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A Guide to Youth Justice in Scotland: policy, practice and legislation

Section 3: Theory and Methods

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Contents

1. Introduction **3**

2. Child Development Theories **4**

Resilience 4

Attachment Theory 6

Neurodevelopment theory 8

3. Offending Behaviour Theories **9**

Risk Need Responsivity Model 10

Good Lives Model 13

Desistance Theory 13

4. Methods **15**

Relationship between worker and client 15

Assessment 17

Formulation 18

Interventions 20

5. Conclusion **25**

6. Bibliography **26**

Appendix 1 ..... **33**

Resilience Matrix 33

1. Introduction

Since the implementation of Getting It Right For Every Child (GIRFEC) in 2006, the youth justice landscape has changed significantly. The approach to working with young people who offend has moved away from a specialist assessment intervention model and become increasingly multi-agency and holistic in nature. The current landscape in Scotland shows that only approximately 30% of Scotland is covered by dedicated youth justice teams, with other service models graduating towards integrated practice models such as: youth justice work being undertaken by children and families practitioners, broader young people's services and criminal justice services (Nolan, 2015). To this end, youth justice practitioners are now defined as all professionals who work with young people who offend. Whilst this may have benefits in terms of providing a consistent approach to meeting the needs of all children and young people, regardless of whether they are engaged in offending behaviour, it has implications for the maintenance of specialist knowledge and skills, professional confidence and therefore the wider workforce development.

The labelling of children's behaviour as criminal can be harmful as it has the potential to stigmatise and reinforce negative self-image and behaviour (Sapouna, Bisset, Conlong, & Matthews, 2015). This is supported by the findings of the Edinburgh Study of Youth Transitions and Crime (McAra, & McVie, 2010), which has shown that young people involved in offending who are warned or charged but have no further contact with the youth justice system have better outcomes than those who become further involved in the system. In fact, the findings suggest that in some cases, doing nothing is better than doing something in terms of achieving reductions in serious offending (Goldson, Hughes, McAra, & McVie, 2010). This study was influential in the development of the Whole System Approach (WSA) in 2011. The WSA sets out that those working with young people who offend should focus on providing early and effective interventions and where possible, divert young people away from formal systems which may lead to compulsory measures, prosecution or custody. The Early and Effective Intervention (EEI) Core Elements Framework sets out the minimum expectations for the effective delivery of EEI in order to provide a shared language and, where possible, a commonality of processes (see Section 4: Early and Effective Intervention).

The WSA also outlines that where young people continue to offend and cannot be diverted away from formal systems through the frequency or severity of their offending behaviour, and all other options have been exhausted, robust community alternatives to secure care or custody should be considered in accordance with the Havana rules for the protection of juveniles deprived of their liberty (UNCRC, 1990) (see Section 5: Managing High Risk). Where there are no alternatives to the removal of liberty, the approach highlights the need for clear pathway planning from the point at which young people have their liberty removed, support and contact during this time, and planning and support on returning to the community (see Section 6: Reintegration and Transitions).

As well as having effective processes in place, practice should be directed by evidence and aimed at achieving meaningful outcomes for children, young people and their families. In order to carry out holistic, child-centred assessments, develop comprehensive formulations and deliver effective, outcomes-led interventions with young people who offend, practitioners must have a good understanding of the drivers to offending behaviour, as well as what assists desistance and social integration. The age, stage and social context of the young

person, along with their cognitive, social and emotional development, and 'hooks for change' (Giordano, Cernkovich, & Rudolph, 2002) should inform the intensity, duration and sequencing of the content and delivery of any targeted intervention.

The theories and methods utilised in youth justice are not unanimously agreed upon and some theories and methods are more developed than others. This section will therefore briefly outline the most commonly utilised child development theories and offending behaviour theories, and will consider the main pros and cons of each of them. It will also consider what the research is currently telling us about the most effective methods to achieve positive outcomes for those young people who offend.

2. Child Development Theories

Children and young people involved in patterns of offending, or more serious offending, are often our most vulnerable, victimised and traumatised children (CYCJ, 2016). It is essential that we ensure their wider needs are being met as these are often the drivers underlying their offending behaviour. Good practice with young people who offend (including preventative practice) is informed by child development theories which collectively emphasise the need to promote positive social and emotional development to reduce vulnerability to future offending. Some examples of these theories are:

- Resilience, vulnerability and protective factors (Daniel & Wassell, 2002)
- Attachment Theory (Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1958)
- Neurodevelopmental Theory (Perry, Pollard, Blakley, Baker, & Vigilante, 1995)

Resilience

Resilience is generally defined as the ability to manage adversity and overcome adverse experiences. Building resilience is underpinned by GIRFEC and should be a key theme of all work with children, young people and their families. Social work, education and health services all emphasise the importance of building on strengths and increasing the protective factors in children and young people whose situations indicate that they are at greater risk of developing social and psychological problems, including offending.

While some personal and social factors are strongly associated with offending, there are important aspects of life which can protect children and young people against risk. Just as some risk factors increase the risk of offending, resilience factors can reduce the impact of adverse events and diminish offending behaviours (Borum, Bartel, & Forth, 2006). The development of resilience is a result of interpersonal processes that reduce the impact of adverse biological, physical and social factors which threaten a child's health and well-being. Resilience has been described as 'an interaction between risk and protective factors within a person's background, which can interrupt and reverse what might otherwise be a damaging process' and 'normal development under difficult conditions' (Fraser & Galinsky, 1997).

Daniel and Wassell (2002) highlight that resilience factors can be located at three ecological levels: the young person, their family relationships, and the wider community. The intrinsic qualities of an individual (individual resilience) fall on a dimension of resilience and vulnerability, whereas the external factors (family and community) fall on a dimension of

protective and adverse environments. The GIRFEC framework recommends that practitioners consider these dimensions as set out in the resilience matrix (see Appendix 1). These two dimensions, when considered together, provide a framework for considering resilience at all ecological levels of an individual's environment. Goldstein and Brooks (2005) call for an emphasis on the interaction between resilient parents, the child and the social environment the young person is developing within. Systemic approaches to developing resilient young people are now better understood.

Resilient children and young people are more likely to overcome difficulties presented to them by life circumstances, be able to make positive life choices, and have better long term outcomes. Gilligan (1997) describes the three fundamental building blocks of resilience as:

- A secure base whereby the child feels a sense of belonging and security
- Good self-esteem, an internal sense of worth and competence; and
- A sense of self efficacy; a sense of mastery and control, along with an accurate understanding of personal strengths and limitations.

Luthar, Cicchetti, and Becker (2000) explored dynamic resilience considering environmental and individual factors. They differentiated between the two areas to be able to define the child-centred internal workings of resilience, and found that focussing on assessing personal attributes of the young person was important to understanding resilience. The research into resilience has found that being able to overcome adversity is not extraordinary but that resilience can be understood as the characteristics of attuned, grounded and supported individuals.

