CHILDREN AND YOUNG PEOPLE IN CONFLICT WITH THE LAW: POLICY, PRACTICE AND LEGISLATION

Section 9: Approaches to Working With Children

June 2026

Children and Young People's Centre for Justice

Featured artwork created by children and young people with justice experience

Children and Young People's Centre for Justice

www.cycj.org.uk

Contents

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 children and young people in conflict with the law has moved away from a specialist assessment intervention model, becoming increasingly multi-agency and holistic in nature. Much of this work is done out-with specific youth justice teams, and whilst this may have benefits in terms of providing a consistent approach to meeting the needs of all children and young people, it also has implications for the maintenance of specialist knowledge and skills, professional confidence and the wider workforce development. This section aims to provide information on approaches to working with children and young people in conflict with the law.

1.1 Policy and legislative context

In 2021 the Scottish Government published *Standards for those working with children in conflict with the law 2021*. Standard 7.2 states that:

> "Interventions and services to reduce the risk of harm must address the specific strengths and vulnerabilities identified by assessment and formulation. They must be developmentally informed, proportionate, timely and delivered by practitioners with the appropriate skills to do so. All risk management plans must be regularly reviewed to ensure strategies and interventions continue to be appropriate and proportionate" (Scottish Government, 2021).

GIRFEC and the Whole System Approach to guide our work in Scotland with children and young people in conflict with the law. The practice guide sections following this one on *Approaches to working with children and young people* (Section 9), focus on the various elements of the Whole System Approach (WSA). The WSA prioritises Early and Effective Intervention (EEI), where rather than charging children who come into conflict with the law, the police work with other relevant agencies to provide timely and appropriate interventions to address the behaviours bringing them to the attention of police. This can also involve no further action. Children can also have behaviours which bring them into conflict with the law responded to via the welfare-based Children's Hearing System. The WSA also states that where possible action should be taken by the Crown Office and Procurator Fiscal Service (COPFS) to divert children and young people away from formal systems, which may lead to compulsory measures, prosecution or custody, where there is an identified need which Diversion from Prosecution may better address. This should be the presumption for all under 18's. The Early and Effective Intervention Framework of Core Elements sets out the minimum expectations for the effective delivery of EEI, with Section 10 of this guide providing fuller information. Section 11 of this guide provide further details on Diversion from Prosecution. The Scottish Government have also made a commitment for Restorative Justice to be available across Scotland to those who wish to access which is detailed in Section 12.

Under the WSA, when children and young people cannot be diverted away from formal systems due to the frequency or severity of their behaviour, they must be supported to attend court and to understand this process. UNCRC Article 40 states children should not be in adult justice systems and should be where possible supported in child specific systems,

like the Children's Hearing System, or Youth Courts, where they can fully participate and have their rights upheld. Section 13 discusses best practice when supporting children and young people at court.

The WSA highlights, that for children and young people whose behaviour may meet the threshold for secure care or custody, robust community alternatives must be considered in accordance with the Havana Rules for the protection of juveniles deprived of their liberty (United Nations Committee on the Rights of the Child,1990). Where there are no alternatives to the removal of liberty, clear pathway planning and support should be present at every stage of the process, and support plans prepared ahead of their return to the community. See Section 16: Reintegration, 14: Residential Childcare and 17: Alternatives to Deprivation of Liberty. The WSA also covers managing children and young people who present a risk of harm, at liberty or otherwise, with further guidance in Section 15: Managing the Risk of Serious Harm. The Standards for those working with children in conflict with the law 2021 must be followed at all times.

In relation to children's rights, the United Nations Convention on the Rights of the Child (UNCRC, 1989) sets out the civil, political, economic, social and cultural rights of every child under the age of 18. The WSA aims to uphold all 54 articles in the UNCRC (1989), including those pertinent to the justice system. Section 3, Child and Human Rights, Our Responsibilities, provides a more detailed overview of the rights landscape, however of particular relevance to this section (as summarised by UNICEF) are:

- Article 5 (parental guidance and a child's evolving capacities): Governments must respect the rights and responsibilities of parents and carers to provide guidance and direction to their child as they grow up, so that they fully enjoy their rights. This must be done in a way that recognises the child's increasing capacity to make their own choices.

- Article 18 (parental responsibilities and state assistance): Both parents share responsibility for bringing up their child and should always consider what is best for the child. Governments must support parents by creating support services for children and giving parents the help they need to raise their children.

- Article 39 (recovery from trauma and reintegration): Children who have experienced neglect, abuse, exploitation, torture or who are victims of war must receive special support to help them recover their health, dignity, self-respect and social life.

- Article 40 (juvenile justice): A child accused or guilty of breaking the law must be treated with dignity and respect. They have the right to legal assistance and a fair trial that takes account of their age. Governments must set a minimum age for children to be tried in a criminal court and manage a justice system that enables children who have been in conflict with the law to reintegrate back into society.

Our approaches to working with children and young people who come into conflict with the law to address their needs (as detailed in previous sections of this guidance) need to be rights respecting, particularly given the implementation of the UNCRC (Incorporation) (Scotland) Act 2024.

As well as having diversionary processes and child-friendly systems in place, the needs underlying the behaviours bringing the child into conflict with the law need to be addressed. This should be achieved through taking account of the findings of the (Independent Care Review, 2020) and the subsequent Promise:

- **Voice** and Article 12 – children must be listened to and given the opportunity to be active participants in the process
- **Family** and Article 5 - families must get support and guidance to overcome any difficulties that get in the way of nurturing their child, wherever possible
- **People** – people in the workforce must be supported to listen and be compassionate in their decision making

This section of the guidance provides an overview of the foundations needed to provide effective supports to meet the needs of children who come into conflict with the law, regardless of which part of the justice system or processes they find themselves involved in. It also considers responses to immediate distress, collaborative safety planning, linking theory to practice, goal setting, measuring progress and preparing for the ending of support. Finally, the importance of staff wellbeing is considered.

2. Foundations for effective supports

Within the youth justice field interventions for violent behaviour (including harmful sexual behaviour) have tended to be based on cognitive behavioural interventions originally designed for adults which are then modified to try and take account of the different learning needs of children

(Allardyce & Yates, 2018; Mitchell & Staniforth, 2017). This has also been the case within Scotland (Allardyce et al., 2021; Vaswani & Simpson, 2015). Typically these interventions have been based on the Risk, Need, Responsivity (RNR) model (Andrews & Bonta, 2010) and desistance theory (Weaver, 2019). However, our increased understanding of neurodevelopment, as well as the impact that adverse childhood experiences can have on a child's development, indicate that interventions adapted from adult-based models are not well suited to many children who come into conflict with the law (Perry et al., 2018; Sheahan et al., 2021; Wigzell & Bateman, 2024)

For example, research into the circumstances of children referred to the Intervention for Vulnerable Youth (IVY) project due to concern over their violent behaviour found that in terms of the types of concerning behaviours presented this not only involved the children's risk of harm to others, but also to themselves, and of victimisation from others. The prevalence of adverse childhood experiences, psychological distress, mental health needs, and neurodevelopmental disorders found was high. Symptoms of attachment disorder and post-traumatic stress disorder were identified for the vast majority of children, yet attachment-based interventions and trauma-focused interventions were explicitly referred to for less than five per cent of the children. The research concluded that there was a clear need to reframe how we conceptualise risk of violence from children and shift to considering violence as a distress response that highlights unmet needs (Murphy, 2018). Similarly, Sadie

et al. (2023) argue that the violent behaviour of children should be reframed as pain-based behaviour, with the recognition that children can behave in this way as a result of many emotions, not simply anger. There is a clear research base indicating that interventions should be neuro-developmentally aware, trauma-informed, and developmentally respectful (Perry et al., 2018).

