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Managing risk of harm in the community: A guide for practitioners and managers working with children

Carole Murphy, Deborah Nolan and Kristina Moodie, CYCJ

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Introduction

> "Almost all of the causes of childhood offending lie beyond the reach of the youth justice system. It is vital that health, education, social care and other services form part of an integrated, multi-agency response to a child's offending, but it is more desirable that these same services intervene with "at-risk" children and families before their problems manifest themselves in offending" (The Taylor Report, 2016: 3).

Children in conflict with the law, like all children, are rights holders[1]. They are entitled to their rights and should have their rights upheld (Lightowler, 2020). Rights are for all children not just for those who do not present with challenging behaviour. Where parts of a child's behaviour present a risk of serious harm to themselves or others, this is often an expression of their vulnerability, and whilst depriving them of their liberty is sometimes necessary, the UNCRC 1989 states that it should be a last resort:

> "…no child shall be deprived of his or her liberty unlawfully or arbitrarily. The arrest, detention or imprisonment of a child … shall be used only as a measure of last resort and for the shortest appropriate period of time" (Article 37(b) UNCRC).

Some children display behaviours that place themselves or others at risk of harm. The number of children who could or should be deprived of their liberty as a result of this is small. However, meeting the needs of these children and managing and reducing risk is inherently complex. Firstly, there is the precarious balance of upholding rights and ensuring the child at the centre is treated as a child, while managing risk and maintaining public safety and confidence. This can be a challenge for children, families, practitioners and the community (Lightowler, 2020). Secondly, children involved in a pattern of offending, or who are involved in more serious offences, are almost always our most vulnerable, victimised and traumatised children. They often display multiple and complex needs, in a breadth of combinations that may be unique (CYCJ, 2016; McAra & McVie, 2010; Murphy, 2018). As such, a range of intensive interventions, bespoke packages of support and services working in partnership are likely to be required to reduce risk.

However, in practice these are not always available, as illustrated by Moodie and Gough in their research with Chief Social Work Officers (CSWO):

[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 guide as it applies to those under 18 years. However, it is acknowledged that some children may prefer to be referred to as young people.

> "…there are young people in secure care because there are not appropriate supports for them in the community or other parts of the system" (Moodie & Gough, 2017: 28).

More recently the Independent Care Review (2020) noted variations in thresholds, availability and standard of support (particularly family support) and approaches across Scotland.

It is internationally agreed that depriving a child of their liberty should be the option of last resort, with the impact and harms of doing so in both the short and longer-term having been well established (see for example United Nations, 2019). However, we need to recognise that for some children experiencing extreme needs, risks and vulnerabilities the only option to keep them and others safe is to deprive them of their liberty, as secure care can save children's lives (Moodie & Gough, 2017; Gough, 2017). The Children's Hearings (Scotland) Act 2011 is clear that if a secure accommodation authorisation is being considered, all the other options available must be considered, as well as ensuring the secure care criteria are met. However, there are divergent views on what could constitute an 'alternative' to secure care or custody, and indeed whether there is such a thing (Walker, Barclay, Hunter et al., 2005). The only legislatively defined option is a Movement Restriction Condition (MRC) (Scottish Government, 2014a), and there is no category of registration with the care and education regulation and inspection agencies, of 'alternatives to secure care'. As such, in this guide intensive community supports will be used to refer to the supports and services provided to children in the community where there is a risk of serious harm to others and deprivation of liberty.

With such complexity, all practice should be situated within the context of child protection, Getting It Right For Every Child (GIRFEC), the Whole System Approach (which also advocates that alternatives to secure care and custody should be utilised wherever possible and appropriate) and the UNCRC (Scottish Government, 2011; 2014b; 2014c). Practice should also be informed by the national risk framework and the Framework for Risk Assessment Management and Evaluation (FRAME) for local authorities and partners for children and young people under 18 (Scottish Government, 2012a; 2014c). FRAME provides detailed guidance for local authorities and partners on the principles of assessment and management of the risk of serious harm. Where a coordinated multi-agency and formal response to concerns regarding risk of harm is required the Care and Risk Management (CARM) process (appendix to FRAME) provides the framework to coordinate and implement this (Scottish Government, 2014c). The FRAME guidance highlights that in order to reduce the likelihood of further harm, risk management plans should be individualised, proportionate to the level of risk, and trauma, developmentally and systems informed. Plans should document how risk is to be reduced, as well as managed (Scottish Government, 2014c). In addition to this, plans should document how the needs of the child are to be met and their rights upheld (Scottish Government, 2014c). Each individual child's needs and the risks their behaviour presents will vary and as such so will the content of any risk management/reduction plan (Scottish Government, 2014c).

The purpose of this guide is to support the implementation of children's rights under Article 37b of the UNCRC thereby reducing the need to deprive children of their liberty, while maintaining the safety of children and others. The guide does this through providing

information on the approaches and responses that can be taken in the community in order to achieve a reduction in the risk of serious harm. The aims are two-fold. Firstly, it aims to assist practitioners to consider what intensive community supports for individual children could look like. These considerations will also likely be relevant for those in team leader positions who will be supporting staff to assess, plan and make decisions in respect of individual children, as well as for chairpersons of meetings within processes that children may be supported in (such as child protection and CARM). Secondly, the guide aims to assist managers to consider what could be provided locally at a service and strategic level to help practitioners and children and families.

The guide is structured around the key elements of approaches and responses known to be helpful at an individual level and what could be considered at a service and strategic level. The different elements considered are:

1. The child's views
2. A clear assessment and formulation
3. Scenario planning
4. A safe environment
5. An appropriate level and type of supervision
6. Victim safety planning
7. Intensive interventions and support packages
8. Monitoring and contingency planning
9. Partnership approach

For each of these elements, the guide poses key questions to be considered by practitioners to assist with the development of intensive community supports and by service managers to aid self-evaluation, planning, service development, and policies. These key questions are summarised in Appendices A and B. In addition, a case example highlights what intensive community support could look like for an individual child across each of these elements.

As the guide is a resource for practice, it can be used, amended and tailored in any way that is useful to the practitioner, agency or the team around the child.

Case example: Introduction

Keith is a 16 year old male who is currently on a Compulsory Supervision Order through the Children's Hearing System. In the past 12 months Keith has been charged on ten occasions with 19 offences. These include breach of the peace (including racial breach of the peace), vandalism, resisting arrest, wasting police time, and assault x 4. Keith is being considered by the secure care screening group following being charged with assault to severe injury and permanent disfigurement at the weekend and remanded to the care of the local authority. The residential home which he is currently living in do not believe that they are able to prevent Keith from harming others again. There are also concerns that Keith is being exploited by adult males to engage in drug running in exchange for free drugs.

1. The child's views

> "The worker will...[never] know more about people and their problems than they [i.e. children] do themselves" (Smale & Tuson, 1993:16).

Under Article 12 of the UNCRC any child who is capable of forming his or her own views has the right to express those views freely in all matters affecting them and those views should be given due weight in accordance with the age and maturity of the child. This right has been partially incorporated into Scots law through section 16 of the Children (Scotland) Act 1995 and section 27 of the Children's Hearings (Scotland) Act 2011, with children often keen to participate in these discussions regardless of the actual outcome (Cashmore & Parkinson, 2009; Gillon, 2019). Children report they find it empowering, rather than "something that happens to them or is done to them" (Hart & Thompson, 2009:24), as long as they perceive that their views have been respected (Taylor & Gollop, 2015). Where professionals' attitudes are child-friendly, children are more likely to feel that they have been taken seriously (FRA, 2017).

