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Chapter 13

Working with violence in children: a developmental and relational perspective

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1. Introduction

In this chapter, we set out to provide the reader with some direction about the management of violence when working with children, and how this feeds into the practices of assessment, formulation and treatment across the spectrum from preventive to reactive work. We look at current practice, signposting areas for practitioners to explore in depth elsewhere, often in other chapters of this book. While we focus on direct practice, it is vital to acknowledge that effective, meaningful work with children relies on good indirect practice (training, supervision, guidance, support, service development) being nurtured at an organisational level.

Children are in a constant state of change and growth; they learn and develop through interaction with others and with the systems of which they are a part. They are full of potential, yet limited by their lack of power to change the potentially damaging aspects of their world. When we encounter them as practitioners, we are meeting their distress in real time, not retrospectively, as we might with adults. Whatever is happening, or has happened, is immediate or in the very near past. Their responses may be raw and inarticulate but are no less an expression of their experience. For this reason, rather than speaking of 'violence' we will be referring to 'pain-based behaviour'.

The term 'pain-based behaviour' was coined by Anglin[1] to focus therapeutic attention on the psycho-social pain that underlies children's 'acting-out' behaviour. In a grounded theory study of what makes for well-functioning residential childcare, he found that this pain was under-acknowledged and often unaddressed. While violence is often assumed to be the product of anger, his findings revealed a much broader and more complex mix at its roots, including grief, loss, abandonment, anxiety, hopelessness, fear and terror. In his words, 'the ongoing challenge of dealing with such primary pain without unnecessarily inflicting secondary pain experiences on the residents through punitive or controlling reactions can be seen to be the central problematic for the care work staff' (p.178). This, we believe, is equally true for the management of anyone coming into contact with violence, at any level of the system.

We argue that this is, in part, because witnessing and responding to the pain-based behaviour of children is very often painful for those around them, including families, carers, and professionals. We also argue that a cultural unconscious exists that cannot bear to acknowledge the fear, shame and despair that children experience and instead finds it more comfortable to gather those feelings under the umbrella of anger, which can then be 'managed'. This approach serves to locate the problem in the child and absolves us as a society, and those immediately around the child, from taking responsibility for the

conditions from which these behaviours typically arise (i.e. from micro-system settings such as families to macro-system forces like poverty, inequalities and political ideologies such as 'austerity'). Dockar-Drysdale[2] refers to this as 'out there' thinking (p.62), challenging us to 'tolerate' looking 'in here' at our own responsibility for violence: our defensiveness and our unconscious complicity in these systems. Strength is required not just for resisting one's own defences, but our collective ones as well.

Throughout the chapter, we acknowledge four main themes in our thinking:

- Work with children needs to be thought about differently from work with adults, because of their relative systemic powerlessness and undeveloped capacities.
- Pain-based behaviour is generated by experiences in relationships and can be understood, contained, and resolved through them.
- Profound distress brings a request for relational containment, and this can be enabled by creating containing systems (support, reflective spaces, training, supervision) around staff, that validate their experiences and provide spaces where they can make sense of children's communication.
- Pain-based behaviour can provoke feelings of fragmentation and splitting within the child, their family, carers, practitioners and teams, and that our aim should be to find integrated, holistic ways of working together that can then support the process of nurturing the child's own sense of integration.

This chapter seeks to reinstate an understanding of, and attention to, the origins of pain-based behaviour that can easily be lost in the language and discourse around the management and prevention of violence in children, both in the research literature and in the practice of care, whether through Child and Adolescent Mental Health Services (CAMHS), in children's homes, or in secure settings. We seek to provide a counterpoint and a challenge to the prevailing tendency to focus responsibility within the individual and to initiate a dialogue where relational and reparative interventions can be considered, together with behavioural ones, as part of a process-informed response to pain-based behaviour.

Finally, we note that the missing voices here are those of the children themselves. Remarkably little research has been done asking children, parents and carers about what they have found helpful in being understood and supported in relation to pain-based behaviour. This will prove a vital source of future progress in this field.

2. Prevalence

Pain-based behaviour in children deserves a great deal of attention from practitioners and researchers because of the ripples of harm and disturbance it generates across multiple systems; because of what it tells us about the environments children are experiencing; and because intervening early prevents later harm. Rivara[3] (p.747) reminds us that 'decades of research by criminologists, sociologists and psychologists indicate that the basis for violence

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rests in childhood and that there is remarkable continuity of behaviour over time'. We know that children frequently experience and witness violence at home and in their communities: in the US-based NatSCEV survey[4] 60% of children surveyed had been exposed to violence in the previous year, 10.2% had experienced maltreatment and 9.7% had witnessed family violence. One in five had experienced maltreatment at some point in the past. The latest national UK survey[5] suggested that 18.7% of adults had experienced some form of childhood abuse; 7.6% had experienced physical abuse and 9.8% had witnessed family violence.