The majority of children and young people develop resilience from the people who surround them: their parents or carers, families and significant others (Black & Lobo, 2008). However, due to the circumstances in which some children grow up, they do not have the opportunities to develop resilience from the people around them. Given the experiences and vulnerabilities of many children involved in offending, it is likely that a significant proportion of them will have low levels of resilience. The development of resilience in children involved in offending is likely to contribute to reductions in offending behaviour and is regarded as a protective factor. It is therefore essential that activities and services delivered by local communities and by practitioners should promote the development of:

- Emotional wellbeing
- Good social skills including empathy, communication, and pro-social behaviour
- Conflict resolution / problem solving skills
- Sense of self-esteem and self-control
- Sense of hope, motivation for personal achievement
- Positive peer group influence
- Positive, supportive and caring adults in their life
- Opportunities for meaningful participation; and
- Access to wider support networks

Attachment Theory

Attachment theory was first developed by John Bowlby in 1958 and has since been expanded on. The central theme of attachment theory, according to Bowlby, is that parents and carers who are available and responsive to an infant's needs establish a sense of security in the child. Bowlby also premised that over time, as the child becomes more independent, they rely on their internal working models of attachment to guide their future social interactions.

Parental inconsistency, abuse and neglect can have a direct impact on the development of a child's brain, on their attachment style and on their emotional regulation (Schore, 2001). Shaw, Owens, Vondra, Keenan, and Winslow (1996) describe that failure to form secure attachments early in life can have a negative impact on behaviour in later childhood and form a pathway into behavioural difficulties. Babies are born dysregulated and require attunement, co-regulation and interaction to be able to develop skills which will allow them to follow a natural process of moving from dysregulation through to self-regulation. When a child's fear and need for protection is not met reliably from caregivers they develop attachment strategies that maximise their chances of receiving care. In extreme situations their focus becomes survival (Zeedyck, 2013) which impacts on brain development and opportunities to develop self-regulation and a resilient emotional system. The resulting attachment pattern that develops is a reflection of the strategy that a child has developed for coping with stress / survival.

There are four key factors to be cognisant of when observing attachment between a child and parent:

1. **Safe Haven:** When the child feels threatened or afraid, he or she can return to the caregiver for comfort and soothing.
2. **Secure Base:** The caregiver provides a secure and dependable base for the child to explore the world.
3. **Proximity Maintenance:** The child strives to stay near the caregiver, thus keeping the child safe.
4. **Separation Distress:** When separated from the caregiver, the child will become upset and distressed (Ainsworth et al., 1978; Main & Solomon, 1986).

Over the years research has focused on the quality and security of attachments. Three different attachment types were identified: secure, insecure-avoidant, and insecure-resistant (Ainsworth et al., 1978); and a further fourth attachment type was subsequently identified: insecure-disorganised (Main & Solomon, 1986, 1990). A secure attachment reflects experience of consistent and responsive care and tends to result in an internal working model that they are loveable, others are caring, and they have the confidence to form healthy relationships. An insecure-avoidant attachment reflects experience of caregivers who were rejecting and unavailable and tends to result in an internal working model that others are rejecting / unresponsive, and they tend to withdraw, become undemanding and self-sufficient. An insecure-resistant / ambivalent attachment reflects experience of inconsistent care, and may result in an internal working model that they are unworthy of others and have a tendency to seek attention and care from others, often through risky or coercive behaviours. Finally, an insecure-disorganised attachment reflects a care experience where the caregiver is frightening but, out of necessity, the frightened child seeks care and

protection from the caregiver who is frightening. This confusing experience tends to result in an internal working model that they are unlovable, others are frightening, and often leads to unpredictable and volatile presentations from young people.

The National Institute for Clinical Excellence has produced a guideline in 2015, Children's attachment: attachment in children and young people who are adopted from care, in care or at high risk of going into care. The guideline covers the identification, assessment and treatment of attachment difficulties in children and young people up to the age of 18 and is helpful for practitioners in education, health and social care.

Research on attachment styles in children and young people who offend is limited, however, the research that is available indicates that insecure attachments are linked to higher levels of hostility and anger as compared to secure attachments (Muris, Meesters, Morren, & Moorman, 2004). In addition, children diagnosed with oppositional-defiant disorder (ODD), conduct disorder (CD), or post-traumatic stress disorder (PTSD) frequently display insecure attachment problems, possibly due to early abuse, neglect or trauma.

Emerging therapeutic approaches view high-risk behaviours (for example self-harm, absconding, violence, harmful sexual behaviour, fire-setting) as being driven by adaptive attachment strategies which are aimed at survival either by eliciting care or by keeping people at a distance (Rogers & Budd, 2015). Within the current literature "external assets" such as support, empowerment, boundaries, expectations and constructive use of time as well as "internal assets" such as commitment to learning, positive values, social competencies and positive identity are recognised as being important constructs to develop for children engaging in high risk behaviours (Fulcher, McGladdery, & Vicary, 2011). As young people develop these skills, the risk of them displaying high-risk behaviours reduces.

However, the quality of the relationship between the carer / professional in developing these assets is key and for some children 'blocked trust' (when they block the pain of rejection and the capacity to delight in order to survive in a world without comfort and joy) can lead to 'blocked care', as it can be difficult to engage them and to help them give up their original strategies for survival. Golding (2007) has indicated that understanding why children behave in the way they do (identifying the need behind the behaviour) can enhance carer / practitioner empathy, in turn making it more likely that the child will experience more positive relational experiences. Carer / practitioner empathy, acceptance, and curiosity form the starting point for children to develop trust and learn new ways of relating to others. Hughes and Baylin (2012) also promote taking a compassionate, playful and creative approach to building relationships.

Golding (2015) has developed a pyramid documenting the priority therapeutic needs for children who have experienced trauma. The base level of the pyramid is about feeling safe, physically and emotionally. In order for any interventions to be effective it is argued that the provision of a safe and secure base is an essential starting point. The second level is focused on developing a trusting relationship so that they are able to begin accepting nurture before moving towards the third level, which focuses on comfort, co-regulation of emotions, and eliciting care from relationships. The next level of the pyramid focuses on empathy and reflection, how to manage behaviour in relation to others, and repairing relationships. The focus then moves to developing resilience and resources with a focus on development of self-esteem and self-identity. The top level of the pyramid focuses on exploring trauma and

mourning losses. It is suggested that only when the building blocks from the previous levels of the pyramid are in place will specialist and specific interventions to help cope with and process traumatic memories potentially be helpful for children and young people.

The National Institute for Clinical Excellence have produced clinical guidelines for the management of Post-Traumatic Stress Disorder (PTSD), although it should be noted that these are currently under review. In 2015 NHS Education for Scotland also produced a guide to delivering evidence-based psychological therapies in Scotland which includes information on the prevalence of trauma and the effectiveness of interventions to address trauma. In addition, the developmentally informed attachment risk and trauma (DART) approach is an emerging approach for working with children and young people in secure settings who are engaging in high-risk behaviours towards themselves and others (Rogers & Budd, 2015).