Despite this, the evidence suggests that overall, children in conflict with the law do not feel respected or listened to, instead feeling powerless or that they have no influence in shaping decisions about their lives (Lightowler, 2020; Vaswani & Gillon, 2018). Research with boys in a Scottish Young Offenders' Institution also highlighted how common it was that children did not understand what had happened to them during the justice process and why they had been sent to a Young Offenders' Institution (Nolan, Dyer & Vaswani, 2018). Children within secure care centres in Scotland have also commented on feeling excluded from meaningful participation in the decisions that are made about their lives, though reported mixed experiences at an individual level with the professionals who support them (Gough, 2017).

Similarly, children and young people from across the spectrum of youth justice reported positive individual interactions with people who cared, listened and believed in them, but too often children felt judged and that people did not take the time to find out who they are and why they are behaving as they are (Cook, 2015). The relationships between the child and those supporting them are crucial in engaging children, intervening effectively and in promoting desistance, with the skills, knowledge, understanding, values and traits required to do so, having been well established (see for example the Scottish Government, 2012b; Youth Justice Improvement Board, 2019; Cook, 2015).

Key questions: The Child's views

Practitioner considerations
❖ Does the child understand their rights, including the right to participate and seek advice and support during decision-making processes? ❖ Does the child understand how they can be supported if they don't think their rights are being upheld? ❖ What are the child's views about how everyone can be kept safe?

- What are the child's views about the concerns that have been raised?
- Who do they think could best support them?
- What support do they think could be provided?
- How can these views be best reflected and taken into account in assessments, reports, plans, and decisions about this child?
- How can the child be supported to participate in meetings and decision-making processes (such as secure care screening, CARM, child protection etc)?
- How can the impact and influence that their views have had be explained to the child?
- What do they think about the potential for a secure care placement?
- What do they think about the alternatives to a secure care placement, including an MRC?
- Is there anything they don't understand or need more information about?
- Would they like to visit secure care and meet some of the staff in case a secure care placement becomes necessary?
- Who would they like to go with them to secure care and help them settle in if that becomes necessary?

Service Manager considerations

- What information do staff give children about their rights and how do they support children if they don't think their rights are being upheld?
- What systems are in place for the views of children to be recorded?
- Are staff clear about how they should gather children's views and the support that they are able to provide to them?
- Are staff confident in doing so and do they have the supports and resources available that they require?
- Are extra resources, materials, training, approaches etc. needed for children with Additional Support Needs, or Speech, Language and Communication Needs?
- What minimum standards are in place if children are being considered for secure care placements?
- What is the process for ensuring children's participation in, and sharing decisions from, meetings with children such as secure care screening, CARM, child protection etc?
- Are working arrangements flexible enough to allow staff time to prepare children for a potential secure care placement?
- What provisions are in place for staff at this critical time so that they can deliver effective support to children and their families?

Case example: The Child's views

Keith initially voiced that he doesn't care if he goes to secure care, stating that he will end up in prison anyway when he gets convicted. He said that if he doesn't go to secure care he will probably be charged with something else anyway as the police are on his back all the time. In relation to the potential of providing intensive community support he looked anxious and said that he will just keep getting into trouble because of using drugs. After a while he said that the older guys will still expect him to do 'stuff' for them and that there's no

getting away from it. However, he did not want to (or feel safe to) provide names and further details. He said that his brother is supportive as he 'gets him' and that his Dad is alright and gives him money sometimes. Keith said he doesn't want to visit secure care but he sat for a short while and information about secure care, including on the Secure Care Pathway and Standards Scotland, was shared. He also looked at the Journey through Justice online resource which he said helped him understand what will happen next. The potential for an MRC was discussed which Keith initially dismissed, however, if it can limit where he is able to go then he says it will give him an excuse not to have contact with the older guys for a while as they won't want him bringing the police to them. Keith said if an MRC can do this, he would prefer this to going to secure care as it would mean he could stay in his placement and be nearer his family.

2. A clear assessment and formulation

The fundamental basis for all responses and interventions where children's behaviours present a risk of serious harm to others should be a holistic, child centred, age and stage appropriate assessment and formulation of need and risk (Johnstone & Gregory, 2015). A clear assessment and formulation should underpin the risk management/reduction plan and the resulting intensive community support that is put in place for each child (Johnstone & Gregory, 2015). In order to effectively manage and reduce the risk of harm occurring it is necessary to understand the factors that are driving the risk of harm, the factors that will mitigate the risk of the harm occurring and the potential scenarios you are trying to prevent. For this reason the assessment should utilise a Structured Professional Judgment (SPJ) approach and be guided by developmentally appropriate tools (Johnstone & Gregory, 2015). The Risk Management Authority (RMA) provide a summary of the empirical evidence for assessment tools in their Risk Assessment Tools Evaluation Directory (RATED), which has a specific section on children and young people. The analysis and resulting formulation should be succinct and concise to aid communication of the information considered key to reducing the risk of serious harm occurring, utilising and promoting a shared language (Johnstone & Gregory, 2015). One useful model for risk formulation is Weerasekeera's (1996) 4P's model which considers predisposing, precipitating, perpetuating and protective factors.

Consideration of the systems that surround the child should form a key part of any assessment and formulation (Scottish Government, 2014c). Bronfenbrenner's (1979) theory of social ecology highlights that individuals are embedded within systems that play an integral part in their life and in shaping their behaviour. The individual is at the innermost level of the concentric circles with each concentric layer representing a system such as family, peers, school, and community, highlighting the reciprocity between the individual and the other systems, acknowledging that they all impact on each other (Bronfenbrenner, 1979). For children, by the very nature of their being children, the systems in which they exist have a significant impact. Tarolla, Wagner et al. (2002) state that research strongly suggests children's offending behaviour is multi-determined by the reciprocal and dynamic interplay of individual characteristics and the key systems of the child as detailed above. However, children have very little control over the situations and the contexts in which they are living and growing up in and changes will need to be made within these systems as well, in order to reduce the risk of serious harm. Wherever possible the child's family/carers and

representatives of the other systems should be partners in the risk assessment and management process (Scottish Government, 2014c).

Key questions: A clear assessment and formulation

Practitioner considerations
❖ What are the key presenting risks/concerns? ❖ Who is at risk of harm? ❖ Has consideration been given to whether Child Protection procedures are required? ❖ Is a referral to the Care and Risk Management process required? ❖ Should a referral to the Children's Reporter be made? ❖ What is the child and their parent's/carers views on the above referrals? ❖ Should a secure care screening meeting be held? ❖ Is the assessment tool developmentally appropriate and suitable for the presenting concern? ❖ Is there a sufficient breadth and depth of information available to inform a clear assessment and formulation? ❖ Have the gaps/limitations in the information available been specified? ❖ Have the child's parents/carers been involved in the assessment? ❖ Is information gathered and shared appropriately and proportionately in line with existing legislation? ❖ What are the factors that predispose the harmful behaviour? ❖ What are the factors that precipitate the harmful behaviour? ❖ What are the factors that perpetuate the harmful behaviour? ❖ What are the factors that play a protective role in preventing the harmful behaviour? ❖ Is there a succinct formulation that others can access to aid their understanding? ❖ How can we communicate this to reach a shared understanding?
Service Manager considerations
❖ What are the common harmful behaviours that practitioners are working to prevent? ❖ Are staff adequately trained in risk practice? ❖ Do they have access to up to date assessment tools that are validated for use with children? ❖ Are they able to access the information they require to complete a robust assessment? ❖ Are staff aware of their duties to ensure children's rights to participate in the assessments and to uphold the child's privacy and confidentiality in the information gathering process? ❖ Are staff given sufficient time to complete robust assessments and formulations? ❖ Do staff have peer support/supervision to assist with assessment and formulation? ❖ Are they confident in using formulation to guide intervention plans? ❖ Is a multi-agency approach used to understand and respond to the risk of harm? ❖ Are staff across agencies adequately trained in Children's Rights, GIRFEC, Child Protection and Care and Risk Management processes?