Interventions focused on 'risk' can also be stigmatising and result in feelings of powerlessness, disengagement and further marginalisation (Deakin et al., 2022). As Creeden (2013, p. 12) highlights, the personal and developmental factors underpinning behavioural problems can often be overlooked when a behaviour management approach is taken to address the behavioural issues. Rather, he proposes a developmental approach that measures progress by the "acquisition and integration of developmental skills and not just by the absence of problematic behaviour". Taking a developmental approach supports the identification of the issues or skills gaps that are creating barriers to positive developmental outcomes and personal resiliency (Creeden, 2013). Our starting point should be to assess which foundation skills might be limited, or absent, and support the acquisition of these before focusing on higher level skills such as those required in many cognitive-based interventions. Our interventions should then generally proceed along a neurodevelopmental framework: "bottom to top (brain stem to neo-cortex), right to left (right hemisphere to left hemisphere), and back to front (occipital lobe to prefrontal cortex)". Using multimodal interventions, the focus should generally be on "bottom-up interventions (e.g., body-based, sensory-based and experiential) before top-down interventions (e.g., insight oriented, analytical, language loaded)" (Creeden, 2013, p. 801). A developmental approach also recognises that a range of factors in the contexts children live within (e.g. family, school, peers, community) influence their healthy development and should be incorporated into support plans.

Whilst meeting children's developmental needs and respecting their rights, we need to make sure that everyone is protected from harm. This includes any risk of the child causing harm to others (and themselves through this behaviour), the risk of harm they may cause to themselves, and the risk of harm they may experience from others. Support should therefore be situated in a proportionate risk reduction response depending on the level, nature and severity of the potential harm and the imminence of the potential harm – and always considering child protection. Initial consideration as to whether child protection actions are required is critical (Scottish Government, 2021).

> "Risk practice in relation to children must be understood through a lens of child development, be trauma and systemically informed, and must consider situational and contextual factors" (Scottish Government, 2021, p. 4)

This is important because many of the factors that underpin children's harmful behaviour are out-with their control (Allardyce & Yates, 2018; Children and Young People's Centre for Justice, 2025; Murphy, 2018). For more detailed information see Section 15 Managing Risk of Serious Harm.

Within the literature there are a number of foundational elements that support effective practice when working with children and young people in conflict with the law. These are

also echoed by practitioners and managers – safe spaces; communication and understanding of needs; strengths-based approach; forming and building relationships; and time. Each of these will be considered in turn.

2.1 Safe spaces

Safe spaces are essential for fostering psychological, emotional, and physical safety for and with the children, young people and families we work with as well as the professionals supporting them. Time, space and compassion may be considered at the core of creating safety and can contribute to creating hope, connections and action in what we do (Scottish Government, 2023). Creating safety is a key foundational building block for any trauma informed environment or intervention (Golding, 2015; Quin, 2019). For a child's resources to move from being focused on survival they need to be in a stable, safe place. Golding's (2015) pyramid of need is a visual way of considering the different levels of intervention and how interventions are reviewed and adjusted (up and down the pyramid) as the needs of children change depending on their current experiences. Feeling safe involves the basic needs that all children need to feel safe and include shelter, warmth, food, feeling understood and supported (Golding, 2020). If circumstances change and they no longer are / feel safe, then interventions need to be adjusted to re-establish safety (Golding, 2020).

Once in this safe place then they are more able to focus on being supported to develop trust in relationships and then on eliciting care from these relationships and experiencing comfort and co-regulation. When these building blocks are in place then they are more likely to be in a place where they can reflect, grow emotionally, develop self-compassion and empathy. These new relationship experiences can challenge core beliefs that they may have held about themselves and other people and support the development of resilience and self-esteem. To make sense of their experiences of trauma and loss and integrate these into their sense of self the foundations of the pyramid need to be in place (Golding, 2020). This is in line with Herman's (1992) phase-based approach to trauma intervention and recovery – safety and stabilisation; remembrance and mourning; and (re)connections; which is the basis for the NHS Education for Scotland (2017) transforming psychological trauma framework.

Similarly, Treisman (2017, p. 80) indicates that "physical, emotional, and relational safety are the cornerstones of any positive therapeutic relationship and any therapeutic re-parenting experience" and provides practical ideas of how this can be done within intervention sessions. These include establishing therapeutic anchors; having structure to sessions; communicating the concept of safety; having reciprocal verbal/written agreements; exploring and identifying triggers and ways to increase feelings of safety; agreeing a signal if they need to take a break or end the session; careful ending of sessions; and creating of safety/coping plans.

Having access to a safe space has been highlighted by children and young people as being central to interventions experienced as 'promotive'. The safe space was not just a physical space but also a 'dialogic' space where there could be sharing of ideas and discussions about opinions and actions without judgment. Safe spaces were described by children and young people as places that felt like home, where they felt wanted and where they could engage in self-discovery and try on different identities (Deakin et al., 2022).

2.2 Communication and understanding of needs

Having a shared understanding of the behaviors causing concern and the driver to these behaviors is of crucial importance. This involves a shared understanding between the child and the practitioner, the child and their family, the practitioner and the child's family, and both internal and external colleagues. It also involves adapting communication styles so that information is accessible, as well as reducing shame and stigma through both the use of language and supporting understanding of why the behaviors may be occurring. A person's identity and any experience because of their identity can also be central to understanding their needs.

Language

From our first interactions with children and families we need to be aware of the language that we use and the impact it can have. The language we use can be inherently blaming and stigmatising (Sapouna et al., 2015). There has been a lot of work recently across Scotland in terms of the language we use including the Our Hearings Our Voice 'Language Leaders' as well as more local initiatives. The Language Leaders group highlight a number of principles that they would like to see applied so that words, tone, and body language are used in a way that supports children to feel safe and included:

- Personalised – words will be personalised to meet the individual needs of the child, including taking account of the child's own wishes and use of language
- Balanced – Reports, letters, and discussions will reflect the strengths and positives in children's lives, ensuring they are balanced against any challenges and risks
- Non-stigmatising – only language which is non-stigmatising and protects children from blame and distress will be used
- Involved – all language used will be clear, easy to understand, and will support children to be involved in decision making (Our Hearings, Our Voice)

Core communication skills

Core communication skills include interpersonal skills, verbal and non-verbal communication skills, observation skills and listening skills. Communication involves exchanging information in both verbal and non-verbal forms as well as using listening and observation skills to truly try and understand what the person is communicating. It can also include symbolic communication for example, punctuality, reliability and attention to detail are symbolic of the worker's care, concern, and competence (Trevithick, 2012).

Communication skills can include:

- Interpersonal skills e.g. Empathy; Responsiveness to expression of emotion; Turn-taking; Structuring time
- Verbal communication skills e.g. Use of language – linguistic sensitivity; Tone; Volume; Speed
- Non-verbal communication skills e.g. Proxemics – distance and physical closeness; Kinesics – movements, gestures, expressions
- Observation skills e.g. Help to formulate hypotheses
- Listening skills e.g. Active; Credulous; Non-selective or non-directive

Miscommunication can happen between the message being sent and the message being received, which can be impacted by our own assumptions and perceptions, so it is important

to check out our understanding with the person we are communicating with. We also need to be aware of cultural differences in communication and the meanings of aspects of the different parts of communication across cultures (Trevithick, 2012).

It is also important to consider how these various aspects of communication may have different benefits/challenges depending on whether the communication is in-person or online and whether some aspects of communication are lost / less noticeable online.

Behaviour is communication

Behaviour is an observable response to our internal and external experiences. The behaviours we see can tell us something about the person's inner state, the stress they are under and their needs; behaviours are communication. However, often our responses to behaviour are developed based on what we see rather than really understanding what sits underneath these behaviours. The behaviours we can see are the 'what', the tip of the iceberg, and the many factors which contribute to them can be hidden from view below the surface. We need to look below the surface to understand why a behaviour is happening, what it is communicating, and the needs it is meeting for a child (The Mehrit Centre, 2023).