Neurodevelopment theory

'Polishing the Diamonds': Addressing adverse childhood experiences in Scotland highlights the association between adverse childhood experiences and injury and death during childhood, premature mortality and suicide, disease and illness, and mental illness. Three mechanisms have been suggested for how exposure to adverse childhood experiences can cause such harm. The first mechanism is through engaging in health-harming behaviours, the second is through the impact on social determinants of health such as education, employment and income, and the third is through neurobiological and genetic pathways as responses to stress can lead to physical changes in the way the brain develops.

The first growth period for a child's brain is in utero up to the first three years of life. This period of time is therefore particularly significant in terms of prevention and early intervention.

Early years: Research into brain development offers a neurological perspective on the damaging effects of pre-birth and early childhood abuse, neglect and exposure to violence, including domestic abuse, on infant brain development. It is argued that poor parental attachment relationships and direct and indirect exposure to abuse and trauma impact negatively on brain development, and can engender emotional and behavioural problems that continue into adulthood. Perry et al. (1995) outline the potential impact of neglect and trauma on infant development which can include the functional capacity of the neural systems that mediate our cognitive, emotional, social and physiological functioning and can result in a variety of difficulties; for example delayed language skills, delayed fine and large motor skills, impulsivity, dysphoria, and hyperactivity. It appears that the longer the child is in an adverse environment, and the earlier and more pervasive their experience, the more pervasive and enduring is the impact. Findings have indicated that there can be some recovery of functional capacity when children are removed from adverse environments, with the less time spent in an adverse environment seeming to lead to more robust recovery (Perry, 2002; Perry et al., 1995).

Adolescence: A child's pathway to physiological, emotional and psychosocial maturity depends on their individual rate of maturation (Prior, 2011; Singh, 2009). During adolescence the brain undergoes rapid neurological development to transform into an adult brain. During this period social and cognitive functioning is affected, increasing young adults' propensity to take risks, behave impulsively and sensation seek, thus impairing their

judgment and ability to interpret social cues (Chater, 2009; Johnson, Blum, & Giedd, 2009). In turn this can lead to poor decision making and can increase the chance of contact with the police. Emerging neuro-scientific research has begun to demonstrate that cognitive development and emotional regulation, akin to full adult maturity and functioning, is not fully developed until at least the mid-20s. For adolescents who have experienced trauma, the impact of their adverse childhood experiences (ACE's – see Section 10: Mental Health) on their brain development can make these typical impulsive / risk-taking behaviours even more profound.

Creeden (2013) suggests that 'viewing the youth within the context of his or her developmental history and optimal developmental trajectory is an essential underpinning for the entire assessment and treatment process' (p.13). In addition to the typical areas considered within a holistic developmental assessment he argues that instruments aimed at assessing a wide range of trauma and neurological conditions be undertaken as well. This enables an understanding of each child's capacity to function at a developmentally expected level and to consider the issues that frequently create significant developmental obstacles for children with behavioural issues. In relation to intervention, he recommends utilising the understanding of neuro-development and neuro-processing for the child as a framework. The approach taken is to attend to the earliest developmental tasks first (for example, attunement, attachment, body awareness, physiological regulation, accurate attending to social cues) and then move to higher level developmental tasks (for example, social rules and skills, personal responsibility, understanding impact of behaviour on others) as appropriate for the individual child.

It is therefore important that the team around the child considers which developmental milestones the child has reached and which ones have not been reached, then ensures that interventions are focused on helping the child reach the developmental milestones appropriate for their age. Interventions should be applicable to the developmental stage of the child and may involve developmentally appropriate play to assist with this. Once the 'foundation' skills are acquired then the more complex issues associated with offending behaviour can be addressed and are more likely to be successful.

3. Offending Behaviour Theories

As with child development theories, there are a number of offending behaviour theories. The theories utilised in youth justice are not unanimously agreed upon but there are three key theories which receive the most attention. This section will briefly outline these three theories and will consider the benefits and limitations of each, however, it should be borne in mind that these theories do not necessarily need to be mutually exclusive.

Risk Need Responsivity Model

The Risk, Need, Responsivity (RNR) model, developed by Andrews and Bonta (2010), has been the dominant model in correctional work. It is based on the theory known as the Psychology of Criminal Conduct and a general personality and cognitive social psychological perspective on criminal behaviour. The RNR model is a psychological approach proposing that intervention undertaken with people who offend is most effective when it follows these three core principles:

- Risk – the level of assessment or intervention should match the level of risk
- Need – treatment or intervention should focus on those factors which are most clearly linked to offending (criminogenic needs)
- Responsivity – the intervention should be tailored to the needs of the individual to enhance their ability to engage

Since its inception the RNR model has been expanded and now refers to 18 principles which are categorised under: overarching principles, structured assessment, programme delivery, staff practices, and organisational, as well as risk, need and responsivity (Andrews, Bonta, & Wormith, 2011). The RNR model is not an intervention approach but a framework through which intervention should be delivered to enhance effectiveness. A number of meta-analysis studies have shown that there is strong empirical support for better outcomes from those interventions that adhere to the RNR principles (Andrews & Bonta, 2010; Andrews & Dowden, 2005; Dowden & Andrews, 2004; Hanson, Bourgon, Helmus, & Hodgson, 2009; Koehler, Lösel, Akoensi, & Humphreys, 2013).

Based on the strong research support for the risk principle there was a move to use risk assessment tools to identify criminogenic needs and the level of risk presented by individuals. These tools have been based on the research evidence that has been gathered over the years about the risk and protective factors that correlate with offending behaviour. There are a number of risk factors that have been consistently identified, which tend to fall into the following categories: individual, family, social, school, and community (Farrington, 2015). Taking a more positive, strengths-based approach, research has recently started to focus on protective factors: those factors that nullify the effects of risk factors or predict a low probability of offending among a group at risk (Ttofi, Farrington, Piquero, & DeLisi, 2016). The well evidenced protective factors tend to fall into similar categories to the risk factors (see table below).

	Risk factors	**Protective factors**
Individual	Impulsiveness; attention problems; low intelligence; low empathy (Farrington, 2015; Jolliffe & Farrington, 2009).	High academic achievement & intelligence; high self-control; low hyperactivity (Farrington, Ttofi, & Piquero, 2016; Jolliffe, Farrington, Loeber, & Pardini, 2016; Ttofi, Farrington, Piquero, Lösel, et al., 2016; Vassallo, Edwards, & Forrest, 2016).
Family	Poor parental supervision; parental substance abuse and mental health problems; parental attitudes that condone offending behaviour;	High parental interest in education; good parental supervision; high family income; good quality caregiver relationships; strong bonds with family (Farrington, 2015;

	inconsistent, punitive or lax discipline; poor affective relations between youth, caregivers and siblings (Farrington, 1996; Farrington, 2015; Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 2009).	Farrington, Loeber, & Ttofi, 2012; Farrington et al., 2016; McAra & McVie, 2016).
Social	Peer delinquency; socio-economic deprivation; early victimisation (Farrington, 2015; Farrington et al., 2012; Hawkins et al., 2000; McAra & McVie, 2016).	Low peer delinquency; having a good relationship with peers; high likelihood of getting caught (Jolliffe et al., 2016; Vassallo et al., 2016).
School	Low school achievement; educational problems; poor attendance; school exclusions (Farrington, 1989; Farrington, 2015; McAra & McVie, 2016; McAra, McVie, Croall, Mooney, & Munro, 2010).	Academic achievement; positive education experiences; retained in education; positive relationship with teachers (Farrington et al., 2012; Farrington et al., 2016; Jolliffe et al., 2016; McAra & McVie, 2016; Vassallo et al., 2016).
Community	High crime levels in community; neighbourhood issues (Farrington, 2015; Farrington et al., 2012; Hawkins et al., 2000).	Community involvement and engagement (Farrington et al., 2016; Jolliffe et al, 2016)

