

Balancing rights and risk: How can we get it right for children involved in violent behaviour?

Carole Murphy, Centre for Youth & Criminal Justice

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Executive summary

Official data suggests that the number of children¹ involved in offending has reduced significantly over the past ten years throughout the United Kingdom (Bateman, 2015; Youth Justice Improvement Board, 2017). Despite this reduction, there is a small, but substantial, percentage of children who present a risk of serious harm² to others. To date there has been little examination of the nature and prevalence of the violent behaviour children engage in within Scotland. However, regular access to this type of information is crucial for both service planning and monitoring of the effectiveness of efforts to reduce violence.

Similarly, it is essential that the needs underlying children's violent behaviour are understood if appropriate interventions are to be provided and future harm is to be prevented. Emerging research clearly demonstrates the complex needs with which a number of these children present (McAra, Goldson, Hughes, & McVie, 2010; Youth Justice Improvement Board, 2017); however, our understanding of how well their needs are being met and how well the risks they present to others are being managed remains unclear.

In order to contribute to the limited knowledge base this study examined the case files for a sample of 63 children referred to the Intervention for Vulnerable Youth (IVY) project due to concern over their risk of serious harm to others. Additionally, 23 practitioner responses to a survey regarding risk practice were examined.

The findings indicate that the less severe forms of violence were by far the most frequent e.g. common assault, threatening or abusive behaviour and handling offensive weapons,

¹ The term 'children' refers to those under 18 years of age as per the United Nations Convention on the Rights of the Child (UNCRC). The term children is used throughout this report to refer to all those under 18 regardless of whether they are in the youth justice or criminal justice system.

² The Framework for Risk Assessment, Management and Evaluation (Risk Management Authority, 2011) proposes the adoption of the following definition of risk of serious harm: 'There is a likelihood of harmful behaviour, of a violent or sexual nature, which is life threatening and/or traumatic and from which recovery, whether physical or psychological, may reasonably be expected to be difficult or impossible'.

however, only one fifth of children had engaged in these less severe forms of violence without having additionally engaged in a more serious form of violence as well.

The mean age of first violence was ten years old, with two fifths of the children engaging in violent behaviour prior to 11 years old. At the point of referral to IVY, the children had been displaying violent behaviour for approximately five years from the known point of first violent behaviour, with almost half having displayed violent behaviour for five or more years since the first violent incident. The risk factors known to be associated with violence were generally found to be high and the protective factors low.

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 and mental health needs found in this sample were high and suggest a clear need to reframe how we conceptualise risk of violence in children and shift to considering violence as a distress response.

Additionally, this research highlights that risk practice often does not match the level of risk practice required to manage the violent behaviour displayed by these children and to reduce the risk of harm to others. For example, use of structured professional judgment approaches, Care and Risk Management (CARM) processes, monitoring and victim safety planning were limited and it was unclear whether the children, and their parents/carers, had access to interventions that could best meet their needs. In addition, the information available indicated that approximately half of the children had been known to social work for nine or more years from the point of first contact, although not necessarily continuously for this period of time.

Balancing the rights of these children and the risks they present is complicated, but it is clear that the risk of violence cannot be sustainably reduced without taking a rights based approach to addressing the needs underlying the violent behaviour.

Based on the findings of this research the following implications for practice are highlighted:

- Violent behaviour by children is considered and reframed as a vulnerability or distress behaviour that highlights unmet needs where appropriate
- Priority is given to ensuring that everyone in Scotland works in a trauma informed manner and those working directly with children who are involved in, or at risk of, violent behaviour are skilled, or have enhanced skills, in responding to trauma reactions as per the NES framework.
- Actuarial risk assessment tools are replaced with more holistic, SPJ tools such as the START:AV, which can assess a broader range of adverse outcomes with a focus on both strengths and vulnerabilities³.
- CARM is audited in local authority areas to identify any additional supports that might be required to effectively manage and reduce the risk of harm children present to others.
- A systemic strengths based approach to intervention is adopted, which involves holistic family intervention including interventions to help meet parental/caregiver needs as well as the needs of the child.
- An improvement planning approach to intervention is used such as 'Plan, Do, Study, Act'⁴ to assist with identifying outcomes, action planning and monitoring progress in achieving outcomes in order to reduce drift.
- A review is undertaken as to how best to meet children's needs when they present with behavioural, systemic, psychological and mental health issues and plans made for service realignment or development of practitioners so that all of the child's needs can be addressed in a holistic manner.
- A multi-disciplinary, tiered, but comprehensive training and development package is produced around assessing and preventing high risk behaviours, including an educational component for communities to highlight the needs of children involved in

³ The Scottish Government have recently supported 100 practitioners being trained in the use of START:AV which should lead to further use of this tool when assessing children.

⁴ <https://www.gov.scot/Resource/0042/00426552.pdf>

violent behaviour, address any misperceptions and highlight effective community responses that can contribute to reduction of violent behaviour.

- Further research examining the risks and needs of those children who engage in violent behaviour later in adolescence and who have not previously been known to services is undertaken to inform potential prevention strategies that can be implemented to reduce the risk of harm to others.

Introduction

The violent behaviour of children and young people is frequently reported in the media alongside detailed descriptions of the violence. Unfortunately though, the underlying reasons why some children and young people engage in violent behaviour is an often neglected topic. This can lead to misperceptions not only about the scale of the problem but also to the root causes. The consequence is that the general public are left with feelings of anxiety and confusion. This lack of context and explanation means that there is little understanding about how to prevent violence.

The World Health Organisation (WHO) have defined violence as:

“The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that results in or has a high likelihood of resulting in injury, death, psychological harm, or deprivation” (WHO, 1996).

Within this broad definition however, violent behaviour can take many different forms. To date there has been little examination of the nature and prevalence of the violent behaviour children engage in within Scotland. However, regular access to this type of information is crucial for both service planning and monitoring of the effectiveness of efforts to reduce violence. Similarly, it is essential that the needs underlying children’s violent behaviour are understood if appropriate interventions are to be provided, future harm is to be prevented

and misperceptions challenged. Official data suggests that the number of children⁵ involved in offending has reduced significantly over the past ten years throughout the United Kingdom (Bateman, 2015; Youth Justice Improvement Board, 2017). In Scotland, between 2006-07 and 2016-17, offence referrals to the Scottish Children's Reporters Administration (SCRA) reduced by 82%, court prosecutions for 12-18 year olds reduced by 78% and children under 18 in custody reduced by 77% (Youth Justice Improvement Board, 2017). However, the nature of the offences and the level of children's involvement in violent offending is less clear.

Police Scotland record crimes and offences under the following categories (Scottish Government, 2017):

- 1) Non-sexual crimes of violence;
- 2) Sexual crimes;
- 3) Crimes of dishonesty;
- 4) Fire-raising, vandalism, etc;
- 5) Other crimes;
- 6) Miscellaneous offences; and
- 7) Motor vehicle offences.

The non-sexual crimes of violence category allows us to clearly identify the prevalence of serious violent offences such as murder, attempted murder and serious assault and the sexual crimes category to clearly identify sexual violence such as rape and indecent assault. However, the miscellaneous offences category includes non-violent offences as well as offences involving less severe forms of violent behaviour such as common assault, threatening and abusive behaviour, stalking and racially aggravated behaviours.

Whilst the 2016-17 data indicates that in Scotland non-sexual crimes of violence recorded by the Police have decreased by 44% since 2007-08, there is no published data indicating what

⁵ The term 'children' refers to those under 18 years of age as per the United Nations Convention on the Rights of the Child (UNCRC). The term children is used throughout this report to refer to all those under 18 regardless of whether they are in the youth justice or criminal justice system.

percentage of these crimes were perpetrated by children (Scottish Government, 2017). In terms of information about the categories of offending that children are involved in, the most recently published Scottish figures date back to 2012-2013 (Scottish Government, 2013). These figures indicated that of the 43,117 offences detected in 2012-13, crimes of dishonesty accounted for 16.2%, fire-raising, vandalism, etc. for 14.1% and other crimes for 12.7%. In terms of violence, non-sexual crimes of violence accounted for only 1.2% and sexual crimes for 1.9%. However, the miscellaneous offences category, which accounted for 53.9%, includes less severe forms of violence as described above.

A review of the violent offences that children were in custody for in Scotland highlighted that of 106 sentences in 2015-16, 18 were for serious assault, 25 for common assault and six for having in a public place an article with a blade or point. Other types of violent offences such as attempted murder, robbery and assault with intent to rob, threatening and abusive behaviour and sexual crimes did result in sentence, however, as these were less than five, no specific figures were provided (Youth Justice Improvement Board, 2017).

Despite the decrease in offending, there is a small, but substantial, percentage of children who present a risk of serious harm⁶ to others. Understanding their needs is crucial if we are to prevent future harm. Emerging research clearly demonstrates the complex needs with which a number of these children present. For example, the Edinburgh Study of Youth Transitions and Crime (ESYTC) (McAra et al., 2010) highlights that 15 year olds involved in violent offending were significantly more likely than their peers who were not involved in violent offending to be victims of crime and adult harassment, engage in self-harming and para-suicidal behaviour, exhibit problematic health risk behaviours, have more problematic family backgrounds and come from socially deprived areas.

⁶ The Framework for Risk Assessment, Management and Evaluation (Risk Management Authority, 2011) proposes the adoption of the following definition of risk of serious harm: 'There is a likelihood of harmful behaviour, of a violent or sexual nature, which is life threatening and/or traumatic and from which recovery, whether physical or psychological, may reasonably be expected to be difficult or impossible'.