- Is there multi-agency understanding of routes to secure care?
- Are secure care screening processes clear, robust and inclusive?

Case example: A clear assessment and formulation

The assessment process was explained to Keith and his family and they chose to engage in the assessment. They understood that the information gathered, from a wide range of sources including school, police and social work, would be shared appropriately and proportionately in line with existing legislation. Access to health information was not available at the time the assessment was completed, which is a limitation to the assessment. The Structured Assessment of Violence Risk in Youth (SAVRY) was used as a guide for the assessment of risk of violence. The resulting formulation is below.

The priority concerns in relation to Keith's current situation are the risk of violence from Keith towards others, the risk of harm Keith may experience as a result of his substance use and the risk of victimisation/exploitation from adults.

Keith has been exposed to neglect from a young age and has experienced parental substance misuse, offending behaviour, poor mental health and domestic violence. He has also experienced many changes in his living situation and some changes in his educational placements. As a result of these events it is likely that Keith's childhood has been characterised by feelings of fear, loss and rejection and that this has prevented him from being able to access, or adequately utilise, personal or social supports. In addition, it is likely that these experiences have impacted on his expectations of others, his ability to trust others and a proneness to perceive threat from others. This is likely to have impacted on his ability to form positive peer relationships. Keith has not had a safe or secure base from which to develop a secure attachment or to develop effective coping strategies, resilience and emotional regulation. In addition, the exposure to aggression and substance misuse at home may have given Keith the message that violence and substance use are a suitable means of managing emotions and solving interpersonal difficulties.

Keith's involvement in violent behaviour appears to have occurred following, or in conjunction with, an escalation in his substance misuse. This was during a period of time when Keith was spending considerable amounts of time unsupervised in the community and there were concerns that he may be being exploited by adults to engage in drug running in exchange for drugs. Keith's substance use may have provided him with a coping strategy to manage his emotions and may have acted as a disinhibitor to his usual behavioural controls. Keith's use of violence may also have provided him with a means through which to gain status or approval/acceptance amongst his peers and to exert some control in his life, particularly when feeling vulnerable.

There appear to be a number of factors that are currently maintaining Keith's problematic behaviours. To date, effective parental management strategies have not been in place. He lacks a secure base and has continued to spend significant periods of time unsupervised in the community with peers who are also engaging in antisocial behaviours. Alongside peer influence, his continued substance misuse is also a key maintaining factor in his violent behaviour. At present Keith has not developed alternative strategies to manage

stress or to deal with difficulties. He also has little consistent and positive personal or prosocial support from family or friends with whom he can discuss concerns and problems and receive guidance from in order to deal with them in an effective manner. At present there is insufficient information as to the immediate motivators for the violent behaviour Keith is engaging in and the potential rewards or reinforcers he is experiencing as a result of engaging in violence. Potential reinforcers such as peer status/approval and increased attention from carers/family should be considered. Without a safe, stable, consistent and nurturing home environment it is unlikely that Keith will be able to form trusting relationships with professionals and begin to engage meaningfully in intervention attempts to address the underlying drivers to his violent behaviour.

Whilst there is an absence of current stable protective factors, there are some current strengths to build on that could offer potential protection against further risk taking or harmful behaviour in the future. Keith's relationship with his father appears to be a positive one and there appears to be some positive contact with his older brother and paternal uncle that could be strengthened. It was also noted that Keith can engage well with professionals when in a stable place and that he enjoys engaging in sport activities. He has also shown the capacity to behave in an empathic and caring manner towards peers.

3. Scenario planning

Scenario planning is a tool that can help to identify how risk factors or vulnerabilities may manifest themselves in the future if effective risk management/reduction plans are absent (Scottish Government, 2014c). It also assists with identifying the actions that are required to prevent these potential scenarios from occurring (Scottish Government, 2014c). Plausible future scenarios should be identified which are based on what is known about the child and consideration should be given to the nature, seriousness, pattern and likelihood of the potential future harm (CYCJ, 2019).

Key questions: Scenario planning

Practitioner considerations
❖ Have potential risk scenarios been considered? ❖ Who is likely to be harmed? ❖ What is the nature of the harm that is likely to occur? ❖ How severe is the harm likely to be? ❖ How imminent is the risk of harm? ❖ Where is the harm likely to occur? ❖ How frequently is the harm likely to happen?
Service Manager considerations

- What are the patterns of risk that present in the local community?
- What are the patterns in the local community of where harm occurs?
- Are multiagency arrangements in place to discuss and plan prevention strategies for likely scenarios/patterns of risk in the community?
- Is the development and provision of service and support based on this analysis of need and risk locally?
- Are these fed in to community planning partnerships?
- What supports are in place for staff to engage in scenario planning for individual children?

Case example: Scenario planning

In the absence of effective risk management/reduction measures there is a high likelihood that Keith will continue to engage in further violent behaviour. This violent behaviour is imminent whilst Keith is in the community with no restrictions and continuing to use substances. This violent behaviour is likely to occur on a regular basis, involve sustained assaults, and is likely to continue to result in significant harm towards others (including injuries such as bruising, broken bones and head injuries). Keith's violence is likely to be against people with whom he has some limited interaction/conflict with but who are otherwise strangers to him. Victims are likely to be adults or other adolescents, and male. Keith will also be at risk of continued exploitation in relation to drug running. There is a potential that this could escalate to drug dealing and that for reasons of safety he may feel the need to carry a weapon to protect himself. This could also potentially increase the risk of injury to others from Keith if situations of conflict were to arise.

However, if Keith has limited access to unsupervised time with peers in the community and is not out late at night in the community then there will be reduced opportunity for him to be exploited and victimised. As a result he will be less likely to have access to substances and he will therefore be less likely to engage in substance use and violence and the risk of harm will be more manageable in the community. If the adult males who are believed to be exploiting him are identified and plans put in place to deter their contact with Keith, then Keith will have less access to substances, the risk of his offending behaviour escalating will reduce and he will be safer.

4. A safe environment

Accommodation is a basic need and right. Research shows that inadequate accommodation is likely to have a significant negative impact on reoffending, and there is a documented link between severe accommodation problems or homelessness and recidivism (SPS, 2017). However, the impacts of insecure or unsafe accommodation are wide ranging including stress and mental health issues, difficulties with family members, substance use and the impact on accessing services such as health, benefits, education, training and employment (The Robertson Trust, 2017). Additionally, the lack of a safe home environment makes it difficult for behavioural change to take place through interventions or supports that are put in

place, rendering this a key consideration in managing/reducing risk (Day, Bateman & Pitts, 2020).