The protective factors identified through research so far are in line with resilience based approaches (Ttofi, Farrington, Piquero, & DeLisi, 2016). Although further research is required to examine the interactions between risk and protective factors, research is clearly indicating that not only does offending and violent behaviour increase as a function of cumulative risk factors, but that it also decreases as a function of cumulative protective factors (Andershed, Gibson, & Andershed, 2016; Dubow, Huesmann, Boxer, & Smith, 2016). A more complete understanding of protective factors for offending behaviour would assist with a more strengths-based, focused approach to intervention.

Due to a lack of consistency in the use of validated risk assessment tools for children and young people in Scotland, there was a move to use the Asset assessment or the Youth Level of Service/Case Management Inventory (YLS-CMI) as the risk assessment tools of choice for general offending. The National Standards for Scotland's Youth Justice Service (2013), which were initially published in 2002, indicated that 'every comprehensive assessment must be completed using Asset / YLS-CMI assessment and other specialist structured risk assessment tools where appropriate'. In 2008 England and Wales moved to the 'Scaled Approach' framework for assessment and intervention, using Asset as the core risk assessment tool. The Scaled Approach was designed to tailor the intensity of the intervention to the assessed likelihood of reoffending and risk of serious harm to others. The Scaled Approach and the 'risk factor prevention paradigm' has been criticised by Case & Haines (2009). Their criticisms in terms of the Scaled Approach focus on the use of a risk category, based on an Asset assessment, to determine which level of supervision or intervention a person receives without taking into account the wider individual and systemic needs of that person. In particular they criticise the methodology used as being undermined by oversimplification, partiality, indefinity and invalidity and argue that it is 'negative' and 'value laden' (Case & Haines, 2016). Rather than conducting risk assessments that categorise individuals into levels of risk, they argue that youth justice should be underpinned

by the Children First, Offender Second model. This model focuses on assessing children in holistic terms including their individual needs and contexts, views children as part of the solution, not part of the problem, and should involve working in partnership with other professionals, children and their families.

Others have also criticised the RNR model for its focus on criminogenic needs and lack of focus on basic human needs, as this has led to a deficits based approach (Ward & Stewart, 2003). A further criticism of the RNR approach has been that the risk factors are presented in a way which makes them appear as individual characteristics, and there is a lack of distinction between those factors that can be changed through the efforts of the individual themselves and those which are socially imposed deprivations that can only be changed by broader social or economic measures (Raynor & Vanstone, 2016). It is claimed that this has led to the social and structural context of offending being ignored and risk reduction efforts being overly focused on deficits and the individual themselves (Hannah-Moffat, 2009).

McAra et al. (2010) highlight that attention to risk has led to mechanistic practice and more punitive policy such as the management of serious violent and sexual offenders in Scotland, and where this involves children and young people, it is in contravention of the Kilbrandon principles.

In Scotland, the use of actuarial tools, or certainly the emphasis that has been placed on the score in England and Wales when using such tools, does not appear to fit well with the Framework for Risk Assessment, Management and Evaluation (FRAME) practice standards. The first practice standard focuses on risk assessment and states that:

> "Risk assessment will involve identification of key pieces of information, analysis of their meaning in the time and context of the assessment, and evaluation against the appropriate criteria. Risk assessment will be based on a wide range of available information, gathered from a variety of sources. Risk assessment will be conducted in an evidence-based, structured manner, incorporating appropriate tools and professional decision making, acknowledging any limitations of the assessment. Risk assessment will be communicated responsibly to ensure that the findings of the assessment can be meaningfully understood and inform decision-making. Risk will be communicated in terms of the pattern, nature, seriousness and likelihood of offending" (p.7).

In addition, the FRAME guidance goes onto state that 'Assessments in relation to the risk of further offending behaviour are best undertaken within the context of structured professional judgement. This should be underpinned by holistic formulation of the relevant developmental, dispositional and environmental factors' (Risk Management Authority, 2011; Scottish Government, 2014). The use of scores and converting these to risk bands in the Asset assessment, and perhaps to a lesser extent YLS-CMI, does not encourage the practice of developing a comprehensive formulation so that the relevant underlying drivers to the behaviour of concern can be understood and risk reduction measures linked directly to these.

Good Lives Model

The Good Lives Model (GLM) (Ward, 2002) is a strengths-based and holistic approach to working with adults and young people who have been involved with offending behaviour and aims to promote the individual's aspirations and plans for more meaningful and personally fulfilling lives (Ward, 2010). However, the GLM and the traditional RNR approach to offender rehabilitation are not mutually exclusive. Risks and needs can be reduced or managed within the GLM framework, which delivers a more holistic, client-centred, and engaging framework within which to do this (Ward & Fortune, 2013).

According to the GLM, all individuals have needs and aspirations and seek 'primary human goods' which are likely to lead to psychological well-being if achieved. Eleven primary goods have been defined: life, knowledge, excellence in play, excellence in work, excellence in agency, inner peace, friendship / relatedness, community, spirituality, pleasure, and creativity. Secondary goods are activities that individuals engage in, in order to achieve primary goods e.g. football may serve as the secondary means by which to meet the need for excellence in play. The desire to achieve primary goods is normal, however, the way in which some individuals try to meet these needs is maladaptive and they harm others in the process. This is often due to a lack of internal or external resources to meet their needs in a more pro-social manner (Willis, Yates, Gannon, & Ward, 2013). For example, harmful sexual behaviour can sometimes be the secondary means by which to meet the need for inner peace or friendship / relatedness. In order to reduce reoffending and help individuals achieve a satisfying life without harming others, the GLM views intervention as an activity that should build capabilities, strengths, opportunities and resources in individuals.

For adolescents, the 11 'primary goods' in the original GLM were condensed to eight 'needs': having fun, achieving, being my own person, having people in my life, having purpose and making a difference, emotional health, sexual health, and physical health. The GLM-A is a framework to help understand the needs that drive a young person's behaviour and inform the interventions that should be implemented and prioritised to help them meet those needs more appropriately (Print, 2013).

There has been limited research on the Good Lives Model with adults, and even less in relation to children and young people. However, initial evaluation findings on the value of the GLM-A has indicated that practitioners and children found it to be a positive and motivational approach (Leeson & Adshead, 2013; Simpson & Vaswani, 2015). One of the criticisms of the GLM is that it is too focused on the individual level of analysis. Given the evidence about the significance of social capital in desistance, it has been argued that there is also a need for more focus on interventions around the familial and social contexts of offending and that legitimate opportunities to develop social capital be improved (McNeill & Weaver, 2010).