Recent findings from a study of the Interventions for Vulnerable Youth (IVY) project, which provides a specialist psychological and social work approach to risk practice for children (12-18 years) who present with complex psychological needs and a risk of serious harm to others, indicated that 93.1% of the sample had experienced at least one adverse childhood experience such as abuse, neglect or growing up in a household where there is domestic violence and 58.5% had experienced four or more (Vaswani, 2018). Similarly, recent research has shown that a high proportion of children in custody in Scotland have experience of living in deprived communities; being excluded from school; being in local authority care as a child; multiple and traumatic bereavements; multiple adverse childhood experiences; receiving head injuries; and suffering from speech, language and communication needs (of different etiologies) (Broderick & Carnie, 2016; Vaswani, 2014; Youth Justice Improvement Board, 2017).

Whilst our understanding of the underlying needs of children involved in violent behaviour is becoming clearer, our understanding of how well their needs are being met and how well the risks they present to others are being managed, whilst retaining rights, remains unclear. In relation to the risk of harm presented to others, there has been considerable debate over the past few years about the value of the different approaches to risk assessment (i.e. actuarial versus professional judgment), with a growing consensus that there are clear benefits to the structured professional judgment (SPJ) approach over the unstructured and/or actuarial approaches (Case & Haines, 2016; Johnstone & Gregory, 2015; Millington & Lennox, 2017; Viljoen, Gray, & Barone, 2015).

In Scotland, one of the national youth justice standards states that everyone referred to a Children's Hearing on offence grounds should have a comprehensive assessment, which must be completed using "ASSET/YLS/CMI and other specialist structured risk assessment tools where appropriate" (Scottish Government, 2013). However, the continued use of both ASSET (Youth Justice Board, 2000) and the Youth Level of Service/Case Management Inventory (YLS/CMI) (Hoge & Andrews, 2002), which are actuarial tools, does not fit with the more recent approach recommended in the Framework for Risk Assessment, Management and Evaluation for children and young people under 18 (FRAME) (Scottish Government, 2014). FRAME was initially published in 2011 and subsequently revised to include guidance

on Care and Risk Management (CARM) planning for children and young people who present a risk of serious harm (Scottish Government, 2014). The purpose of FRAME is to bring consistency, evidence-informed practice and proportionality to the way in which agencies assess, manage and evaluate the risk presented by offending behaviour. The framework highlights that assessments in relation to the risk of further offending behaviour should take an SPJ approach and should be informed by thinking of children as children first because offending is often a result of unmet needs. The CARM process should ensure a transparent, proportionate and rights-based approach that places the child or young person at the centre of decision-making and considers risks and needs holistically. The process is underpinned by Getting it right for every child (GIRFEC) (Scottish Executive, 2007) and ensures that decisions about risk inform the Child's Plan in a meaningful way.

Despite the existence of the national youth justice standards, FRAME and CARM, the results of an unpublished Centre for Youth & Criminal Justice (CYCJ) survey conducted in 2016 highlighted a development need in risk practice with over 75% of practitioners identifying development needs in managing high risk young people, working with vulnerable/high risk girls, working with challenging behaviour, risk assessments, sexual offending and violent offending. This survey highlighted a broad development need and CARM training has since been developed and delivered in Scotland to highlight best practice in managing high risk behaviours. However, practitioners' skills in implementing the various elements of the SPJ approach remains unclear, as does the level and quality of implementation of the FRAME and CARM guidance and adoption of the SPJ approach. Without this knowledge, it is difficult to identify the advancements needed in practice to improve outcomes for these children and to prevent future victims.

This paper describes the method used to gather data from the IVY project and a survey of the youth justice workforce in order to progress our understanding of the nature of violence children are presenting with, the drivers underlying their violent behaviour and existing risk practice to reduce violence. The IVY project is funded by the Scottish Government and is based in CYCJ at the University of Strathclyde. It commenced in September 2013 as a nationwide service for Scotland to provide a specialist psychological and social work approach to risk assessment, formulation and management for children who present with complex psychological needs and a risk of serious harm to others. The IVY project has three

tiers: Level 1: Consultation, Level 2: Specialist assessment and Level 3: Specialist intervention.

At Level 1, the referrer can request a two hour consultation meeting with the IVY team, which comprises of Social Work, Clinical and Forensic Psychology staff. During the consultation the child's developmental trajectory, mental health, emotional, behavioural and interpersonal functioning are explored and consideration is given to how these might be linked to their risk of serious harm to others. The IVY team use the SPJ principles to help the referrer develop (or refine) a working risk analysis and formulation, and risk management plan. A risk analysis report is provided to the referrer following the Level 1 consultation and, as per best practice in risk assessment, includes background information, risk and protective factor ratings, formulation, scenario planning and risk management/reduction recommendations. The risk analysis report is often informed by the use of an SPJ tool such as the Structured Assessment of Violence Risk for Youth (SAVRY) (Borum, Bartel, & Forth, 2006) supplemented with any other relevant literatures.

The results presented in this paper add to our knowledge in three main areas. Firstly, the data provides a crucial insight into the nature of the violent behaviour children are displaying. Secondly, the data extends the growing evidence base on the complex needs of children engaging in violent behaviour and highlights the need to reframe how we conceptualise risk. Finally, the data contributes to the sparse knowledge about how risk practice is implemented in the field. Based on these findings, the implications for practice are considered in relation to developing more effective risk practice in Scotland.

Method

Ethics

This research was given ethical approval by the University of Strathclyde's Ethics Committee based in the School of Social Work and Social Policy. This scrutiny focuses on the well-being of participants and the security of data collected during the duration of the study.

Participants

Children. The current study examined the risks, needs and risk practice for a group of 63 children (52 male, 11 female) referred to the IVY project due to concern over their risk of serious harm to others. The mean age of the children was 15 years (range 12-18 years) and they came from 24 out of the 32 Local Authorities across Scotland. In terms of ethnicity, 88.9% were white, 1.6% were Asian and for 9.5% of children the data was missing. At the time of referral to the IVY project 84.1% were classed as looked after children⁷. In terms of legal status 58.7% were on a Compulsory Supervision Order; 3.2% on an Interim Compulsory Supervision Order; 4.8% on Voluntary Supervision; 4.8% on a Permanence Order; 4.8% on a Community Payback Order; 3.2% on Remand or Sentence; and 12.7% in the 'Other' category. None of the children in this sample were subject to Multi-Agency Public Protection Arrangements (MAPPA). At the time of referral, 19% of the young people were living in a secure setting; 4.8% in supported accommodation; 28.6% in a residential setting; 27% in the parental home; 3.2% in another family home; 6.3% in foster care; 3.2% in an adoptive family home; 4.8% in their own tenancy; 1.6% in prison; and 1.6% were homeless.

Practitioners. The responses of individuals who completed the risk practice survey were examined. The survey was advertised through the CYCJ website and the monthly CYCJ e-bulletin. The completion rate of the survey was low with only 23 completed responses. These responses came from individuals in various locations across Scotland. Of the responses, 57% indicated that they were supervisors or managers and 43% indicated that they were practitioners. In terms of their years of experience, 70% of respondents indicated that they had over 10 years of experience, 22% had 5-10 years of experience, 4% had 1-5 years of experience and 4% less than one year's experience.

Procedure

Consent was obtained from referrers at the point of referral to the IVY project to use the information provided for both risk formulation and research purposes. Historical and current risks, concerns, experiences and protective factors are shared with the IVY project by

⁷ The Children (Scotland) Act 1995 defines 'looked after children' as those in the care of their local authority.

multi-agency professionals working with the child in a referral form, and then elaborated on verbally in the multi-disciplinary Level 1 consultation clinic. This information is used to develop an individualised risk formulation, often informed by the completion of a SAVRY risk assessment tool (Borum et al., 2006) or other relevant assessment. The SAVRY contains 30 items including Historical, Social/Contextual and Individual risk factors along with six protective factors. The risk factors are rated as High, Moderate or Absent/Low as per the guidance contained in the manual. The resulting formulation is fed back to referrers in the form of a risk analysis report. This research constituted a secondary analysis of referral information and the risk analysis reports documenting the assessment and formulation clinics at Level 1.

During the three-year period between September 2013, when the project started, and August 2016, the IVY project received 129 referrals. Of these referrals, 121 (94%) had a Level 1 consultation that was completed. Of those children for whom a Level 1 consultation had been completed, 63 (52%)⁸ had a SAVRY completed by the IVY project to inform the risk analysis report. Only those children for whom a SAVRY assessment was completed were included in this research as this indicated that there was concern specifically over their use of violence and that there was sufficient information available to be able to identify risk, needs and previous risk practice.

In order to gather the data for this study, information contained in the referral form to IVY and the risk analysis report produced following the Level 1 consultation for these 63 children was coded according to a coding sheet. The information coded included:

- Presenting risk behaviours and mental health needs
- Nature of the violent behaviour such as type of violence engaged in, the age at first engagement in violent behaviour and the duration of time that the violent behaviour had been occurring
- Presence or absence of the SAVRY risk and protective factors (listed on page 17)
- Risk practice strategies utilised by professionals prior to referral to IVY

⁸ There are various reasons why a SAVRY would not have been completed following the Level 1 consultation including a lack of information, need for further assessment or inappropriate referral.

- Barriers to progress in reducing or managing the risk of violence presented to others
- Recommendations made following the Level 1 consultation

In terms of the youth justice workforce survey, consent was obtained from practitioners prior to commencement of the on-line survey. The survey focused on:

- Implementation of CARM processes
- Use of the recommended SPJ approach (assessment, formulation, scenario planning and risk management planning)
- Levels of perceived skill in using the SPJ approach
- Areas where support/training is required
- Ascertaining the best methods of supporting workforce development

Results

What is the nature and prevalence of violent behaviour by children?