In turn, aggression and violence are common reasons for referral to CAMHS[6] and are frequently associated with diagnoses of attention-deficit/hyperactivity disorder (ADHD), conduct disorder, oppositional defiant disorder and autistic spectrum conditions. Childhood aggression is thought to be a risk factor for a wide range of difficulties in adolescence ([7, 4]); whilst most aggression subsides in early childhood, around 15%[8] continue to show such difficulties into adulthood. This kind of pain-based behaviour can lead to school exclusions, peer difficulties, emotional distress, and involvement in the criminal justice system. Early intervention is therefore of particular value. At the extreme end of the scale, we can see that there were 16,000 proven violent offences in the UK by under 18s in the year ending March 2019[9], the 'dark figure of crime' including unreported or undetected offences likely to be far higher[10].

3. Guidance

The National Institute for Health and Care Excellence (NICE) Guidelines regarding violence and aggression in children[11] offer a useful overview of practice in the area, making recommendations for preventive and anticipatory measures to reduce the risk of violence and aggression, ways to manage it by therapeutic means, and then ultimately to contain it via restraint, seclusion and tranquilisation. There is a natural degree of overlap with the guidance relating to the treatment of conduct disorder[6], which goes into greater depth regarding recommended psychosocial interventions. Key points are summarised in the table below:

Prevention

- Staff should be trained to use restrictive interventions (e.g. restraint) suitable for children, but should avoid or minimise their use wherever possible
- Psychosocial strategies should be used wherever possible.
- Staff teams should be well-led, trained and supportive
- Staff should provide meaningful therapeutic activities, should know their patients well, and work to balance safety with freedom and privacy.
- Safeguarding and collaboration are key principles

Assessment

- Underlying mental health, cognitive, trauma-related, culture or other relevant factors should be identified and relevant practice guidance followed

Management
- Age-appropriate interventions promoting self-soothing and self-control, and support and training for parents, should be offered
- De-escalation should precede any more restrictive intervention
- Punishment-based interventions are unacceptable
- Mechanical restraint should not be used
- Restraint, rapid tranquilisation and seclusion (never in a locked room) should only be used according to the guidance and with close medical monitoring.

The guidance is due to be updated, following a surveillance proposal in 2019 that highlighted the need for a future review to consider the importance of trauma-informed care and support, and to offer a greater consideration of service users' human rights. In addition, the guidance will need to consider the introduction of the Bild Restraint Reduction Network (RRN) Standards (published in April 2019)[12], which are now mandatory for all training on restrictive interventions delivered to NHS-commissioned services.

4. Assessment

Understanding pain-based behaviour in the context of development and relationships

Assessing pain-based behaviour in children requires us to integrate numerous ideas and sources of information that the vast literature in this area has yielded, to inform the creation of contexts in which the child can feel able to tell us, in whatever ways he or she can, about what is going on. The starting point is to provide an environment in which the truth of what is going on can emerge, in terms of collaborative, exploratory and empathic relationships between professionals, the child and their network. Once that is in process, the mechanics of how the assessment takes place, and what components it may include, can be worked through. Good and meaningful assessment is multi-modal and takes into account the qualities of multiple levels and parts of the child's system, risk and protective factors, and, crucially, the relational environment that surrounds the pain-based behaviour itself.

The principle that informs this chapter is that violence is never 'unprovoked' or 'random', but arises in the child as a response to a real or perceived threat to their psychological or physical integrity, in the context of a relationship or a network of relationships. Our role as practitioners is to understand this threat from the perspective of the child's experience and construction of it, and why the child has responded to it in the way he or she has.

In order to do this, we must hold in mind a sense of curiosity about where the child is, developmentally, at a given moment. This is as essential in our observations in spaces in which direct assessment takes place as it is in what we learn about the moments and

conditions in which pain-based behaviour is being enacted. Depending on the qualities of those environments, neither will represent more than a snapshot of the child's capabilities, and information must be gathered from multiple sources, and most of all, from children themselves. This may include home and school observations, play- or discussion-based assessment meetings with the child, with family members, siblings and sometimes peers if appropriate, in a clinic, at school, or in the home; interviews, including developmental histories, with parents (or other caregivers, including staff in residential care or custodial settings) and teachers; gathering and synthesis of past notes and reports; psychometric tests and symptom questionnaires such as those listed in the table below; specific observational assessments where indicated; and consultations with other key professionals in the network.

