonomy in decision-making, if they don't already in this regard. Supporting them to seek and manage time with family and the joys and disappointments this may bring should be a consideration of the hearing, to best support children to manage key relationships into adulthood.

Article 10: Right to freedom of expression:

"Everyone has the right to freedom of expression." This covers the freedom to hold opinions and to both receive and impart information and ideas without unnecessary state intervention. Public authorities should not interfere with this right unless such interferences are prescribed by law and necessary.

This relates closely to a child's participation in a hearing, which is covered below.

Article 13: Right to effective remedy:

"Everyone whose rights… are violated shall have an effective remedy". This must be a consideration when supporting children whose rights have been violated. Supports are covered below, though see the Interpersonal Violence section of this guide in relation to those who may have been harmed by children in the Children's Hearings System.

Human Rights Act 1998

This incorporates the ECHR into UK law, giving legal recourse to victims (or would be victims) of having their rights infringed unjustifiably.

United Nations Convention on the Rights of the Child (UNCRC) and the UNCRC (Incorporation) (Scotland) Act 2024

The United Nations Convention on the Rights of the Child is an international rights treaty that sets out the civil, political, economic, social, and cultural rights of every child under the age of 18. There are 54 articles, the first 42 holding practical significance for children, the remaining 12 procedural. The Children and Young People's Commissioner Scotland (CYPCS), who is responsible for promoting and enforcing children's rights in Scotland, has produced the following resources on the UNCRC: UNCRC Simplified Articles (a child-friendly version of the UNCRC) and a summary of the UNCRC available on the UNICEF UK website.

The UNCRC is binding under international law and carries an obligation for governments to ensure its full implementation. It was recently incorporated into Scot's law under the UNCRC (Incorporation)(Scotland) Act 2024 affirming the legal obligation of the Scottish Government to give effect to the UNCRC and setting out related provisions to ensure compliance.

The UN Committee on the Rights of the Child (CRC) monitors UNCRC implementation and issues guidance to assist states to meet certain rights. The UK was last reviewed in 2023. The resultant UK Concluding Observations 2023 expressed concern that the age of criminal responsibility remains lower than the recommended minimum of age 14 throughout the UK (currently 12 in Scotland and 10 in England, Wales and Northern Ireland). Concerns were also raised that 16- and 17-year-olds are not always treated as children within the justice system, whilst being clear that no child should be prosecuted in the adult justice system. The Children (Care and Justice) (Scotland) Act 2024 goes some way to rectifying this by redefining the term 'child' to all persons under the age of 18 in a number of contexts. This does not mean that children will never be prosecuted in the criminal justice system, but aims to reduce the number of children prosecuted by providing age-appropriate alternatives, like the Children's Hearings System.

The CRC also issues guidance on specific children's rights/issues, known as General Comments, including the implementation of rights during adolescence, children's rights in relation to the digital environment, and rights in the child justice system, which is discussed below.

General Principles and the Children in the Justice System

From the UNCRC, four "General Principles" have been highlighted as key to interpreting all other articles and as playing a fundamental role in realising all the rights in the UNCRC for all children. These are:

- Non-discrimination (Article 2);
- The best interests of the child (Article 3);
- The right to life, survival, and development (Article 6); and
- The right to be heard (Article 12).

Non-discrimination, Article 2:

All children in conflict with the law should be given equality of opportunity, which they may require additional support for, such as with communication, emotional regulation, or mental health. They must not face discrimination in relation to accessing education or a safe place to live.

Best interests of the child, Article 3:

The best interests of the child must be at the heart of all decisions relating to all children involved with the justice system. A rights-based approach recognises that children differ from adults in their physical and psychological development, and their emotional and educational needs. This underpins the basis for the lesser culpability of children and means that to protect their best interests, rehabilitation must be prioritised when supporting children who come into conflict with the law.