The current research examining the IVY data looked at the nature of the violent behaviour with which the children referred to IVY presented. It should be noted that this data represents the Police Scotland crimes or offences most closely matched to the descriptions of the child's behaviour, regardless of whether they were actually charged or convicted of the behaviour. The analysis indicated that the mean number of types of violent behaviour prior to referral to IVY was four (range 1-8; SD 1.63). Figure 1 below shows the percentage of children engaging in the various types of violence with common assault (91%), threatening or abusive behaviour (76%) and handling offensive weapons (67%) by far the most common. Whilst this data highlights that the less severe forms of violence are the most frequent, it should be noted that only 21% of children had engaged in these less severe forms of violence without having additionally engaged in a more serious form of violence as well. From the information available it was not possible to measure the frequency with which individual children were engaging in violent behaviour.

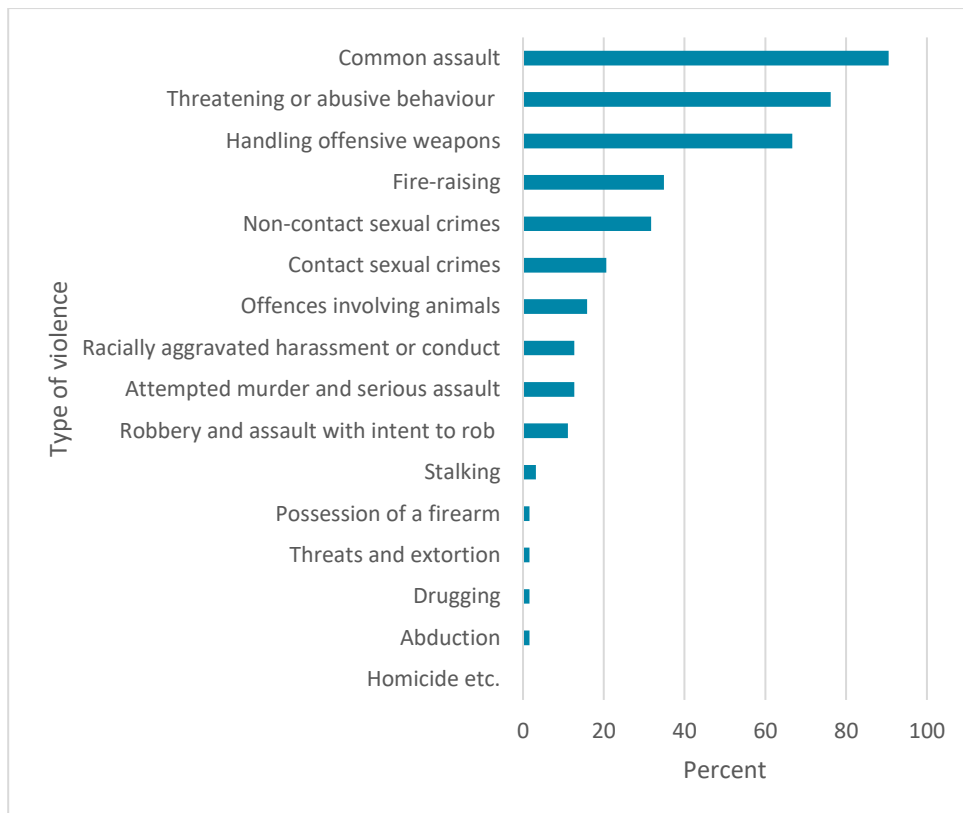


Figure 1: Prevalence of type of violence

In terms of age at first violence, the mean reported age was 10.25 years (range 3-17; SD 3.52) with 41% of the children engaging in violent behaviour prior to age 11 years. At the point of referral to IVY, the children had been displaying violent behaviour for a mean duration of 5.2 years from the known point of first violent behaviour (range 1-14; SD 3.61), with 48% of the children having displayed violent behaviour for five or more years since the first violent incident. However, as noted above, the frequency of violent behaviour between these two points was not possible to determine reliably.

In contrast, the information available indicated that less than 5% of children engaged in their first violent behaviour age 15 years or over, with 13.3% of children having only been known to engage in violent behaviour over the past year prior to referral to the IVY project.

What needs do children involved in violent behaviour present with?

The current review of the IVY data adds to our knowledge about the needs with which children who are engaging in violent behaviour present. In terms of the types of concerning behaviours presented in the IVY Level 1 consultation, this not only involved the children's risk of harm to others but also to themselves and of victimisation from others. Figure 2 shows the percentage of children who presented with various types of risk concern. The largest percentage was risk of engaging in violent behaviour (94%) which was closely followed by general offending (83%). It is also noted that the majority (i.e. over 50%) also presented with risk of self-harm, substance use and unauthorised absences from home and/or school. In relation to victimisation, 37% of children were considered to be at potential risk of being harmed by others. The mean number of types of risk presented per person was 5.65 (range 3-10; SD 1.67), with 74.6% of children presenting with five or more types of risks.

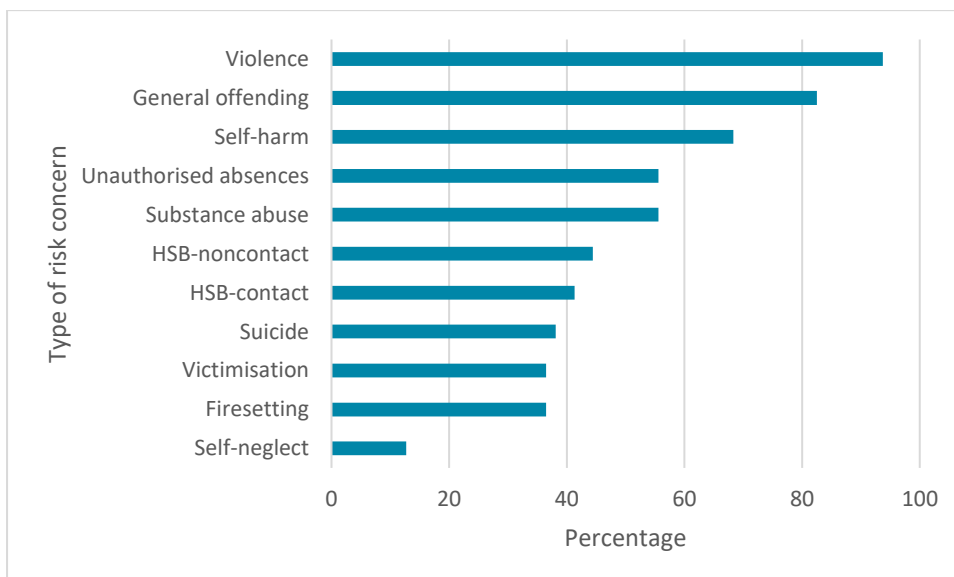


Figure 2: Prevalence of type of risk concern

In relation to mental health, all children who were referred to the IVY project were considered against the criteria in the Diagnostic and Statistical Manual of Mental Disorders, Fifth edition (American Psychiatric Association, 2013). Where the symptoms described indicated that they would likely meet the diagnostic criteria it was recorded as such, but does not constitute a formal diagnosis. As can be seen from Figure 3, attachment disorder and post-traumatic

stress disorder are overwhelmingly represented in this group with 92.1% and 74.6% respectively. The mean number of types of psychiatric diagnoses presented per person was 4.0 (range 1-7; SD 1.44), with 63.5% displaying four or more.

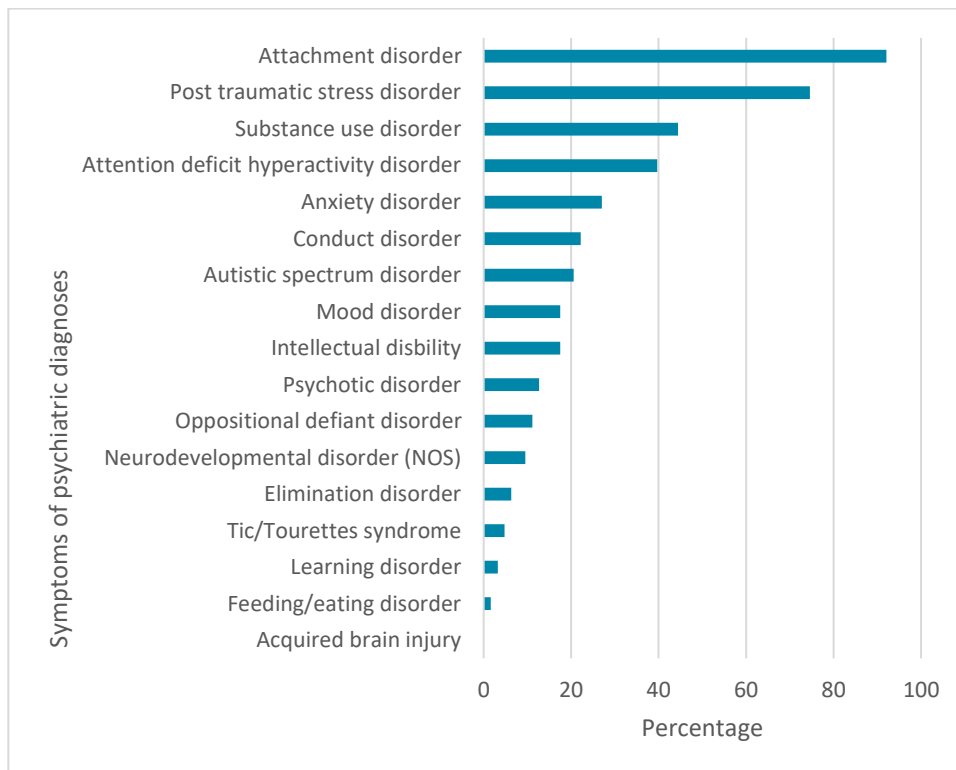


Figure 3: Prevalence of symptoms of psychiatric diagnoses

As can be seen in Tables 1 and 2, the prevalence of risk factors rated as high was relatively large and the prevalence of protective factors was relatively small. Approximately two thirds of the children had experienced high levels of caregiver disruption, maltreatment in childhood, exposure to violence in the home and poor school achievement with additional children experiencing moderate levels of these factors. In fact, the absence of, or low levels of, early caregiver disruption, maltreatment in childhood, exposure to violence in the home and poor school achievement were noted in less than 20% of the children. In terms of social/contextual factors, more than three quarters of the children were considered to be experiencing high levels of stress and poor coping, poor parental management of their behaviour, and over half experiencing peer rejection and peer delinquency. With regards to more individual factors, over two thirds were regarded as having high levels of negative attitudes, anger management problems, risk taking/impulsivity, poor compliance and low