There is clear evidence that adverse experiences in childhood can have long term impacts on emotion, cognition etc, and ultimately behaviour and life outcomes. However, we need to understand how these adverse experiences have disrupted developmental processes and are impacting present behaviour so that we can develop better intervention strategies (McLaughlin & Sheridan, 2016). For example, neglect may have impacted language development and therefore communication; physical abuse may have impacted attachment styles and relationship skills; domestic abuse may have influenced cognitions/thinking styles. Often behaviour is 'the only means by which a child or young person who has experienced considerable adversity or who has other developmental difficulties can express their needs and wants' (Johnstone, 2020). These behaviours are a form of communication, often termed distress behaviours or pain-based behaviours (Murphy, 2018; Roles & Johnstone, 2024; Sadie et al., 2023), and can include for example violence, non-violent offending, substance use, unauthorised absences, non-suicidal self-injury, suicide attempts, health neglect, victimisation, and harmful sexual behaviour.

For some time in Scotland there have been calls to take a developmentally appropriate and trauma-informed approach to supporting children who have come into conflict with the law through engaging in behaviour that has harmed others. Distress/harmful behaviours can arise from experiencing developmental trauma and there is a considerable focus in Scotland on being a trauma informed nation and providing trauma responsive interventions (NHS Education for Scotland, 2017). Indeed, those who contributed to the Independent Care Review (2020) identified that key professionals such as police, sheriffs and social workers should be supported to take a more trauma-informed approach. However, we need to be mindful that various other factors can contribute to distress behaviours as well and not limit our focus to a predominantly trauma one (Smith & Monteux, 2023). For example, work by Roles and Johnstone (2024) has highlighted that variables such as relational, behavioural, cognitive, systemic, and mental health can also impact on a child's development. It is important that these other factors are considered alongside trauma in assessments to aid in our understanding of the function of the distress behaviours for the individual and to ensure that practice is inclusive and responsive to any protected characteristics.

Assessment and formulation

The starting point for any intervention should be a comprehensive assessment and formulation so that there is a clear, and shared, understanding of what the needs are that the intervention should be targeting. The *Getting it right for every child* framework should underpin any assessment of a child's needs (Scottish Government, 2022). Depending on professional/theoretical background assessments and formulations can take various forms. However, they should be developmentally appropriate and child friendly.

Understanding distressed or pain-based behaviour firstly requires the child to feel safe to be able to communicate about what is going on. Working in a manner that is collaborative, exploratory, and empathic can support creation of a safe environment (Sadie et al., 2023). Assessment should be multi-modal, systemic, examine vulnerabilities and strengths and take account of the child's relational environment. It should take into consideration the child's developmental stage as well as analyse specific behavioural incidents to identify antecedents and consequences (Sadie et al., 2023). It has also been argued that when formulating in relation to children that an eclectic approach should be taken whereby a range of perspectives/theories are adopted (e.g. biological, psychological, cognitive and social) so that the needs of children at different stages of development can be included (Manassis, 2014).

Formulations should be able to be "written with and for the child and should be a tool for therapeutic engagement and the facilitation of a wider understanding" (Sadie et al., 2023, p. 10). Children should be active participants so that formulations can include personal meaning of experiences rather than a list of factors which is not necessarily comprehensible to the child (Morgan, 2015). The sharing of formulations with the child, their family and other relevant professionals is important in helping everyone around the child understand the behaviours and the triggers so that appropriate responses can be put in place to reduce the risk of any distress/harm happening. Although formulating should be a collaborative process, there also needs to be consideration given to the child's current psychological and cognitive functioning in terms of how much they are able to cope with /comprehend at certain times (Morgan, 2015).

When a child is displaying distress behaviours there may be a need for the assessment and formulation to be guided by tools/models that are more specific to the presenting behaviours. For example, sometimes assessments will be guided by specific assessment or mapping tools such as the START:AV, AIM 3, or Young People's Sexual Behaviours Mapping Tool (King-Hill, 2026; Leonard & Hackett, 2019; Viljoen et al., 2014). However, these should always link in with the child's plan (Scottish Government, 2023). formulation model that helps to organise/structure the information gathered from assessments and is commonly used is the 4 P's model (Weerasekera, 1996). The 4Ps formulation model has recently been adapted by Leeds City Council as part of their practice model. This adapted 'Rethink formulation' contains 6Ps. The 6Ps are:

- Precipitating – what triggers things
- Predisposing – family history, challenges and vulnerabilities
- Protective – what positives and strengths are there
- Presenting – what is happening right now that is causing concern

- Predicting – what could happen if things don't change
- Perpetuating – what keeps the issues going

The precipitating, predisposing and protective factors influence the presenting issues; which in turn feeds into the predicting and perpetuating factors; with the perpetuating factors feeding back into the presenting issues (Leeds City Council).

Formulating is the starting point of a circular and continuous process that guides the interventions that follow. Formulation is a set of hypotheses, which should be reviewed and revised as appropriate as more information becomes available and as these hypotheses are tested out in intervention (Morgan, 2015). A good hypothesis creates a logical link between your formulation and your next steps. It summarises your understanding of what's happening, what needs to change and how it could be changed. The systematic unpicking of different factors that children and their family are presenting with or experiencing using formulation, helps to prevent leaping to the 'solution' or 'intervention', before the steps required to achieve change are clearly understood and agreed. Typically, the perpetuating factors that keep the presenting issues going should be the priority target for interventions. Looking at it from a need's perspective, what we are saying is that the more of these needs (and the needs are typically developmental) that we meet the more that 'risk' of harm/distress behaviours are likely to diminish.

Identity and its impact on need

A comprehensive assessment and formulation involve understanding people's experiences, perspectives and identities, all of which can impact on their needs. Sadie et al. (2023) highlight the importance of a relational approach to equality and emphasise the need to take time to understand the meaning of any protected characteristics for the individual child, not making any assumptions, and asking them how they would like you to work with them. Under the Equality Act 2010 there are nine 'protected characteristics': age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or beliefs, sex, and sexual orientation. It is important to consider how multiple characteristics interact with one another, sometimes compounding negative effects. Taking the unique interactions between characteristics and identities into consideration is referred to as taking an 'intersectional approach', or 'intersectionality'.

> "Intersectionality is a lens through which you can see **where power comes and collides**, where it interlocks and intersects. It's not simply that there's a race problem here, a gender problem here, and a class or LBGTQ problem there." Professor Kimberlé Crenshaw

So, we need to think about not just separate elements of identity, but how they interact with each other, and the potential cumulative effects of these on power (or lack thereof). Power operates in everyone's lives, creating advantages and disadvantages that change over time and place. Exertion and resistance of power exist on structural levels (e.g. discriminatory policy) to individual interactions (e.g. use of racist language). Power relations include 'power over', but also 'power with' (collective power). This often means controlling or deciding what someone can or can't do. When working with children we must find a balance between protecting safety (control) and protecting rights. Power imbalance can lead to violence, exploitation, coercion, abuse and cruel and degrading treatments. For children with one or multiple marginalised identities, risk of these experiences is often already increased (World Health Organization, 2019).

There may be a number of factors linked to a child's protected characteristics that play a role in a child's distress/harmful behaviours (e.g. experiencing bullying, exclusion, negative attitudes), or there may be no link whatsoever. It is therefore essential that professional judgment is used to try and make sense of these interactions and to develop an individualised intervention in collaboration with the child and their family. It is also important to acknowledge that different family members may have different views on the importance or acceptance of these characteristics, which in some circumstances may lead to conflict. We all have our own (complex) identities and experiences that influence why and how we work. Sometimes this gives us a really valuable point of connection with a child. However, it can also make it trickier for us, and we might need to factor in additional reflection, support, and self-care time.

2.3 Strengths based approach

Strengths based models take a positive approach by emphasising competencies (Vandevelde et al., 2017). This approach builds up aspirations and capabilities enabling individuals to take responsibility for their own lives (Devaney et al., 2023). Initial evaluation findings on the value of the strengths-based Good Lives Model with children who come into conflict with the law has indicated that practitioners and children found it to be a positive and motivational approach that communicated interest in the individual and belief in the capacity for positive change (Fortune et al., 2014; Leeson & Adshead, 2013; Vaswani & Simpson, 2015). Out with the focus on offending behaviour, strengths-based approaches have been used with children and families. For example, Early and GlenMaye (2000) found that this type of approach helped the family identify resources for coping, as well as helping them to use existing strengths to sustain hope and a sense of purpose. In addition, MacLeod and Nelson (2000) found that in interventions with vulnerable families, an approach that empowers individuals is critical.