The right to life, survival, and development, Article 6:

Contact with the justice system can have a detrimental impact on child development. Detaining children can have extremely negative consequences and seriously hamper a child's reintegration into society. The justice system should support children's optimum development at every point. Panel Members have significant oversight here, reviewing assessments and care plans with a rights respecting lens allowing an additional layer of safeguarding and scrutiny to ensure this right is protected.

The right to be heard, Article 12:

This gives children the right to express their views, feelings and wishes freely in all matters affecting them and to have them considered and taken seriously. This won't always mean their wishes are granted, but they should be respected and actively considered in accordance with their age and maturity, essentially their 'evolving capacities', which will be discussed in detail below. This right applies throughout legal processes and involvement with the Children's Hearings System.

Participation and the Right to be Heard

Article 12 is known as the right to participation. Children should feel supported, as well as able, to express their views openly and participate in decisions affecting them, possessing the knowledge required to make informed decisions, including the likely consequences of each outcome.

General Comment No.12 (2009) The right of the child to be heard acknowledges the concept of "participation" having emerged from practice implementing Article 12, defining it as "widely used to describe ongoing processes, which include information-sharing and dialogue between children and adults based on mutual respect, and in which children can learn how their views and those of adults are taken into account and shape the outcome of such processes".

Participation takes many forms, such as one-to-one conversations, group work and feeding into consultations like the Independent Care Review. Participation is successful when young people's views are given weight and influence decision-making. As a concept, it is much wider than children simply providing their views: if done well it is an ongoing process which allows children to use their voice and experiences to shape systems and processes that affect them, truly influencing change.

Some basic guidance and ways to attain views, project voice and participation is highlighted below.

7 Golden Rules of Participation

The Children and Young People's Commissioner Scotland has, along with children, produced the 7 Golden Rules of Participation, designed to help those working with children to support them to understand, experience and exercise their participation rights. Versions are available using the above link for children, young people, and those with speech and language difficulties or additional support needs.

The 7 Golden Rules of Participation and some key principles are provided below, which is particularly helpful for Panel Members when engaging with children. Reading the full document via the above link is also recommended:

1. Understand my rights: Children want information about all their rights under the UNCRC and want adults to be aware of these too and the importance of listening to them.

2. A chance to be involved: A key point here is that children want honesty, they don't want to be asked their opinion if it won't make a difference. They also want to feel welcomed.

3. Remember it's my choice: Children need to easily understand what is expected of them and what the outcomes could be, and to participate in a way that's right for them. They also have the right to choose not to participate.

4. Value me: Children should be involved from the start, listened to and taken seriously, and given an explanation if their views do not lead to the changes they ask for.

5. Support me: Adults should keep going until they find a way to communicate with children that they understand, and check that they do, rather than assume.

6. Work together: Respect and learning from each other is important – disagreement is OK, but time should be made to talk to children about this.

7. Keep in touch: Decisions should be provided to children, with an explanation of why they have been made. Children should have a chance to ask questions, either at the time or at a later date, and need to know how to do this.

Lundy's Model of Participation

The Lundy Model of Participation is based on the premise that children already have a voice, however adults must create spaces and opportunities where these can be heard by those who have the power to use them to influence change. The four tenets of this model are:

- Space: Children must be given safe, inclusive opportunities to form and express views.
- Voice: Children must be facilitated to express their view.
- Audience: Children's views must be listened to.
- Influence: Children's views must be taken seriously and acted upon, where appropriate. If the view cannot be acted upon, this must be explained to them.

Panel Members have scope to fulfil all aspects of this model during hearings, with further reading available in the full reference and CYCJ's Participation chapter to guide this.

Participating in the Children's Hearings System

General Comment 12 expands upon what states must do to promote Article 12: reinforcing that as one of the UNCRC general principles it should be considered in interpretation and implementation of all other rights. In hearings, consideration must be given to ensuring the environment is such that the child is able to express views freely and participate in proceedings.

Children's hearings can be daunting, unpredictable, worrying environments for children. The Independent Care Review highlighted the power imbalances felt by children and families against the views of professionals, children being asked their views in a situation that can feel unfamiliar and punitive.