empathy/remorse. Individual protective factors such as resilient personality traits, strong commitment to school, positive attitudes toward intervention and authority, strong attachment bonds, strong social support and pro-social involvement were evident in less than one third of the children.

Table 1: Prevalence of SAVRY risk factor ratings

SAVRY Risk Factors	%		
	Absent/Low	% Moderate	% High
History of violence	0	10	90
History of nonviolent offending	15.3	18.6	66.1
Early initiation of violence	5.3	38.6	56.1
Past supervision/intervention failures	11.1	40.7	48.1
History of self-harm or suicide attempts	39.7	32.8	27.6
Exposure to violence in the home	16	12	72
Childhood history of maltreatment	18.2	16.4	65.5
Parental/caregiver criminality	37.7	20.8	41.5
Early caregiver disruption	12.1	24.1	63.8
Poor school achievement	12.5	25	62.5
Peer delinquency	20.3	25.4	54.2
Peer rejection	10.7	21.4	67.9
Stress and poor coping	0	6.8	93.2
Poor parental management	3.6	21.4	75
Lack of personal/social support	6.8	47.5	45.8
Community disorganisation	44	18	38
Negative attitudes	5.2	24.1	70.7
Risk taking/impulsivity	6.9	12.1	81
Substance use difficulties	44.6	16.1	39.3
Anger management problems	5.2	17.2	77.6
Low empathy/remorse	6.1	20.4	73.5
Attention deficit hyperactivity difficulties	62.5	8.9	28.6
Poor compliance	3.4	23.7	72.9
Low interest/commitment to school	17	34	49.1

^a n ranges between 49-60

Table 2: Prevalence of SAVRY protective factor ratings

SAVRY Protective Factors	% Present
Prosocial involvement	23.3
Strong social support	24.1
Strong attachment bonds	30.6
Positive attitudes toward intervention and authority	16.7
Strong commitment to school	17.5
Resilient personality traits	12.3

^b n ranges between 49-60

How are needs and risks addressed for children involved in violent behaviour?

The current research examined the prior documented risk practice for the 63 children in this sample. The findings indicated that in 31.7% of cases there was reference to a risk assessment having been completed prior to referral to IVY. Various types of risk assessment were completed with the most frequently used being ASSET (14%), then SAVRY (6.3%), Assessment, Intervention and Moving-On 2 (AIM2) (Print, Morrison, & Henniker, 2001) (4.8%), Level of Service/Case Management Inventory (LS/CMI) (Andrews, Bonta, & Wormith, 2004) (3.2%), YLS/CMI (1.6%), Short Term Assessment of Risk and Treatability: Adolescent Version (START:AV) (Viljoen, Nicholls, Cruise, Desmarais, & Webster, 2014) (1.6%) and Juvenile Sex Offender Assessment Protocol (J-SOAPII) (Prentky & Righthand, 2003) (1.6%)⁹. In 12.7% of cases there was reference to the use of multi-agency CARM / risk management processes. In relation to the various elements of the SPJ approach, clear evidence of formulation was found in 4.8% of the referrals.

Attempts to manage/reduce the risk of harm were categorised according to Supervision, Monitoring, Intervention and Victim Safety Planning strategies. Coding of the information available indicated that the use of monitoring strategies to measure changes in frequency,

⁹ In one case two risk assessment tools were completed so the figures do not add up to 100%.

intensity or duration of behaviours were mentioned infrequently, with 77.7% making no mention of clear monitoring strategies. The monitoring strategies that were referred to were monitoring contact with others (14.3%), internet use (4.8%) and electronic monitoring (3.2%).

Supervision on the other hand was referred to much more frequently, with 19% making no clear reference to supervision strategies. Reference was made to the following supervision strategies: subject to a compulsory supervision order through the Children's Hearing System (73%), secure care (31.7%), restricted contact with others (20.6%), bail (17.5%), custody (9.5%), criminal justice supervision (9.5%), movement restriction conditions (4.8%) and parental supervision restrictions (3.2%). In terms of victim safety planning, there was no explicit mention of any victim safety planning in 87.3% of cases. Those that were mentioned included safety plans (6.3%), staff protocols (6.3%), plans for unwanted contact (1.6%) and improvements to physical security (1.6%)¹⁰.

For all children there was reference to the interventions that had been tried. A referral to CAMHS (77.8%) was the most common intervention strategy (although this does not mean that the referral was accepted or that, if accepted, intervention was provided), with medication (31.7%) and intensive support packages (31.7%) the next most frequent. Figure 4 shows the percentage of cases where it was clearly documented that these intervention strategies had been tried.

¹⁰ In two cases there were two forms of victim safety planning mentioned so the figures do not add up to 100%.

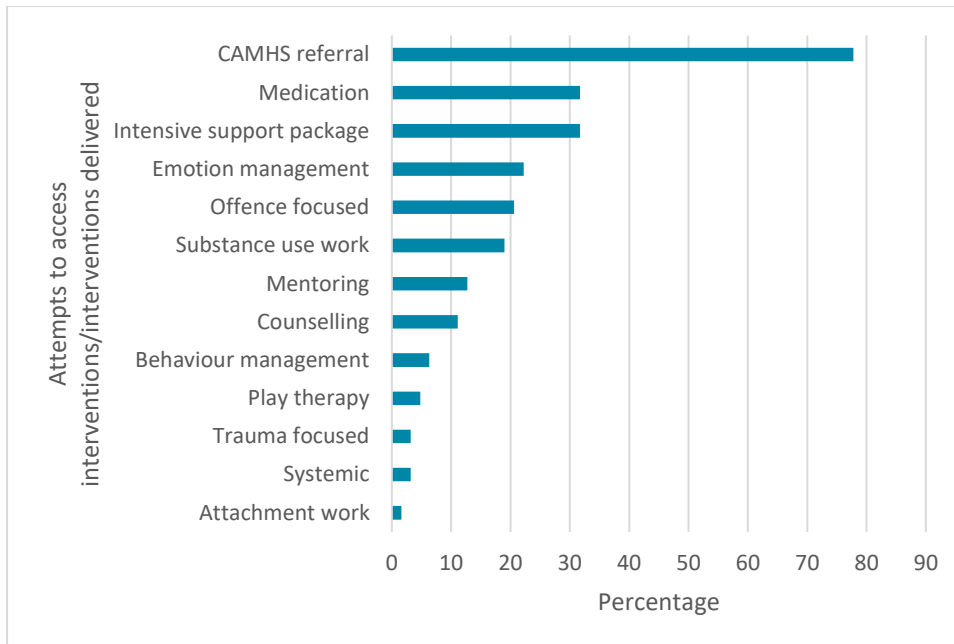


Figure 4: Prevalence of attempts to access interventions/interventions delivered

In addition, the information available indicated that the mean length of time from when the children first had social work involvement to the point of IVY referral was 7.65 years (range 0-18, SD 5.64), with 50% having been known to social work for nine or more years from the point of first contact. It should be noted that this does not necessarily mean that they had been open to social work services continuously for this period of time. The data also indicated that 7.7% of children had not previously been known to social work services and that a further 13.5% had been known to social work for less than one year. The mean number of out of home local authority placements per child was 3.14 (range 0-12, SD 2.85), with 33.3% having experienced four or more out of home local authority placements.

Given the length of time since the first known violence and referral to the IVY project, the potential barriers to effecting a reduction in the children’s violent behaviour were gathered from the available information. Figure 5 shows the prevalence of the potential barriers. The most common potential barriers identified were difficulty engaging the child¹¹ (65.1%),

¹¹ Difficulties engaging with the child included reference to the child’s difficulty in attending and engaging in scheduled appointments at services, which can in some services result in referrals being closed due to lack of attendance and engagement. However, this lack of attendance and engagement can be due to the child’s lack of trust in adults, the chaotic lifestyle around them, and the inflexibility of systems to adapt to their needs.

difficulty engaging the family (58.7%), parental criminal attitude (57.1%), parental substance use (52.4%) and parental mental health (50.8%).

