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CHILDHOOD ADVERSITY

Outcomes, Risks & Resilience

Access Evidence is a series of evidence reviews for front line practitioners working with children and young people.

Produced by CES

ACCESS EVIDENCE

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Introduction

Few topics can provoke as strong and emotive a response as the unfortunate, negative experiences that can happen to a child. The issue of adversity features regularly in literature, sociology, political discourse and in the media. The impact of adverse events on children and the understanding of *how* adversity happens has been a very influential area of work in psychology and health, and has generated a major body of research and theory. This report reviews the evidence and research on adversity in childhood, and considers some implications for front line practitioners who work with children and young people.

The report is the first in the AcCESs Evidence series produced by the Centre for Effective Services (CES), which aims to produce evidence-informed resources to support front line practitioners working with children, young people and families. This resource has been co-produced with front line practitioners, who have been involved in both the design and production phases.

The AcCESs Evidence series of evidence reviews aims to contribute to the creation of a common understanding and a common language for practitioners across a range of services.

How this report is structured

This report begins with an overview of what is meant by adversity, and describes different types of adversity. It then looks at how single and multiple adverse experiences affect children differently; it examines the consequences of adversity and it considers how adverse events affect children throughout their lives. Some key facts and figures on different types of adversity are included. The report discusses the concept of resilience and considers how it can be promoted among children. While adversity may be caused by external structural factors that pose considerable challenges from a policy perspective (e.g. poverty), practitioners have a key role to play in promoting resilience.

As it is challenging to make generalisations about different forms of adversity, the report focuses on three different examples in some detail. These examples are featured in this report as 'Spotlights'. A short glossary of terms is included at the end of the report.

This report contains a rapid review of the literature in the area of childhood adversity and how it affects children during their lives. It does not claim to be a systematic review or an exhaustive account, or indeed a review that covers all of the types of adversities that children, young people and families may experience. As this is an area of the literature that is both incredibly expansive and diverse, the report focuses on existing summaries,[1] large-scale longitudinal studies and a smaller number of individual studies, where relevant.

The appendices to the report include helpful frameworks, assessments, online resources and evidence-based and evidence-informed programmes which may be of interest to practitioners working with families, children and young people facing some form of adversity.

Who should read this report?

The report presents some of the key messages emerging from research and relevant messages for practitioners working with children, young people and families. These practitioners include youth

[1] For example, systematic reviews, meta-analyses and literature reviews

workers, teachers, Gardaí, social workers, psychologists, general practitioners (GPs) and other professionals.

What do we mean by adversity?

Adversity may be defined as a lack of positive circumstances or opportunities, which may be brought about partially by physical, mental or social losses, or by experiencing deprivation or distress.[2] Adversity in childhood can be categorised in a number of different ways. These may include the length of time involved, the severity of the adverse circumstances, whether single or multiple events occur, the length of time elapsing from the occurrence of adversity to the presumed outcome, and the methodology used to establish how often adversity has occurred. In turn, different types of adversity have very different types of consequences. Moreover, the same adversity can express itself very differently in terms of effects on social or economic outcomes and circumstances.

An important distinction can be made between **structural adversity** which involves a relatively static condition that persists for a long time (such as several years in childhood) and more **transient events** that involve a relatively short interval. The experience of poverty in childhood is an example of an important structural influence that has been reported as a having profound effect on children's ability to learn, and on their academic achievement. However, it is important to note that while this is a helpful distinction in certain respects, it may mask conditions such as having a parent in prison, which is neither a structural adversity not a transient one.

Different types of adverse events may have different consequences for children. Transient events may vary greatly in their severity, and extreme events may even result in post-traumatic stress (PTSD). Minor adverse events are sometimes referred to in the literature as 'hassles'.[3] While minor 'hassles' may not have a huge impact on later outcomes, there is evidence from the study of everyday life of adults that they may have a major impact on quality of life. For example, a study of the experiences of teachers at the beginning of their careers showed that a series of small, negative events resulted in less occupational satisfaction.[4]

There is a difference between adverse events that are under the control of a relevant adult and events that happen accidentally, or for which no human agent can be identified. In the case of abuse, the perpetrator of the abuse can be identified; by contrast, for many illnesses, no human agent can be easily identified. No simple generalisations can be made about which kind of event causes the most serious consequences. However, the victim's perception of the perpetrator of abuse is a considerable influence on subsequent well-being.[5] This is an example of what is known in psychology as 'the pattern of attribution'.

This rapid review of the literature is concerned with two main aspects of adversity:

1. Experiences that have the most lasting and negative consequences
2. Adversities that are most frequently found in family settings.

[2] Hildon, Smith, Netuveli and Blane (2008)
[3] Kanner, Coyne, Schaefer and Lazarus (1981)
[4] Kitching, Morgan and O'Leary (2009)
[5] Shors (2006)

The literature reviewed indicates that adverse events in childhood can be categorised under the following eight broad headings:[6]

- Poverty and debt
- Child abuse and neglect (including physical, psychological and sexual abuse)
- Family violence
- Parental illness and disability
- Parental substance misuse
- Parental mental health issues
- Family separation or bereavement
- Offending and anti-social behaviour.

How are services for children, young people and families experiencing adversity organised?

Before outlining some of the important research in the area of adversity in childhood, it is helpful to consider how relevant services are organised. In the 1990s, in the UK, Pauline Hardiker and her colleagues developed a model to facilitate understanding of the different levels of need in a population of children.[7] This model is now widely used and has served as a planning framework for services by governments in both Ireland and the UK. The model outlines four levels of intervention:[8]

- **Level 1:** This refers to what are deemed universal, population-level services such as education and health services. It can also refer to additional services made available at the population level in disadvantaged communities, such as intensive early childhood care and education and youth work services. Practitioners at this level may include those working in early childhood care and education, ante-natal support services, primary and secondary education, public health nursing, as well as GP and youth development settings.

- **Level 2:** This refers to services for children with some additional needs. Individual children and families usually access these services through referral. Practitioners working at this level may include those involved in services such as family resource centres and home visiting programmes.

- **Level 3:** This level refers to supports for individual children or families who have serious or chronic difficulties. Support is usually provided through a complex constellation of services, and State intervention is common. Practitioners working at this level may include those working in services such as child welfare and protection, mental health, youth justice and targeted youth work.

- **Level 4:** This level represents the most intensive type of services that intervene when a family has broken down and the child may be taken into State care. Practitioners working at this level may include those working in services such as child welfare and protection, inpatient mental health settings, custodial youth justice settings and residential settings.

[6] Davidson et al (2012); Spratt (2011)
[7] Hardiker, Exton and Barker (1991a); Hardiker, Exton and Barker (1991b)
[8] Owens (2010)

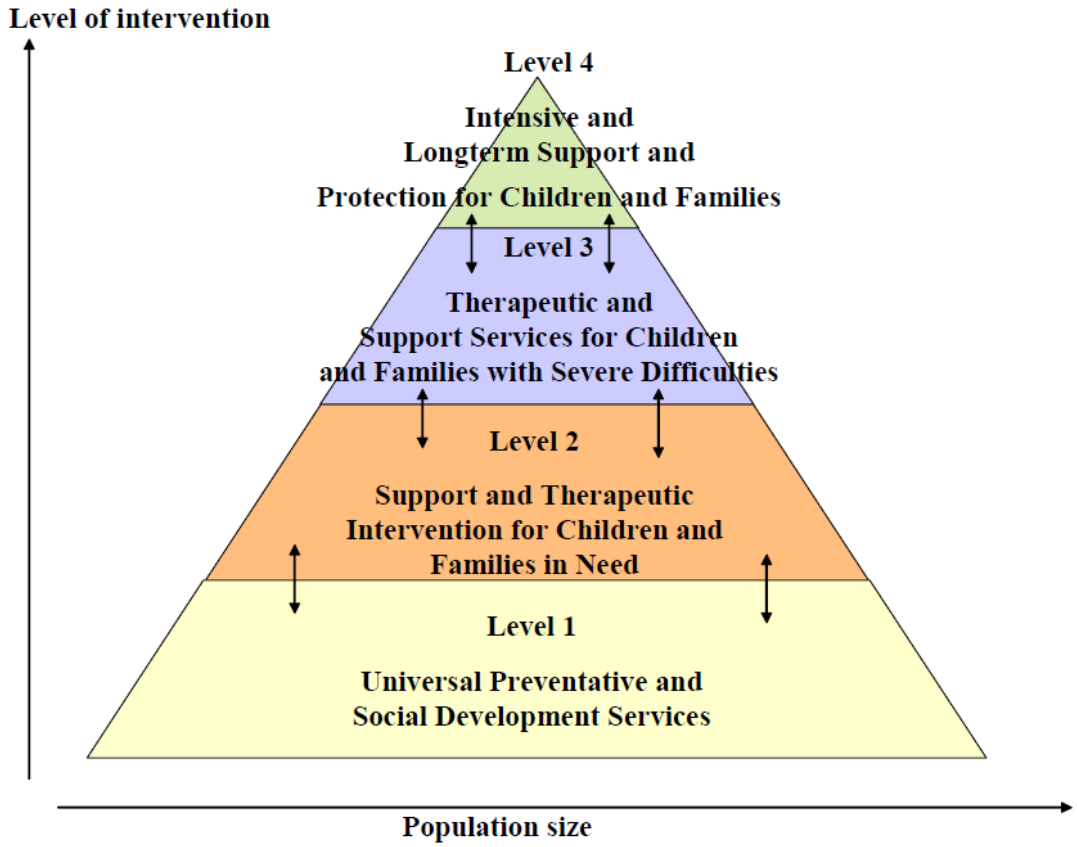

Figure 1. Hardiker Model (Source: Hardiker et al, 1991)

It is widely acknowledged that early intervention (either early in the problem, or early in the developmental life course) at Levels 1 and 2, through the provision of basic care such as early years services, produces positive outcomes, and may obviate the need to seek specialist services at a later date. The aim of the higher levels of support (Levels 3 and 4) is to change the family circumstances positively, so that the family can once again be supported by Level 1 services (and therefore no longer needs specialist services) alongside the mainstream population.[9]

The Hardiker Model can be extended to engage in partnership working with other statutory agencies, and with the voluntary and community sector, to locate their services along this continuum. Review of research on the topic of adversity should be conducted with this model in mind, and the importance of a prevention and early intervention approach to issues in the lives of children, young people, and their families, should be borne in mind at all times.