Desistance Theory

Trotter (2016), amongst others, has argued that the central focus that has been placed on risk assessment and management can undermine attempts to promote positive changes in the lives of individuals who have engaged in offending behaviour and undermine the various social goods that may result from such changes. Also, it has largely been assumed that the factors that lead an individual into offending are the factors which will lead them out of offending (Trotter, 2016). For practitioners interested in reducing reoffending, it is essential

to understand the change agents (McCulloch, McNeill, Green, & Lancaster, 2008) involved in ending offending - the process of 'desistance'. Desistance is often regarded as a process because it is not possible to know the exact moment when offending behaviour ceases permanently. As Maruna (2001) highlights - how can we measure desistance other than posthumously? In order to reduce reoffending it is important to understand when, why and how change occurs. The literature in relation to desistance has grown over the past few years, however our understanding of the processes underlying desistance in children and young people is still limited.

Maruna (2001) identified three broad theoretical perspectives important to understanding desistance:

> **Ontogenic theories** which stress the importance of age and maturation and suggest that children and young people can outgrow certain behaviours as they mature.
>
> **Sociogenic theories** which stress the importance of social bonds and ties and suggest that if the individual has family ties, positive social relationships and are in education or employment, they are less likely to offend as they have more to lose than those who have no social bonds.
>
> **Narrative Theories** which stress the importance of subjective changes in the person's sense of self-identity, personal and social 'connectedness' or integration, which in turn are reflected in changing motivations, greater concern for others and consideration of the future. The way the young person makes sense of their situation, the changes they make and the way they view and value themselves can have an impact on their own behaviour, concern for others and more consideration as to their own future (Maruna, 2000).

These three theoretical perspectives are interconnected and stress the importance of the relationships between 'objective' changes in a person's life and 'subjective' assessment of the value or significance of these changes. They support the case for more holistic responses and suggest that the 'key' to stopping offending is likely to reside somewhere in the interface between developing personal maturity, changing social bonds associated with life transitions, and individual subjective narrative constructions built around key events, transitions and changes. Indeed, Maruna and Farrall (2004) have distinguished between *primary* and *secondary* desistance where primary desistance is the change in behaviour and secondary desistance is a related change in self-identity as a non-offender. More recently researchers have also referred to *tertiary* desistance which refers to a shift in an individual's belonging to and acceptance by a moral community (McNeill, 2016). Long-term change therefore also depends on how the individual is seen by others and the actions others take, and there is recognition that desistance is not just a personal process but a social and political process (McNeill, 2016; Nugent & Schinkel, 2016). We therefore need to engage with situations and contexts, as well as individuals, to support change and manage risks (Bottoms, 2014). Nugent and Schinkel (2016) have recently proposed replacing primary, secondary and tertiary desistance with the following terms: *act desistance* - for non-offending, *identity desistance* - for the internalisation of a non-offending identity, and *relational desistance* - for recognition of change by others. The changes are proposed in order to move to a terminology that describes the different aspects of desistance better and does not suggest sequencing in time or importance.

Following a review of the research evidence on desistance, McNeill, Farrall, Lightowler, and Maruna (2012) state "Desistance requires engagement with families, communities, civil society and the state itself" (p. 2). They identified eight central principles for practice:

- Being realistic about the complexity and difficulty of the process
- Individualising support for change
- Building and sustaining hope
- Recognising and developing people's strengths
- Respecting and fostering agency (or self-determination)
- Working with and through relationships (both personal and professional)
- Developing social as well as human capital
- Recognising and celebrating progress

Through a desistance lens a number of domains have been highlighted as being significant in supporting children and young people's journeys away from offending (HMI, 2016):

- Building relationships and engagement
- Engagement with wider social contexts / networks
- Effectiveness in addressing key structural barriers
- Creating opportunities for change and community integration
- Promoting positive identity and self-worth
- Motivating children and young people
- Active management of diversity needs
- Constructive use of restorative approaches

McNeill (2016) argues that desistance from offending behaviour involves supporting relationships and building strengths and hope, rather than focusing on risks and deficits. While individual offence focused work might be appropriate for some individuals, the social needs of the child or young person must also be addressed.

4. Methods

In order to achieve good outcomes for children and young people involved in offending we need to use our theoretical knowledge to aid our understanding of the vulnerabilities, needs and risks that produce offending behaviour for specific individuals, as well as their strengths and protective factors. In other words, moving from a generic understanding of what causes offending behaviour, to what the relevant drivers to offending are for specific individuals. We also need to draw on theory and research to inform our knowledge about what interventions are likely to be effective and how to deliver these to achieve the best outcomes. This section will look at the evidence base for effective methods of intervention.

Relationship between worker and client

Building relationships is crucial to ensuring that comprehensive, collaborative assessments and formulations can be undertaken and that interventions are effective. The relationship between client and worker is also seen as pivotal in promoting or hindering desistance.

However, when working to effect change in the behaviour of children and young people it is essential that high quality working relationships are also formed with the young person's parent(s) / carer(s). Recognising the importance of relationships, the Common Core of Skills, Knowledge & Understanding and Values for the "Children's Workforce" in Scotland resource was published in 2012. This describes the skills, knowledge and understanding, and values that everyone should have if they work with children and young people and their families and sets them out within two contexts: relationships with children, young people and families, and relationships between workers.

Trotter (2015) suggests that successful outcomes are strongly related to the quality of the interaction between worker and client. Workers who can positively influence their clients are more likely to be enthusiastic, warm and optimistic, using creativity and imagination. Additionally, McNeill (2002) describes optimism, trust and loyalty as being essential to effective working relationships with clear roles, boundaries and mutual expectations. Green, Mitchell and Bruun (2013) suggest genuineness and advocacy as important elements of the working relationship for young people. Trust is a significant factor in motivating young people to engage with adults, and Milbourne (2009) has pointed to previous negative experiences within the context of statutory services and residential care as impacting on a young person's ability to trust others. As highlighted earlier, Hughes has developed a therapeutic model based on the principles of PACE: taking a **P**layful approach, and displaying **A**cceptance, **C**uriosity and **E**mpathy, which forms the starting point for children to develop trust and learn new ways of relating to others. Dyadic Developmental Practice (DDP) is an intervention for families with adopted or fostered children, or for children in residential care, who have suffered from significant developmental trauma. It brings together knowledge about attachment, developmental trauma, neurodevelopment and child development and has the PACE principles at its core in order to engage and build trusting relationships (for more information see https://ddpnetwork.org/about-ddp/).

Research on intervention effectiveness has shown that the way professionals approach work with their clients can impact on the whole package of care. Trotter (2013) reviewed the research into effective supervision and found that it is characterised by prosocial modelling and reinforcement, problem-solving, relationship and cognitive behavioural skills. In an Australian juvenile justice setting, Trotter (2012) examined direct observation and taped interviews of supervision practice. Practice was coded for skills such as relationship, role clarification, prosocial modelling, problem-solving, and use of CBT techniques. Findings indicated that when supervised by officers who demonstrated these skills, low to medium risk offenders had a further offending rate of 52% in comparison to 74% when supervised by less skilled officers. The difference was less and not statistically significant for high risk offenders, 83% compared to 93%.