Key questions: A safe environment

Practitioner considerations
❖ What needs does the child have in relation to accommodation? ❖ What would make their home environment safer and sustainable? ❖ Do they feel claimed in their home environment? ❖ Does the child believe that they have a stable home? ❖ Is the home stable enough for intervention work to be effective? If not, how could this be achieved? ❖ Has a potential change of home environment been discussed with the child? ❖ Has the child been given information on secure care? ❖ Have they had the opportunity to visit/have a virtual tour of where they might be moved to for safety reasons? ❖ Have any gaps in availability of appropriate safe accommodation been recorded? ❖ Do we have Corporate Parenting duties for this child? If so, how can these be fulfilled? ❖ Is the child eligible for continuing care? If so, how can this be explained, promoted, made available and supported?
Service Manager considerations
❖ Is there sufficient availability of community-based outreach support in your local area to support a child remaining in their home environment? ❖ What accommodation options are available for children where there is a significant risk of harm to others/themselves? ❖ Is there a culture of claiming children and providing a secure base that is unconditional? ❖ Are the accommodation options always available? ❖ Are there good links with housing providers? ❖ Are continuing care options consistently explored and resourced where applicable? ❖ Is there funding/finance available to ensure consistent availability? ❖ What are the mechanisms for having resources agreed locally? ❖ How are gaps in provision recorded and fed into service planning? ❖ Have Corporate Parenting duties been considered along with the local Children's Services Plan?

Case example: A safe environment

A safe and stable place for Keith to live is crucial for interventions to improve outcomes to be effective. As such it was deemed important that wherever possible Keith should remain

in his current placement to reduce further loss and rejection. In order to support this it was agreed first and foremost that Keith should be considered within the CARM process so that there could be a shared multi-agency agreement about the risk reduction approach taken. Keith and his father attended the initial CARM meeting. With the support of his social worker and residential care staff, Keith was able to explain that he wanted to remain in his current placement and would engage with the supports put in place. At this meeting, it was agreed that Keith would remain in his current placement but that additional support would be put in place for Keith and the care staff, particularly in the evenings when the difficulties tend to arise. Additionally, it was agreed that warning signs that risk was escalating would be monitored and a contingency plan would be developed detailing everyone's role should these difficulties arise.

It was believed that if Keith was moved to a different placement he would experience further instability and loss of relationships that are the current building blocks for a secure base. At present, this is a strength that could assist with the development of effective coping strategies, resilience and emotional regulation.

5. An appropriate level and type of supervision

One of the aims of supervision is to manage and/or decrease risk by overseeing aspects of a child and their environment, which can at times involve placing restrictions on a child's freedoms (Scottish Government, 2014c). Research by Murphy (2018) identified a range of supervision strategies that had been tried/were currently being used with children referred to the Interventions for Vulnerable Youth (IVY) service. These included compulsory supervision orders through the Children's Hearing System, restricted contact with others, parent/carer restrictions, Movement Restriction Conditions (MRC), criminal justice supervision (such as community payback order, restriction of liberty order), bail, secure care, and custody. Although referred to in almost 80% of cases, following the referral and consultation, increased supervision was recommended in over half of IVY level 1 risk analysis reports, suggesting that the level of supervision may have been deemed insufficient to address identified needs, risks and concerns (Murphy, 2018).

As detailed above, a children's hearing may only make a secure accommodation authorisation if they have first considered all other alternatives, including an MRC (Scottish Government, 2014a). MRCs require the child to comply with certain restrictions (such as remaining in or away from certain locations for specified periods of time), with their compliance with restrictions monitored by an Electronic Monitoring Device (tag) (Scottish Government, 2014a; 2014c). In accordance with the welfare principle of the Children's Hearings System, any young person subject to an MRC must receive an intensive package of support, with access to at least some of the supports 24 hours per day, seven days per week (Scottish Government, 2014a). Between 2014 and July 2018, MRC's were utilised 134 times (McEwan, 2019). The use of MRCs through the Children's Hearing System from 2014 and 2017 has ranged between 20-31 times per year, averaging 27 times per year (McEwan, 2019).

Despite some examples of effective and creative use of MRCs to support individual children in their specific situations (see McEwan, 2019; Simpson and Dyer, 2016), the use of MRCs

by the Children's Hearing System appears to be lower than would be expected, with Simpson and Dyer (2016) having explored some of the possible reasons for the gap between the stated policy aspirations and practice reality. It is clearly concerning if children are being deprived of their liberty when intensive community based supports, including those that enable restrictions on a child's freedoms such as MRCs, could be more appropriately utilised.

Key questions: An appropriate level and type of supervision

Practitioner considerations
❖ What aspects of a child's behaviour and environment need to be overseen? ❖ Are there aspects that need restricted to keep the child or others safe e.g. internet access, contact with specific individuals, certain locations, times in the community? ❖ Are restrictions proportionate to the risk presented? ❖ Are opportunities to safely promote the child's development being utilised? ❖ How will these restrictions be reviewed? ❖ How will it be determined that it is safe to remove/reduce the restrictions? ❖ What action will be taken if the restrictions are not effectively reducing risk? ❖ Has the restriction of other people's liberty been considered? ❖ Do the restrictions considered match the risk scenarios identified? ❖ Does the child meet the secure care criteria? ❖ Is an MRC necessary and appropriate? ❖ What are the child's views on supervision, restrictions and support?
Service Manager considerations
❖ What options are available for intensive support packages to go alongside any restrictions? ❖ How are gaps in options identified and needs analysed? ❖ How often are MRCs considered in the local area? ❖ Do staff and partners have a good awareness of MRCs? ❖ How does learning from the outcomes of using MRCs take place? ❖ Are MRCs considered as an alternative every time secure care is being considered? ❖ Do reviews of secure care screening decisions take place and are the outcomes of these analysed? ❖ Do reviews of secure care authorisations and implementation take place? ❖ How is feedback from children and families on decisions and supports sought and used to inform future decisions and service development? ❖ Are there resources that can be used flexibly at times where there is a high risk of harm?

Case example: An appropriate level and type of supervision

At the secure care screening it was agreed that Keith met the secure care criteria under section 83(6) Children's Hearings Scotland Act 2011 in that he was likely to cause injury to another person through his violent behaviour. It was also agreed that, as all alternatives had not been tried, instead of recommending to the children's hearing that Keith's Compulsory Supervision Order include a secure accommodation authorisation, a Movement Restriction Condition (MRC) would be recommended to restrict the times that Keith is in the community and a package of support made available to Keith. In the report prepared for, and at the hearing, Keith's social worker explained that Keith was assessed as meeting the secure care criteria in that there was imminent risk of his violent behaviour causing serious harm to others. However, it was argued that the less restrictive response of an MRC would be the more appropriate and proportionate option at this time. The social worker explained that this would enable Keith to remain in his current placement (with the importance of this explained as detailed above) in the community, where it was assessed he would have the best opportunity for making sustained behavioural change, and that this would help Keith feel safest. It was also recognised that while all other community-based alternatives had been exhausted, an MRC had not. At the Hearing Keith expressed his consent to the order being made and said that he wanted to use this opportunity, as he would prefer this to going to secure care. He also indicated that he understood the expectations of the MRC and the consequences of non-compliance. His father also consented, stating he felt secure care and being removed from his current placement and family would increase the risk of harm in the longer term. The Panel agreed with this recommendation, making Keith subject to an MRC for a six month period, to be reviewed by the hearing six weeks after implementation.

Given that the offences tend to occur in the evening and at night it was agreed that the standard MRC hours would be 7pm to 7am. During these hours Keith would be expected to be at the residential home, with his father's home address as a contingency address. However, these hours would be amended to fit in with the supervised activities Keith engages in. As part of the intensive support package that accompanies the MRC Keith will be encouraged to identify and choose supervised activities that he can engage in, including sports activities. He will also be given a choice as to who he takes part in these activities with, which may differ depending on the type of activity. As there is a likelihood that Keith may try to abscond during his curfew time, it was agreed that there will always be an additional professional available during the evening to help engage Keith in activities and provide extra supervision. This also means that if Keith does try to abscond then there is someone available to go out, look for Keith and bring him home.