Solution-focused practice focuses on change in an imagined future and the problem solving is focused on moving towards what is wanted, rather than moving away from an unwanted problem (NSPCC, 2015). There is evidence supporting the use of solution focused approaches to increase optimism and hope with children and families and to reduce aggression, anxiety and depression as well as improving outcomes for those children who had been involved in offending behaviour (Hopps et al., 1995; Milner & Bateman, 2011; Seagram, 1997; Woods et al., 2011). Prowle and Hodgkins (2020) have identified some strategies for incorporating a strength-based approach into practice. These include:

- Support identification of what is going well and can be levered
- Identify strengths and assets around individuals
- Use strategies that increase confidence and self-esteem
- Value individual's contributions
- Allow meaningful participation in decision-making
- Encourage individuals to engage in self-care
- Aid peer support and community involvement

However, competence and self-esteem only increase with positive experiences of competence and agency so we also need to facilitate situations where children and families can experience success, even small ones, as this creates motivation to attempt to address more challenging issues and tasks.

2.4 Forming and building relationships

The Independent Care Review highlighted that forming and building relationships with the child and everyone in the child's network is important, for example, the practitioner relationship with the child, the practitioner relationship with the family, the child's relationship with the family, and all relationships with the wider support network.

Frequently behaviour is an expression of emotions such as fear, rejection, or loss due to their experiences within relationships (Johnstone, 2020; Sadie et al., 2023) take the view that:

> "pain-based behaviour is relational; it originates in relational experiences and is expressed in relation to others" (Sadie et al., 2023, p. 12)

Relationships are therefore key to repair and recovery and every contact with a child is important (Rogers & Budd, 2015). Sadie et al. (2023) also highlight that working with children is different to working with adults as often we are working with a child's distress in real time as opposed to retrospectively as can be the case with adults. This can often get lost when the discussion is focused on the assessment and reduction of the risk of harm to others, whereas we have a responsibility to protect everyone from harm and to aid their recovery when harm has occurred. Sadie et al. (2023) refer to four main themes in their thinking. The first of these is that due to children's systemic powerlessness and their undeveloped capacities, work with them needs to take a different approach from work with adults. The second is that because pain-based behaviour arises from experiences in relationships then it can be 'understood, contained, and resolved through them'. The third theme is about containment, relational containment of the child is enabled by having containing systems around staff, so ensuring that experiences are validated and that there are safe spaces to reflect. The final theme is about the need to have integrated and holistic ways to work together to avoid splitting and fragmentation. One of the principles is that violence arises as a response to threat (whether real or perceived) in the context of 'a relationship or network of relationships' (p.4). What we need to do is to understand the threat from the child's perspective. We therefore need to be curious and understand their behaviour through using various methods including observation in the moment.

Established patterns of behaviour are transformed by new experiences, and new experiences are framed and interpreted within a prior history of adaptation (Duschinsky, 2020; Sroufe, 2016). As we begin working with families and children, they are still likely to focus on what has not worked in the past rather than how things can change. Again, it is important to look for small changes and small victories in the beginning as these can build momentum for bigger challenges.

There is lots of evidence from children, families and practitioners about what qualities and skills help with forming and building good relationships. Findings from the Independent Care Review (2020) found that:

> "relationships with people who show affection and love was fundamental to individuals' sense of wellbeing, happiness and safety" (p.32).

Throughout the review the aspects of relationships that were consistently highlighted as important were people who:

- Were always there for them
- Loved, accepted, and respected them for who they were
- Were ambitious for them and helped them succeed
- Stuck with them through thick and thin
- Were willing to go the extra mile
- Treated them fairly and included them, as part of their family or setting
- Were part of their life, beyond childhood and into adulthood (p.248)

Additionally, the qualities they valued in professionals were someone:

- Who listened to what they felt and what they wanted
- Worked with them as an individual and did not judge them
- Held positive but realistic ambitions for them
- Demonstrated an interest above and beyond the job
- Was consistent and reliable
- Was friendly, kind, not bossy, and had a sense of humour
- Took time to understand what they had been through
- Acknowledged positive changes they noticed in them
- Kept them updated and fed back in an appropriate way about decisions (p.256).

In response to the gap in research about how effective relationships are established within the youth justice field (in comparison to the vast research on formal evidence-based interventions such as cognitive-behavioural interventions based on Risk Need Responsivity principles), Fullerton et al. (2021) examined the literature to identify what the key features of effective relationships are and what helps the development of these between youth justice workers and young people. They found a number of core skills that were important to developing effective relationships. These were:

- Active listening
- Taking time to get to know the person
- Empathetic responding
- Advising
- Guiding
- Modelling pro-social behaviours
- Challenging ideas/behaviours in a manner that didn't judge and was non-threatening

Additionally, they found several practitioner qualities that were important which were:

- Dependability
- Consistency
- Commitment to the young person
- Warmth

- Humour

Fullerton et al. (2021) concluded that the combination of these qualities and skills enabled the development of mutual trust and therefore the development and maintenance of effective relationships. They also highlighted three different types of supportive relationships that young people benefit from. Firstly, a coach-like relationship where practical support is offered, secondly a friend-like relationship where social support is offered, and thirdly a parent-like relationship where practical, social and emotional support is offered. When they examined the mechanisms of change most likely to lead to helpful outcomes they found that the following were key: skills and attributes of the worker; strengths-based and person-centred approaches; working alliance involving co-production, joint planning and goal setting; emotional and practical care and support; recognition of achievements; authoritative (firm but fair) style; purposive conversations; challenge without damage; building social capital – making connections; balanced relationship; worker resilience; and long-term commitment. Their findings were developed into a framework for relational practice.

These aspects and qualities are similar to those found in research elsewhere. For example, Deakin et al. (2022) found that relationships characterised by 'respect, recognition, listening, trust, patience and acknowledging mistakes' empowered children and young people to be able to explore their identity and be able to make changes in their lives (p.113). Other factors considered helpful were challenging views by providing constructive support which provided both structure and boundaries; and consistency of support (Deakin et al., 2022). The children and young people identified that these relationships enabled them to develop confidence and motivation and to engage in opportunities for development and change in a way that interventions focused on risk-management did not.

2.5 Time

Building the foundations for effective interventions takes time. It takes time to create safe spaces, to understand experiences and perspectives, to build effective relationships, and to reflect with children after situations/crises have occurred. Time is also required for reflective practice in supervision, developing practitioner knowledge and skills, seeking advice from others, and time for preparation.

It also takes time for children's skills to develop, and for changes in behaviour to take place. It is important to recognise the time span needed to support development of new less distressed/harmful behaviours; the distressed/harmful behaviours may have been developing for 15 years so we need to have realistic expectations of the timeframe for change to occur. Development and change will not be linear and will not be dependent on service timeframes. It is also worthwhile acknowledging that there may be setbacks experienced along way which to some extent is normal and should be expected if behaviours are long standing.

Morgan (2015) considers setbacks as 'detours in treatment':

> "it might be more useful to think of adolescents taking side roads. They may lose time in treatment (in that they do not take the most direct route), but they do not lose ground. Instead, they

> undertake their own route, learning as much from the routes that they did not find helpful, as the ones they did" (p.161).

Time is also required for other's skills to be developed and for system adaptations/changes to take place that support a reduction in children's distressed behaviours.