Widely used measures of aggression and violence in children and adolescents:

- Strengths and Difficulties Questionnaire[13]
- Child Behavioural Checklist[14]
- State Trait Anger Expression Inventory II[15]
- Beck Youth Inventories (BYI-II)[16]
- Brief Rating of Aggression By Children and Adolescents (BRACHA)[17]
- Structured Assessment of Violence Risk in Youth (SAVRY)[18] and the Structured Assessment of Protective Factors for Violence Risk in Juveniles (SAPROF-YV)[19]
- Disruptive Behaviour Rating Scale[20]

While in early childhood some forms of aggression may be seen as developmentally healthy expressions of emotions, such as excitement, frustration and loss, as children grow older we expect them to develop ways of expressing such emotions without doing harm to others. Children who have experiences of developmental trauma, neglect, limited stimulation and educational opportunities, intellectual disability, illness and neurodevelopmental difficulties can be thrown off course from this normal and complex developmental process of growth, adaptation, refinement and integration. Growing up under challenging conditions can impede or distort development and leave children more vulnerable in their relationships and less able to express their feelings in safe and contained ways (for example, through talking or seeking comfort); their feelings of distress remain unresolved.

Among the ways in which we might understand this, the concept of developmental integration is a useful one in understanding children's pain-based behaviour. Dockar-Drysdale[2] describes the process of developing as an integrated person through the experience of loving containment by the mother or primary caregiver, and states that 'the self is built from such experiences, so that where there are gaps in primary experience, there will be corresponding gaps in the self' (p. 65). Observing the characteristics of children in residential care, she noted two features, 'panic' and 'disruption'. The uniquely human drive to make sense of what is happening to us - what Stokoe[21] calls 'the Curiosity Drive' - means that children are constantly making meaning, in formative and powerful ways, of

their experiences, and adapting accordingly, within the bounds of what is possible for them socially, cognitively, biologically and relationally. Where children are surrounded by difficult, frightening and unpredictable relationships, they may learn, consciously and unconsciously, that others cannot be trusted, that they must remain constantly on guard, that they must protect and defend themselves from shame or threat, that parts of themselves are intolerable or uncontrollable, and that their needs are only met when distress is amplified, or suppressed. Some feelings may feel so overwhelming or unendurable that they can only be expressed as action; panic or disruption.

Risk and protective factors

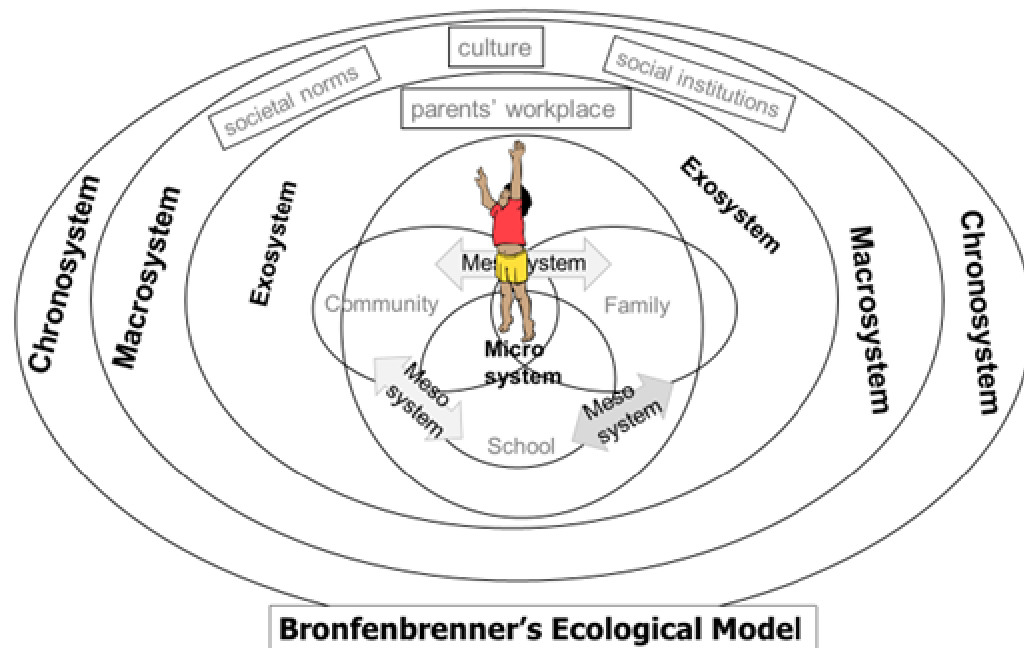
The developing literature has much to offer in guiding the process of assessment, identifying key risk and protective factors that enrich our understanding of the child and prevent us from forgetting or turning a blind eye to things that matter, and creating frameworks (as shown below) that enable us to consider multiple parts of each child's 'social ecology' in a holistic way.