6. Victim safety planning

Victim safety planning aims to reduce the likelihood of, and impact of, harm to specific individuals or groups who may potentially be victimised (Scottish Government, 2014c). The focus is on working with potential victims and known victims to improve their safety and maximise their resilience to reduce their risk of being harmed by the child (Scottish Government, 2014c). This is done through devising preventative or contingency strategies (RMA, 2011).

The IVY research (Murphy, 2018) examining risk practice prior to referral to IVY found that victim safety planning was explicitly mentioned in only 12.7% of cases. It may have been utilised in more cases but not explicitly mentioned. Where victim safety planning was mentioned this included safety plans (6.3%), staff protocols (6.3%), plans for unwanted contact (1.6%) and improvements to physical security (1.6%). Following the referral and consultation, additional safety measures, which included child protection measures and victim safety planning, were recommended in over half of the risk analysis reports.

Key questions: Victim safety planning

Practitioner considerations
❖ Who are the potential victims of harm? ❖ Is there a need to notify and warn anyone of potential harm? ❖ Are there steps potential victims can take to keep themselves safe? ❖ Has a safety plan been developed? ❖ Do you know what strategies to use/who to contact if there is an escalation in risk? ❖ What roles are the multi-agency partners playing in these? ❖ Are police markers required? ❖ Have the risks and plans been communicated to all those who need to know? ❖ Does anyone need support to be able to fulfil their part of the plan?
Service Manager considerations
❖ What service level responses are in place for victims? ❖ What supports are provided to child victims to prevent risk of future offending? ❖ Are working relationships between Police and Social Work responsive? ❖ What support is available for families at risk of harm from their children? ❖ What training exists for staff e.g. de-escalation techniques, communicating risk to potential victims? ❖ Is there joint understanding about de-escalation across professionals so families get consistency?

Case example: Victim safety planning

It was agreed that work would be undertaken with Keith to discuss the concerns around the risk of harm to himself and to others and to try and collaboratively develop safety plans, offering Keith choices and options within these. The development of these plans will also involve his family, care staff, social work and police. The safety plans will clearly detail the actions that will be taken to keep Keith and others safe so that everyone is clear about what to expect. The plans will cover what happens if Keith leaves the home without permission, what happens if he is under the influence of substances and what happens if he starts to become aggressive. As a minimum the plans will cover triggers and warning signs, de-escalation strategies, safe spaces to go to, and who to contact for support or if

the safety plan is not working in order to keep people safe. This will be done within the context of giving Keith clear messages that this is because he is cared for and everyone wants him to be safe and remain staying in the community.

It was additionally agreed that the police would put plans in place to gather intelligence to identify the older adults exploiting Keith and then put measures in place to prevent this.

7. Intensive interventions and support packages

In order to meet children's needs and to reduce and manage risk, the provision of intensive interventions and support is often necessary. Under the Risk, Need, Responsivity (RNR) model (Andrews & Bonta, 2010) the intervention should focus on those factors that are most clearly linked to offending and should be tailored to the needs of the individual, while based on evidence and research. This will often require agencies to work together to provide wraparound support, bringing together the efforts of significant individuals in the child's life and ensuring support is available when this is needed (Scottish Government, 2011).
The IVY research revealed that, prior to referral to IVY, the interventions that had most frequently been tried or were currently in place were a referral to CAMHS (77.8%; although this did not mean that the referral was accepted or that, if accepted, intervention was provided), medication (31.7%) and intensive support packages (31.7%) (Murphy, 2018). Following the consultation the risk analysis report made recommendations for further intervention work in 68.3% of cases. These included interventions around mental health, emotion regulation, relationships, trauma, substance misuse and offence focused work (Murphy, 2018). In research by Nolan et al. (2017:16) children and young people in custody reported that they deemed the availability, accessibility and awareness of leisure activities, apprenticeships or employment, accommodation, addictions support and offence focused work in the community as important in preventing and reducing offending. However, they also reported that there was a lack of available opportunities in the community, or at least awareness of these opportunities:

> "You get opportunities in jail, like doing the Construction Skills Certification Scheme card, Duke of Edinburgh…outside you don't know where to go and access that stuff" (Brian)

The provision of intensive community-based support can be challenging. For example, research completed by Moodie and Gough (2017) with CSWOs highlighted issues including lack of choice and availability of such services; high costs and financial constraints; the commissioning processes and practices (which could for example make it difficult to purchase flexible 24/7 out-reach type family support in a crisis); a lack of specialist resources (for example, for children with Autistic Spectrum Disorders and associated learning needs and behavioural issues, post-trauma needs, self-harming and/or suicidal behaviours despite these children often having other legislative enshrined entitlements). Similarly, for children on the edge of secure care, the lack of 'step-up' or 'step-down' options to enable flexibility of approach and 'bridging' between secure care and the community was highlighted (Moodie & Gough, 2017). In addition, the majority of CSWOs shared concerns about what they identified as high levels of unmet mental health and wellbeing need, with around half reporting difficulties with accessing appropriate mental health assessment, support and

treatment for young people at Tier 3 and Tier 4, which has been echoed in other work (Scottish Government, 2018). These issues have been reiterated in the Scottish Parliament Justice Committee (2019) inquiry into secure care and prison places for children and young people in Scotland and the Care Inspectorate's (2020) review into the deaths of looked after children.

It is therefore critical that a range of community options are available to meet identified risk and support the management and reduction of risk. The forthcoming Secure Care Pathway and Standards Scotland specify that children's needs should be met by appropriate supports in the community which are right for the child and the people who are important to them, promoting safety and preventing liberty from being restricted. Unmet need should be recorded and services should look to address these needs (Scottish Government, 2011). Crucial services include:

- Universal and specialist health services
- Opportunities for social inclusion and pro-social activities
- Role models/mentoring
- Leisure and sport
- Positive and nurturing relationships
- Employment, education and training
- Positive peer relationships

Building on the previous discussion about children being a part of systems, reviews of the effectiveness of interventions in reducing offending behaviour have consistently found that family-based and multi-systemic interventions are the most beneficial (Farrington & Welsh, 2003; Humayun & Scott, 2015; Moodie, Vaswani, Shaw et al., 2015; NICE, 2013). Murphy (2018) concluded that one of the reasons why the current systems may not be successful 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, with interventions often focused on the individual child. Whilst such interventions will match some of the individual needs that children present 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 (Murphy, 2018). This is particularly crucial given the developmental stage of children and their limited ability to take responsibility for risk management, with the Scottish Government (2014c) advising that the responsibility and control for risk management must initially be held by the adults and systems within which the child lives and interacts. In doing so, parents/carers have a key role, with risk management often heavily reliant on their supervision and monitoring. It is therefore critical that their ability and capacity to undertake any such role is fully assessed and supported (McNeill, 2009; Scottish Government, 2014c).

Murphy (2018) identified that the most frequently cited potential barriers to effecting a reduction in the children's violent behaviour were difficulty engaging the child, difficulty engaging the family, parental criminal attitude, parental substance use and parental mental health. It is important to recognise that the responsibility for engaging children and families, as well as providing any information and support required to do so and working collaboratively to address barriers, sits with practitioners and their service (Independent Care Review, 2020). Various key features for effectively engaging with families and providing intensive support have been identified (see for example Youth Justice Improvement Board, 2019). The Independent Care Review (2020), albeit having a different focus, identified ten principles of intensive family support which included being responsive and timely; working

with family assets; promoting empowerment and agency; holistic and relational; therapeutic; non-stigmatising; flexible, persistent and patient. It is crucial that staff are aware of and can address any feelings that a family may have that they are to blame for their child's behaviours or stigmatised by their contact with services. It is also important to recognise and assess carers' own needs including personal, social and emotional support; support them in their caring role; and provide practical and emotional advice and support (Scottish Government, 2011).