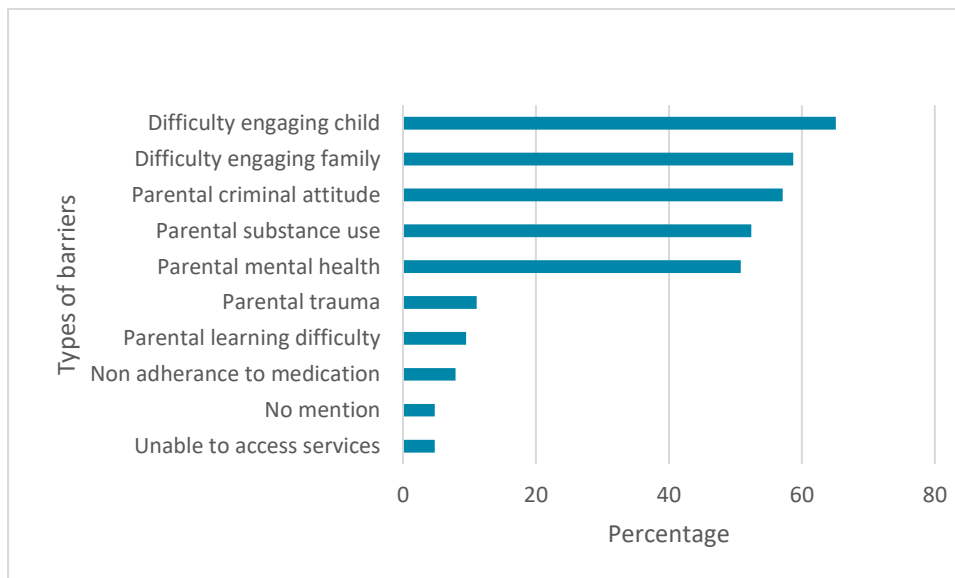


Figure 5: Prevalence of systemic barriers

Following the IVY Level 1 consultation a risk analysis report was written by IVY staff based on the information available. This took an SPJ approach utilising formulation and scenario planning to develop risk management and reduction recommendations. Figure 6 details the recommendations made in the risk analysis report. For a large percentage of children it was considered that further information (79.4%) and assessment (77.8%) was required to ensure comprehensive formulation and intervention planning. Further assessments that were recommended included attachment and personality functioning, neurodevelopmental disorder, cognitive, mental health, psychosexual development, parenting and trauma assessments. In addition, a more in-depth psychological risk assessment was recommended in 30.2% of cases. Recommendations of intervention work with the child were made in 68.3% of cases and included interventions around mental health, emotion regulation, relationships, trauma, substance misuse and offence focused work. Other recommendations that were made in the majority of cases included increased supervision (58.7%), increased monitoring (85.7%) and additional safety measures (55.6%) which included child protection measures and victim safety planning.

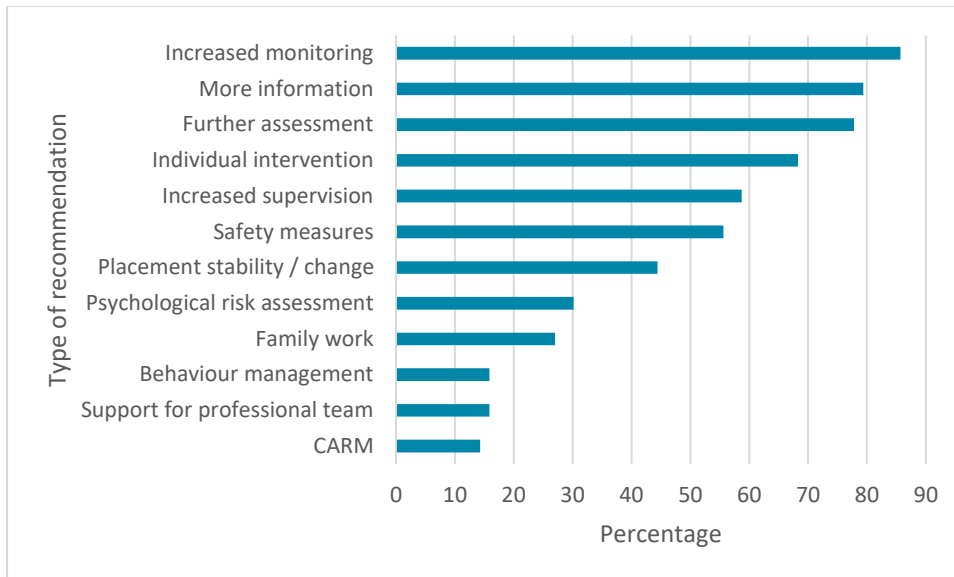


Figure 6: Prevalence of IVY recommendations

What are the views of the youth justice workforce in relation to risk practice?

In relation to CARM training, 74% of respondents to the survey indicated that practitioners in their local area had attended CARM training and 78% indicated that managers in their local area had attended CARM training. Approximately 50% of respondents indicated that processes had been changed following FRAME and CARM guidance and training. Some of the changes noted by respondents included the inclusion of young people and their families in multi-agency meetings, a recognition from senior managers for the need for a CARM approach, development of policies and procedures, introduction of CARM guidelines and multi-agency meetings, clearer and updated guidance and ongoing development of CARM. With regards to risk assessment tools and formulation models Table 3 shows the percentage of those that respondents indicated they used.

Table 3: Prevalence of risk assessment tools and risk formulation models used

Risk assessment tool	Percentage	Formulation model	Percentage
ASSET	52%	4P's	57%
AIM2	47%	Systemic	30%
SAVRY	43%	CBT	17%
START:AV	17%	None	9%
YLSCMI	9%	3Ds	4%
Other ^c	9%	Other	0%
None	4%		

^cThe tools referred to in the 'Other' category were LS/CMI, SARA, RM2K/SA07, JSOAPII, SERAF and ERASOR.

In relation to scenario planning, 64% of respondents indicated that they used this in their risk practice and in terms of risk management/reduction measures, 65% indicated that they used monitoring, 83% supervision, 83% intervention and 57% victim safety planning.

As well as asking respondents about the elements of the SPJ approach that they used, they were also asked to indicate how skilled they thought supervisors/managers and practitioners are in the various elements of the SPJ approach. Table 4 details the responses, which indicate that the respondents see room for improvements in risk practice. In particular, 60% of respondents indicated that supervisors/managers and practitioners were slightly skilled or not at all skilled in developing formulations. In addition 52% of supervisors/managers and 48% of practitioners were viewed as being slightly skilled or not at all skilled in scenario planning.

Table 4: Ratings of Supervisor/Manager and Practitioner skill in the elements of the SPJ approach

		Extremely skilled	Very skilled	Moderately skilled	Slightly skilled	Not skilled at all
Use of risk assessment tools	Supervisors / Managers	4%	26%	57%	13%	0%
	Practitioners	0%	26%	65%	9%	0%
Development of formulations	Supervisors / Managers	0%	15%	25%	35%	25%
	Practitioners	0%	20%	20%	45%	15%
Scenario planning	Supervisors / Managers	0%	19%	29%	19%	33%
	Practitioners	0%	19%	33%	15%	33%
Development of risk management / reduction plans	Supervisors / Managers	0%	36%	50%	14%	0%
	Practitioners	0%	36%	46%	18%	0%
Evaluating outcomes / changes in risk	Supervisors / Managers	0%	27%	46%	27%	0%
	Practitioners	5%	23%	45%	27%	0%
Written and verbal communication of risk	Supervisors / Managers	0%	24%	62%	14%	0%
	Practitioners	0%	29%	52%	19%	0%

Respondents to the survey were asked to identify the areas where additional support or training in relation to risk practice were required. Analysis of the responses indicated that over half of the respondents thought that there was a need for further support/training in relation to the CARM process, formulation, scenario planning, risk management, measuring outcomes and communication of risk. The details of the responses are in Figure 7. This need was for both supervisors/managers and practitioners. The identified need for support/training

in specific risk assessment tools was slightly less but with a clearer need for training in SPJ tools such as SAVRY and START:AV over more actuarial tools such as YLS/CMI and ASSET.

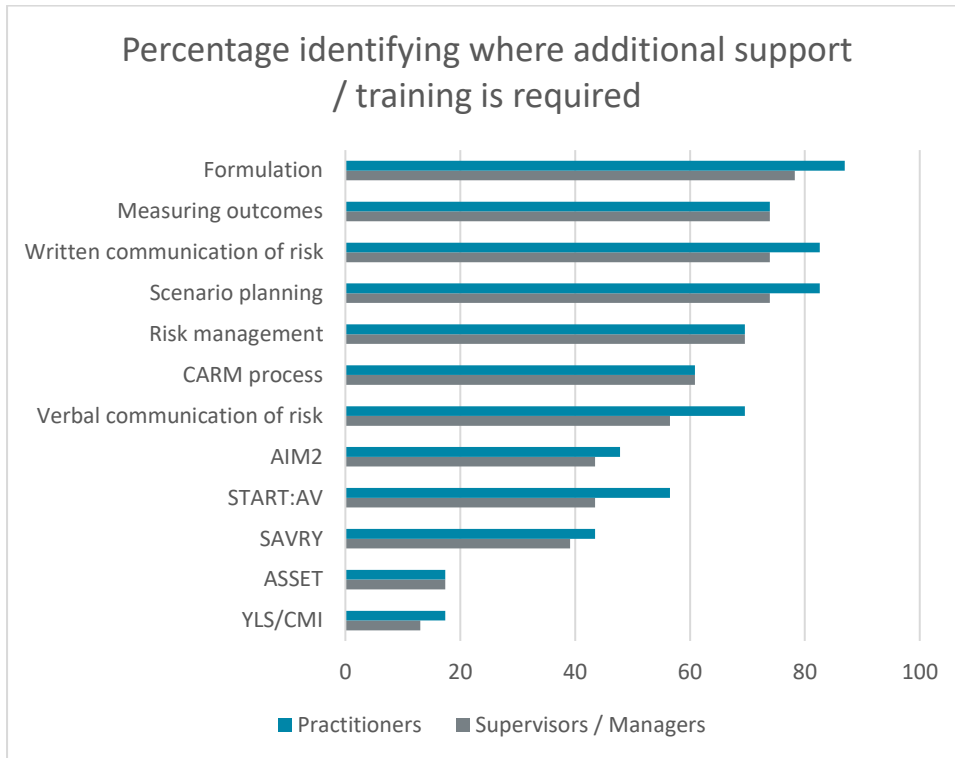


Figure 7: Prevalence of additional support / training needs

Respondents were also asked to indicate the format of support that would be helpful for their area. Analysis of these responses indicated that over half of respondents felt that e-learning, training courses, reading further literature and events would be beneficial for both supervisors/managers and practitioners. Over half of respondents additionally identified that practitioners would benefit from supervision as a form of support in relation to risk practice (see Figure 8).