Risk factors that repeatedly emerge from research into the lives and experiences of children who express their pain through violence include prior victimisation and experiences of violence, abuse and neglect at home, at school or in the community[22]. Socio-economic and family factors such as poverty, poor housing conditions, having parents who suffer with mental health difficulties, substance abuse, and/or involvement in offending, and who cannot easily foster the child's social competence, problem-solving or academic engagement, are commonly found[23]. Other studies identify the characteristics of the ways children think and feel, noting difficulties in understanding and managing social relationships, misperceiving others' behaviour as threatening and hostile[24], and a tendency towards 'moral disengagement' (i.e. dehumanizing the victims of their violence, minimising the consequences of such behaviour, and reconstructive violence as performed in the service of 'good'[25]). These might, of course, be understood as defensive adaptations to traumatic and disturbing experiences, and to feelings of shame and fear.

In contrast, protective factors appear to be the inverse, including internal qualities such as high empathy[26] and social and emotional competence[27]. Lösel and Farington[28] offer a comprehensive summary of direct and 'buffering' protective factors for youth violence, noting that social factors (such as living in a non-deprived and non-violent neighbourhood, medium socio-economic status, a positive school or class climate and 'strong school bonding'), family factors (such as a close relationship to at least one parent and intensive parental supervision) and individual factors (such as above-average intelligence, low impulsivity/easy temperament, enhanced anxiety, prosocial attitudes and academic achievement) acted in a dose-response relationship; the more protective factors in place, the lower the probability of violence.

Bringing these considerations together in a meaningful way, Bronfenbrenner's seminal ecological systems theory of human development[29] sparked a shift towards holistic approaches to child assessment that still exerts significant influence today. The seemingly

simple model at the core of his theory (illustrated below) offers an organising frame for assessing the multiple layers of influence on a child's development and the dynamic interplay between them. The ability to hold these complexities in an immediately comprehensible form makes this model not only elegant, but strengthens its utility.



The *microsystem* holds immediate settings in which a child's life unfolds and tends to include family setting(s), school, community and, in the case of many of the children addressed in this chapter, alternative care settings. With the advent of social media and computer gaming, virtual settings (where children 'do' friendship and identity work) should also be considered[30]. Absences of one or more settings should also be considered particularly relevant to understanding the developmental needs of children who display serious pain-based behaviour. The *mesosystem* comprises the interrelations between two or more settings in the child's microsystem; for example, the degree of mutual respect and good communication between parents and school personnel will influence a child's development in myriad ways. The *exosystem* refers to those settings in which the child is not an active participant, but where events occur which nevertheless exert influence. Settings in which parents experience a strong sense of wellbeing or significant assaults on their dignity, for example, or staff meetings in which a child is spoken about in a demeaning manner would all be located in that child's exosystem. The *macrosystem* comprises the patterns manifest in the wider social institutions and ideologies common to a particular subculture or culture. Thus, seemingly intangible concepts such as gender norms or stigmatisation, as well as analyses of social policies (for example, austerity), gain traction in the service of illuminating the particular experiences and needs of particular children

while at the same time avoiding the tendency to locate their difficulties at the level of individual families. Bronfenbrenner later introduced the *chronosystem* to his model to explicitly address the dimension of time and the importance of identifying the impact of experiences and events on subsequent development[31]. Finally, children's active agency in their own development, and particularly their influence on the settings of their microsystem, is also explicitly recognised by Bronfenbrenner.

Thus we have a tangled, complex web of relationships, settings, systems and events in the assessment of children's developmental needs, both generally and specifically related to their pain-based behaviour. Understanding this is required to avoid the unnecessary infliction of secondary pain. This model supports the identification of those elements one might otherwise miss in assessments, and to consider the dynamic ways in which they all interact and influence particular children's development over time.

A recent contribution specific to this area is the framework for assessment and intervention around violence ('FAIV')[32] that unites Bronfenbrenner's model with specific considerations of client and practitioner factors. The model can encompass developments in practice, as it sets out core principles rather than specifics. A diagrammatic version of the model can be found below:

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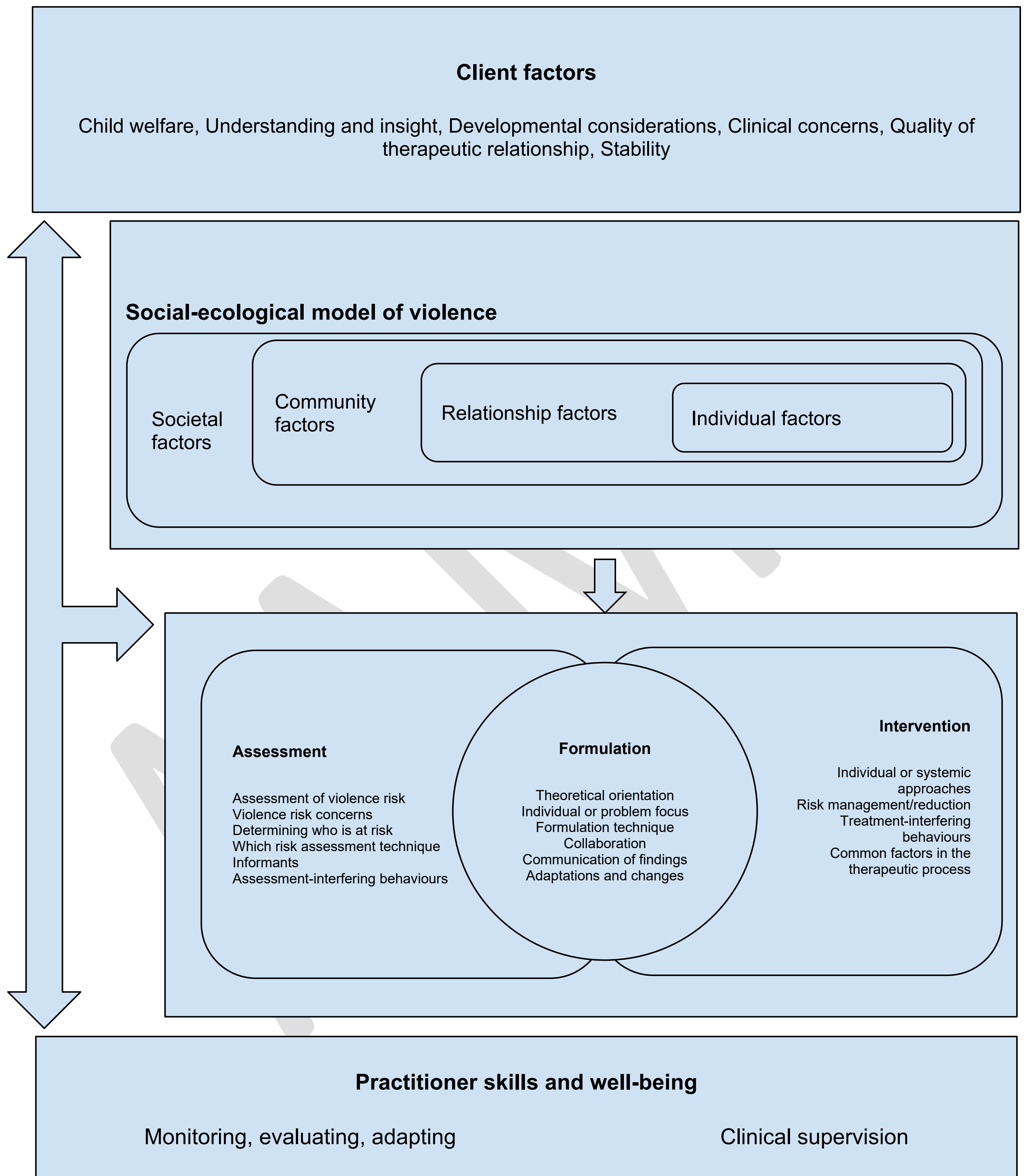

Within a wider model such as the FAIV, structured professional judgement (as opposed to relying on clinical judgement, or actuarial risk assessment only) is widely understood to be the most reliable and meaningful method underlying an assessment. It combines attention

to empirical risk factors (static, dynamic and protective, measured using a variety of inventories) with professional, clinical judgement and expertise gained from a comprehensive assessment of the child in question in the light of psychological theory[10]. It involves a step-by-step process whereby detailed background and current information is considered against structured evidence-based protocols, relevant future scenarios are explored, and potential interventions that help to manage the identified risks are suggested.

Practice points: Assessment

- **Pay attention to the child's development (cognitive, emotional, physical, social) and the integration of their developmental capacities**
- **Analyse specific violent incidents, their contexts, antecedents, process and consequences, with close attention to the possible meanings of these from the child's perspective**
- **Use multiple methods of assessment, including observation, across contexts**
- **Look closely at the quality, variety and history of the child's close relationships**
- **Use an ecological systems perspective to bring together your understanding of the risk and protective factors operating at each layer of the child's experience of the world**
- **Aim throughout to create a safe and trusting environment where the child can begin to talk about what is going on**

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5. Formulation

Arising from the assessment process, therapeutic work should have at its centre the process of formulation, in collaboration with the child and key people in his or her system. Open to being re-thought and re-written as the situation changes, a formulation is a dynamic and meaningful narrative explanation of what is going on, in the context of a range of relevant psychological theories. Its value is explanatory and generative, opening up new ideas for engaging, supporting and helping the child and surrounding systems. Typically, formulations bring together a diverse range of complex ideas in a structured and organised way, for example, by dividing information into 'predisposing', 'precipitating', 'presenting', 'perpetuating' and 'protective' categories (the 'Five Ps model'[33]), and may incorporate ideas from numerous theoretical paradigms or take different forms, accordingly. They can, and should, be able to be written with and for the child, and should be a tool for therapeutic engagement and the facilitation of a wider understanding.