Key questions: Intensive interventions and support packages

Practitioner considerations
❖ Based on the risks/vulnerabilities identified in your formulation, what are the key priority interventions for reducing risk? ❖ What steps are needed in the intervention plan to address these priorities? ❖ What strengths/protective factors will your interventions draw on? ❖ What order should the interventions be in? ❖ Do the planned interventions cover the change required in the systems surrounding the child? ❖ What support do parents/carers or families require? ❖ How are new skills/strategies communicated to others so that consistent messages and reinforcement can be provided? ❖ What plans are in place to make sure changes are sustainable without professional involvement? ❖ What are the outcomes being worked towards and how will it be known these have been achieved? ❖ How will interventions be reviewed?
Service Manager considerations
❖ Is commissioning of intervention services based on an analysis of the intervention needs of children? ❖ Are in-house staff skilled and confident in developing and delivering best practice interventions? ❖ Are training and development opportunities provided to staff based on an analysis of staff needs? ❖ Is there flexibility for the interventions available to meet the needs of individual children, their specific circumstances and the intensity required? ❖ How are staff supported to review progress, identify any barriers to progress and address these? ❖ Is there flexibility in services to increase capacity if needs change? ❖ Are the intervention aims, outcomes and any barriers shared with multi-agency partners on a regular basis? ❖ How is multi-agency working promoted and supported at a strategic level? ❖ How is unmet or inappropriately met need recorded, monitored and addressed?

Case example: Intensive interventions and support packages

If Keith has positive prosocial supports that he trusts and can gain advice from then he will be more likely to learn how to resolve issues and manage emotions. It was therefore agreed that work would focus on helping Keith develop a support network of those who he trusts most and to identify who can provide what support e.g. emotional, financial, practical support. This would also include identifying what helps in various scenarios and what does not help but makes the situation worse. This will feed into the safety plans. Keith has already indicated that his brother 'gets him' and that his father provides practical support at times. It will be important to start with these existing supports and to look at ways these can be developed and strengthened.

Given what we know about Keith it was agreed that all professionals will consistently reinforce positive behaviours and engagement, communicate that they care about him and his wellbeing and that they will continue to try and keep him safe. They will do this by putting in clear boundaries and expectations whilst developing routines that include having fun and that create a positive home environment. They will also work alongside Keith's family to help everyone develop their relationships and to share advice on how they can effectively support Keith to effect behaviour change. Throughout this everyone will model good emotion management, problem solving and conflict resolution. It was agreed that all individuals in Keith's support network will engage with Keith in a solution focused way and work to develop hope and goals for the future. Staff will encourage good sleep routines and encourage Keith to be more active in choosing the food for meals and to help make the meals. They will also try to engage Keith in conversations about his ambitions and interests so that these can be developed to provide him with a sense of positive identity and a positive role within the home and/or the wider community.

Once Keith's behaviour is more stable and trusting relationships have been developed then work with Keith to help him understand his substance use and violent behaviour can start. Depending on the outcome of this, cognitive behavioural therapy could be considered to look at the link between his thoughts, feelings and behaviour with a view to reducing future substance use and violence.

8. Monitoring and contingency planning

In the context of reducing the risk of harm to others, monitoring plays a key role. There are various aspects that should be monitored to determine whether the plans in place to reduce the risk of harm are being effective or whether risk is continuing to escalate (Scottish Government, 2014c). These include the monitoring of whether:

- Early warning signs/triggers to risk of harm are appearing
- Plans are being followed as intended by all partners
- Conditions/supervision requirements are being adhered to
- Adverse outcomes are reducing

- Improved wellbeing is being achieved
- Vulnerabilities/risk factors are reducing
- Strengths/protective factors are increasing

A core principle of the RNR model (Andrews & Bonta, 2010) is that the level of assessment or intervention should match the level of risk. As such, and in order to provide appropriate and proportionate interventions, the team around the child will need to agree how it will be known whether the level (and type) of risk is changing. The team will also need to agree how this is to be reviewed, assessed and monitored, so as to know when the intensity of support should be increased, decreased or varied to the current level of risk (Scottish Government, 2011; 2014c). Early warning signs that might indicate that risk is increasing should be identified and contingency plans should be developed to address the risk scenarios identified and triggered when the early warning signs appear (Scottish Government, 2014c). Such plans should outline clearly the courses of action that would need to be taken in such circumstances, by whom and how quickly (Scottish Government, 2014c).

Murphy (2018) in the review of IVY cases indicated that the use of monitoring strategies to measure changes in frequency, intensity or duration of behaviours were mentioned infrequently, with only 22.3% making 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%). Following the IVY consultation, increased monitoring was recommended in over 85% of IVY level 1 risk analysis reports (Murphy, 2018).

Key questions: Monitoring and contingency planning

Practitioner considerations
❖ What are the triggers to the risk of harm that we should be monitoring? ❖ What are the warning signs that the risk of harm is escalating? ❖ Has a contingency plan been developed to address these? ❖ What do we need to track to measure change? ❖ Who is best placed to monitor the different aspects? ❖ How frequently should the different aspects be monitored? ❖ Who is informed about changes in what is being monitored and when? ❖ How soon do we realistically expect to see change in the different aspects?
Service Manager considerations
❖ What supports are provided to staff to determine what should be monitored and to support them with reviewing this information? ❖ What is the role of multi-agency partners/CARM in monitoring these elements? ❖ Is CARM information formally recorded and used to inform service provision? ❖ Are there audits to examine whether plans are followed after CARM meetings and whether these are effective in reducing risk? ❖ Is there built in resource to record and analyse this information?

- Who does this information feed into to inform service planning?

Case example: Monitoring and contingency planning

It was agreed that various things would be monitored by all those involved with Keith. Firstly, the peers Keith is spending time with and where he is spending his time would be monitored, including the older adults he has contact with. In addition, the frequency, intensity and duration of Keith's absconding, substance use, aggression and violent behaviour will take place on a weekly basis. It was highlighted that all those involved in the care of Keith should acknowledge that behaviour change is not something that will take place over night but that it will take some time for these changes to become more consistent and sustainable. Detailed monitoring of these will provide an indication of whether they are reducing in frequency.

At the CARM meeting it was agreed that everyone involved with Keith will be familiar with the contingency plan and will know what to do if there are warning signs that Keith is thinking about absconding, using substances or becoming aggressive. If these warning signs start to appear then Keith's support network will be contacted to provide support, advice and to spend time with Keith and to support the alternative strategies identified in collaboration with Keith. It was also agreed that the safety plans will be enacted by everyone when appropriate.

9. Partnership approach

Given the difficulty of any one agency in meeting all of the needs of children and the wider systems to manage/reduce risk, partnership working is key. As detailed previously, children, their parents/carers and families should be key partners in any risk assessment and management. Children have the rights to be fully involved and participate in all decision-making that affects them. This should also involve members across agencies who form the team around the child, working in collaboration (Scottish Government, 2014c). Collaborative working can be supported by having a shared understanding of the tasks, processes, principles, and roles and responsibilities both generally and in respect of this child and their risk management plan, and effective working relationships (Scottish Government, 2014c). In addition, communication between partners, including shared language and understanding of key terms, definitions, plans and thresholds is important, as is shared and sound decision-making, based on lawful information-sharing, thorough assessment, critical analysis and professional judgement.

In respect of secure care, CSWOs have expressed concern about gaps in understanding and 'ownership' of risks between and across agencies (Moodie & Gough, 2017). It is therefore crucial that staff across agencies are supported in understanding and undertaking such work, that staff feel cared for and that their wellbeing is prioritised.