3. Responding to immediate distress

3.1 Containment and the 3R's

Sadie et al. (2023) argue that responses to pain-based behaviour should be grounded in containment theory and be relational, similar to attachment theory. The stages of containment include: the child projects the uncontainable feelings onto the practitioner; the practitioner remains calm and receptive, absorbs these feelings, processes them and acknowledges them empathically; the practitioner responds in a manner that begins to meet the expressed need; the child's emotions and experiences become more thinkable and manageable. Essentially:

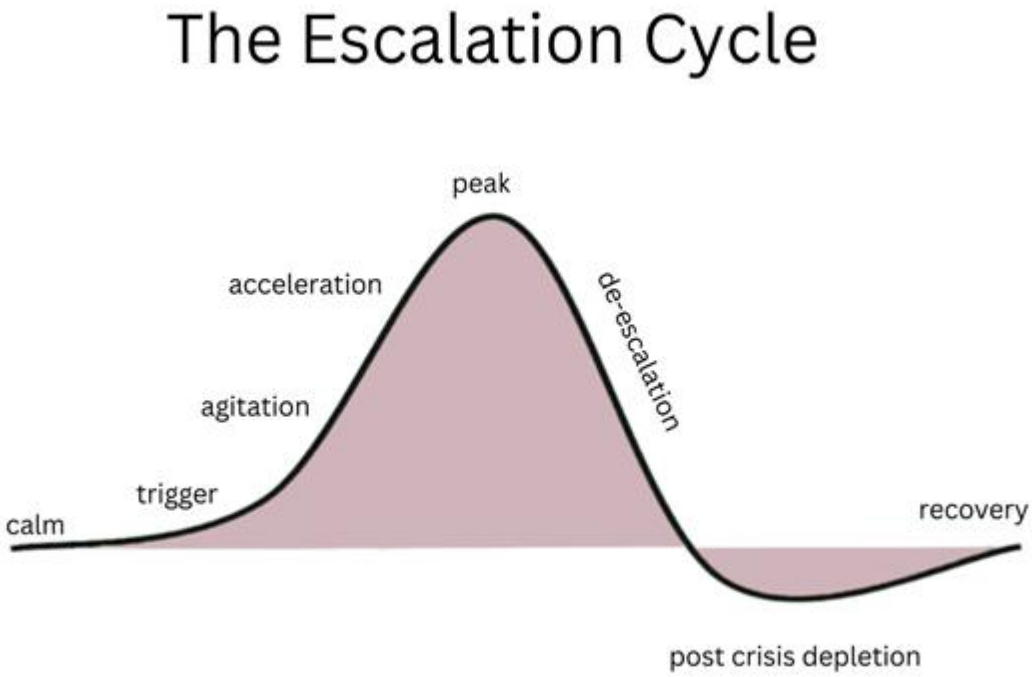
> "the practitioner becomes a container for the child who, through repeated experiences of containment, becomes more able, more often, to contain (i.e. to use thinking to manage) his or her experiences and emotions" (p.11).

It is important to recognise that containment is not in itself a developmental milestone that is 'achieved', it fluctuates across time and circumstances. Containment may also be helpful or required in the network of relationships that surround the child, including with other colleagues within the workforce. Once there is a level of containment, it is then important to provide opportunities for 'understanding, resolution and reparation afterwards' so that children can learn to communicate their distress or pain in a manner that is less harmful (Sadie et al., 2023, p. 24).

Bruce Perry uses a simple sequence of intervention, the 3R's, to support children who have experienced trauma to learn, think and reflect. The first step is to help the child **Regulate**/calm their fight/flight/freeze responses. The second step is **Relate** which involves connecting with the child through the attuned relationship. The third step is to then **Reason**, supporting the child to reflect and learn (Beacon House Therapeutic Services & Trauma Team, 2024). It is important to keep the family in the parenting role where possible and support them with the development/continued use of these skills.

3.2 The escalation cycle

The escalation cycle is a useful tool to think through the stages that a child (or adult) goes through when distressed and their behaviour is escalating. It is also a helpful tool for considering our reactions at each of these stages and what is helpful or not so helpful. It can help us plan for escalations in behaviour so that we can reduce or minimise any risk occurring as a result. The different stages of the escalation cycle are detailed below along with strategies that can be helpful at each of the stages (Colvin, 2004; Colvin, 2010).



In the **calm** phase we want to work towards prevention of escalation. We want to identify triggers and warning signs and develop a plan to reduce these or intervene early when they do occur. We also want to spend time teaching and developing alternative ways of communicating needs rather than through the behaviour of concern:

- What do they need to communicate?
- When do they need to communicate it – what are the warning signs?
- How is it best to communicate their needs?
- How do we practice this new communication?
- Who needs to know about this?

We also want to spend time developing and practicing calming strategies e.g. breathing, relaxation, mindfulness. It is critical that the child is actively involved in these discussions so we can understand their experiences and so that they can contribute to solutions that will work for them. Parents/caregivers/practitioners should also be aware of their own triggers and warning signs and have a plan for how to keep calm and remain in their window of tolerance; and how to keep everyone safe.

When **triggers** occur then the focus is on trying to remove or modify the trigger to get back to a state of calm. Triggers can be wide ranging, and we need to understand the triggers specific to each individual child. For some children a trigger can be a smell, or a noise, or something that is said. For others it can be a time of year or a place. For others it can be certain people including authority figures.

When triggers occur distraction may help, for example the provision of water/food, moving to a safer/calmer place, turning down lights/noise, having other people leave the room etc. It may also be useful to get on the child's level which may mean sitting on the floor, as having someone over you or behind you can feel intimidating/threatening. Body language and facial expressions at this time should be watched. It is important to validate their emotions at this stage and attempt to identify what they need. The aim is to decrease stimulation and avoid any extra stimulation sources. If they can self-regulate then you may want to give them the space to do this. If they need support, then you will likely want to stay with them and support them with co-regulation. However, it is important to recognise the individual nature of what will be supportive at this point as quiet can be a trigger for some people, especially if a child has been used to noisy or chaotic environments.

When children enter the **agitation** phase we want to try and de-escalate the situation. However, often our responses to a child's behaviour can serve to escalate the behaviour rather than de-escalate it. One way to de-escalate situations is to avoid 'over-talking' and not getting into discussions during the crisis (Coogan, 2017). We need to recognise when the situation is building up to conflict; learn how to engage to bring it back down; not be drawn into attempts to build the tension; help the child to find a way to regulate their emotions and/or get out of the situation they are finding uncomfortable; and change our thought patterns, language used, behaviours and responses (Bonnick, 2019). At this stage some options/choices of what they can do next can be given but it is important to not overload them. It's important at this stage to not remind/nag/follow them round trying to have the last word. Instead give them additional space and extra processing time. Continue to check your own body language and facial expressions. Remember discussions about the behaviours can happen later when everyone is in a calmer frame of mind.

In the **acceleration and peak** stage, the aim is to maintain safety until the de-escalation phase commences. If you have a plan already then follow it, unless something is making it unsafe to do so. There will be different elements to a safety plan e.g. make sure they have plenty space and don't feel blocked in or trapped; don't try to reason or raise your voice to get your point across; avoid extra demands/stimulation; calmly remove any potentially dangerous objects; have others leave the room/area; make contact with supports (this may have been done in earlier phases).

In the **de-escalation and depletion stage** it is important to support the continued de-escalation through maintaining a calm environment, using slow/ quiet talk – or maybe silence, supporting slow deep breathing, and offering water/snacks. Remember it takes at least 20-30 minutes until the body gets back to normal after a perceived or actual threat. Don't be tempted to engage in recovery or discussions about the behaviour too soon or the situation may escalate again.

In the **recovery phase** it is important to ensure that calm is fully restored before resuming routines/schedules. Don't nag/blame/rehash what started the cycle but instead revisit this as a learning opportunity in the calm phase.

In the **calm phase**, involve the child in discussions about what was happening beforehand, what the triggers were, how to limit triggers, how else their need for support can be communicated etc. Based on these discussions the safety plan should be modified as required. Opportunities should also be provided to rebuild/repair relationships that may have been harmed.