Panel Members should endeavour to make hearings feel as inclusive as possible for children, informed by the CHS Children's Participation and Rights Strategy. Basic good communication skills such as smiling, using open body language, being friendly and welcoming should not be overlooked. 16- and 17-year-olds may have been to hearings before and understand that they can have serious consequences. Clear, direct communication is crucial. Let them know why they are there, what the purpose of the hearing is, possible outcomes, and how the outcome will be decided, with reference to how their views can influence this. This allows the child to decide how much they will participate. Information must be given in a way they understand, so take time to ask if there is any information they wish re-explained or provided in a different way.

The Independent Care Review found that children can feel their views are dismissed in hearings. If a child's views cannot be fully implemented then Panel Members should explain in their decision-making why this is, as well as explaining what can be done to work towards these views and highlighting how the child's views did impact decision-making.

All children in the Children's Hearings System are entitled to advocacy under the Children's Hearings (Scotland) Act 2011. Hearings Advocacy covers everything children need to know about advocacy and their rights, a useful resource for Panel Members. Not all children choose to express their views, but all should be aware they can provide them through an advocacy worker, trusted person, or in writing.

Further information on advocacy in the Children's Hearings System can be accessed in CHS's Practice and Procedure Manual here.

Scotland's Promise that all children will grow up loved, safe and respected, has the foundation of voice at its heart, stating decision-making must be based on what the child needs and wants, with active listening and engagement fundamental to the way Scotland supports children and families.

Children's rights in juvenile justice, Article 40

This requires states to develop and promote separate systems for children accused of or found to have broken the law. It includes a requirement to establish specialised laws and policies, as well as authorities and institutions for children different to those designed for adults, with the Children's Hearings System fulfilling a large part of this function. It requires that states establish a minimum age of criminal responsibility, and measures to divert children from formal

judicial processes. Importantly it sets out the right for children in contact with the justice system to be treated in a way that is "consistent with the child's sense of dignity and worth". All aspects of the child justice system must consider the child's age, promote their reintegration, and support them to assume a constructive role in society. This requires all those involved, including Panel Members, to be knowledgeable on child development and promoting child wellbeing.

General Comment No. 24: Children's rights in the justice system provides further guidance. Published in 2019, it reflects new knowledge on child and adolescent brain development (see Brain Development section), and evidence of effective practices including restorative justice (see Interventions section). The overriding focus is on diverting children away from formal justice processes, which in Scotland covers Early and Effective Interventions and Diversion from Prosecution (see Interpersonal Violence section), as-well as involvement with the Children's Hearings System. It also specifies that "The child has the right to remain silent and no adverse inference should be drawn when children elect not to make statements", which must also be respected during hearings.

The Promise was clear that children should have "the totality of their cases dealt with in an environment that upholds their rights and allows them to effectively participate in proceedings". The Children's Hearings System can provide this environment, favoured by the Promise over criminal courts for supporting children in conflict with the law, advising that even when cases are tried at criminal courts the vast majority should be concluded within the Children's Hearings System. As noted in the UNCRC, quoted from the Declaration of the Rights of the Child, "the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection".

Sliding Scale of Autonomy for Children

Whist children learn to exercise their rights on their journey to becoming an adult, laws place restrictions on what they can do at certain ages. This is designed to protect them from exploitation, keep them safe, and allow adults to make some important decisions as they develop this capacity.

Young Scot provide a comprehensive list of rights and entitlements of children of different ages: What Can You Do at What Age?, some of which are as follows:

At age 12 you can:

- Be found guilty of a criminal offence (12 is the current age of criminal responsibility in Scotland);
- Consult a solicitor and take a case to court; and
- Access your personal records.

At age 16 you can:

- Consent to lawful sexual intercourse;
- Get married or enter into a civil partnership;
- Leave home without parent/guardians' consent;
- Leave school;
- Work full time and pay National Insurance;
- Change your name without parental consent; and
- Vote in Scottish Parliament and local council elections.