Key questions: Partnership approach

Practitioner considerations
❖ What support will the child and their family/carers require to engage in the plan? ❖ What is their existing support network like and could this be improved? ❖ Do they view this as a collaborative approach, feel valued and included and their rights are respected? ❖ Does the child consent to information being shared? ❖ What do partners need to work together effectively? ❖ Who else needs to be involved? ❖ How will services work together and support be coordinated? ❖ Do you feel that the multi-agency partners are sharing the responsibility for reducing the risk of harm? If not, how can this be addressed? ❖ How can you communicate to others that you require more support? ❖ What level of support is in place for you and could this be improved? ❖ Who can you seek support from on a more informal basis?
Service Manager considerations
❖ Are the various multi-agency partners working as a partnership and sharing responsibility for reducing risk? ❖ How do we ensure all partners who need to be involved are? ❖ Is there an appreciation for each other's roles and an understanding that change requires time? ❖ Are staff receiving regular supervision? ❖ Do staff understand their legal duties of confidentiality to the child and in respect of information sharing? ❖ Do processes allow for regular communication and support to involved partners? ❖ Are there regular opportunities for peer support? ❖ Are supervisors/managers aware of the signs of developing stress and burnout and do they monitor these? ❖ What supports are in place for staff when there are signs of stress or burnout? ❖ How do we support staff, and learn from, situations where serious harm does occur, or there are near misses?

Case example: Partnership approach

At the initial CARM meeting it was agreed that the responsibility for managing the risk of harm that Keith was currently presenting to others, and the risk that he was at from others, was a shared responsibility and that everyone in the CARM team had a role to play in reducing this. It was acknowledged that on a day-to-day basis the residential care staff and Keith's social worker would likely have the largest role to play in this and that they would need the support to be able to engage in their role effectively. It was also recognised that

the family would hopefully play a significant part in this and that they would require support as well. It was therefore decided that there would be a weekly core group meeting to discuss the progress made as a team, any barriers to this progress and what support was needed to overcome these barriers. The discussions from the core group meeting would be fed back to the CARM chair on a weekly basis so that they could monitor the situation and agree additional support and resources as required. A full CARM meeting would initially take place on a monthly basis to review progress, unless circumstances indicated a more urgent need for a further CARM meeting.

In addition to this, it was agreed that the social worker would access weekly supervision to discuss any issues arising and that key residential care staff would meet with their manager on a weekly basis for supervision. In relation to Keith's family, the social worker will explore with them what support they have available to them from family and friends and explore whether this can be strengthened in any way. Care staff will speak to Keith about the support that has been provided to him, how he has found this and whether this can be improved and strengthened.

Conclusion

Some children display behaviours that place themselves or others at risk of harm. The number of children who could or should be deprived of their liberty as a result of this is small. However, meeting the needs of these children, upholding their rights and managing and reducing risk is inherently complex. This guide has aimed to assist in navigating such complexity in practice by providing a structure to help practitioners and their managers with individual children and managers at a service and strategic level. The nine key elements that should be considered in approaches and responses have been illuminated through key questions for practitioners and service managers as well as a case example. As the guide is a resource for practice, it should be amended and tailored in any way that is useful to the practitioner, agency or the team around the child.

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Appendix A

Key questions: Considerations for practitioners

Key questions for practitioners to consider when developing intensive community supports for individual children. These questions will also likely be relevant for those in team leader positions who will be supporting staff to assess, plan and make decisions in respect of individual children, as well as for chairpersons of meetings within processes that children may be supported in (such as child protection and CARM).

The child's views
❖ Does the child understand their rights, including the right to participate and seek advice and support during decision making processes? ❖ Does the child understand how they can be supported if they don't think their rights are being upheld? ❖ What are the child's views about how everyone can be kept safe? ❖ What are the child's views about the concerns that have been raised? ❖ Who do they think could best support them? ❖ What support do they think could be provided? ❖ How can these views be best reflected in and taken into account in assessments, reports, plans, and decisions about this child? ❖ How can the child be supported to participate in meetings and decision making processes (such as secure care screening, CARM, child protection etc)? ❖ How can the impact and influence that their views have had be explained to the child? ❖ What do they think about the potential for a secure care placement? ❖ What do they think about the alternatives to a secure care placement, including an MRC? ❖ Is there anything they don't understand or need more information about? ❖ Would they like to visit secure care and meet some of the staff in case a secure care placement becomes necessary? ❖ Who would they like to go with them to secure care and help them settle in if that becomes necessary?
A clear assessment and formulation
❖ What are the key presenting risks/concerns? ❖ Who is at risk of harm? ❖ Has consideration been given to whether Child Protection procedures are required? ❖ Is a referral to the Care and Risk Management process required? ❖ Should a referral to the Children's Reporter be made?

- Should a secure care screening meeting be held?
- Is the assessment tool developmentally appropriate and suitable for the presenting concern?
- Is there a sufficient breadth and depth of information available to inform a clear assessment and formulation?
- Have the gaps/limitations in the information available been specified?
- Have the child's parents/carers been involved in the assessment?
- What is the child and their parent's/carers views on the above referrals? Do they consent to information being shared?
- What are the factors that predispose the harmful behaviour?
- What are the factors that precipitate the harmful behaviour?
- What are the factors that perpetuate the harmful behaviour?
- What are the factors that play a protective role in preventing the harmful behaviour?
- Is there a succinct formulation that others can access to aid their understanding?
- How can we communicate this to reach a shared understanding?

Scenario planning

- Have potential risk scenarios been considered?
- Who is likely to be harmed?
- What is the nature of the harm that is likely to occur?
- How severe is the harm likely to be?
- How imminent is the risk of harm?
- Where is the harm likely to occur?
- How frequently is the harm likely to happen?

A safe environment

- What needs does the child have in relation to accommodation?
- What would make their home environment safer and sustainable?
- Do they feel claimed in their home environment?
- Does the child believe that they have a stable home?
- Is the home stable enough for intervention work to be effective? If not, how could this be achieved?
- Has a potential change of home environment been discussed with the child?
- Has the child been given information on secure care?
- Have they had the opportunity to visit/have a virtual tour of where they might be moved to for safety reasons?
- Have any gaps in availability of appropriate safe accommodation been recorded?
- Do we have Corporate Parenting duties for this child? If so, how can these be fulfilled?
- Is the child eligible for continuing care? If so, how can this be explained, promoted, made available and supported?

An appropriate level and type of supervision
❖ What aspects of a child's behaviour and environment need to be overseen? ❖ Are there aspects that need restricted to keep the child or others safe e.g. internet access, contact with specific individuals, certain locations, times in the community? ❖ Are restrictions proportionate to the risk presented? ❖ Are opportunities to safely promote the child's development being utilised? ❖ How will these restrictions be reviewed? ❖ How will it be determined that it is safe to remove/reduce the restrictions? ❖ What action will be taken if the restrictions are not effectively reducing risk? ❖ Has the restriction of other people's liberty been considered? ❖ Do the restrictions considered match the risk scenarios identified? ❖ Does the child meet the secure care criteria? ❖ Is an MRC necessary and appropriate? ❖ What are the child's views on supervision, restrictions and support?
Victim safety planning
❖ Who are the potential victims of harm? ❖ Is there a need to notify and warn anyone of potential harm? ❖ Are there steps potential victims can take to keep themselves safe? ❖ Has a safety plan been developed? ❖ Do you know what strategies to use/who to contact if there is an escalation in risk? ❖ What roles are the multi-agency partners playing in these? ❖ Are police markers required? ❖ Have the risks and plans been communicated to all those who need to know? ❖ Does anyone need support to be able to fulfil their part of the plan?
Intensive interventions and support packages
❖ Based on the risks/vulnerabilities identified in your formulation what are the key priority interventions for reducing risk? ❖ What steps are needed in the intervention plan to address these priorities? ❖ What strengths/protective factors will your interventions draw on? ❖ What order should the interventions be in? ❖ Do the planned interventions cover the change required in the systems surrounding the child? ❖ What support do parents/carers or families require? ❖ How are new skills/strategies communicated to others so that consistent messages and reinforcement can be provided? ❖ What plans are in place to make sure changes are sustainable without professional involvement? ❖ What are the outcomes being worked towards and how will it be known these have been achieved? ❖ How will interventions be reviewed?