Often our responses to a child's behaviour can serve to escalate the behaviour rather than de-escalate it. It is important to resist provocation, breathe calmly and deeply, and leave the situation if need be, giving the message that you are leaving to remain calm and to think about the situation. When the situation is calmer, it can be helpful to consider situations where there hasn't been an escalation, what was helpful in those situations and how to make it more likely these helpful responses are used in the future. Coogan (2017) promotes the use of 'pressing the pause button' whereby the crisis or outburst is not responded to immediately, instead the child is told calmly that the behaviour will be dealt with later when everyone is calm. This strategy allows time to think about an appropriate response without escalating the situation, whilst at the same time indicating that the issue will be returned to.

4. Collaborative safety planning

Where a child's distressed behaviour can lead to the harm of others or themselves it is essential that there are safety plans in place to reduce the likelihood of this happening. These safety plans can be for responding to immediate distress or they can be longer term safety plans for example to enable someone to remain in school or reduce harm from them going missing. It is important that there is clarity about the behaviour of concern the safety plan is for, where the plan is for, and who is involved in the plan.

It is crucial that children (and their families/carers) are involved in developing the plan wherever possible. Safety plans for responding to immediate distress should consider questions such as: What do they find helpful or unhelpful from others? What won't work or will make things worse? Where is their safe space? Who is best for them to contact if they start feeling distressed or threatened? At what point should the safety plan be put into action – what are the triggers / warning signs? What steps need to be taken to make the environment physically safe? These questions apply to both children and parents/carers. Longer term safety plans may have more of a focus on making spaces or places safer, increased supervision and monitoring, reducing/increasing contact with certain people, or routines and structure. The content of the plans will very much be determined by the individual child and the circumstances that surround them.

Safety plans could include – a safe space to go to when not feeling safe (for everyone); who to contact / let know there is a situation; use of a codeword; locking/unlocking doors; moving to place visible to others; inclusion of others who can hear disturbances e.g. neighbours; use of support network; being clear about what is not acceptable and the actions that will be taken (Bonnick, 2019). Safety plans should also take account of situational and contextual changes that could enhance safety for all (Scottish Government, 2021).

Whilst we may need safety plans to keep everyone safe, these should be proportionate and rights upholding. They should facilitate opportunities for children to meet their developmental needs and have their rights respected in a safe manner (Allardyce & Yates, 2018; Scottish Government, 2021) Safety plans should be reviewed regularly to ensure the plan is effective, remains proportionate and whether the plan continues to be required (Allardyce & Yates, 2018; Scottish Government, 2021).

5. Theory to practice

To bridge the gap between theory and practice Johnstone (2020) has created the ABC Framework to support assessment, understanding and responses to children's distress behaviours. As highlighted previously, work by Roles and Johnstone (2024) has noted that various variables such as relational, behavioural, cognitive, systemic, and mental health can impact on a child's development as well as trauma. As a result, the ABC framework draws from a range of sources such as developmental, psychological, mental health and forensic literatures. It integrates the main developmental theories so that a multi-dimensional approach can be taken when supporting children to understand their behaviour and when developing responses to reduce distress behaviours. The six main areas considered within the framework are – Attachment style, Behavioural experiences, Cognitive and communication style, Developmental trauma, Emotions and mental health, Family and systemic factors, and Gender specific needs (Roles & Johnstone, 2024).

The ABC framework helps practitioners to consider which of these needs are underpinning distressed behaviours, with different needs potentially underpinning different behaviours. It also helps to link what we know theoretically about each of these needs to our responses in practice therefore providing a good foundation for the design of individualised and developmentally appropriate interventions across these domains. Roles and Johnstone (2024, p. 2) report that "practitioners and young people themselves achieve an understanding of the child that illuminates the roots of their distress and ensures responses are sensitive and targeted to promote change".

The ABC framework is additionally supported by the 6D model which provides a structured framework for considering the states of mind that a child or young person may experience in the lead up to, as well as during distressed episodes, and therefore the responses most likely to have a positive impact at that moment in time.

The Care Inspectorate have commented positively on the detailed and comprehensive assessments and formulations of the children's needs in the two secure care centres where this framework has been/is used. In particular, they reported the positive views that children had about their engagement in the process, how this had contributed to them feeling more settled, and that as a result both children and staff had a very good understanding of the children's needs and how to support them (Care Inspectorate, 2023, 2024).

6. Collaborative goal setting, progress and endings

The traditional focus on reducing recidivism through interventions often leads to intervention goals and progress being measured by whether the identified problem behaviours have diminished or ceased. Whilst an important goal, it can limit the focus to the 'absence of bad' and sometimes miss focusing on positive changes in drivers/needs underpinning the behaviour and leading to pro-social development (Creeden, 2018). Strength-based practice involves developing collaborative relationships with the aim of working to create change, achieve positive outcomes and empower children and families. It involves identifying and drawing on strengths and using these as levers to support this change and create motivation

and hope (Geiger & Schelbe, 2021). An important step in intervention is to collaboratively set clear goals that are directly related to the issue(s) to be addressed.

Once there are agreed goals then it is helpful to explore the problems in more detail so that the development of realistic strategies to address the problem can be achieved. For example, Trotter (2017) suggests exploring the following questions:

- What is the history of the problem?
- When does it occur?
- How did it begin?
- What has the family done to address the problem previously?
- Have these things helped or hindered?
- Are there occasions when the problem is not present?

A solution focused approach can be helpful when considering goals for example thinking about the behaviours and interactions you would like to see rather than those you don't want to see. The use of the Miracle question can be helpful – imagine that overnight a miracle happened – all your problems have gone. How would you feel? What would you be doing? What would you be thinking? What would other people notice? (Stallard, 2021). It is also important to think about the framing of goals e.g. reframe 'x will attend school' to 'school will be a safe place for x to attend' as this shifts responsibility from the child to the adults around them to ensure school is a safe space for them to attend.

It is likely that different children and family members involved will have slightly different, or largely different, goals. This also applies to the different parts of the system, including the practitioner. Identifying where these goals might overlap or intersect and then prioritising them is important. When thinking about goals for intervention Ellis et al. (2020) consider both the child's needs and also whether the social environment or system of care is sufficiently able to support the child's needs. They consider the social environment needs across three layers: 1) stable – caregivers within the family and system are able to support the child's needs and protect them from undue stressors; they have sufficient resources to meet the child's needs and there are beneficial services in place; 2) distressed – caregivers across family and system of care are not fully attuned to the child's needs or are unable to help / do not sufficiently protect the child from stressors in the environment; or lack the resources/services to do so; 3) threatening – continued threat to the child's safety within their social environment or the services in place are not functioning well enough to protect the child. The aim of considering these two dimensions is to ensure the intervention goals and subsequent plan contain the intensity of services required to 'make changes within the most stressed parts of the child's social ecology' (Ellis et al., 2020, p. 360)

Thinking through potential barriers to achieving the goals in advance and planning how these can be overcome upfront is also helpful for creating the best chances of success. Questions to consider include:

- What are everyone's goals? Are there similarities?
- What are we trying to achieve (not avoid)?
- What are everyone's priorities?
- Are they SMART?

It is also necessary to consider how you will monitor progress in achieving the goals and what the child and family think will be helpful in monitoring progress. The are different ways

in which this can be done. For example, psychometric assessments, diaries/charts, changes in START:AV or AIM 3 ratings, or individualised rating scales. Key questions to consider are:

- What is the baseline frequency/severity?
- What would improvement look like?
- How will you measure/evidence improvement?
- Who will measure/evidence improvement?

It is also worthwhile acknowledging that there may be setbacks experienced along the way which to some extent is normal and should be expected if behaviours are long standing.

The ultimate aim of supports should be to empower the child and their family to be able to make and sustain changes to reduce harmful behaviours and improve outcomes without the ongoing need for professional support. The decision to end support should be informed by information gathered through monitoring changes in the areas that were driving distress/harmful behaviours and whether there has been a reduction in these as a result. Whilst it should be clear from the outset that the aim is empowerment, it will be necessary to prepare individuals for endings and to ensure that they have the resources required for maintaining change. This will include records of any plans or strategies they have been using and reminders of strengths, achievements, and skills. It will also be helpful for them to think about their support networks and how they can continue to access support from those around them when the formal support ends (Murphy, 2021).