[9] Owens (2010)

The effects of single and multiple adversities

Research suggests that 'multiples matter'[10] and, while children have an increased chance of recovering from one adverse event, they may find it much more challenging to overcome multiple adversities. The cumulative negative impact, or **cumulative harm**, of exposure to single versus multiple adversities has been extensively covered in the literature.[11] The evidence base indicates that there is a strong relationship between the number as well as the intensity of negative events that occur in childhood, and short, medium and long-term outcomes.

Furthermore, the Adverse Childhood Experiences (ACE) Study carried out in the US found that one adverse event may lead to another. This study of over 17,000 people found that 87% of respondents who had been exposed to one type of adversity reported being exposed to at least one other type of adversity.[12] For example, a parent's drinking may result in family conflict, which in turn may result in separation or divorce. This can lead to additional consequences, such as a reduction in family income[13] and an unstable home environment for one or both parents. These factors are often associated with negative behavioural outcomes for children and adolescents.[14] While such 'knock-on' effects do not always occur, there is a greater risk of cumulative effects or cumulative harm when one adverse event occurs.[15] Domestic violence is one particular type of adversity that has been highlighted as being predictive of exposure to multiple adverse experiences.[16]

Davidson and colleagues[17] highlight the difficulty in precisely defining how many families are affected by multiple adversities, but they note that 20-25% of service users are in contact with a number of different services. They also note an estimate that 2% of families in the UK experience five or more adverse experiences. In the literature, four or more ACEs is sometimes used as the cut-off point to identify those at risk of very poor outcomes.

Despite the difficulties in determining exactly how many families are affected by multiple adversities, what it clear from the evidence base is that social inequality plays a role in determining what groups experience multiple, rather than single, adverse events. Children living in poverty are more likely to be exposed to family problems, and live in crowded or unsuitable housing.[18] Those living in disadvantaged areas are also more likely to experience four or more adversities in childhood.[19] This is known as a 'double burden', where children and young people living in disadvantaged areas and circumstances are more likely to be exposed to adversities and less likely to be exposed to **protective factors** which can enhance their coping or resilience in the face of such difficulties.[20] Examples of protective factors include social capital, education and positive relationships with peers, carers and/or significant adults.

[10] Spratt (2011)
[11] Davidson, Bunting and Webb (2012); Spratt (2011)
[12] Dong, Anda and Fellitti (2004)
[13] Mahon and Moore (2011); Gadalla (2008).
[14] Singh and Ghandour (2012); Appleyard et al (2005)
[15] Davidson et al (2012); Bromfield, Gillingham and Higgins (2007)
[16] Spratt (pending publication)
[17] Davidson et al (2012)
[18] Gutman, Brown, Akerman and Obolenskaya (2010)
[19] Bellis, Lowey, Leckenby, Hughes and Harrison (2014)
[20] Allen (2014)

The long-term impact on health and mental health as a result of experiencing multiple adversities is well established. There are indications that adverse experiences in childhood may be associated with psychosis in later life; research reported that 69% of women who were using mental health services had been subjected to sexual abuse, physical abuse or both; the corresponding figure for men was 59%.[21]

Longitudinal data highlight the impact that the experience of multiple adversities in childhood can have on health outcomes in adulthood. An Irish study based on the Irish Longitudinal Study on Ageing (TILDA) reported a 'lasting legacy' of childhood adversity for disease risk in later life. McCrory and colleagues[22] focused on three major types of adverse events during childhood; physical abuse, sexual abuse and parental alcohol/drug abuse. The results showed that the experience of adversity in childhood was associated with significant increased risk in later life of cardiovascular disease, lung disease, asthma and psychiatric disorders. Furthermore, the association with diseases and childhood adversity was higher for those diseases that were related to stress response, as in the case of cardiovascular disease and psychiatric disorders, and lower for diseases such as cancer and diabetes. In a separate study, experiencing two or more adverse events in childhood led to a twofold increase in the risk of a premature birth for women, regardless of maternal age, smoking, or educational status.[23]

How widespread is adversity?

An understanding of how prevalent different types of adversity are is important information for commissioning, planning and delivering services. This information can also help practitioners to assess the likelihood of adversities among the service user groups they work with on a daily basis. Prevalence rates for adversity depend on how adversity has been defined, assessed or measured. There are many different terms and conceptualisations of adversity used across the literature, which makes it difficult to measure how many children are affected.

Different approaches have also been used to determine the frequency with which children experience adversity. In one commonly used technique, people (children, adults or parents) are given a list and asked to indicate whether or not they have experienced the event in question. Reponses tend to depend on how broad and inclusive that list is, the definition of the event, as well as the time frame. Estimates that have been published indicate that quite a large number of children experience some form of adversity. The ACE study was conducted between 1995 and 1997 among a sample of over 17,000 people. The study focused on 10 types of childhood trauma that have a critical influence on a child's life:

- Physical abuse
- Sexual abuse
- Emotional abuse
- Physical neglect
- Emotional neglect
- Mother treated violently
- Substance abuse
- Household mental illness

[21] Read, Morrison and Ross (2005)
[22] McCrory, Dooley, Layte and Kenny (2015)
[23] Christiaens, Hegadoren and Olson (2015)

- Parental separation or divorce
- Imprisonment of a household member.

The study findings indicated that experiencing some form of adversity is quite common, with approximately two-thirds of individuals in the study reporting that they had experienced at least one of these types of adversity in childhood.[24]

Another approach to studying frequency involves focusing on a very specific area, confirming whether the event happened, and ascertaining information on the context and severity of the experience. The SAVI study (Sexual Abuse and Violence in Ireland) involved a random sample of Irish adults and sought information on experiences of sexual abuse in childhood and adulthood. It is especially interesting that the findings demonstrate how dependent the outcome is on the precise information sought. For girls aged under 17 years, 20% had experienced 'contact abuse' but, importantly, a further 10% indicated that they had experienced non-contact abuse.[25] The implication is that there is no one defining statistic for abuse; it may be 'one in four', or more or less, depending on the precise focus of the inquiry.

How widespread is adversity among children?

Growing Up in Ireland is an ongoing national longitudinal study of children in Ireland, tracking how children and their families develop as they grow up. Information has been collected on both youngsters and infants, with detailed information sought from parents, teachers and children themselves on all relevant features of their development. It provides valuable information on the extent to which children are experiencing adversity in Ireland. Parents were asked if their child had experienced any of the adverse events listed (see below). Results indicated that, even though the child cohort was aged just nine years, a minority had experienced each type of adversity, with parental divorce being the most prevalent.[26] Other adversities encountered by children included the death of a parent, substance abuse by parents, and mental illness in the immediate family.

It is also striking that approximately 5% had experienced two or more adverse events. This group is especially vulnerable and needing attention.

The following graph is based on information from Growing Up in Ireland (GUI) study data, and provides an insight into the incidence of difference forms of adversity experienced by children in Ireland. However, it is important to note that these data do not contain information on the direct experience of abuse, and 'hidden' adversity may not be accounted for in these data.

[24] Anda and Brown (2010)
[25] Dublin Rape Crisis Centre (2002)
[26] Williams et al (2009)

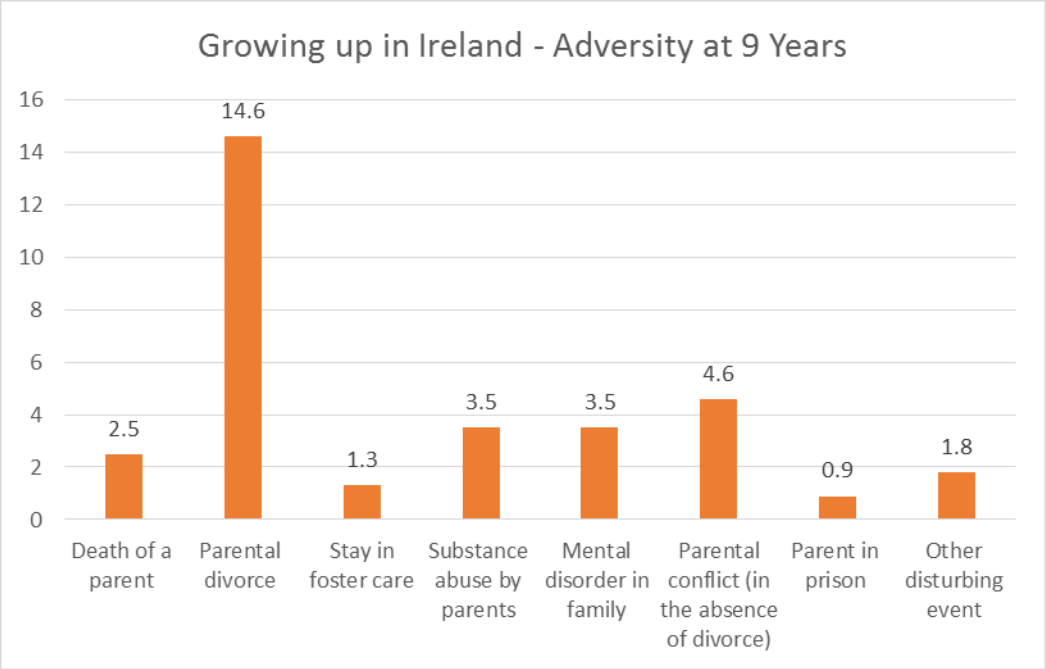

Figure 2. Parent report of children in the Growing Up in Ireland (GUI) study who have experienced adverse events by nine years of age

Adversity: facts and figures

This section provides some key statistics for both Ireland and Northern Ireland on the different forms of adversity in the lives of children and young people:

Poverty and debt

Data from the 2015 Survey on Income and Living Conditions[27] (SILC) in Ireland reported that 8.2% of the population were living in consistent poverty, and one-parent households were more likely to be living in consistent poverty. From 2008 to 2013 the number of people at risk of poverty increased from 4.2% to 8.2%. The proportion of those experiencing some form of enforced deprivation more than doubled during the 2008–2013 period (from 13.7% to 30.5%), and one-parent households with children had the highest rates of deprivation when compared with other households (63.2%).