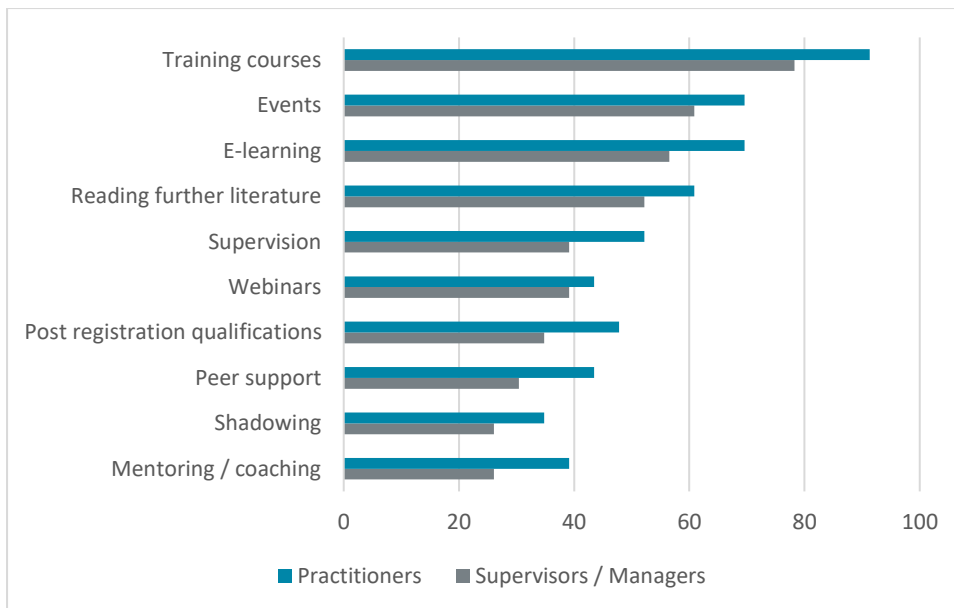


Figure 8: Prevalence of support format

Discussion

The depth and breadth of the needs of children involved in violent behaviour is stark, as is the range of the types of risk with which they present. In relation to their violence, these findings highlight that some children had displayed aggressive behaviour from a very young age. Around two-fifths of the children were known to have engaged in violent behaviour before the age of 11 years. Early onset of violent behaviour is one of the key predictors of violent behaviour continuing into adulthood (Borum et al., 2006) and as such it is important that the needs underpinning this are fully assessed, understood and addressed early on in the child's development in order to prevent continuation and further escalation. However, half of the children in this sample had displayed violent behaviour for five or more years prior to the referral to the IVY project and half had been known to social work for nine or more years from the point of first contact, although not necessarily continuously. In addition, children often experienced a number of out of home placement breakdowns, commonly due to their aggressive and violent behaviour, with around a third having four or more placements. In relation to the types of violence, the most frequent were common assault, threatening or abusive behaviour and handling offensive weapons. However, only around one-fifth of children had engaged in these behaviours with no indications of having engaged in a more serious form of violence as well. Unfortunately, these findings do not provide any

insight into the frequency of the violence displayed as it was not possible to do this from the information available. Overall, these findings highlight that the current systems are not effective in reducing violence for a significant number of children.

One of the reasons for the difficulties faced in reducing the violent behaviour may be the complexity of needs the children in this sample present with. As well as behaviours harmful to others such as violence, harmful sexual behaviour and general offending, over half of the children also presented with behaviours harmful to themselves such as self-harming, substance use and having unauthorised periods away from home and/or school. On average, they presented with six types of risk behaviour, including risk of victimisation from others.

In relation to their childhood experiences, around two thirds had experienced high levels of caregiver disruption, maltreatment in childhood and exposure to violence in the home, with additional children experiencing moderate levels of these factors. There were also issues of parental mental health, parental substance use, parental criminal attitudes and poor parental management documented in over half of the cases. In terms of their own mental health issues, the vast majority of children presented with symptoms indicating that they would meet the criteria for attachment disorder and trauma. High levels of co-morbidity were indicated with children presenting with an average of four different mental health issues. These findings are consistent with the growing body of evidence that children involved in violent behaviour are often our most victimised, traumatised and vulnerable children (McAra et al., 2010; Vaswani, 2018; Youth Justice Improvement Board, 2017).

Complex or developmental trauma reflects the difficulties thought to be associated with experiencing multiple and chronic traumatic events or processes over the course of development, which often occur in a relational context. The experience of childhood trauma may influence the risk of violent behaviour in numerous ways. This can include interpersonal symptoms of trauma such as uncertainty about the reliability and predictability of the world; distrust and suspiciousness; emotional symptoms such as numbing, dissociation and dysregulation; and behavioural symptoms such as poor modulation of impulses, aggression against others, self-destructive behaviour, oppositional behaviour, communication of traumatic past by re-enactment in day-to-day behaviour or play and difficulty understanding

and complying with rules (Cook, Blaustein, Spinazzola, & van der Kolk, 2003; Johnstone, 2017; Raja & Rogers, 2017). Given the adversity that many of the children in this sample have experienced and the prevalence of trauma symptoms described, it is likely that many of the children are hypersensitive/hypervigilant for signs of 'danger', which can result in even mild threats or objectively 'harmless' triggers invoking significant fight, flight or freeze responses. It is therefore probable that a number of the violent incidents were reactions to feeling unsafe and/or threatened in some way rather than well thought out and planned attempts to engage in violence (Raja & Rogers, 2017; Rogers & Budd, 2015). It therefore appears that for the majority of the children in this sample their violent behaviour could be reframed as simply another form of distress response or a vulnerability. The fact that the average age of the children at the first noted violent incident was only ten years old also adds weight to this argument.

However, Johnstone (2017) has clearly documented the potential pathway for some children from attachment difficulties and trauma experiences in childhood to a later diagnosis of 'psychopathy' in adulthood should these difficulties not be effectively assessed, formulated and appropriate interventions provided. Ensuring that Scotland is a trauma informed society and that agencies or services who are in contact with children at risk of engaging in violent behaviour are skilled, or have enhanced skills, in responding to trauma (NHS Education for Scotland, 2017) could very likely result in a reduction of less serious violent assaults which often occurred in the home/care environment or when there was police presence - thus the threat system activated - and provide opportunities for more positive future pathways.

A further reason why the current system may not be effective in reducing violence for a significant number of children is that the quality and level of risk practice does not match the complex needs of these children. The level of needs and vulnerabilities that children present with can help us understand their behaviour but it should not detract from the risk of harm they can present to others and the necessity to consider the safety of others and to work to protect society from further harm and victimisation. The information available indicated that risk assessment tools were not frequently used and when they were used, these often were not appropriate for the presenting behaviours. Given that all children were referred to IVY in relation to concerns about their violent behaviour, it is surprising that the SAVRY and START:AV had been used so infrequently by practitioners earlier in their journey. Risk

assessment tools show better predictive accuracy for the outcomes they were designed to assess and the populations they were intended for (Desmarais, 2017; Desmarais, Johnson, & Singh, 2016; Fazel, Singh, Doll, & Grann, 2012; Williams, Wormith, Bonta, & Sitarenios, 2017). For example, studies have found that both ASSET and YLS/CMI are less powerful at detecting violent offending than general offending, which is in line with their purpose as they are intended to be assessment tools for general offending (Fearn, 2014; Schmidt, Campbell, & Houlding, 2010; Welsh, Schmidt, McKinnon, Chattha, & Meyers, 2008). The potential consequences of using inappropriate risk assessment tools, or not using them for the populations for which they were designed, could be far reaching, including for them, their loss of liberty and for others, significant harm.

There was also limited evidence of comprehensive formulation and robust risk management planning having been used in this sample. The information available indicated that only a small percentage of children had been referred to a multi-agency CARM/risk management process prior to referral to the IVY project. In relation to risk management/reduction strategies, monitoring and victim safety planning were referred to infrequently despite these being key to contingency planning and the reduction of, or minimisation of the impact of, any future violence (Millington & Lennox, 2017). In contrast, supervision and intervention strategies were referred to for the majority of children. The interventions that were evident through the current research were largely individual interventions aimed at changing the child's behaviour. These included interventions such as substance misuse, emotion management and offence focused work. Whilst these interventions clearly match some of the individual needs that the children in the study presented with, any changes in their behaviour as a result are unlikely to be sustained if the contributing home and community factors are not also addressed. In line with the theory of social ecology (Bronfenbrenner, 1979), research consistently indicates that interventions which are systemic in nature are the most effective (Hackett, 2014; Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002; National Institute for Health and Care Excellence, 2013). Intensive support packages were referred to for around one third of the children in this sample although it was not always clear as to whether they involved systemic work or whether they were largely focused on the individual child. Explicit reference to systemic work was evident for less than 5% of children. Interestingly, explicit reference to attachment based intervention and trauma focused intervention was made in less than 5% of cases. This is despite our findings (and similar

findings reported in the literature about violence) that over three quarters of children were showing symptoms indicative of attachment disorder and / or trauma. In over three quarters of cases, at least one attempt to secure mental health treatment had been made with a prior referral having been made to Child and Adolescent Mental Health Services (CAMHS)¹² and around one third of children were reported to have been prescribed medication to assist in managing their behaviour. Thus, even when children were accepted by CAMHS, it would seem that treatment modalities and options were limited.