Research has also indicated that the more workers discussed problems from the young person's perspective, the more engaged the young people were. This was in contrast to young people being found to be less engaged the more the problems were identified by the worker without the young person's input (Trotter, 2012). These findings highlight the need to work collaboratively with the child or young person to set the goals for intervention. Recognising the strengths and potential of young people from the first contact, rather than focusing solely on problems to be fixed, is crucial to engagement and developing motivation. Even in short meetings, how workers interact with clients can have a major impact.

Young people who have lived experience of the youth justice system (Cook, 2015) have identified that their positive experiences involved having one consistent worker and a worker who:

- Had a belief in the young person
- Had a vision or belief in their futures
- Were there during their worst spells as well as better ones
- Helped them to understand their choices
- Went ‘above and beyond’

All of the above indicate that promoting positive behaviours, listening, challenging, showing respect and understanding and including young people in decision making are all essential in relationship building and achieving positive outcomes.

Assessment

Bronfenbrenner’s theory of social ecology (Bronfenbrenner, 1979) highlights that individuals are embedded within systems that play an integral part in their life and in shaping their behaviour. The individual is at the innermost level of the concentric circles with each concentric layer representing a system such as family, peers, school, and community. Children and young people often have limited control over the systems within which they are embedded, making it necessary for a systemic approach to be taken to reduce offending behaviour. A comprehensive, holistic, and systemic assessment and formulation should therefore be the starting point for any intervention plans to reduce the offending behaviour that children and young people are engaging in. This should ensure that the interventions provided are individualised and proportionate, and therefore most likely to be effective.

In adhering to good practice and holistic working when focusing specifically on risk associated with the child’s offending behaviour, it is necessary to be mindful that children may experience other forms of vulnerability and victimisation not associated with offending behaviour and that the National Guidance for Child Protection in Scotland may need to be followed. The National Risk Framework (Calder, McKinnon, & Sneddon, 2012) aids the assessment and intervention planning process, broadly speaking, for children and young people where welfare and / or child protection concerns exist. The purpose of the tool is to support practitioners from a wide background in the process of identifying, analysing and managing risk. This guidance was developed in collaboration with the Scottish Government to assist with the conceptualisation of risk across various domains of practice. Whilst this framework is not specific to youth justice practice, it is beneficial to consider applying this framework to ensure that risk, in its broadest sense, is addressed in a holistic way. For example, a young person who may be displaying offending behaviour may also be a victim of violence at home by parents, constituting a child protection concern. The risk to the young person may therefore need to be assessed alongside the risk posed by the young person’s offending behaviour.

The wellbeing of children and young people is at the core of the GIRFEC approach and is broader than child protection and welfare. Wellbeing has been described in terms of eight indicators to assist a common understanding of what wellbeing means: Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible, and Included (SHANARRI). The National Practice Model is helpful in considering the quality of life for the child or young

person at that point in time and identifies the individualised support that child needs to help them reach their full potential and flourish.

However, there are specific circumstances where children and young people may present a risk of serious harm to others because of their own behaviours, and in such cases, additional guidance is needed. As stated above, the Framework for Risk Assessment Management and Evaluation (FRAME) for local authorities and partners for children and young people under 18 provides a template for child-centred practice in risk assessment and management. The appendix to the FRAME document details the Care and Risk Management (CARM) planning guidance (see Section 5: Managing the Risk of Serious Harm). In terms of assessing the risk of reoffending with a view to reducing this, it is useful to identify the key risk factors and protective factors linked to the offending behaviour. The use of appropriate and validated risk assessment tools can be a helpful aid in order to ground the assessment in the knowledge base of the factors we know are linked to offending, and further makes for an evidence-based assessment. The Risk Assessment Tools Evaluation Directory (RATED) is an online document produced by the Risk Management Authority (RMA) which highlights various different risk assessment tools available for assessing children and young people along with the evidence that supports the tools' validity. However, the directory was last updated three years ago and there have been subsequent developments since this time such as the publication of the Short-Term Assessment of Risk and Treatability: Adolescent Version. Although risk assessment tools are crucial for structuring our assessments we need to ensure the assessment is individualised, and the RMA indicates that risk assessment is best undertaken within the context of a structured professional judgment approach.

Formulation

Most children and young people who are, or have been, involved in offending will for the most part spend considerable periods of time when they are not offending, and will have occasions when they do not engage in such behaviour, despite having the opportunity to do so. We therefore need to gather information about the strategies and skills they use at these times, and their strengths and interests, to inform our holistic understanding of their behaviour. In addition to the research on risk and protective factors described above, there is also an emerging body of evidence that children involved in more serious offending are almost always the most vulnerable, victimised and traumatised young people (CYCJ, 2016). Given what we know about children who engage in violent behaviour and the clear links between vulnerability, often as a result of ACE's (see Section 10: Mental Health) and violence, we need to conceptualise them as children in need, rather than as offenders. This is in line with the National Strategy for Community Justice which encourages partners to use the terms 'person with convictions' or 'person with an offending history', rather than 'offender'.

It is essential that risk assessments be undertaken within the context of a structured professional judgment approach and that they are underpinned by a holistic formulation. In fact, Johnstone and Gregory (2015) have stated that "risk assessment should be viewed as incomplete in the absence of a risk formulation" (p. 106). Without formulation, a risk assessment will amount to a mechanistic rating or scoring of risk factors with no comprehension of the meaning or function of the offending behaviour for the individual, and as a result, the ability to develop individualised, proportionate and effective risk management

/ intervention plans will be limited. There is also a need to ensure that our assessments and formulations take into account gender differences in the pathways to offending behaviour (see Section 7: Vulnerable Girls and Young Women). As the research literature demonstrates, many of the risk factors linked to offending behaviour in children are out with the control of the child. Assessments and formulations therefore need to be systemic and consider family, peers, school, and community.

To develop a comprehensive formulation it is important to first of all consider the individual manifestation and relevance of risk factors. Douglas, Blanchard, and Hendry (2013) highlight that to understand the individual manifestation of risk factors (i.e. what they look like for individuals), consideration should be given to the onset, course, severity, nature of change, acuteness of change, periodicity, recent change, current status, and future concerns. In terms of relevance, simply because a risk / protective factor has been identified at the general level as an important risk factor, and is *present* for an individual, it is not necessarily *relevant* or causal to the individual's behaviour of concern. There is therefore a need to understand and examine the relevance of the risk / protective factor to that individual's behaviour. Douglas et al.(2011) have indicated that a risk factor is relevant to an individual's risk for violent behaviour if it:

1) was a material contribution to past violence
2) is likely to influence the individual's decision to act in a violent manner in the future
3) is likely to impair the individual's capacity to employ non-violent problem-solving techniques or to engage in non-violent or non-confrontational interpersonal relations, or
4) is necessary to manage this factor in order to mitigate risk.