Recent figures from Northern Ireland reveal that 21% of the population were living in poverty, with 23% of children living in poverty in 2013/14 and 30% of children living in absolute poverty.[28]

Child abuse and neglect

Reporting data from Tusla, the Child and Family Agency in Ireland, indicate that there is growing pressure on child welfare and protection services, with referrals to child protection services increasing by 101% during the period 2006–2012. Referrals to child welfare services rose by 82% (from 11,579 to 21,043) in the same period.[29]

In 2013, approximately 26,000 children were known to social services in Northern Ireland as a 'child in need', representing an increase of 6% from the previous year.[30] The data collected show that neglect and physical abuse were the most common reasons for placing children on the child protection register.[31]

The number of children in care has consistently increased over the past 10 years in both Ireland and Northern Ireland. In 2013, there were 6,469 children in care. This represents an increase of 28% since 2004.[32] In 2014, in Northern Ireland, there were 2,858 children in care, an increase of 23% since 1999.[33] However, it is worth noting that, as is the case with a great deal of national data, these rates can rise as well as fall, and can be affected by changes to assessment, referral and other service thresholds. Interpretation of such data should aim to distinguish between incidence (the number of new cases emerging over a given time period) and prevalence (how common something is in a given population at a given point in time), and that administrative data cannot be read as meaning a straightforward increase in the number of children experiencing adversities.

Family and gender-based violence

Data from the GUI study show that 12% of nine-year-olds had experienced conflict between their parents.[34] Information on the prevalence of family and gender-based violence is also collected by community and voluntary sector organisations. Safe Ireland's Annual Statistics report that in 2013,

[27] CSO (2015)
[28] Nisra (2015)
[29] Tusla (2012)
[30] Department of Health, Social Services and Public Safety (2014)
[31] Ibid
[32] Department of Health (2014)
[33] Department of Health, Social Services and Public Safety (2014)
[34] Williams et al (2009)

8,033 women and 3,424 children received support from domestic violence services in Ireland.[35] Of these children, 2,699 were living in a refuge and 140 were living in transitional housing. In total, 46,137 calls were answered by the service.[36] Women's Aid in Northern Ireland handled over 55,000 calls during a one-year period in 2013–2014, with 454 women and 459 children referred to refuge services during the same period.[37]

Another indicator of this kind of adversity is the number of domestic violence applications that are made to the Courts. In 2014, there were 13,528 such applications, representing an increase of 36% since 2011.[38] Data collected by police services in Northern Ireland show that the PSNI responded to 28,287 domestic abuse incidents in a one-year period during 2014–2015, the highest level recorded over the past decade.[39, 40]

Parental illness and disability

Parental illness and disability can have adverse consequences for children, due to how these factors impact on wider opportunities for social inclusion and participation. For example, the most recent data available from the 2011 Census in Ireland show that people with disabilities have lower levels of educational attainment than the general population, are less likely to participate in the labour force, and are less likely to have access to broadband, or to own a car.[41] Northern Ireland Census data show that families where a parent or child has a disability are more likely to experience poverty.[42]

A number of sources indicate the prevalence of parental disability and illness. Findings from the GUI study indicate that 13% of nine-year-olds had experienced serious illness or injury of a family member.[43] According to Census data, 4,228 children under the age of 15 years provided care to a friend or family member with a long-term illness or disability, with 9.2 hours being the average number of hours of care provided per week.[44] According to the most recent Northern Ireland Census, 21% of the population had a long-term health problem or disability that limited their daily activities, 12% provided unpaid care, and a quarter of those provided 50 hours or more of unpaid care per week.[45] The Census also shows that just over 9% of households with dependent children had at least one person with a disability or long-term illness.[46]

Information from the Department of Social Protection in Ireland indicates that the number of people in receipt of illness, disability or caring payments who had dependent children in 2013 was 38,833. In total, 99,255 children were living in households where an adult was in receipt of one of these payments.[47]

[35] Safe Ireland (2014)
[36] Ibid
[37] Women's Aid Northern Ireland (2014)
[38] Courts Service (2014)
[39] PSNI (2015)
[40] Department of Health, Social Services and Public Safety (2005)
[41] Ibid
[42] NISRA (2014)
[43] Williams et al (2009)
[44] CSO (2012)
[45] NISRA (2012)
[46] Ibid
[47] Department of Social Protection (2014)

Parental substance use

There is substantial evidence that parental substance use has serious adverse effects on children's lives. Data on the prevalence of drug use in families are available from various sources. Data from the GUI study indicate that 4% of nine-year-olds had experienced drug taking or alcoholism in their immediate family, while data from the infant cohort found that 19% of mothers consumed at least one alcoholic drink during their pregnancy.[48]

According to the National Drug Treatment Reporting System, 7,549 people were treated for problem alcohol use in Ireland in 2013. Almost a fifth (19%) of people treated for alcohol misuse reported using at least one other drug.[49] Data from a Health Research Board report showed that over a fifth of those in treatment for problem alcohol use were living alone with their children or with partners and their children.[50] Studies involving men who were in treatment for substance abuse showed that approximately 50% of these men had also perpetrated domestic abuse in the previous 6–12 months.[51]

According to estimates by the Health and Social Care Board, approximately 40,000 of children in Northern Ireland are affected by parental alcohol misuse, with approximately 40% of children on the child protection register as a direct result of alcohol misuse.[52]

Parental mental ill health

Measures of the prevalence of parental mental ill health vary, and can differ depending on what is included in the definition. The Health Research Board's National Psychological Distress and Well-being survey (2007) found that one in seven people had experienced a mental health difficulty in the previous year.[53] The Department of Health publishes data on admissions to psychiatric hospitals, and its records show that there were 18,457 admissions to psychiatric hospitals in 2013.[54] The Northern Ireland Census for 2011 found that 6% of people reported having an emotional, psychological or mental health condition.[55] More recently, the Health Survey Northern Ireland found that almost a fifth of people experienced mental ill health.[56]

According to the GUI study, 4% of nine-year-olds had experienced mental ill health in their immediate family[57] with findings from the GUI infant cohort indicating a relationship between stress and depression and lower levels of parental sensitivity.[58] Sources from Northern Ireland estimate that between 60,000 and 75,000 children are living with a parent with a mental health condition.[59]

Family separation/bereavement

Data published by the Courts provide some indication of the prevalence of family separation. The 2014 Courts Service Annual Report shows that there were 1,271 applications for judicial separation

[48] Layte and McCrory (2014)
[49] Health Research Board (2015)
[50] Mongan, Hope and Nelson (2009)
[51] Barnardos (2010)
[52] Department of Health, Social Services and Public Safety (2009)
[53] Tedstone Doherty, Moran, Karalova-O'Doherty and Walsh (2007)
[54] Department of Health (2015)
[55] NISRA (2012)
[56] Department of Health, Social Services and Public Safety (2014b)
[57] Williams et al (2009)
[58] Nixon, Swords and Murray (2013)
[59] Children and Youth Programme (2013)

and 3,831 applications for divorce in 2014.[60] The most recent Census in Northern Ireland (2011) shows that 4% of people were separated, 5% were divorced and 7% were widowed.[61]

The GUI study is a useful indicator of the prevalence of both family separation and bereavement, and contains data collected on the number of children who have experienced either event. Findings from the GUI study indicate that 43% of nine-year-olds had experienced the death of a close family member, with 3% experiencing the death of a parent.[62] Parental separation or divorce had been experienced by 15% of children in the same study, and 18% of nine-year-olds were living in single-parent families. The study found that family structure was related to income, with single parent families more likely to have lower incomes.[63]

Data from the Department of Health, Social Services and Public Safety show that there were almost 64,000 single parents with dependent children households in Northern Ireland in 2011.[64] Data from the same source indicate that approximately one in six children in Northern Ireland experience the separation of their parents before they finish school.[65]

Offending and anti-social behaviour

In 2014, 13,408 people were sent to prison in Ireland; 81% of these people were male.[66] The Northern Ireland Prison Services data reveal that, in a one-year period between June 2014 and June 2015, 8,772 people were sent to prison with an average sentence length of 5.9 years.[67]

Data collected on visits to prisoners provide some indication of the number of children affected by parental incarceration. The Irish Prison Service estimates that 200,000 adult family and friend visits and 80,000 child visits to prisoners take place every year.[68] A freedom of information (FOI) request to the Northern Ireland Prison Service revealed that 25,031 visits by 4,865 children took place in Northern Ireland's prisons in 2013.[69] Of the nine-year-old children who participated in the GUI study, 1% had a parent in prison.[70]

[60] Courts Service (2015)
[61] NISRA (2012)
[62] Williams et al (2009)
[63] Ibid
[64] Department of Health, Social Services and Public Safety (nd)
[65] Ibid
[66] Irish Prison Service (2015)
[67] Northern Ireland Prison Service (2015)
[68] Shatter (2012)
[69] Torney (2014)
[70] Williams et al (2009)

What are the immediate and long-term outcomes of adversity?

The time that elapses between the experience of adversity and the presumed consequences is another differentiating factor. Many studies identify outcomes that occur immediately following a negative event.

As highlighted by Spratt,[71] there is a challenge in synthesising the research on the outcomes of adversity, as generally such research focuses on either specific forms of adversity (mainly abuse and neglect) or specific populations and general outcomes, or general populations and specific outcomes. For this reason, we will now focus on three different examples of adversity and how they affect children's lives. These three 'spotlights' aim to represent adversities which characterise the different aspects of the child's environment, including macro-structural influences (such as poverty), events within the family system (such as parental divorce/separation) and events which may be intra-familial or extra-familial in nature (such as child sexual abuse).