Recent work by Johnstone and colleagues[34], developing the 'Power-Threat-Meaning Framework', has sought to bring a consciousness of power relationships, oppression, threat and the personal construction of meaning into the practice of formulation. This

development has helped to relocate pain - in this case as we understand it as communicated through violence - into a wider consideration of social, economic, historical and cultural factors and experiences. It is essential that a formulation takes account of the multiple systems identified in the child's social ecology.

6. Responses to pain-based behaviour: principles and practice

Principles: containment, relationships and holism

Addressing pain-based behaviour requires responses grounded in containment; these must be relational and, in extreme situations, may need to be physical. Within this context of containment practitioners can identify and meet unmet needs in the child and his or her system, and create the potential, ultimately, for healing and change.

Containment serves as a central theory through which we can make sense of children's pain-based behaviour and understand what practitioners need in order to respond helpfully and consistently. The term 'containment' is often used pejoratively to mean holding children within a status quo and lacking any real progress (or even intention of progress). The meaning of containment we are referring to here was developed by Wilfred Bion[35] and subsequently incorporated across a wide array of fields and disciplines. Bion identified the caring processes between primary caregiver(s) (in his day, the mother) and infant during the first few years of life as the basis for the development of thinking in order to manage raw experience and emotion. This ability develops further in toddlerhood through the introduction, or more extensive use, of oral interpretation by caregivers of toddlers' emotional states and experiences. Children who act out their pain through their behaviour are often unable, temporarily or throughout much of their day-to-day, to contain it.

Bion drew parallels between what happens between the primary caregivers and infant, and the therapist and patient, to illuminate the processes involved in bringing about and/or restoring the capacity to think in the client. These processes include projective identification of unbearable (or uncontainable) feelings onto the caregiver or therapist or, for the sake of this discussion, practitioner. The practitioner who maintains calm receptiveness is able to absorb these feelings, to process them actively and cognitively, and to respond with empathic acknowledgement. In early years development, when this informs and infuses feeding, soothing and changing nappies, infants repeatedly experience the uncontainable being made containable. Similarly, when a practitioner absorbs and makes sense of the emotional communication of a child or young person and responds in a manner that (begins to) meet the expressed need, that child or young person's emotions and experiences become more thinkable and manageable – more containable. Put simply, the practitioner becomes a container for the child who, through repeated experiences of containment, becomes more able, more often, to contain (i.e. to use thinking to manage) his or her experiences and emotions.

Containment theory is a close kindred to attachment theory[36, 37] and Winnicott's theorising about the holding environment[38]. These are all beneficial perspectives for understanding

pain-based behaviour. We argue that containment theory has greater elasticity in its explanatory power, in that it is just as usefully applied to indirect practice (i.e. processes that support practice at individual and organisational level) as it is to direct practice between practitioners and children. In direct practice, beyond significant dyadic relationships, processes of containment can be identified or cultivated in the network of relationships to which a child belongs, as well as in the rhythms, rituals, routines and even organisation of the physical environments within which the child's life unfolds. Moreover, containment is neither static nor a developmental milestone that one achieves; we all experience times where our ability to think clearly (or at all) becomes compromised. The capacity to use thinking to manage experiences and emotions vacillates throughout life, not only due to the relative strength or fragility of one's developmental foundations, but to the ongoing, dynamic interplay of strengths, vulnerabilities, protections and adversities encountered throughout the life course.

Good therapeutic practice, whatever the modality, must involve the cultivation of a state of mind and style of interaction that is directly responsive to the cues of the child, and is based on a set of ideas and values about the child and the work that include empathy, genuineness, curiosity, acceptance, playfulness and flexibility[39]. This echoes Vygotsky's concept of the 'zone of proximal development'[40] (p. 86): in essence, the creation of a relational environment in which the child can flourish and reach his or her potential. A key principle is to cultivate a mode of working where the therapist attempts to meet the child and their family in their 'comfort zone' rather than requiring them to adjust themselves to expectations that may seem foreign or uncomfortable[41].