At age 17 you can:

- Give blood; and
- Hold a licence to drive a car or small motorbike.

At age 18 you can:

- Vote in General and European Parliament elections;
- Buy alcohol and drink alcohol in a bar;
- Buy nicotine products; and
- Make an application for a Gender Recognition Certificate.

When considering a 16- or 17-year-old from a social work perspective, this sliding scale of autonomy approach can be complex. 16- and 17-year-olds may be covered by both Adult Support and Protection legislation as well as Child Protection guidance. Practice can vary across local authorities, and at times, even within local authorities when governed by different decision-making processes, as detailed in Iriss' Understanding age in Child Protection guidance and Adult Support and Protection legislation Report.

Achieving Children's Rights, Article 5, Parental Guidance and Evolving Capacities

Children have evolving capacities as they transition through adolescence into adulthood. As such, Article 5 of the UNCRC recognises that adults must provide children with appropriate direction and guidance to exercise their rights, in line with these evolving capacities.

Parent Club, a Scottish Government website for parents, provides guidance on a variety of issues, with sections on Raising a Teenager and Children's Rights advising how parents can promote them.

When rights appear to clash, the overriding consideration must be the best interests of the child. Article 3 of the UNCRC dictating that in all actions concerning children "the best interests of the child shall be a primary consideration".

Examples:

(a) Parental actions under Article 5 may interfere with a child's right to privacy, Article 16, when a parent checks content on a child's phone, worried their child is placing themselves at risk online.

(b) Restrictions placed on a child's free time by residential care staff may interfere with Article 15, freedom of association, which affords them the right to meet with other children and join groups.

(c) A Social Worker may propose imposing a movement restriction condition on a 16-year-old to stop them going to a friend's house where they have consumed drugs with an adult peer group.

Panel Members must make decisions when conflicting views are presented, fully exploring individual views and circumstances to establish what options are available which promote the child's interests, alongside other rights. What is best for the child in the above examples will depend on other factors. Whilst under Article 5, parents/guardians must

provide the child with appropriate guidance, "This must be done in a way that recognises the child's increasing capacity to make their own choices."

At 18 children become fully autonomous adults. As such 16- and 17-year-olds need appropriate autonomy to learn from experiences how to make the best decisions possible when they turn 18. Looking at the above examples, those responsible for children may claim restrictions are in their 'best interests', but Panel Members must evaluate whether they also fulfil the functions of Article 5. This will depend on the rest of the child's care plan.

Examples:

- *Checking a child's phone and then providing education and guidance round the legal implications of abusive messages, or the dangers on messaging profiles on social media, is appropriate. Simply reading messages and blocking certain content invades privacy and does not assist with developing capacity to keep oneself safe.*

- *Stopping a 17-year-old going out late at night and forbidding them to meet certain friends because they have been staying out much later than curfew and in trouble with Police might be a useful short term safety measure, providing time for reflection, but longer term is disproportionate to age, and without being part of a wider intervention provides little scope for promoting a child's increasing autonomy. Increasing time out incrementally and promoting good communication, providing alternate use of time and education and reflective work around the implications of coming to the attention of the Police offers a more holistic, purposeful, and age-appropriate plan.*

- *Movement restriction conditions should only ever be a last resort and as part of a wider intensive support package which is designed to safeguard and promote behavioural change. Intensive support should be attempted before any restrictions are placed on a child's liberty.*

Taking Action

Children and Young People's Commissioner Scotland works to protect children's rights and make sure they are upheld, challenging the Government if they think a child's rights has been breached.

Citizens Advice Scotland provides free advice on various issues.

Together Scotland is an alliance of Scottish children's charities that works to improve the awareness, understanding and implementation of the UNCRC.

See CYCJ's Practice Guide chapter Child and Human Rights, Our Responsibilities for further information and resources, including Rights Respecting? Scotland's approach to children in conflict with the law.

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