Spotlight on – poverty and educational disadvantage

Children and young people living in disadvantaged areas are known to be at risk of poorer performance in school.[72] The need to establish the prevalence and distribution of educational disadvantage is of major importance from the perspective of the successes/failures of the educational system. Furthermore, because the initiatives to address disadvantage are at school level, precise criteria have been established, resulting in schools being designated for entitlement to various initiatives including DEIS (Delivering Equality of Opportunity in Schools) in Ireland,[73] and changes to the Common Funding Scheme for schools in Northern Ireland.[74]

The literacy performance of students in schools designated as disadvantaged continues to fall behind that of other students.[75] The attainment gap between children from rich and poor backgrounds can be seen before a child reaches two years of age and widens throughout the education system. For example, a study conducted in Ireland found that over a quarter (27%–30%) of children in schools in disadvantaged areas had serious literacy difficulties.[76] Similarly, in 2008–2009 in Northern Ireland, the number of school-leavers who achieved at least five GCSEs at Grades A–C ranged from 100% in more affluent areas to less than 30% in disadvantaged areas.[77]

On a related note, there is evidence that children who perform well academically are more resilient, and that doing well in school is a protective factor against disadvantage and stress in later life.[78] However, it is not only doing well at school that is protective for children: school engagement is as important, and school liking and positive school experiences help to build resilience in children.[79]

The link between experiencing this particular type of adversity and educational disadvantage may reflect several risk factors. For example, socially disadvantaged children are more likely to have poor

[71] Spratt (2010)
[72] Roulstone, Law, Rush, Clegg and Peters (2011)
[73] Department of Education and Science (2005)
[74] Department of Education (2014)
[75] Weir and Archer (2005); Slavin, Lake, Chambers, Cheung and Davis (2005)
[76] Eivers, Shiel, Perkins and Cosgrove (2005)
[77] Public Health Agency (2011)
[78] Allen (2014)
[79] Newman (2004)

communication skills and significant language delays – difficulties which become more pronounced as children progress through the educational system. Health and academic achievement are also closely linked; failure to maintain at least a reasonable level of health is often a barrier to achievement, and low achievement is often an indicator of poor health in later life.[80]

National data in Ireland also report an association between school absenteeism and disadvantage, which may result in children falling behind in school.[81] The GUI study[82] also showed that nine-year-old children from less advantaged backgrounds are less likely to engage in the types of out-of-school activities that appear to enhance academic performance. They suggested that in the longer term, children's recreation patterns may serve to widen the social class gap in achievement. This is supported by further findings from the GUI study, when children were aged 13 years, which indicated that children from households with higher income and higher educational attainment levels were more likely to report positive interactions with their teachers, lower rates of difficult behaviour, and more positive attitudes towards school.[83]

Spotlight on – parental separation/divorce and child behaviour and well-being

In comparison to some types of adversity, the number of children and young people experiencing parental divorce or separation is on the increase. An analysis of calls to Childline in the UK reported that divorce/separation was one of the top five most frequent reasons for calls to Childline by children.[84] The separation process can be a turbulent time for parents, children and the wider family unit. It is a process of significant change, including but not limited to, ending a long-term relationship, conflict and confrontation with ex-partners, moving home and changing school, experiencing a decline in the standard of living and legal proceedings. Children may lose contact with grandparents and extended sources of social support, and see their parents developing new romantic relationships. Studies primarily conducted in the USA, have reported that children who experience parental separation/divorce score lower on a range of emotional, behavioural, social, health and academic outcomes.[85] The greatest impact on child adjustment appears to be in the domain of child behavioural problems.[86]

However, the impact on child outcomes appears to be influenced by the level of conflict present in the parental relationship prior to separation or divorce. Children whose parents had high-conflict relationships, and were separated, were less negatively affected by parental break-up than children whose parents had low-conflict relationships.[87] In other words, the perception of parental separation/divorce as an adverse event may depend on the nature of the parental relationship beforehand. When a child is removed from a high-conflict environment after a relationship breaks down, it does not necessarily lead to more negative outcomes for youngsters. This is supported by findings from a 12-year longitudinal study which concluded that children brought up in high-conflict families are better adjusted if their parents' divorce, as opposed to stay together.[88]

[80] Public Health Agency (2011)
[81] Millar (2013)
[82] McCoy, Quail and Smith (2012)
[83] Growing Up in Ireland (2012)
[84] Carpentieri (2006)
[85] Sun and Li (2002); Frisco, Muller and Frank (2007); Amato (2001)
[86] Rhoades (2008)
[87] Kushner (2009); Booth and Amato (2001)
[88] Amato et al (1995) as cited in Kushner (2009)

Importantly, a number of protective factors have been highlighted in the literature as supporting better child outcomes following separation/divorce.[89] These include:

- involvement of the non-residential parent, with economic support being particularly important;
- reduced conflict in the post-divorce/separation period;
- living with the parent who has the best psychological well-being;
- parenting styles, with parental warmth, responsiveness, authoritative discipline and appropriate monitoring and supervision;
- shared parental custody, with studies indicating that shared custody, as opposed to sole custody, has a positive influence on child adjustment.

Spotlight on – child sexual abuse (CSA) and mental and physical health

Research consistently shows a link between exposure to childhood physical and sexual abuse, and the development of mental health and health problems during childhood and in later life. A number of different definitions of sexual abuse may be found in the literature, but, in general, sexual abuse occurs when an infant, child or young person is used by another person for their gratification or sexual arousal, or for the gratification/arousal of others.[90] More girls than boys are sexually abused; most abusers are male and less than a fifth of abusers are female. Rates of abuse are approximately two to three times higher among children with physical and intellectual disabilities.[91]

A number of issues should be borne in mind when dealing with this type of adversity – including the different manifestations of the abuse, the degree and length of time of the abuse, and the relationship of the child to the abuser.[92] Research indicates that abuse that is more frequent, invasive, or occurs over a longer time period, and the degree to which the child's trust in an adult was violated are all associated with more profound negative effects in both the short term and the long term.[93]

Children and young people who have suffered the trauma of sexual abuse can present with a number of profound internalising behaviours (e.g. withdrawal, somatic symptoms, self-harming behaviours, anxiety, depression, low self-esteem) and externalising behaviours (e.g. aggression, hyperactivity, illegal behaviour, substance abuse, frustration, suspicion and lack of trust in others) as well as sexualised behaviour and school-based attainment problems.[94]

Reviews of the literature on the impact of child sexual abuse in adulthood referenced studies that reported long-term impacts on mental health in adulthood, such as depression, anxiety, psychosis, self-harm, personality disorders, bulimia nervosa, interpersonal problems, sexual problems, and substance misuse.[95] Impacts on physical health in adulthood include cardiovascular and gastrointestinal problems and compromised physical function. Studies have also shown that females who report a history of sexual abuse in childhood have significantly higher health service use.[96]

[89] Kushner (2009)
[90] Health Service Executive (2011)
[91] Carr (2006)
[92] Davidson, Devaney and Spratt (2010)
[93] Carr (2006)
[94] Carr (2006)
[95] Davidson et al (2010), Felliti et al (1998), Putnam (2002), Hillberg, Hamilton-Giachritsis and Dixon (2011)
[96] Walker et al (1999)

Studies suggest that the negative impact on physical health is a result of the high levels of stress hormones which are released by children exposed to abuse and/or other types of significant adversity, which compromises their immune system in the long term.[97] Research also indicates that the relationship between child sexual abuse and depression in adulthood is mediated by the resultant interpersonal difficulties that individuals who are sexually abused can experience.[98]

School transitions have been identified as a particular risk period for children experiencing maltreatment – either beginning school or beginning secondary education.[99] One of the reasons suggested by the literature is that children and young people are moving to different service systems, where the level of surveillance may change. It has also been suggested that the period leading up to, and during, transitions increases stress for both youngsters and their families. This has important implications for other outcomes, as the ability of children to successfully negotiate educational transitions can impact on their academic performance, school engagement, psychosocial well-being and development, peer relationships, and even how long they decide to stay in school.[100] This may serve to aggravate the negative outcomes and distress associated with child abuse.[101]

[97] Brunner and Marmot (2006) as cited in Davidson et al (2010)
[98] Whiffen et al (2000)
[99] Stewart, Livingston and Dennison (2008)
[100] Anderson, Jacobs, Schramm and Splittgerber (2000); Brady, Canavan, Cassidy, Garrity and O'Regan, 2012; Akos and Galassi (2004)
[101] Stewart et al (2008)

What can help to mediate the impact of adverse events?

Just as the evidence indicates that multiple adverse experiences have a relatively deep impact on later aspects of development, any serious adverse experience can have an effect on different outcomes. The research shows that there may be effects on mental health, social and personal outcomes, physical health, as well as on the likelihood of anti-social behaviour. In addition, as shown in the review by Davidson and colleagues,[102] there may also be effects on economic indicators.

An important question remains as to how the effect of adversity on these later outcomes is mediated, which provides us with evidence on how practitioners can intervene to reduce negative outcomes. As reported above, the evidence base indicates a significant link between being subject to sexual abuse in childhood and later mental health difficulties and psychiatric disorders. The work of Whiffen and colleagues[103] suggests that the main mediating factor may be problems of social and interpersonal relationships. Research indicates that the experience of abuse may result in deficits or limitations in the capacity for interpersonal relationships, which in turn results in greater likelihood of mental health problems.

Research also considers the impact of adversity on physical health, and what factors can mediate this relationship. The results of the ACE study suggest two processes through which childhood adversity may result in health problems.[104] One is through the lifestyle habits that are adopted by an individual in coping, but which may result in negative health consequences; such habits include cigarette smoking and other forms of substance use. Another factor may be the high levels of stress hormones that are generated by the experience of adversity, and which in turn have an impact on health and well-being. The results of the TILDA study appear to be consistent with both of these explanations of the link between childhood adversity and later health problems.[105]

The evidence linking childhood adversity with subsequent anti-social behaviour is important, particularly if the mediating factors can be identified and thus provide guidelines for intervention. The research reviewed by Farrington[106] indicates that physical abuse and neglect in childhood is a major factor in becoming an offender in later years. Several processes may be involved. It may be that the neglect and abuse have disruptive effects on the bonding and attachment to parents, which has been shown to be a critical factor in positive social behaviour. Another factor may be the modelling of parental behaviour that comes about as a result to repeated exposure to violence.[107] A third process may involve the generation of negative emotions, including anger and resentment, which may result in a predisposition towards violence.[108]

Resilience and salutogenesis

A number of different terms are used for the possible positive outcomes of negative processes, such as **resilience, coping** and **salutogenesis**. This section of the report will focus mainly on the resilience

[102] Davidson et al (2012)
[103] Whiffen et al (2000)
[104] Fellitti et al (1998)
[105] McCrory, Dooley, Layte and Kenny (2015)
[106] Farrington (2007)
[107] Bandura (1997)
[108] Anda et al (2006)

literature, as this research is a core element of the adversity literature. However, it will also draw on research in relation to salutogenesis.