7. Staff wellbeing

The role of supporting children through difficult times is crucial, but the work can take its toll if those supporting the child are not taken care of, as recognised by the promise.

There are various ways in which this work can impact on staff:

> "Vicarious trauma results from exposure to trauma survivors and is marked by cognitive changes in meanings, beliefs, schemas and adaptations; secondary traumatisation is measured by symptoms of trauma in workers; compassion fatigue is marked by PTSD symptoms and other symptoms of "burnout", which is itself a concept which is understood as resulting from a range of organisational stressors rather than only exposure to trauma survivors" (Pelech et al., 2021, p. 266)

The organisational culture and behaviours can also cause trauma for individuals. Related to this are the concepts of moral distress and moral injury. Moral distress is described as:

> "the psychological unease that is triggered when a professional identifies the ethically or morally correct action to take in a situation but is unable to perform this due to constraints" (Beadle et al., 2024, p. 2)

and has been linked with burnout and compassion fatigue. Moral injury occurs as a result of sustained moral distress and is associated with mental health issues (Beadle et al., 2024).

A systematic literature review by Ireland and Huxley (2018) identified five themes linked to vicarious and secondary trauma in staff working with psychologically traumatised children. These were lack of organisational support, lack of healthy work-life balance, lack of appropriate training, failure to use self-care techniques, and staff failure to share when they

are experiencing symptoms. Ireland and Huxley (2018) highlighted that not being able to have clear boundaries between working hours and non-working hours was frustrating for mental health workers. They also identified that although staff recognised the importance of self-care for others many did not implement the strategies themselves.

Research has also looked at the effects of working with children who have displayed harmful sexual behaviour. Practitioners and managers in the UK working with children and young people who have displayed harmful sexual behaviour have reported low confidence in working with this group and having feelings of upset, worry and anxiety when thinking about their work (Clements et al., 2017). Research by Almond (2013) in the UK with 16 practitioners has indicated that the positive experiences of working with children and young people who have engaged in harmful sexual behaviour far outweighed the negative impact, and that organisational factors are more directly linked to negative impact. These included feeling under-valued / de-valued, management remoteness and culture, and services being target driven. Some negative impacts identified were feeling more vulnerable and having heightened suspicion of males, whereas others talked about feeling safer and understanding the male perspective more. Listening to the children's own abusive experiences had more of a negative impact than discussing the children's own abusive behaviour. A systematic review of studies looking at the impact of working with children and young people who had engaged in harmful sexual behaviour by Pelech et al. (2021) found that there is a significant emotional and psychological impact where their world views can shift, and their personal relationships can be impacted.

However, there can also be positive effects of indirect exposure to trauma known as vicarious resilience which is associated with positive changes in thinking and behaving as a result of engaging empathically with individuals' trauma experiences (Méndez-Fernández et al., 2022). Méndez-Fernández et al. (2022) found that social workers experienced more intense vicarious resilience and less severe vicarious trauma when they implemented recovery experiences more frequently and received support from supervisors and co-workers. Preventing and addressing vicarious trauma and burnout is crucial through reflective supervision, peer support, and self-care strategies like mindfulness and work-life balance (Musselbrook, 2024). This foundation enables healing, resilience, and sustainable care, ensuring safety and well-being for all.

8. Conclusion

This section has highlighted approaches that can be taken when working with children and young people who come into conflict with the law. Whilst GIRFEC and the WSA provide the frameworks for prevention, early intervention, and diversion from the justice system, as well as support for children and young people when they do enter the justice system, this section emphasises the foundational elements of support for children to make sure practice is effective across all elements of the justice system.

Understanding the needs underpinning children's behaviour and reframing these as distressed/pain-based behaviours means that a more rights respecting approach is taken to reduce the distress/pain that children are experiencing and in turn the harmful behaviours

they have engaged in. Taking a developmental and trauma-informed approach to children and young people in conflict with the law not only supports their recovery and reintegration but also reinforces their respect for the rights of others.

9. References

Allardyce, S., & Yates, P. (2018). Working with children and young people who have displayed harmful sexual behaviour. Dunedin.

Allardyce, S., Yates, P., & Krothe, G. (2021). Future directions in interventions with children and young people who have displayed harmful sexual behaviour. Edinburgh: NSPCC.

Almond, T. (2013). Working with children and young people with harmful sexual behaviours: Exploring impact on practitioners and sources of support. Journal of Sexual Aggression, 20, 333-353. http://dx.doi.org/10.1080/13552600.2013.836576

Beacon House Therapeutic Services & Trauma Team (2024). www.beaconhouse.org.uk

Beadle, E., Walecka, A., Sangam, A., Moorhouse, J., Winter, M., Munro Wild, H., Trivedi, D., & Casarin, A. (2024). Triggers and factors associated with moral distress and moral injury in health and social care workers: A systematic review of qualitative studies. PLoS ONE, 19(6): e0303013. https://doi.org/ 10.1371/journal.pone.0303013 .

Bonnick, H. (2019). Child to parent violence and abuse: A practitioner's guide to working with families. Pavilion Publishing and Media Ltd.

Care Inspectorate. (2023). St. Mary's Kenmure Secure Accommodation Service Inspection Report.

Care Inspectorate. (2024). Rossie Secure Accommodation Service Inspection Report.

Children and Young People's Centre for Justice. (2025). A Guide to Youth Justice in Scotland: policy, practice and legislation. https://www.cycj.org.uk/resource/youthjusticeinscotland/

Clements, K., Ryder, B., Mortimer, E., & Holmes, D. (2017). Workforce perspectives on harmful sexual behaviour: Findings from the Local Authorities Research Consortium. London: National Children's Bureau.

Colvin, G. (2004). Managing the Cycle of Acting-Out Behavior in the Classroom.

Colvin, G. (2010). Defusing disruptive behaviour in the classroom. Thousand Oaks, CA:Corwin.

Coogan, D. (2017). Child to parent violence and abuse: Family interventions with non-violent resistance. Jessica Kingsley.

Creeden, K. (2013). Taking a developmental approach to treating juvenile sexual behaviour problems. International Journal of Behavioural Consultation and Therapy, 8(3-4), 12-.

Deakin, J., Fox, C., & Harragan, A. (2022). Help or hindrance? Rethinking interventions with 'troubled youth'. International Journal of Law in Context, 18, 100-115.

Devaney, C., Brady, B., Crosse, R., & Jackson R. (2023). Realising the potential of a strengths-based approach in family support with young people and their parents. Child and Family Social Work, 28, 481-490.

Duschinsky, R. (2020). Alan Sroufe, Byron Egeland, and the Minnesota longitudinal study of risk and adaptation. In R. Duschinsky, Cornerstones of Attachment research (pp. 337-426). Oxford University Press. https://doi.org/10.1093/med-psych/9780198842064.003.0004

Early, T., & GlenMaye, L. (2000). Valuing families: Social work practice with families from a strengths perspective. Social Work, 45(2), 118– 130. https://doi.org/10.1093/sw/45.2.118

Ellis, B., Saxe, G., & Twiss, J. (2020). Trauma systems therapy: Intervening in the interaction between the social environment and a child's emotional regulation. In V. Ardino (Ed.)

Post-traumatic syndromes in childhood and adolescence: A handbook of research and practice (pp. 373-390). John Wiley & Sons.

Fortune, C., Ward, T., & Print, B. (2014). Integrating the good lives model with relapse prevention: Working with juvenile sex offenders. In W. O'Donohue & D. Bromberg (Eds.), Toolkit for working with juvenile sex offenders (pp. 405-426). New York, NY: Elsevier Science.

Fullerton, D., Bamber, J., & Redmond, S. (2021). Developing effective relationships between youth justice workers and young people: A synthesis of the evidence. REPPP Review, University of Limerick.