Current thinking adjures us to value the child, but not his or her challenging or aggressive behaviour. Whilst this way of using language may aid various therapeutic practices[42] it is problematic if it reflects a similar lack of integration in the practitioners' conceptualisation of what is going on. Seeing children as separate from their behaviour invites practitioners to separate their responses to behaviour from the personhood of the child. We take the view that pain-based behaviour is relational; it originates in relational experiences and is expressed in relation to others. It has meaning, history, and context and is co-created and dynamic. Any useful and humane approach to a child in this kind of pain will address this meaning, history and context through the process of creating and sustaining a healing relationship, within a larger systemic context in which this way of working is supported. Within such a safe, contained and containing relationship there is scope for both empathy and challenge on the part of the practitioner and for children to explore the edges of their feelings and experiences. This process asks practitioners to hold simultaneously the ambivalence and complexity in the task of supporting a child's integration. Dockar-Drysdale[2] suggests that we as professionals must '*hold the violence and the child* together' (p. 67). The authors are reminded of a recent recruitment campaign for custodial officer roles in the youth estate that asked, '*Can you see the child and not the crime?*'. In fact, the essence of providing meaningful and containing holistic care to children who are being sanctioned for causing pain to others is to be able to see both the child *and* his or her experiences in their entirety. The most innovative approaches to practice, described below, embody exactly this commitment.

Practice

Preventative work

Much has been written in recent years about the 'public health' approach to violence where the emphasis is on prevention, as it might be with, for example, an infectious disease. Violence Reduction Units and similar initiatives in Glasgow, New York, Chicago and London have supported projects to strengthen local communities where violence has been prevalent through a variety of means including reducing school exclusions, offering parenting programmes, enhancing after-school provision and developing initiatives that respond to specific local needs. Developing closer links between CAMHS services and schools, locating counselling services within school settings, offering training for teachers, and spaces and opportunities to develop young people's social and emotional skills are all examples of promising preventative practice that addresses some of the systemic difficulties in the roots of much pain-based behaviour and attempts to offer support in accessible, inclusive ways.

Promising practice: The Well Centre[43]

Recognising the need for a preventative, holistic and accessible health service for young people at risk of offending in Lambeth, south London, GP Stephanie Lamb set up a joint service with youth work and violence prevention organisation, RedThread, to offer a walk-in 'one-stop shop' for adolescents. At the clinic, which opened in 2011 in a well-established local youth club, young people can see a GP, a CAMHS practitioner, or engage with specialist youth workers trained in social prescribing who can address a range of unmet physical and mental health needs. A further clinic in Streatham extended their reach, as did a partnership with Lambeth Youth Offending Service. All young people are offered a biopsychosocial assessment, with a case-finding approach to tapping into mental health needs, with on-site counselling, sexual health, medical care and outreach services available, and in liaison with other services, such as housing, to enable coordinated care across the multiple systems around each young person. The service is valued by young people in the borough for its responsive, non-judgmental, holistic ethos and for the ease with which they can get the help they need without negotiating multiple referrals to disparate teams. The Well Centre has inspired the design of services in other boroughs, such as Spotlight, in Tower Hamlets.

An alternative trend - and, in the opinion of the authors, a counterproductive and potentially harmful one - is the use of 'zero-tolerance' and punitive systems, particularly evident in some secondary schools in the UK and America, where strict rules and behavioural sanctions including detention, isolation and exclusion are applied. Borgwald et al.[44] argue that zero-tolerance approaches are ineffective, counterproductive and unjust, over-used, often racially disproportionate and likely to promote covert bullying and unhelpful stigmatizing. In addition, they note that 'treating bullying as a crime and removing

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a child from the school is, in practice, transforming children from being children with behavioural problems into quasi-adults whose rights to an education are forfeited, a form of criminal punishment' (p. 6-7). Such practices potentially preclude opportunities for forgiveness and repair, instead generating bitterness and reinforcing a sense of rejection. Exclusion from education deprives children of broader social contact and wide educational opportunities, leaving them more vulnerable to anti-social influences in alternative provisions such as Pupil Referral Units (PRUs), and more exposed to difficulties at home and in their communities, propelling children along the 'PRU to prison pipeline'[45, 46].

Specific psychologically-informed programmes aimed at the prevention of violence are not well-researched, possibly reflecting the early stages of the development of such interventions. The last Cochrane review in this area[47] attempted to evaluate programmes preventing gang involvement but was not able to proceed due to a lack of available studies meeting their criteria. The Gang Resistance Education and Training ('GREAT') programme, a school-based American intervention in which children are taught a nine-week program by law enforcement officers, yielded positive results in terms of prosocial attitudes and a decline in some forms of delinquency in a large-scale evaluation[48] but has not been used in the UK.