Resilience

There are many different definitions of **resilience**, but perhaps the most widely accepted definition is provided by Lyons and colleagues,[109] who describe resilience as *'the capability of individuals or systems (such as families, groups, and communities) to cope successfully in the face of significant adversity and risk'*. The definition of resilience is reported as having its roots in research on risk and stress. Risk in this domain is defined as any influence that intensifies the probability of onset, or emergence, of difficulties.[110] The majority of resilience research has been conducted with children or adults who grew up in disadvantaged family circumstances, such as experiencing child abuse, neglect and deprivation.

Resilience should not to be viewed as a stable personality trait, but instead as a process which operates in a social context and along a continuum. Palmer[111] describes a continuum of effective resilience, ranging from basic survival to flourishing resilience. Resilience may interact with, but is not dependent on, individual traits and features. Rather, it is a dynamic process which can accumulate, or indeed reduce over time, and is influenced by experiences, opportunities and relationships.[112]

Protective factors are a central tenet of the resilience literature, and interact with risk to produce more positive or neutralised effects. A protective factor is an attribute, situation, condition or environmental context that works to buffer an individual from the likelihood of negative effects of a particular problem.[113] A number of important protective factors have been identified in the literature at the levels of the individual, the family, school and community.[114] **Vulnerability factors** are those that increase the likelihood of stress or aggravate the effects of risk. This review proposes a strengths-based approach and, as a result, focuses on protective factors.

Different protective factors have been described in the literature. Such factors include positive relationships that provide security and positive reinforcement, and support for this is evident in the literature on child attachment patterns. **Attachment** is defined as *'the affectional bond or tie that an infant forms between himself or herself and the mother figure – a bond that tends to be enduring and independent of specific situations'.*[115] Attachment theory argues that the early parent-child interactions provide the basis for how children view their relationships with their parents, with the attachment style becoming more stable over time. The formation of a secure attachment pattern in infancy is associated with more positive developmental outcomes in children. The four main attachment styles are defined from observed infant behaviour – when infants were reunited with their mother or primary caregiver following a brief separation period.[116] The four styles are as follows:

[109] Lyons, Mickelson, Sullivan and Coyne (1998)
[110] Kirby and Fraser (1997)
[111] Palmer (1997)
[112] Allen (2014)
[113] Owens (2010)
[114] Harrop, Addis, Elliott and Williams (2006)
[115] Ainsworth, Blehar and Waters (1978)
[116] Smith, Cowie and Blades (2003)

- **Avoidant:** Infants with avoidant attachment are characterised by avoidance of contact or interaction with the mother (or primary caregiver) where distress experienced by the infant is not caused the departure of the caregiver.
- **Secure:** Infants who are securely attached make efforts to gain and maintain contact and proximity with their caregiver, especially when reunited after the separation period. They may or may not be distressed during separation, but distress is due to the absence of their caregiver.
- **Ambivalent:** Ambivalent attachment is where the infant resists contact and interaction with the caregiver upon reunion, but does not ignore them, thus giving the impression of ambivalence.
- **Disorganised:** This attachment pattern is characterised by disorganised behaviour in the separation period, where there is no clear pattern and the infant may have strange responses to the situation.

It has been suggested by some researchers that bonding with the child's primary caregiver provides the foundation for resilience[117] and that some instances of adult psychopathology are due to the inability of young children to obtain secure attachments to a primary caregiver.[118] In fact, Shonkoff and Garner[119] argue that it is the protective adult relationships that a child has which determine the extent to which environmental stressors are 'tolerable' or 'toxic', as they assist the child's adaptive coping. However, it is important to stress that positive attachment opportunities are not limited to the early years of infancy, as initially suggested in the literature. There is evidence of cases where secure attachment to mentor figures at age 10, after severe abuse, can foster resilience.[120] Further research reports that an affectional bond with a significant adult in the child's life can serve as a buffer against the development of mental health difficulties when exposed to adversities.[121]

A warm and nurturing family environment has been reported in the literature as serving as a buffer against exposure to adversities. A review reported that there was evidence in 18 preceding reviews of the protective influence of a supportive family environment for children experiencing disadvantage. The presence of a strong parent-child relationship, an authoritative parenting style, adequate parental supervision and monitoring, a supportive communicative family environment and family practices such as nurturing motivation, high expectations and support for achievement were reported as protective against adversity.[122] Promoting resilience in children can thus be difficult when those they rely on to promote it, i.e. parents, may be the source of the adversity experienced in certain cases; except in cases where the type of adversities experienced are entirely located outside the home.

Positive identity factors such as self-esteem and self-efficacy are also referenced in the resilience literature as potential protective factors. It has been argued that individuals with a sense of self-esteem and self-efficacy appreciate their own worth, and are more likely to cope successfully.[123] This is supported by a recent review on the role of resilience in maintaining health, which also concluded

[117] Parrott, Jacobs and Roberts (2008)
[118] Sroufe (2000)
[119] Shonkoff and Garner (2012)
[120] Stein, Fonay, Fergusson and Wisman (2000)
[121] Blundo (2002); Burns, Hoagwoord and Mrazek (1999)
[122] Harrop et al (2006)
[123] Rutter (1985)

that a positive ethnic or racial identity can serve as a protective factor against exposure to adversity among minority ethnic groups.[124] In addition, children who report experiencing more positive emotions more frequently may recover from stressful events more quickly.[125] Social competence and self-reflection have also been cited as protective factors.[126] Presumably, social competence helps individuals to identify additional support outside the family. On a related note, the literature indicates that positive hobbies or extra-curricular activities can help children feel accomplished, and also help to increase self-efficacy. This can help to build resilience.

'Social capital' emerges as a positive influence on resilience throughout the literature. This concept advocates that in building resilience, social connections, contexts and resources – more than an individual's capacity to withstand adversity – act as a protective factor against adversity.[127] For youngsters experiencing adversity, the expression of support from, most importantly, families – but also from schools and communities – are examples of valuable social capital that can promote resilience. A supportive and cohesive community can influence psychosocial factors that promote resilience through feelings of connectedness and being involved.[128] In the school setting, high teacher expectations, opportunities for participation in school life and positive interactions have been reported as protective factors for children experiencing adversity.[129]

In other words, social capital and resilience are 'developmental assets' which can be activated through various sources of social support.[130]

On a related note, positive peer connections and hobbies can also help promote resilience. Peer influences are greater in adolescence than in early childhood, however.[131] Research suggests that positive social support from peers, either through school, membership of clubs, and so on, can help youngsters to detach themselves from an adverse home environment and thus foster resilience.[132] Peer contact can also help develop interpersonal and social skills, which are also important in developing resilience.

In summary, what emerges is that resilience should not be viewed as a special personal characteristic where an individual has to succeed, or not, in the face of adversity. Harrop and colleagues[133] state that viewing resilience as a trait can lead to 'victim blaming' and can be used as a political tool to reduce poverty alleviation measures. Resilience is best understood as an interaction between psychological process and ecological influences. In the words of Masten,[134] it is both nature and nurture.

[124] Harrop et al (2006)
[125] Ong, Bergman, Bisconti and Wallace (2006)
[126] Guralnick and Neville (1997)
[127] Davidson, Bunting and Webb (2012)
[128] Harrop et al (2006)
[129] Ibid.
[130] Pinkerton and Dolan (2007)
[131] Crosnoe and Elder (2004)
[132] Rutter (1999)
[133] Harrop et al (2006)
[134] Masten (2001)

Salutogenesis

Salutogenesis is an approach which focuses on the factors that support health, as opposed to the factors that cause disease.[135] The approach originated in the work of Aaron Atonovsky and his research on women living in Israel who had survived the Holocaust during the Second World War; Atonovsky's research found that despite the considerable hardship experienced, many of these women still enjoyed good health.

This approach argues that stress and difficulties are an inevitable part of life. The core concepts of salutogenesis are 'general resistance resources' (GRRs) and a 'sense of coherence' (SOC). The GRRs are biogenic, material and psychosocial influences that make it easier for people to view and understand their lives as consistent and organised (for example self-esteem, social support and financial resources).[136]

The sense of coherence (SOC) is a theory which refers to how individuals make sense of their surroundings. It is theorised that the presence of GRRs promotes life experiences which facilitate the development of a strong SOR. An SOR has three core components.[137]

- comprehensibility: the cognitive element (how people see the world);
- manageability: the instrumental or behavioural component;
- meaningfulness: the motivational component (how the person is motivated to think and act).

[135] Antonovsky (1987)
[136] Lindstrom and Eriksson (2006)
[137] Lindstrom and Eriksson (2006)

Debates in the literature: Can there be 'positive' consequences of adverse events?

One area of research that has given rise to debate is an old idea that adversity can be beneficial, particularly in the long term. There are at least three lines of argument of how adversity can become beneficial. Research by Seery and colleagues[138] has demonstrated a curvilinear relationship between experience of adversity and mental health. Specifically, those who experienced *some* adversity had better outcomes than those who had encountered either no adversity or a great deal of adversity. In other words, it seems that the experience of coping with low levels of adversity enabled people to deal with later encounters, even if these encounters were difficult.

Research findings on 'benefit finding' is somewhat more controversial. One of the arguments supporting 'benefit finding' is that traumatic events can shatter our beliefs about the world to the extent that we function in a wiser way afterwards. In other words, following an encounter with traumatic adversity, people rethink 'what life is about' and make a fresh start. Two researchers who have advocated this very strongly are the UK psychologists, Linley and Joseph.[139] It should be stressed that the 'positive effects', when they are found, apply only to adults. Furthermore, while people often talk about an unexpected positive outcome of an adverse event, the overall effects may still be negative. On balance, the idea of 'adversarial growth' remains open to dispute.