Overall, very little detail was available regarding the interventions that had been tried, with children or parents/caregivers, such as what the goals/desired outcomes were, the action plan/strategies to achieve these, the progress/barriers to achieving these and the evidence for this from monitoring of behaviours. This may be due to these elements being absent or simply due to a lack of explicit reporting of these. If absent, or not explicit, this may be a contributing factor to the length of time that social work services are involved with these children and their families, as well as change not being sustained due to the intervention focus not always being systemic.

Whilst the current findings indicate that risk practice is not always in line with the FRAME and CARM guidance, specific training around FRAME and CARM was not delivered until 2016, after the referrals in the current research had been made. In addition, the Risk Management Authority document (RATED)¹³, which summarises the evidence base for various risk assessment tools, was last updated in relation to youth justice in 2013. Additionally, the national youth justice standards which were produced in 2002, and last updated in 2013, refer specifically to the use of ASSET and YLS/CMI. Initial indications from the risk practice survey would indicate that some improvements have been made following CARM training. However, this was based on a small number of respondents who were self-selecting. An audit of CARM in local authority areas would be able to determine whether this is the case and identify further support required.

¹² From the information available it was not possible to reliably identify the number of referrals to CAMHS that were accepted and progressed.

¹³ <http://rated.rmascotland.gov.uk/>

A more holistic structured professional judgment approach to assessment informed by the START:AV could aid our understanding of need and our action planning to reduce adverse outcomes from occurring (Viljoen et al., 2014). The START:AV appears to offer potential to assist with the reframing of violent behaviours as it considers vulnerabilities and strengths, rather than risk factors, and focuses on wider adverse outcomes than just violent behaviour. It also has a clear focus on formulation to make explicit the link between assessment and risk management planning. A further potential benefit of the START:AV is that it is designed to be completed every three months so that changes in strengths and vulnerabilities can be tracked and provide a regular focus for prioritising interventions depending on need. Whilst there is a limited evidence base for the use of START:AV in the United Kingdom, the tool is grounded in evidenced principles and looks promising.

In terms of future risk management/reduction, recommendations were made following completion of the SAVRY by the IVY project, which informed the formulation and risk analysis report. For over half of the children increased supervision, monitoring and victim safety planning were recommended. The monitoring of changes in behaviour is crucial to determine the effectiveness of interventions and to prevent drift. In the majority of cases, it was believed that further information was required in order to understand the child's behaviour better and there were a high level of recommendations for further assessments. These assessments were often those that could be provided through specialist mental health and psychological services such as cognitive assessments, assessments of adaptive functioning, trauma, attachment, personality, psychosexual, mental health, and neurodevelopmental assessments. However, despite over three quarters of the children having been referred to CAMHS at some point, these assessments had not been undertaken by specialist services. Anecdotally, practitioners report that referrals are often not accepted or progressed by CAMHS because the child's behaviour is deemed a behavioural or social issue rather than a mental health issue or because of a position that the child needs to be in a stable home environment before any therapeutic work can be undertaken.

Rejected CAMHS referrals have recently been subject to research, the findings of which lend their support to this anecdotal information (Scottish Government, 2018). In particular, it is of concern that of all the referrals to CAMHS examined in the recent research, two thirds were rejected prior to a face to face meeting and almost half of the rejected referrals were for

12-18 year olds. The most frequent reason for rejection was that they were deemed unsuitable (62%). When the unsuitable group of rejected referrals were broken down further, 52.8% were unsuitable because they did not meet the NHS Board criteria and 23% due to there being no mental health/illness identified. Interestingly, the research highlighted that the largest percentage of referrals to CAMHS were for behavioural problems (Scottish Government, 2018). There is a clear need for clarity about the referral criteria for CAMHS, as the NHS defines CAMHS as a term for 'all services that work with children and young people who have difficulties with their emotional or behavioural wellbeing'. In addition, the information on their website for children and young people indicates that CAMHS can help if 'you feel angry or are struggling to control your behaviour or temper' (NHS, 2018).

Based on the emerging research it would appear that mental health, behavioural and systemic issues are often present together and without a comprehensive understanding of how these interlink then it is difficult to move towards stability for the child. The research also suggests that across the developmental trajectory, behavioural problems can predate the onset of more overt psychiatric and mental health symptoms. There would appear to be a skills gap in the workforce as very few practitioners have the skills necessary to address behavioural, systemic, emotional and mental health issues. Therefore, those children who have psychological difficulties such as attachment, trauma and neurodevelopmental difficulties and who are engaging in violent behaviours towards others, are often not receiving interventions that adequately meet their needs and improve their wellbeing.

However, this skills gap is likely to be compounded by system barriers which need to be understood so that they can be removed, as at present we are not fulfilling some children's rights to the best of Scotland's ability:

- Article 3 (best interests of the child). The best interests of the child must be a top priority in all decisions and actions that affect children.
- Article 19 (protection from violence, abuse and neglect). Governments must do all they can to ensure that children are protected from all forms of violence, abuse, neglect and bad treatment by their parents or anyone else who looks after them.
- Article 20 (children unable to live with their family). If a child cannot be looked after by their immediate family, the government must give them special protection and

assistance. This includes making sure the child is provided with alternative care that is continuous and respects the child's culture, language and religion.

- 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.

There is a need to examine the roles of all agencies involved in Children's Services and to consider how partnership working, collaboration and consultation can be promoted in order to fulfil the rights of children more effectively. It will be important to ensure that this involves education providers as well, as they are working hard to reduce school exclusions and require support to be able to manage and reduce violent behaviours within schools. This is already happening in some local authority areas and learning from where this is working effectively should be shared and built upon in other areas.

On a positive note the youth justice workforce is motivated to develop their practice and improve outcomes for children involved in offending. In particular, a previous unpublished CYCJ survey highlighted a desire to improve practice in how high risk behaviours are managed. The findings from the current risk practice survey indicate that since this time practice may have improved with more use of the SPJ approach; however, there remains a clear desire to develop practice in the various elements of the SPJ approach even further, for both practitioners and supervisors/managers. Despite the sample of survey respondents being small, it is clear that there is definitely a desire for further training/support to improve risk practice which should be prioritised for investment and development.

One of the limitations to this research is that it does not examine the difference in risks and needs between those children who were engaging in violent behaviour from an early age and for a considerable period of time prior to referral to the IVY project and the small percentage of children who had only recently engaged in violent behaviour from the age of 15 years with no previous social work service involvement. This is clearly an area where further exploration is required in order to ensure that the risks and needs of these children are further understood and potential prevention strategies can be implemented.

Conclusion and implications for practice

This research has provided a more detailed insight into the nature of the violent behaviour that a sample of children in Scotland are displaying and the complex needs with which they present. The prevalence of adverse childhood experiences, psychological distress and mental health needs described suggests a clear need to reframe how we conceptualise risk of violence in children and shift to considering violence as a distress response. Given these findings it is clear that we are not always getting it right for every child; not only are we not protecting them from abuse and neglect but we are failing to provide them with the resources required to address their resulting needs and fulfil their rights.

Additionally, this research has contributed to the sparse knowledge about how violence risk practice is implemented in the field and has highlighted that current risk practice often does not match the level of risk practice required to manage the violent behaviour displayed by these children and to reduce the risk of harm to others. Balancing the rights of these children and the risks presented by these children is complicated, but it is clear that the risk of violent offending cannot be sustainably reduced without taking a rights based approach to addressing the needs underlying the violent behaviour.

Whilst there are indications that offending involving children has decreased and significant progress has been made through the implementation of the Whole System Approach in Scotland (Murray, McGuinness, Burman, & McVie, 2015) there remains a small group of children who present a risk of serious harm to others. FRAME and CARM have provided a welcomed framework and process for managing the risk of serious harm within a transparent, proportionate and rights-based approach that places the child at the centre of decision-making and considers risks and needs holistically. Training in the CARM process across Scotland has provided the foundations for effective risk practice. However, there is a need to progress this to the next level by ensuring that there is investment in the workforce to ensure that they have access to up to date knowledge about best practice, training in appropriate SPJ risk assessment tools and in effective intervention approaches for high risk behaviours. There is also a need to review the wider service systems in place, the barriers

that are regularly faced by practitioners in accessing the appropriate resources and skills sets, and to identify solutions to this. A collective response across agencies is required to get it right for children involved in violent offending and to prevent children in the future from displaying violent behaviour.