Monitoring and contingency planning
❖ What are the triggers to the risk of harm that we should be monitoring? ❖ What are the warning signs that the risk of harm is escalating? ❖ Has a contingency plan been developed to address these? ❖ What do we need to track to measure change? ❖ Who is best placed to monitor the different aspects? ❖ How frequently should the different aspects be monitored? ❖ Who is informed about changes in what is being monitored and when? ❖ How soon do we realistically expect to see change in the different aspects?
Partnership approach
❖ What support will the child and their family/carers require to engage in the plan? ❖ What is their existing support network like and could this be improved? ❖ Do they view this as a collaborative approach, feel valued and included and their rights are respected? ❖ Does the child consent to information being shared? ❖ What do partners need to work together effectively? ❖ Who else needs to be involved? ❖ How will services work together and support be coordinated? ❖ Do you feel that the multi-agency partners are sharing the responsibility for reducing the risk of harm? If not, how can this be addressed? ❖ How can you communicate to others that you require more support? ❖ What level of support is in place for you and could this be improved? ❖ Who can you seek support from on a more informal basis?

Appendix B

Key questions: Considerations for service managers

Key questions for managers to consider when thinking about what could be provided locally at a service and strategic level to help practitioners and children and families. These questions should aid self-evaluation, planning, service development, and policies

The child's views
❖ What information do staff give children about their rights and how they can be supported if they don't think the child's rights are being upheld? ❖ What systems are in place for the views of children to be recorded? ❖ Are staff clear about how they should gather children's views and the support that they are able to provide to them? ❖ Are staff confident in doing so and do they have the supports and resources available that they require? ❖ Are extra resources, materials, training, approaches etc. needed for children with Additional Support Needs, or Speech, Language and Communication Needs? ❖ What minimum standards are in place if children are being considered for secure care placements? ❖ What is the process for ensuring children's participation in, and sharing decisions from, meetings with children such as secure care screening, CARM, child protection etc? ❖ Are working arrangements flexible enough to allow staff time to prepare children for a potential secure care placement? ❖ What provisions are in place for staff at this critical time so that they can deliver effective support to children and their families?
A clear assessment and formulation
❖ What are the common harmful behaviours that practitioners are working to prevent? ❖ Are staff adequately trained in risk practice? ❖ Do they have access to up to date assessment tools that are validated for use with children? ❖ Are they able to access the information they require to complete a robust assessment? ❖ Are staff aware of their duties to ensure children's rights to participate in the assessments and to uphold the child's privacy and confidentiality in the information gathering process? ❖ Are staff given sufficient time to complete robust assessments and formulations? ❖ Do staff have peer support/supervision to assist with assessment and formulation? ❖ Are they confident in using formulation to guide intervention plans? ❖ Is a multi-agency approach used to understand and respond to the risk of harm?

- Are staff across agencies adequately trained in Children's Rights, GIRFEC, Child Protection and Care and Risk Management processes?
- Is there multiagency understanding of routes to secure care?
- Are secure care screening processes clear, robust and inclusive?

Scenario planning

- What are the patterns of risk that present in the local community?
- What are the patterns in the local community of where harm occurs?
- Are multi-agency arrangements in place to discuss and plan prevention strategies for likely scenarios/patterns of risk in the community?
- Is the development and provision of service and support based on this analysis of need and risk locally?
- Are these fed in to community planning partnerships?
- What supports are in place for staff to engage in scenario planning for individual children?

A safe environment

- Is there sufficient availability of community-based outreach support in your local area to support a child remaining in their home environment?
- What accommodation options are available for children where there is a significant risk of harm to others/themselves?
- Is there a culture of claiming children and providing a secure base that is unconditional?
- Are the accommodation options always available?
- Are there good links with housing providers?
- Are continuing care options consistently explored and resourced where applicable?
- Is there funding/finance available to ensure consistent availability?
- What are the mechanisms for having resources agreed locally?
- How are gaps in provision recorded and fed into service planning?
- Have Corporate Parenting duties been considered along with the local Children's Services Plan?

An appropriate level and type of supervision

- What options are available for intensive support packages to go alongside any restrictions?
- How are gaps in options identified and needs analysed?
- How often are MRC's considered in the local area?
- Do staff and partners have a good awareness of MRC's?
- How does learning from the outcomes of using MRC's take place?
- Are MRC's considered as an alternative every time secure care is being considered?
- Do reviews of secure care screening decisions take place and are the outcomes of these analysed?

- Do reviews of secure care authorisations and implementation take place?
- How is feedback from children and families on decisions and supports sought and used to inform future decisions and service development?
- Are there resources that can be used flexibly at times where there is a high risk of harm?

Victim safety planning

- What service level responses are in place for victims?
- What supports are provided to child victims to prevent risk of future offending?
- Are working relationships between Police and Social Work responsive?
- What support is available for families at risk of harm from their children?
- What training exists for staff e.g. de-escalation techniques, communicating risk to potential victims?
- Is there joint understanding about de-escalation across professionals so families get consistency?

Intensive interventions and support packages

- Is commissioning of intervention services based on an analysis of the intervention needs of children?
- Are in-house staff skilled and confident in developing and delivering best practice interventions?
- Are training and development opportunities provided to staff based on an analysis of staff needs?
- Is there flexibility for the interventions available to meet the needs of individual children, their specific circumstances and the intensity required?
- How are staff supported to review progress, identify any barriers to progress and address these?
- Is there flexibility in services to increase capacity if needs change?
- Are the intervention aims, outcomes and any barriers shared with multi-agency partners on a regular basis?
- How is multi-agency working promoted and supported at a strategic level?
- How is unmet or inappropriately met need recorded, monitored and addressed?

Monitoring and contingency planning

- What supports are provided to staff to determine what should be monitored and to support them with reviewing this information?
- What is the role of multi-agency partners/CARM in monitoring these elements?
- Is CARM information formally recorded and used to inform service provision?
- Are there audits to examine whether plans are followed following CARM meetings and whether these are effective in reducing risk?
- Is there built in resource to record and analyse this information?
- Who does this information feed into to inform service planning?

Partnership approach
❖ Are the various multi-agency partners working as a partnership and sharing responsibility for reducing risk? ❖ How do we ensure all partners who need to be involved are? ❖ Is there an appreciation for each other's roles and an understanding that change requires time? ❖ Are staff receiving regular supervision? ❖ Do staff understand their legal duties of confidentiality to the child and in respect of information sharing? ❖ Do processes allow for regular communication and support to involved partners? ❖ Are there regular opportunities for peer support? ❖ Are supervisors/managers aware of the signs of developing stress and burnout and do they monitor these? ❖ What supports are in place for staff when there are signs of stress or burnout? ❖ How do we support staff, and learn from, situations where serious harm does occur, or there are near misses?