A third view, and one which has the most credibility in terms of supporting evidence, is that adverse events can be offset by other features of a child's life as described in the research on resilience, considered above.

Caveats

A number of caveats in the literature should be acknowledged. First, the literature does not differentiate between severe trauma and more prevalent adverse events in a consistent way. Second, there is a lack of standardisation in the literature on the conceptualisation of resilience. Third, while a focus on resilience is important, and while the use of a strengths-based approach to help promote resilience in children and young people is also important, it may not fully address instances of exposure to extreme and dangerous multiple adversities.

It is also important to highlight that the majority of the studies on childhood adversity and more long-term outcomes are cross-sectional[140] in nature, with retrospective reporting by respondents, as experiments – involving allocating some people to experience adversity and others to not experience adversity – would not be an ethical approach.

Conclusion

This review has examined what we mean by adversity and its outcomes. The literature indicates that children can find it challenging to overcome exposure to multiple adversities, and social inequalities can play a role in determining exposure. There are also long-term impacts to experiencing multiple adversities, including mental health problems and physical health problems such as cardiovascular disease.

Given the difficulty in making generalisations about the outcomes of adversity due to its varied presentations, spotlights on particular types of adversity highlighted negative outcomes for children

[138] Seery, Holman and Silver (2010)
[139] Linley and Joseph (2005)
[140] A representative sample of people surveyed at one point in time

and young people – which can persist into adulthood in some cases. The link between poverty and educational disadvantage is reported widely, with children living in disadvantaged areas at risk of poorer performance in school. This gap between children from affluent and disadvantaged backgrounds can be seen before a child reaches two years of age, and the gap widens as these children progress through school. By contrast, performing well academically can help promote resilience in children.

A spotlight on parental divorce or separation – one the most prevalent types of adversity experienced by children across the island of Ireland – revealed that there are a number of risks associated with this type of family disruption, especially in the domain of child behaviour. However, the risk posed by this type of adversity is dependent on the nature of the parental relationship, with children growing up in the context of a high-conflict parental relationship faring better if their parents separate as opposed to stay together.

Child sexual abuse (CSA) is another type of adversity that can produce significant negative outcomes, in terms of mental and physical health, well into adulthood. Girls, children with physical and intellectual disabilities and those going through educational transitions are reported as being at an increased risk of CSA. The terrible trauma of CSA can result in profound internalising behavioural problems (e.g. withdrawal, somatic symptoms such as stomach aches and headaches, self-harming behaviours such as cutting, anxiety, depression and low self-esteem) and externalising behavioural problems (e.g. aggression, hyperactivity, illegal behaviour, substance abuse and lack of trust in others). There may also be sexualised behaviour and problems with school work. CSA may also result in long-term mental health problems such as psychosis, eating disorders and depression, and long-term health problems such as cardiovascular issues and generally increased use of health services.

Research on the issue of what mediates the relationship between adversity and negative outcomes indicates that a critical factor is the impact of exposure on the ability to develop and maintain positive social relationships. An additional factor is the increased production of stress hormones and negative coping behaviours, such as smoking and substance abuse that individuals may develop, which can impact on health.

The literature on resilience and salutogenesis highlights the protective factors which can help those experiencing forms of adversity. Protective factors at the individual level include intrinsic motivation, a positive mind-set, a positive ethnic or racial identity, social competence and self-reflection. On a related note, positive hobbies or extra-curricular activities can help increase resilience through increased feelings of mastery and self-efficacy.

Protective factors within the family and peer groups include a secure and nurturing relationship with caregivers, an authoritative parenting style, adequate parental supervision, high expectations for achievement, and positive peer support. There are also protective factors at the school and community level, such as positive connections in their community, increasing social capital, and positive interactions with school staff.

The literature also indicates that there may be positive outcomes of experiencing negative events, with some research pointing to ‘adversarial growth’; however this is a contested area. It appears that resilience is not an individual trait and it depends on a number of conditions, which may not be in place for all children. According to Allen, the wider social inequalities are also apparent in inequalities in resilience according to disadvantage – those who need it most tend to have it least.

As the statistics indicate, exposure to adversity is, unfortunately, a reality for many children, young people and families. Practitioners working at the front line with children, young people and families have a valuable and significant role in play in creating opportunities to help the development of resilience and adaptive coping.

Practice implications

This section presents the implications for front line practitioners based on the evidence. Practice implications were further informed by consultation and feedback from a diverse advisory group of practitioners working with children and families in different settings. They include practitioners in services such as child protection and welfare, early years care and education, youth justice, health, and the community and voluntary sector. Implications are general, so they can apply to multiple groups of practitioners who work with children, young people and families. They focus on:

- What practitioners can do to identify and recognise children and young people at risk of experiencing adversity.
- How practitioners can support children and young people to help them to cope with adversity.

It is important to note that the implications of the evidence on adversity extend to policy issues as well as being relevant to practitioners. At the policy level, there are implications such as increased resourcing, improving quality assurance processes, information sharing protocols and threshold issues in relation to reporting and referrals – all of which are relevant. However, the purpose of this review is to extract practice implications that can apply to all practitioners who work with children, young people and families.

The aim is to provide implications for practice which can be readily implemented in front line service settings.

A number of factors in children's lives influence how they cope with and manage adversity, including extreme or multiple adversity. Such factors include the **environment** (i.e. home, school, club or other setting), the **people** in children's lives (i.e. parents, family members, teachers and other professionals), the **experiences** that children have (i.e. their educational and social development) and the **connections** in their lives (i.e. how these factors interact).

By being aware of and paying attention to these four sets of factors, practitioners can identify and recognise the presence of adversity, can support children in developing resilience, and can facilitate appropriate interventions and make connections with other relevant practitioners and services. Some examples of possible implications for practice are included under these four headings.

Supporting children and young people experiencing adversity can be challenging. Practitioners' own personal experience of adversity can influence how they understand, identify and assess it. Practitioners may themselves require access to support as they assist children and families to cope with adversity.

The environment

The home, school and other environments play an important and complementary role in children's social-emotional development and positive self-identity. For example, children's achievement in school can be improved if they are supported to develop relationships and friendships.

- **Parenting programmes can support parents to help their children to deal with adversity at home.** Parenting programmes can help parents at home to promote consistency in care approaches and attachment at an early stage. A strong parent-child attachment lays a foundation for social and emotional development and the ability to cope with challenges. Attachment provides a sense of security which helps children to develop relationships outside the home.

- **Home visiting programmes can respond to adversity by taking a prevention and early approach.** Home visiting programmes can help to promote safety in the home, encourage positive parenting and recognise when support is needed, or when a child, parent or family is at risk.

- **Schools, sport clubs, community health settings and other universal services used by children and young people should signpost information on what services to contact in the event of a crisis at home.** Caregivers, children and young people may not know where to find relevant information, or may be reluctant to use smartphones or other technology in case their search activity is recorded.

People

All adults in a child's life can be a source of support, and can promote resilience in children and young people. Consistency is an important feature in children's relationships with adults, and can help children to cope with adversity.

- **The presence of 'one good adult', who is a positive role model and source of support, is really important.** This person might be a family member, a practitioner or other significant adult in the child's life. The presence of one caring adult can help children develop the skills that form the basis for success in education, work and life.

- **The presence of a consistent caregiver, or approach in care, can help to identify problems early, and intervene when they arise.** Practitioners who listen, who are caring and empathetic in their encounters with children, and build good rapport and trust are more likely to spot problems early on. Consistency can be promoted by allocating key workers, year heads and tutors to particular groups of children in education, community and high-support settings.

- **Mentors for children can play an important role in providing support, building trust and promoting resilience.** Formal mentoring roles, such as key workers, liaison officers and case workers, have a particular value. Informal mentoring can also help if it provides consistent support.

Experiences

Practitioners can support children to cope with different experiences they encounter as they grow up. Practitioners can also watch out for the presence of adversity, and identify children at risk at an early stage.

- **High expectations for achievement are important for children.** All adults in a child's life should have high expectations, and should encourage and support children's efforts and achievements. Expectations are among the most important influences on various aspects of development, but especially on school performance. The success children experience in school, even in one area of learning, can have an impact on their social skills and, subsequently, on their behaviour.

- **Practitioners should watch out for sudden or marked changes in the behaviour of children or young people.** Challenging behaviour (e.g. disruptive, aggressive or violent episodes), or changes in behaviour, where an outgoing child may suddenly become withdrawn, can be warning signs. Practitioners need to pay attention to these changes, and to track and investigate the behaviour if it continues.

- **Big changes and transitions present challenges and opportunities for children and young people.** While managing change is an important life skill, children need help to manage major transitions, for example moving school (primary to post-primary) or changes in family circumstances (for example in the case of divorce/separation of parents).

- **Extra-curricular activities and hobbies can promote mastery experiences**, which in turn create a sense of self-efficacy, stronger feelings of control and the ability to manage adversity. This has a positive impact on other aspects of children's lives, including achievement as well as social and emotional development.

Connections

The connections between adults and services in a child's life are important. Children benefit where services and supports in their lives are working together.

- **Practitioners should be aware of other support services working with families.** Reviews of serious child abuse point out that complex needs and risks in families and children escalate when practitioners and services do not work together or share information. Practitioners should explore the services that families are using and have a good knowledge of other services, networks or structures that may be relevant to a particular situation.

- **Screening procedures and assessments should identify children at risk of experiencing multiple adversities.** Studies show that some adversities, such as domestic violence, may increase the risk of exposure to others. Developmental or other existing screening procedures at initial referral provide an opportunity to identify more than one adversity and to intervene early for children at risk.

- **Whole-school approaches can help to foster resilience and well-being, and in turn enhance academic achievement.** Whole-school approaches work particularly well for children at risk. For example, breakfast clubs or mental health and well-being promotion programmes which are organised using a whole-school approach for all children mean that individual children do not feel singled out.

Glossary of key terms

Adversity can be defined as a lack of positive circumstances or opportunities, which may be brought about partially by physical, mental or social losses, or by experiencing deprivation or distress.

Attachment is defined as the affectional bond or tie that an infant forms between himself or herself and the mother figure – a bond that tends to be enduring and independent of specific situations.