Additionally, a comprehensive formulation should offer an understanding of the interaction and role of risk and protective factors for the individual. Lewis and Doyle (2009, p. 290) state that "risk formulation may be regarded as a form of analysis that can assist practitioners to explain the origins, development, and maintenance of risk behaviour, while providing a crucial link between assessment and management…". One helpful model for organising information and developing a formulation is Weerasekera's 4P's model (Weerasekera, 1996). This model considers predisposing factors (pre-existing vulnerabilities that predispose a child to developing problem behaviour), precipitating factors (more recent events that trigger the onset, or exacerbation of the problem behaviour), perpetuating factors (those maintaining the problem behaviour), and protective factors (those that ameliorate or reduce the problem behaviour).

Areas to consider when completing your assessment and formulation are:

- strengths, protective factors and resilience factors
- developmental history including any attachment issues
- current level of functioning (cognitive, social, behavioural) to inform engagement and intervention strategies
- whether there are any potential biological or neurodevelopmental difficulties
- the extent of any exposure to adverse childhood experiences
- the nature, frequency, duration and intensity of the behaviours
- functional analysis of the behaviours
- the outcome of any previous attempts to modify the behaviours

- parental or carer's level of concern about the behaviours and their capacity to support behaviour change

Common features of formulations conducted in the mental health field have been identified and are helpful for us to consider when developing a risk-based formulation. They are: inferential (speculates about possible futures and provides an explanation for the speculations); action-oriented (assists with development of intervention plans); theory-driven (guided by a theory of problem cause or solution); individualised (driven by details of the individuals history); narrative (encoded in natural language not formulas, calculations or numbers); diachronic (anchored in information about the past, the present, and possible futures); testable (intended to be tested); and ampliative (produces new knowledge) (Hart, Sturmey, Logan, & McMurran, 2011).

One issue arising from these common features of formulation is the theory which should be used to underpin the formulation. As there is no single theory of offending behaviour in children and young people, various theories need to be drawn on such as Risk Need Responsivity, Desistance and the Good Lives Model. In addition, formulations involving children and young people should be developmentally informed, systems informed, trauma informed, and vulnerability informed (Johnstone & Gregory, 2015). Drawing the 4P's information together with theoretical knowledge enables the development of a narrative risk formulation which should provide the basis for a clear, focused, proportionate and individualised risk management / intervention plan (see Section 5: Managing Risk of Serious Harm for information on risk management planning).

It should be borne in mind that a formulation is changeable and should be collaborative and incorporate information from significant adults and professionals, as well as the young person themselves. It is a *potential* explanation of the concerning behaviour(s), it is our best professional judgment based on the knowledge we have at the time, and it should be reviewed regularly. A comprehensive formulation of risk is a skill that should be supported by appropriate training, supervision and reflective practice.

Interventions

There are a variety of approaches to interventions for children and young people who engage in offending behaviour. In Scotland, the Whole System Approach advocates early and effective intervention for children and young people who are at the early stages of being involved in offending behaviour which tends to focus on the child's welfare needs (see Section 4: Early and Effective Intervention). This section focuses on offence specific interventions which are currently identified as best practice in the most recent reviews.

General and violent offending

Interventions for children and young people engaging in general offending and violent offending have often been based on cognitive-behavioural principles and have covered elements such as anger management, social skills training, and social problem solving skills. There is evidence of the effectiveness of cognitive behavioural programmes through meta-analytic studies (Koehler et al., 2013; Landenberger & Lipsey, 2005; Lösel & Beelmann, 2003; Tong & Farrington, 2006). Additionally, a meta-analysis of general offending behaviour interventions in Europe for young people (up to the age of 25) indicated that behavioural and

cognitive behavioural interventions were most effective, and that those interventions that were delivered in accordance with the RNR principles showed the greatest effects (Koehler et al., 2013).

There is, however, a stronger evidence base for family-based interventions and systemic interventions (Humayun & Scott, 2015). This is not surprising since children are embedded within various systems, and research on the risk factors underlying offending behaviour in children and young people often highlights the importance of systemic risk factors. Individual intervention work with the child will have limited success if the context within which the child is embedded is not taken into account and does not direct the approach taken. For example, family issues particularly likely to underlie offending behaviour include poor parental supervision, parental substance abuse and mental health problems, parental attitudes that condone offending behaviour, inconsistent or lax discipline, and poor affective relations between youth, caregivers and siblings. On the other hand, having a strong bond with at least one parent or carer, and having intensive parental supervision, are likely to act as protective factors or to promote desistance.

Reviews of the research literature indicate that family-based interventions and multi-systemic interventions can be effective in reducing offending behaviour (NICE, 2013; Farrington & Welsh, 2003; Humayun & Scott, 2015; Moodie, 2015). A review of high quality family-based crime prevention programs (including home visiting, day care / preschool, parent training, school-based, home / community programmes for older children, and multi-systemic therapy) found that generally the prevalence of offending could be reduced by approximately 10-15% by implementing such interventions (Farrington & Welsh, 2003). They found that the most effective interventions used parent training while the least effective types were those based in schools.

The NICE guideline *Antisocial behaviour and conduct disorders in children and young people: recognition and management* offers best practice advice on the care of children and young people with a diagnosed or suspected conduct disorder, including looked-after children and those in contact with the criminal justice system. The NICE guideline recommends that for the treatment of conduct disorder, group / individual parent training programmes are offered to the parents of children and young people aged between three and 11 years, and for children and young people aged 11-17 years, it is recommended that multimodal interventions such as multi-systemic therapy are offered. Additionally the guideline recommends that when working with parents and carers, workers should:

- Discuss with young people, of an appropriate developmental level, emotional maturity and cognitive capacity, how they want parents or carers to be involved, and that this should happen at intervals to take account of any changes in circumstances;
- Be aware that parents / carers might feel blamed for their child's problems or stigmatised by their contact with services, so directly address any concerns they have and set out the reasons for and purpose of the intervention; and
- Offer parents / carers an assessment of their own needs including personal, social and emotional support; support in their caring role; and advice on practical matters and help to obtain support.

Many families have multiple difficulties or needs and it may be that some of these need to be addressed before they can engage meaningfully in family work. It is important that the onus

for overcoming any barriers to the family's active engagement sits with practitioners and their service, and that we work collaboratively with the family to overcome these. *Support and Services for Parents: A Review of the Literature in Engaging and Supporting Parents* identified that some of the key features that contribute to successful engagement with families are:

- Adoption of a 'strengths-based' approach, building upon existing strengths
- Providing opportunities to share experiences and difficulties with others in similar situations
- Providing home based services where practical to alleviate issues such as transportation, child care, and anxiety
- Completing a thorough assessment of the family situation so that interventions are responsive to immediate and long-term needs
- Ensuring fathers or significant males are included in interventions
- Developing shared agreement on the problems to be dealt with and the goals of the intervention
- Starting with small simple tasks with easily achievable goals
- Ensuring open and clear communication

The review also concluded that a variety of different interventions are necessary to meet the differing needs of families. Those indicated by research to be the most effective interventions were:

- Parent training for children under eight years old;
- Parent training supplemented by direct individual development work for 8-12 year olds; and
- Structured family work such as Functional Family Therapy or Multi-systemic Therapy for adolescents.