Based on the findings of this research the following implications for practice are highlighted:

- Violent behaviour in children is considered and reframed as a vulnerability or distress behaviour that highlights unmet needs where appropriate.
- Priority is given to ensuring that everyone in Scotland works in a trauma informed manner and those working directly with children who are involved in, or at risk of, violent behaviour are skilled, or have enhanced skills, in responding to trauma reactions as per the NES framework.
- Actuarial risk assessment tools are replaced with more holistic, SPJ tools such as the START:AV, which can assess a broader range of adverse outcomes with a focus on both strengths and vulnerabilities¹⁴.
- CARM is audited in local authority areas to identify any additional supports that might be required to effectively manage and reduce the risk of harm children present to others.
- A systemic strengths-based approach to intervention is adopted, which involves holistic family intervention including interventions to help meet parental/caregiver needs as well as the needs of the child.
- An improvement planning approach to intervention is used such as 'Plan, Do, Study, Act'¹⁵ to assist with identifying outcomes, action planning and monitoring progress in achieving outcomes in order to reduce drift.
- A review is undertaken as to how best to meet children's needs when they present with behavioural, systemic, psychological and mental health issues and plans made for service realignment or development of practitioners so that all of the child's needs can be addressed in a holistic manner.

¹⁴ The Scottish Government have recently supported 100 practitioners being trained in the use of START:AV which should lead to further use of this tool when assessing children.

¹⁵ <https://www.gov.scot/Resource/0042/00426552.pdf>

- A multi-disciplinary, tiered, but comprehensive training and development package is produced around assessing and preventing high risk behaviours, including an educational component for communities to highlight the needs of children involved in violent behaviour, address any misperceptions and highlight effective community responses that can contribute to reduction of violent behaviour.
- Further research examining the risks and needs of those children who engage in violent behaviour later in adolescence and who have not previously been known to services is undertaken to inform potential prevention strategies that can be implemented to reduce the risk of harm to others.

References

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: Fifth edition (DSM-5)*. Washington DC: American Psychiatric Association.
- Andrews, D. A., Bonta, J., & Wormith, S. J. (2004). *The Level of Service/Case Management Inventory (LS/CMI)*. Toronto, Ontario, Canada: Multi-Health Systems.
- Bateman, T. (2015). *NAYJ briefing. The state of youth justice 2015: An overview of trends and developments*. Retrieved from <http://thenayj.org.uk/wp-content/uploads/2015/10/State-of-Youth-JusticeOct15.pdf>:
- Borum, R., Bartel, P., & Forth, A. (2006). SAVRY: Structured assessment of violence risk in youth: Professional manual: PAR.
- Broderick, R., & Carnie, J. (2016). *Young People in Custody 2015*. Retrieved from <http://www.sps.gov.uk/Corporate/Publications/Publication-3908.aspx>
- Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by design and nature*: Cambridge, MA: Harvard University Press.
- Case, S., & Haines, K. (2016). Taking the risk out of youth justice. In C. Trotter, G. Mclvor, & F. McNeill (Eds.), *Beyond the risk paradigm in criminal justice*: Palgrave
- Cook, A., Blaustein, M., Spinazzola, J., & van der Kolk, B. (2003). *Complex trauma in children and adolescents*: National Child Traumatic Stress Network.
- Desmarais, S. L. (2017). Commentary: Risk Assessment in the Age of Evidence-Based Practice and Policy. *International Journal of Forensic Mental Health*, 16(1), 18-22. doi:10.1080/14999013.2016.1266422
- Desmarais, S. L., Johnson, K. L., & Singh, J. P. (2016). Performance of recidivism risk assessment instruments in US correctional settings. *Psychological services*, 13(3), 206.
- Fazel, S., Singh, J. P., Doll, H., & Grann, M. (2012). Use of risk assessment instruments to predict violence and antisocial behaviour in 73 samples involving 24 827 people: systematic review and meta-analysis. *British Medical Journal*, 345, e4692. doi:10.1136/bmj.e4692
- Fearn, G. (2014). *Youth crime: An investigation into the effectiveness of general re-offending risk assessment tools*. University of Birmingham UK,
- Hackett, S. (2014). *Children and young people with harmful sexual behaviours*: Dartington.

- Hoge, R. D., & Andrews, D. A. (2002). Youth Level of Service / Case Management Inventory: MHS.
- Johnstone, L. (2017). Youth psychopathy: A developmental perspective In S. Bailey, P. Chitsabesan, & P. Tarbuck. (Eds.), *Forensic child and adolescent mental health: Meeting the needs of young offenders*. Cambridge: University Press.
- Johnstone, L., & Gregory, L. (2015). Youth Violence Risk Assessment: A Framework for Practice. In *Young People in Forensic Mental Health Settings* (pp. 96-122): Springer.
- Krug, E. G., Dahlberg, L. L., Mercy, J. A., Zwi, A. B., & Lozano, R. (2002). *World report on violence and health*. Geneva: World Health Organization.
- McAra, L., Goldson, B., Hughes, G., & McVie, S. (2010). Youth crime and justice: Key messages from the Edinburgh Study of Youth Transitions and Crime. *Criminology & Criminal Justice*, 10(2), 179-209. doi:10.1177/1748895809360971
- Millington, J., & Lennox, C. (2017). Risk assessment and management approaches with adolescent offenders. In S. Bailey, P. Chitsabesan, & P. Tarbuck (Eds.), *Forensic child and adolescent mental health: Meeting the needs of young offenders*. Cambridge: University Press.
- Murray, K., McGuinness, P., Burman, M., & McVie, S. (2015). *Evaluation of the Whole System Approach to Young People who Offend*. Edinburgh: Scottish Government.
- National Institute for Health and Care Excellence. (2013). Antisocial behaviour and conduct disorders in children and young people: recognition and management.
- NHS. (2018). Retrieved from <https://www.nhs.uk/using-the-nhs/nhs-services/mental-health-services/camhs-information-for-children-and-young-people/>
- NHS Education for Scotland. (2017). Transforming psychological trauma: A knowledge and skills framework for the Scottish workforce.
- Prentky, R., & Righthand, S. (2003). Juvenile Sex Offender Assessment Protocol-II (J-SOAP-II): Manual
- Print, B., Morrison, T., & Henniker, J. (2001). An inter-agency assessment framework for young people who sexually abuse: Principles, processes and practicalities. In M. C. Calder (Ed.), *Juveniles and children who sexually abuse: Frameworks for assessment*. UK: Russell House Publishing.
- Raja, S., & Rogers, A. (2017). Post-traumatic stress disorder, adjustment disorder and complex trauma in young people at risk of entering the criminal justice system. In S. Bailey,

P. Chitsabesan, & P. Tarbuck (Eds.), *Forensic child and adolescent mental health: Meeting the needs of young offenders*. (pp. 152-165). Cambridge: University Press.

Risk Management Authority. (2011). *Framework for Risk Assessment, Management and Evaluation*.

Rogers, A., & Budd, M. (2015). Developing safe and strong foundations: The DART framework. In *Young People in Forensic Mental Health Settings* (pp. 356-389): Springer.

Schmidt, F., Campbell, M. A., & Houlding, C. (2010). Comparative Analyses of the YLS/CMI, SAVRY, and PCL:YV in Adolescent Offenders: A 10-year Follow-Up Into Adulthood. *Youth Violence and Juvenile Justice*, 9(1), 23-42. doi:10.1177/1541204010371793

Scottish Government. (2013). *Training resource manual - Volume 2 - Children's Hearings Handbook*. Edinburgh: Scottish Government.

Scottish Executive. (2007). *Getting it right for every child: Guidance on the Child's or Young Person's plan*. Edinburgh: Scottish Executive.

Scottish Government. (2013). *Scottish Policing Performance Framework: Annual Report 2012-13*. Edinburgh: Scottish Government.

Scottish Government. (2014). *Framework for risk assessment, management and evaluation for children and young people under 18*. Edinburgh: Scottish Government.

Scottish Government. (2017). *Recorded crime in Scotland 2016-17*. Edinburgh: Scottish Government.

Scottish Government. (2018). *Rejected Referrals Child and Adolescent Mental Health Services (CAMHS): A qualitative and quantitative audit*. Edinburgh: Scottish Government.

Vaswani, N. (2014). The Ripples of Death: Exploring the Bereavement Experiences and Mental Health of Young Men in Custody. *The Howard Journal of Criminal Justice*, 53(4), 341-359. doi:10.1111/hojo.12064

Vaswani, N. (2018). *Adverse childhood experiences in children at high risk of harm to others.*: Centre for Youth and Criminal Justice.

Viljoen, J. L., Gray, A. L., & Barone, C. (2015). Assessing Risk for Violence and Offending in Adolescents. *Learning Forensic Assessment: Research and Practice*, 357.

Viljoen, J. L., Nicholls, T. L., Cruise, K. R., Desmarais, S. L., & Webster, C. D. (2014). *Short-term assessment of risk and treatability: Adolescent version. START:AV User Guide*.

Welsh, J. L., Schmidt, F., McKinnon, L., Chattha, H. K., & Meyers, J. R. (2008). A comparative study of adolescent risk assessment instruments: predictive and incremental validity. *Assessment*, 15(1), 104-115. doi:10.1177/1073191107307966

WHO. (1996). Global Consultation on Violence and Health. Violence: A public health priority Retrieved from World Health Organisation, Geneva:

Williams, K. M., Wormith, J. S., Bonta, J., & Sitarenios, G. (2017). The Use of Meta-Analysis to Compare and Select Offender Risk Instruments: A Commentary on Singh, Grann, and Fazel (2011). *International Journal of Forensic Mental Health*, 16(1), 1-15.

doi:10.1080/14999013.2016.1255280

Youth Justice Board. (2000). *ASSET*: Youth Justice Board.

Youth Justice Improvement Board. (2017). *Children and young people in custody in Scotland: Looking behind the data*: Youth Justice Improvement Board.