Protective factors are attributes, situations, conditions or environmental contexts that work to buffer an individual from the likelihood of negative effects of a particular problem. Examples of protective factors include social capital, education and positive relationships with peers, carers and/or significant adults.

Resilience is the capability of individuals *or* systems (such as families, groups, and communities) to cope successfully in the face of significant adversity and risk.

Salutogenesis is an approach which focuses on the factors that support health, as opposed to a focus on the factors that cause disease.

Social capital is a concept which advocates that in building resilience it is social connections, contexts and resources which act as a protective factor against adversity.

Structural adversity involves a relatively static condition which persists for a long period (such as several years in childhood).

Vulnerability factors are those which increase the likelihood of stress or aggravate the effects of risk.

Appendix A – Online tools and resources

Tools/Assessments

There is a wide array of tools and resources available online to support practitioners who work with children, young people and their families who may be experiencing adversity in their lives. The following are some examples of assessment tools and frameworks identified by the CES and the practitioners we consulted with. This is not a comprehensive overview of all tools and resources in the area, but instead provides a **'snapshot'** of the **types** of tools and resources relevant to this topic which may be of use to front line practitioners.

Assessment framework	Description
Framework for the Assessment of Vulnerable Children & their Families (Ireland) (Buckley, Whelan and Horwath, 2006)	The aim of this framework is to standardise practice across a range of organisational and service settings. The framework is based on a core set of values, which include ensuring the immediate safety of the child, a child-centred/ecological approach to assessment, and an evidence-based, inclusive approach to assessment. The assessment framework includes both a tool and practice guidance. The tool cover three core dimensions of the child's life: the child's needs, parental capacity to meet these needs, and the family and community capacities to meet these needs. The assessment framework also brings the practitioner's attention to important areas (parental drug misuse, domestic violence etc.) and indicates how the impact of these areas might be considered against the three core dimensions of the child's life.
Framework for the Assessment of Children in Need and their Families (England and Wales) (Department of Health, 2000)	Introduced in England and Wales in 2000, this framework provides a systematic and consistent way of collecting information about a child and their environment, especially when the child is thought to be 'in need'. The framework highlights important areas to address in assessment, which include developmental needs, parental capacity to respond to those needs, and the impact of wider family and environmental factors on the child and parents/carers while protecting the child's welfare and safety.
My World Triangle (Scotland)	The My World Triangle is an assessment framework used as part of the *Getting it Right for Every Child* approach to child well-being, welfare and protection in Scotland. It highlights overarching areas that are important to the development of all children, which reflect the ecological approach to child development. Like the assessment frameworks presented above, the My World Triangle highlights three areas that assessment attend to: the developmental needs of the child, the parental capacity to respond to those needs, and wider family/environmental factors. This assessment can serve as a starting point in identifying what risks may be present in the child's life, and it includes five key questions that practitioners should consider: • What is getting in the way of the well-being of this child or young person?

	• Do I have all the information I need to help this child or young person? • What can I do now to help this child or young person? • What can my agency do to help this child or young person? • What additional help, if any, may be needed from others?
Signs of Safety (Australia) (Turnell and Edwards, 1999)	Signs of Safety was developed in Western Australia in the 1990s and, since then, has become a widely used approach to child protection casework. It adopts a strengths-based interview technique and also draws on techniques from Solution Focused Brief Therapy (SFBT). The Signs of Safety framework expands the investigation of risk to include strengths and 'Signs of Safety' that can be built on to stabilise and strengthen a child's and family's situation, and develop an appropriate action plan. Risk assessment is conducted with a standard one-page Signs of Safety assessment protocol. Accompanying tools such as the 'Three Houses' and 'Words and Pictures' tools are used to involve children in safety planning.
Standardised measures	
Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1997)	The Strengths and Difficulties Questionnaire (SDQ) is a freely available, brief, 25-item standardised measure which was designed to assess emotional well-being and problem behaviours in children and young people aged 3–16 years (Goodman, 1997). It is a helpful tool for identifying children's needs. There are different versions of the form, which can be filled in by parents, teachers and the children themselves. The items are divided into five subscales, four negative and one positive, which together produce a Total Difficulties score encompassing the following: • Emotional symptoms • Conduct problems • Hyperactivity/inattention • Peer relationship problems • Prosocial behaviour Information on how to mark and interpret scores is available at: http://www.sdqinfo.com/
Child and Youth Resilience Measure – 28 (CYRM - 28)	The Child and Youth Resilience Measure was designed as part of the International Resilience Project (IRP), Resilience Research Centre (RRC), in collaboration with 14 communities in 11 countries around the world. This is a measure with psychometric properties and can be used to assess resilience in youth across cultures. The CYRM-28 is a 28-item questionnaire that explores the resources (individual, relational, communal and cultural) that may bolster the resilience of youth aged 9–23 years old. This measure is a part of the RRC Evaluation Tool Basket which is designed to help programmes and organisations complete their own internal evaluation. Quantitative and qualitative stages in the development of this measure ensure that the CYRM-28 has good content-related

	validity across research sites. Crossover comparison analyses of the findings from the quantitative administration of the pilot measure with 1,451 youth, in addition to qualitative interviews with 89 youth, support the CYRM-28 as a culturally sensitive measure of youth resilience (Ungar and Liebenberg, 2011).
The Social Emotional Health Survey System (Furlong, You, Renshaw, O'Malley and Rebelez, 2013)	The Social Emotional Health Survey System (SEHSS) is a set of assessments designed to measure core psychological components of covitality. Covitality describes how character strengths co-occur to produce increased levels of subjective well-being. Covitality could provide greater understanding around how strengths interact, and could further inform intervention and prevention programmes. The SEHSS includes Elementary, Secondary, and Higher Education versions, all of which provide insight into the psychological self-schemas that form the platform on which each child can build a life of character and purpose. They provide a set of assessments designed to measure core psychological mindsets related to the construct of covitality and positive well-being. Studies conducted by the developers have found evidence which supports the structural validity of the SEHSS for males and females and across U.S. sociocultural groups. Additional research is under way to examine the invariance of the SEHSS under more restrictive conditions, such as when it is translated into other languages and used in cross-national research.

Other websites and online tools

Barnardos Ireland and the UK

Both the Irish and the UK Barnardos websites have a wide range of resources, information and research publications which cover topics relevant to childhood adversity such as child protection and welfare, domestic violence, young carers, bullying, internet safety, parenting, child poverty and advocacy. The Barnardos Ireland website has a host of free ebooks on issues including positive parenting, helping children and young people to cope with death, bereavement and suicide, parental substance abuse and infant mental health.

www.barnardos.ie

www.barnardos.org.uk

National Society for the Prevention of Cruelty to Children (NSPCC, UK)

The dedicated Services and Resources section of the National Society for the Prevention of Cruelty to Children (NSPCC) website features publications, research, and statistics on a host of important topics. In particular, it features accessible factsheets and briefings for practitioners on topics such as assessing children and families, information sharing and confidentiality, and guidance on statutory provisions for safeguarding children and young people in the UK.

www.nspcc.org.uk

The Harvard Center on the Developing Child (USA)

The Harvard Center on the Developing Child develops resources, including evidence briefs, and tools in the area of early childhood development. Materials are written and presented in highly accessible formats, including short summaries, videos and games. A variety of resources is available, including briefs on adversity and resilience.

Resource Library: http://developingchild.harvard.edu/resources/

The National Elf Service (UK)

Includes 'The Mental Elf' – blogs and evidence briefs on different aspects of mental health, including adversity in childhood and building resilience. 'The Child Elf' includes regular blogs and briefs on various aspects of child health and development, while 'The Social Elf' includes briefs and research of interest to social workers.

Sign up for regular updates by email or browse the website.

http://www.nationalelfservice.net/

That Difficult Age: Developing a more effective response to risks in adolescence (Evidence Scope, Research in Practice)

Evidence briefs and tools and resources for working with children and young people and developing resilience.

Click here

Appendix B – Examples of relevant evidence-based and evidence-informed programmes in Ireland

A number of programmes delivered in Ireland and Northern Ireland have been shown to produce positive results both in responding to the needs of children and young people experiencing adversity and in building protective factors to cope with adversity. Below are some *examples* of such programmes, organised under the following four headings:

- Family support and community services
- Parental attachment and parenting behaviours
- Social-emotional development and positive self-identity
- Mentoring and peer support

The following does not include the full range of relevant evidence-based and evidence-informed programmes in this area. Instead, it attempts to give an overview of programmes responding to the needs of children and young people experiencing adversity, and building protective factors to cope with adversity, which CES is aware of, or which practitioners have told us they implement in their service settings. Each programme described below has **some supportive evaluative evidence.** Several programmes have been evaluated using robust methodologies such as randomised control trials, whereas others have supportive evidence from different methodologies.

Family support and community services

Practitioners working with children and families should have a good knowledge of other services, networks or structures that may be relevant to a particular situation. The following are examples of evidence-based and evidence-informed family support and community services to which families could be referred or signposted to.