Harmful sexual behaviour

In relation to concerns about sexual behaviour (whether concerns are about a child potentially being harmed or exploited, or about potentially harming others), a useful starting point is the Brook Sexual Behaviours Traffic Light tool. This tool is designed to help professionals:

- distinguish healthy sexual development from harmful behaviour across the ages ranges 0-5, 5-9, 9-13 and 13-17 years, although the developmental stage of individuals should be taken into account as well as their chronological age;
- make decisions about safeguarding children and young people; and
- assess and respond appropriately to sexual behaviour in children and young people with interventions depending on whether the behaviour is assessed to be in the green (safe and healthy development), amber (potential to be outside of safe and healthy development) or red (outside of safe and healthy behaviour) category.

Early interventions with children and young people displaying harmful sexual behaviour (HSB) to others have largely been based on adult sex offender models, with adaptations for use in work with young people. In the UK, the majority of intervention practice has been cognitive behavioural therapy interventions based on the relapse prevention model. This

work typically involves detailed behavioural analysis of the HSB; identifying and modifying cognitive distortions; developing victim empathy; education about sex, consent and healthy relationships; emotion management; self-management skills; social skills training; modifying unhealthy sexual arousal; and risk management strategies (Hackett, 2014). However, it is increasingly recognised that interventions need to be child-centred, holistic, strengths-based, and target areas of more general unmet need as well as addressing the HSB.

Ward, Yates, and Willis (2012) indicate that the GLM can enhance current existing practices and aims to improve on treatment effectiveness through a motivational approach. In fact, initial research indicates that adding GLM principles to RNR practice can increase motivation as indicated through increased engagement, reduced drop-out rates from intervention and better outcomes (Mann, Webster, Schofield, & Marshall, 2004; Ware & Bright, 2008). Willis et al. (2013) have provided helpful guidelines as to how the GLM can be integrated into practice. They are clear that practitioners can exercise flexibility and creativity in integrating the GLM into their practice, as long as the core constructs are embedded throughout the intervention and the approach taken is consistent with the guidelines provided.

In addition, G-MAP have produced a guide, Intervention and planning using the Good Lives Model, to assist professionals to construct individual programmes of work that are specific to the needs of children and young people and their unique circumstances. More recently they have published a book 'The Good Lives Model for Adolescents Who Sexually Harm' which provides comprehensive therapeutic guidelines and case illustrations to demonstrate how the GLM-A can be used in practice (Print, 2013). The G-MAP model of intervention is more commonly referred to as the Safer Lives Programme in Scotland. It was introduced in Scotland in 2008 and a number of individuals in Scotland have been trained as trainers. Further details on trainers are available from the Centre for Youth & Criminal Justice.

Although the Good Lives Model has a twin focus of enhancing well-being and reducing harm, good practice still requires professionals to conduct a needs / risk assessment and implement risk management processes to promote individual and community safety at the start of and throughout the work. A Good Lives plan will outline ways of helping the individual address areas of need and should contribute to the population of a risk management plan and ultimately, the overall aims of the Child's Plan.

Initial evaluation findings on the value of the GLM-A has indicated that practitioners found it to be a helpful framework to aid the understanding of professionals, children and carers of the needs being met by the harmful sexual behaviour, as well as an excellent framework for engaging and motivating children and carers in therapeutic work. The initial evaluation findings from children highlighted that they were able to understand the GLM-A, it helped them to understand their own harmful sexual behaviour and what needed to change, it was motivational, and it provided them with hope that things could get better (Leeson & Adshead, 2013). Additionally, a survey considering the impact of implementing Safer Lives in Scotland concluded that practitioners viewed it as having a positive impact on their practice, most often by adding to their available 'tool kit', but at times in a more transformative way. Almost all of the practitioners viewed the approach as an excellent fit with their own professional values and liked the return to a more positive and person-centred approach rather than one dominated by a risk management perspective (Simpson & Vaswani, 2015).

Hackett (2006) has outlined a framework for resilience-based interventions with young people displaying HSB. The core elements include:

- Developing supportive relationships for young people with at least one key non-abusive adult in their lives
- Helping young people to build positive and reciprocal peer relationships
- Encouraging school success and educational achievement
- Nurturing young people's talents and interests
- Building family resilience by offering primary caregivers a safe person they can confide in
- Encouraging participation and planning so that young people and families are centre stage in the planning process
- Giving young people opportunities to set and achieve goals and pro-social ambitions

Interventions for HSB also need to consider the systems within which the child is embedded and be supported by wider systemic work which involves the family, school, peers and community. Parents or carers should be involved in the intervention so that any relationship / home issues can be addressed but also so that they can reinforce learning and put in place any necessary boundaries / risk management strategies.

Research has shown strong support for family-based interventions and Hackett (2014) has documented a number of helpful aims for a family-support approach:

- Seek to draw on and harness strengths within families
- Broaden the social support dimension of family life
- Bolster families' level of social support
- Teach parents about the importance of supervision, how to identify situations of risk and how to implement risk-management strategies
- Help parents learn about children's sexual development and, in particular, what are appropriate and inappropriate sexual behaviours at different developmental stages
- Help parents identify when they need to inform other people about their child's sexual behaviours, how they should go about this and what level of information needs to be shared
- Help parents explore and review family rules about sex and sexuality
- Support parents in identifying appropriate ways and opportunities to talk to their children about sexual matters
- Learn about specific behavioural parenting strategies in order to respond to challenging behaviours presented by children
- Improve communication patterns in the family and enhance the quality of parent-child interactions

It is clear from the literature that interventions for children and young people involved in offending behaviour are most likely to be effective when they are child-centred, holistic, strengths-based, goal-oriented, collaborative, and involve family and other systems. It is crucial that interventions are individualised and proportionate, and this can be achieved by developing an intervention plan that is based on comprehensive assessment and formulation.

5. Conclusion

This section has emphasised the importance of acknowledging the different needs and strengths of each individual so that any planned intervention is child-centred. Assessment and formulation, which is the starting point of intervention, needs to take account of developmental factors, attachment, and neurodevelopmental factors as well as offending behaviour theories so that interventions can be individually tailored and delivered in a manner which is responsive to the individual. Assessments for those children and young people who are a risk of serious harm to others should be informed by FRAME guidance and underpinned by the use of the CARM process. These protocols inform the intensity, duration and sequencing of intervention and the processes to manage risk, if any are required. The outcomes from the assessment, formulation and intervention planning should be included in the Child's Plan and reviewed regularly, not only to assess progress, but also to highlight any relevant changes in the child or young person's situation.

In meeting both the wellbeing and offending needs of a child or young person who is displaying offending behaviour, it is important that intervention does not stigmatise or further label them and their families. This, in conjunction with the recognition of any existing strengths and / or protective factors that may be further developed in order to motivate, enhance resilience, build human and social capital and effect positive change, will encourage responsive participation and increase the probability of the effectiveness of any programme of work.

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Appendix 1

Resilience Matrix