Geiger, J., & Schelbe, L. (2021). The Handbook on Child Welfare Practice. Springer.

Herman, J. (1992). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. Journal of Traumatic Stress, 5(3), 377-391.

Hopps, J., Pinderhughes, E., & Shankar, R. (1995). The power to care: Clinical practice effectiveness with overwhelmed clients. New York: Free Press.

Ireland, C., & Huxley, S. (2018). Psychological trauma in professionals working with traumatised children. The Journal of Forensic Practice, 20(3), 141-151. https://doi.org/10.1108/JFP-10-2017-0045

Johnstone, L., (2020). The ABC model of developmentally informed formulations for understanding the psychological, mental health and risk needs of high-risk youth. Contact lorrainejohnstone@protonmail.com.

Leeds City Council (n.d.). One minute guide: Rethink formulation process. https://www.leeds.gov.uk/one-minute-guides/rethink-formulation

Leonard, M., & Hackett, S. (2019). The AIM3 Assessment Model: Assessment of adolescents and harmful sexual behaviour. The AIM Project.

Macleod, J. & Nelson, G. (2000). Programs for the promotion of family wellness and the prevention of child maltreatment: A meta-analytic review, Child Abuse and Neglect, 24(9), 1127-49.

Manassis, K. (2014). Case formulation with children and adolescents. The Guilford Press.

Matthews, P., Poyner, C., & Kjellgren, R. (2019). Lesbian, gay, bisexual, transgender and queer experiences of homelessness and identity: Insecurity and home (o) normativity. International Journal of Housing Policy, 19(2), 232-253.

McLaughlin, K., & Sheridan, M. (2016). Beyond cumulative risk: A dimensional approach to childhood adversity. Current Directions in Psychological Science, 25(4), 239–245. DOI: 10.1177/0963721416655883.

Méndez-Fernández, A., Aguiar-Fernández, F., Lombardero-Posada, X., Murcia-Álvarez, E., & González-Fernández, A. (2022). Vicariously resilient or traumatised social workers: Exploring some risk and protective factors. The British Journal of Social Work, 52(2), 1089–1109. https://doi.org/10.1093/bjsw/bcab085

Milner, J. & Bateman, J. (2011). Working with children and teenagers using solution focused approaches: Enabling children to overcome challenges and achieve their potential. Jessica Kingsley Publishers, London.

Mitchell, P., & Staniforth, C. (2017). Cognitive, behavioural and related approaches in young offenders. In S. Bailey, P. Chitsabesan, & P. Tarbuck (Eds), Forensic child and adolescent mental health: Meeting the needs of young offenders (pp. 254-265). Cambridge University Press.

Morgan, W. (2015). Violence among young people: A framework for assessment and intervention. In A. Rogers, J. Harvey & H. Law (Eds.), Young People in Forensic Mental Health Settings Psychological Thinking and Practice, (pp. 143-166). Palgrave MacMillan.

Murphy, C. (2021). Children in conflict with the law: An intervention planning approach. Children and Young People's Centre for Justice. https://www.cycj.org.uk/resource/intervention/

Musselbrook. (2024). Wellbeing and the social work practitioner. https://www.iriss.org.uk/blog/big-picture/wellbeing-and-social-work-practitioner

NHS Education for Scotland. (2017). Transforming Psychological Trauma: A Knowledge and Skills Framework for the Scottish Workforce.

NSPCC. (2015). Solution-focused practice: A toolkit for working with children and young people.

Pelech, J., Tickle, A., & Wilde, S. (2021). Professionals' experiences of working with children and young people with harmful sexual behaviour: A systematic review using meta-ethnographic synthesis. Journal of Sexual Aggression, 27(2), 264-284. https://doi.org/10.1080/13552600.2020.1846801

Perry, B., Griffin, G., Davis, G., Perry, J., & Perry, R. (2018). The impact of neglect, trauma and maltreatment on neurodevelopment: Implications for juvenile justice practice, programs, and policy. In A. Beech, A. Carter, R. Mann & P. Rotshtein (Eds.), The Wiley Blackwell Handbook of Forensic Neuroscience, First Edition, Volume 2, (pp. 815-835). John Wiley & Sons Ltd.

Prowle, A., & Hodgkins, A. (2020). Making a difference with children and families: Re-imagining the role of the practitioner. Red Globe Press

Quin, S. (2019). Layers of healing care. Scottish Journal of Residential Child Care, 18(1).

Roles, O., & Johnstone, L. (2024). Words into action: Bridging the gap between theory and practice when supporting young people in secure care. Scottish Journal of Residential Child Care: An international journal of group and family care experience, 23(1).

Sadie, C., Steckley, L., McGinnis, S., & Sales, J. (2023). Working with violence in children: A developmental and relational perspective. In M. Khwaja & P. Tyrer (Eds.), The prevention and management of violence. Accepted Author Manuscript.

Scottish Government. (2021). Standards for those working with children in conflict with the law 2021.

Scottish Government. (2023). Time Space Compassion – supporting people experiencing suicidal crisis: An introductory guide.

Scottish Government. (2023a). Getting it right for every child Practice Statement GIRFEC Child's Plan October 2023.

Seagram, B. (1997). The efficacy of solution-focused therapy with young offenders. Unpublished doctoral dissertation, York University, New York, Ontario. Cited in Kim, J. (2008). Examining the effectiveness of solution focused brief therapy: A metaanalysis. Research on Social Work Practice, 18(2), 107-116.

Sheahan, F., Hughes, N., Williams, H., & Chitsabesan, P. (2021). Dismantling barriers to justice for children affected by neurodisability. In G. Lansdell, B. Saunders & A. Eriksson (Eds.), Neurodisability and the Criminal Justice System, Comparative and Therapeutic Responses (pp.72 – 90). Edward Elgar Publishing Limited. https://doi.org/10.4337/9781789907636

Smith, M., & Monteux, S. (2023). Trauma-informed approaches: A critical overview of what they offer to social work and social care. Iriss.

Stallard, P. (2021). A Clinician's Guide to CBT for Children to Young Adults: A Companion to Think Good, Feel Good and Thinking Good, Feeling Better. John Wiley & Sons Ltd.

Trotter, C. (2017). Collaborative family work in youth justice. In P. Ugwudike, P. Raynor, and J. Annison (Eds.), Evidence-based skills in criminal justice: International research on

supporting rehabilitation and desistance (pp. 353-372). Policy Press. https://doi-org.proxy.lib.strath.ac.uk/10.1332/policypress/9781447332961.001.0001

Treisman, K. (2017). A therapeutic treasure box for working with children and adolescents with developmental trauma: Creative techniques and activities. Jessica Kingsley Publishers.

Trevithick, P. (2012). Social work skills and knowledge: A practice handbook. Maidenhead: McGraw-Hill/Open University Press.

The Mehrit Centre. (2023). Behaviour is communication. https://self-reg.ca/behaviour-is-communication/

Vandevelde, S., Vander Laenen, F., Van Damme , L., Vanderplasschen, W., Audenaert, K., Broekaert, E., & Vander Beken, T. (2017). Dilemmas in applying strengths-based approaches in working with offenders with mental illness: A critical multidisciplinary review, Aggression and Violent Behavior, 32, 71–79

Viljoen, J., Nicholls, T., Cruise, K., Desmarais, S., & Webster, C. (2014). Short-term assessment of risk and treatability: Adolescent version. START:AV User Guide. Mental Health, Law and Policy Institute.

Weerasekera, P. (1996). Multiperspective case formulation: A step towards treatment integration. Krieger Publishing Company. http://psycnet.apa.org/record/1998-07251-000

Woods, K., Bond, C., Humphrey, N., Symes, W., & Green, L. (2011). Systematic review of solution focused brief therapy (SFBT) with children and families. Department for Education Publication.

World Health Organization. (2019). Freedom from coercion, violence and abuse: WHO QualityRights core training: mental health and social services.