Strengthening families

'Strengthening families' is a seven-session group parenting and youth skills programme that includes separate weekly parent effectiveness training and child skills-building, followed by a family session to promote good parenting skills and positive family relationships, proven to reduce aggressive and hostile behavior, substance abuse in adolescence, and improve family relationships.

http://www.blueprintsprograms.com/factsheet/strengthening-families-10-14

Functional Family Therapy

Functional Family Therapy is a short-term family therapy intervention and juvenile diversion programme which helps at-risk children and delinquent youth to overcome adolescent behaviour problems, conduct disorder, substance abuse and delinquency. Therapists work with families to assess family behaviours that maintain delinquent behaviour, modify dysfunctional family communication, train family members to negotiate effectively, set clear rules about privileges and responsibilities, and generalise changes to community contexts and relationships.

http://www.blueprintsprograms.com/factsheet/functional-family-therapy-fft

Multisystemic Therapy

Multisystemic Therapy (MST) is an intensive, home-based intervention for families of youth with social, emotional, and behavioural problems. Masters-level therapists engage family members in

identifying and changing individual, family, and environmental factors that are believed to contribute to problem behaviour. Intervention may include efforts to improve communication, parenting skills, peer relations, school performance, and social networks.

http://www.blueprintsprograms.com/factsheet/multisystemic-therapy-mst

Youth Advocate Programme

The Youth Advocate Programme (YAP) was introduced in the US in the 1970s to facilitate young people's reintegration into the community after incarceration. YAP in Ireland is aimed at children aged 8 to 18 years old who are at significant risk of being placed in care or incarceration. YAP is a strengths-based, intensive, family-based intervention that aims to keep children in their communities and out of care or custody. The core of the programme is a mentoring service provided for up to six months, which is uniquely available 24 hours a day to the young person.

http://www.yapireland.ie/

Springboard

The Springboard family support service operates throughout Ireland and is open to all families, but targets those in particular need; intervention can last up to a year or more. Each service provides a range of programmes and intervention approaches, including individual work to assess particular needs and provide appropriate responsive intervention, group work that can include parenting programmes or specific groups for children, family work including parent or child and group sessions, and drop-in facilities for advice or information sharing.

http://trutzhaase.eu/wp/wp-content/uploads/R-2001-Springboard.pdf

Neighbourhood Youth Projects

Neighbourhood Youth Projects are community-based youth development and family support services working with young people aged 10 to 18 years and their families. Through working with young people, families and communities, relationships are strengthened, difficulties are overcome and this benefits the young person's development. Young people are encouraged to find solutions to their own problems and engage in positive behaviour to achieve their full potential. Neighbourhood Youth Projects are jointly managed by Foróige and the Health Service Executive (HSE) with the support and guidance of local community representatives through a local advisory committee.

https://www.foroige.ie/our-work/projects-services-and-programmes/neighbourhood-youth-projects

Differential Response Model

The Differential Response Model is an approach to child welfare, which was originally developed in the USA. It aims to provide two possible routes for dealing with concerns about a child's welfare: a formal investigation to determine if abuse has occurred, or, alternatively, a non-adversarial assessment of the services and support that a family needs in order to keep a child safe.

https://www.childwelfare.gov/pubs/issue-briefs/differential-response/

Garda Youth Diversion Projects

Garda Youth Diversion Projects are local, community-based youth development projects which seek to divert children and young people from becoming involved (or further involved) in anti-social or

criminal behaviour. The projects offer opportunities for education, employment training, sport, art, music and other activities. They facilitate personal development, promote civic responsibility, and seek to support good relations between the Gardaí and the community.

http://www.iyjs.ie/en/IYJS/Pages/WP08000062

Restorative Practice

An approach that aims to develop capacity in a community or institution to manage conflict and tensions by repairing harm and building relationships. It complements and supports other approaches such as coaching, mediation and restorative justice. Restorative practice is used in a wide range of settings, including criminal justice agencies, educational settings, and community services, statutory and voluntary organisations.

http://www.restorativepracticesireland.ie/

Parental attachment and associated parenting behaviours

Parental attachment and associated parenting behaviours have a crucial part in helping children cope with adversity. The following are examples of home-visiting and group-based parenting programmes that can help to promote safety in the home, encourage positive parenting and recognise when support is needed, or when a child, parent or family is at risk.

Lifestart Growing Child Programme

The Lifestart Growing Child Programme is a home-visiting programme with parents of children aged 0-5 years that is aimed at supporting the child's physical, intellectual, emotional and social development, and promoting school readiness. The focus of the programme is on empowering parents, strengthening parent-child relationships through building emotional attachment, and helping to provide a high-quality home learning environment.

http://www.lifestartfoundation.org/programmes-services/the-growing-child

Parent-Child Psychological Support Programme

The Parent-Child Psychological Support Programme is a clinic-based programme for parents and 3–18-month-old infants to monitor infants' growth and development in all areas, including social-emotional development and attachment. Particular focus is placed on parents' well-being, allowing for early identification of need and the provision of additional support as appropriate.

http://www.youngballymun.org/our_work/ready_steady_grow/pcpsp/

Preparing for Life

Parenting for Life is a home-visiting programme by mentors with tip sheet information and activities based around child development and parenting, from pre-birth to starting school. It is designed to improve child development, school-readiness and parental skills.

http://preparingforlife.ie/

Parents Plus

Parents Plus is a suite of group-based parenting programmes intended to support parents to maximise their children's learning, language and social development, as well as reduce behaviour problems.

http://www.parentsplus.ie/

Triple P Positive Parenting Programme

The Triple P Positive Parenting Programme is a multi-level parenting programme that tailors information, advice and professional support to the needs of individual families, and is focused on reducing childhood emotional and behavioural problems. It recognises that parents have differing requirements regarding the type, intensity and mode of assistance they may require. It is delivered through a variety of means, including group work, seminars, and workshops.

www.triplep-parenting.net

Marte Meo

Marte Meo is a model for parents and professional caregivers to support their caregiving role. Through the use and analysis of video recordings that record normal daily interaction moments in naturalistic settings (the family home), Marte Meo therapists offer guidance on specific behaviours, check if a new behaviour is working, and provide opportunities for parents to see positive outcomes of their enhanced parenting skills.

http://www.martemeo.com/

The Incredible Years

The Incredible Years is a suite of group-based parenting programmes designed to strengthen parent-child interactions and attachment; reduce harsh discipline, and foster parents' ability to promote children's social, emotional and academic development.

http://incredibleyears.com/

Odyssey (formerly Parenting Your Teen)

Odyssey is a group-based programme delivered over eight two-hour sessions to groups of parents, underpinned by Family Systems Theory. Session topics include teenage development, problem-solving, rules and consequences and communication.

http://www.odysseyparenting.org/practitioner-training/odyssey-parenting-your-teen-programme/

PEEP – Learning Together Programme

The PEEP – Learning Together Programme is a group-based intervention for parents that offers effective ways of helping parents and carers to improve their children's life chances by making the most of everyday learning opportunities – listening, talking, playing, singing and sharing books and stories together.

http://www.peeple.org.uk/

Social-emotional development and positive self-identity

Both home and school play an important and complementary role in social-emotional development and positive self-identity. The following school-based and community-based programmes aim to promote social-emotional development and well-being, resilience, and pro-social behaviour.

Zippy's Friends

Zippy's Friends is a positive mental health programme aimed at five to seven-year-olds of all abilities, and teaches young children how to develop skills to cope with problems that may occur in adolescence and adulthood. It teaches them how to cope with everyday difficulties, to identify and talk about their feelings and to explore ways of dealing with them.

http://www.hse.ie/eng/services/news/media/pressrel/newsarchive/200920082007Archive/July_2009/Zippy%E2%80%99s%20Friends%20Pilot.html

Promoting Alternative Thinking Strategies (PATHS)

Promoting Alternative Thinking Strategies (PATHS) is a classroom-based social emotional learning programme for primary school students to reduce aggression and behaviour problems in children. The PATHS curriculum teaches skills in five conceptual domains: self-control, emotional understanding, positive self-esteem, relationships, and interpersonal problem solving.

http://www.blueprintsprograms.com/factsheet/promoting-alternative-thinking-strategies-paths

FRIENDS for Life

'FRIENDS for Life' is a school-based positive mental health programme that promotes emotional resilience, and reduces anxiety in children and adolescents. The programme helps students to develop effective strategies to deal with worry, stress and change, and teaches the skills required to reduce anxiety and promote resilience. Teachers can run the programme as a whole school anxiety prevention programme, as a whole class or small group intervention, or with an individual student.

http://www.nbss.ie/interventions-projects/positive-health-and-well-being /friends-for-life

Mind Out

MindOut is a 12-session mental health programme which takes a positive approach to the promotion of emotional and mental health among young people. The emphasis is on giving time to young people to explore what challenges their mental health and looking at the ways they cope, ranging from personal coping skills and informal networks of support to professional or voluntary support services.

http://www.youthhealth.ie/content/mindout-mental-health-promotion-programme-out-school-settings

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http://www.blueprintsprograms.com/factsheet/promoting-alternative-thinking-strategies-paths

The Incredible Years

The Incredible Years suite of programmes for teachers and pre-school practitioners is intended to provide professionals with the skills and the curriculum to better manage classroom behaviour and promote children's pro-social behaviour, school readiness/school engagement, and reduce children's aggression.

http://incredibleyears.com/

Roots of Empathy

A school-based programme focused on raising levels of empathy, resulting in more respectful and caring relationships, and reduced levels of bullying and aggression. It is delivered by a neighbourhood parent with their infant, who visit the classroom every three weeks over the school year. A trained Roots of Empathy Instructor coaches students to observe the baby's development and to label the baby's feelings.

http://www.rootsofempathy.org/

Mentoring and peer support

Mentors and peers can play an important role in being a positive role model and source of support in times of adversity, and in promoting resilience to adversity. The following are examples of mentoring and peer support programmes that respond to a range of needs.

Big Brothers Big Sisters

Big Brothers Big Sisters is a youth mentoring programme for 10–17 year-olds which aims to impact the social, emotional, identity and cognitive development of young people at risk. It involves weekly meetings between young people and matched volunteers for one year or more.

https://www.foroige.ie/our-work/big-brother-big-sister/about-big-brother-big-sister

Rainbows Programme

Rainbows is a peer support programme to assist children who are grieving a death or separation in their family. It provides a safe setting in which children can share their feelings, emotions and struggles with others who have similar experiences. They are supported in this process by a trained facilitator. Rainbows uses materials such as journals, story books, games and activities which form a structured programme to lead the children gently through the grieving process.

http://www.rainbowsireland.ie/

Mentoring for Achievement

Mentoring for Achievement is a two-year school-based programme to support children identified by school personnel as being at risk of academic failure and early school-leaving, and to assist them in developing school continuance skills. It can be delivered in both individual and small group formats. Students are assigned to a trained mentor who works within the school setting. The programme aims to enhance academic achievement, support social skills development, increase school attendance, and assist in the transition to post-primary education.

http://www.archways.ie/our_programmes/mentoring_for_achievement_programme/

Young Person's Probation Mentoring

Young Person's Probation Mentoring is a mentoring service for young people who are involved with Young Person's Probation, which is provided by Le Chéile. Mentors act as a positive role model, advisor and friend, and work with a young person for three hours a week for up to two years.

http://www.lecheile.ie/category/what-we-do/youth-mentoring/

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