In treatment, educational and other social settings, initiatives such as the Enabling Environments programme[49], and the development of trauma-informed ways of working where principles of safety, trustworthiness, choice, collaboration, and empowerment are genuinely integrated into working practices, promote conditions that are intended to prevent violence and encourage positive and therapeutic relationships. Some key principles specific to creating an environment that precludes violence in residential care for children are offered by Dockar-Drysdale[2] (p. 68), all of which require staff to be committed to taking up a caring, reflective, adult position:

Four principles for preventing violence in residential child care[2]

'1. to accept responsibility for keeping lines of communication always open, so that violent acting out can be converted into the communication of anger;
2. to contain and know our violent feelings so that we do not need to use children to act these out for us;
3. to respect the 'territorial imperative' and to provide insulation for children; and
4. to be responsible for containing children who are not themselves able to accept responsibility.'

By the 'territorial imperative' and 'insulation', she refers to the need for privacy and ownership over physical space.

Treatment

Therapies, intervention and treatment (terms which are used fairly interchangeably in the literature depending on the dominant traditions within the given setting) to address

aggression and violence may be delivered through a variety of services including CAMHS, via social care and local authorities in residential child care, and through specialist services in community, educational and secure settings. Any intervention must be based upon the relevant practitioners being able to assess and formulate, keeping in mind the concept that any difficult and challenging behaviour may be based upon pain and trauma, whatever setting they may be working in.

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Children and Young People's Mental Health Services

Access to mental health services in England and Wales is delivered through a tiered system.

- Tier 1 is about ensuring that all those working with children across a range of settings have a good understanding of the variety of ways in which emotional difficulties present, and the capacity to recognise these, respond appropriately and provide direction to sources of further help; thus professionals working within education settings, social care and all health services seeing children, must be trained in the presentation of emotional disorders, and be aware of how to refer on the children that require more specialised assessment.
- Tier 2 services are delivered across the community, with mental health practitioners being based in schools and other community services, to ensure greater, easier and more embedded access to help for children, in familiar settings; prevention and de-escalation of emotional difficulties is an underlying focus of these services, based upon the precept that more significant and enduring problems can be prevented and diverted.
- Specialist CAMHS represents Tier 3, with skilled mental health practitioners across a range of disciplines available in all areas, although the waiting times can be prohibitive, with children and their families experiencing considerable delays in accessing treatments and interventions. Professionals working within Tier 3 CAMHS will come from a range of disciplines: specialist mental health nurses; clinical psychologists; family therapists; specialist mental health social workers; Child and Adolescent Psychiatrists. Assessments and treatments may be unidisciplinary or multidisciplinary.
- Tier 4 services are in place across larger geographical areas to provide specialist assessment and treatment, and in-patient care as necessary, including specialist Eating Disorder Services.
- The advent of F-CAMHS (Forensic CAMHS), since 2016, has led to the creation of a nationally commissioned network of specialist teams offering consultation, training, liaison and expert assessment to CAMHS teams around particularly complex children with forensic needs.
- In addition to mainstream mental health services, the Voluntary Sector also provide mental health services, often for circumscribed problems. For example the NSPCC and Barnardo's provide services for survivors of sexual abuse, for young people showing harmful sexual behaviour.

Services across the tiers are commissioned through local Clinical Commissioning groups, but also through Social Services and models of joint funding. More recently schools, especially large academy groups, have become commissioners in their own right. Although the original thinking was for there to be a seamless, tiered service addressing the needs of children and young people, with fluidity and easy transition between the services, the commissioning models and fragmentation of funding has meant that it can be very difficult for families, and indeed professionals, to know where a young person's needs may best be met; unfortunately young people can experience being "bounced" between services, and experience considerable delay before reaching the right professional to meet their specific needs. Additionally, families can experience internal waiting lists within services, which causes further delay to treatment.

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It is important to understand that children displaying pain-based behaviour may present in a myriad of settings, and linking them in to the most appropriate intervention will depend upon how and when they present, and a robust assessment and formulation. Unfortunately, these children may find it difficult to access a service that will meet their needs. Specialist CAMHS will often reject referrals where challenging behaviour is the principal symptom, stating that they are not commissioned to meet the needs of this population. Children may be referred to alternative services or third-sector organisations, or simply knocked back. This process misses the core understanding that the visible behaviour often relates to underlying relational trauma and may reflect the operation of numerous biological, psychological and social factors that could have been addressed and de-escalated. By failing to link them with practitioners who understand about the difficult experiences that might have led to the development of pain-based behaviour, services deny children timely and helpful interventions. In order to ensure that these vulnerable children are picked up early, it is important to teach and train around pain-based behaviour, across all children and young people's mental health and specialist services, so that there can be broader discussions about the origin of the behaviours, and better practice to change the course for the children involved.

Below we describe parent-, child- and system-focused interventions, including medication, that may be used to address pain-based behaviour.

Parent-focused interventions

Programmes offering training and support to parents are a well-researched mode of treatment, and some have shown considerable effectiveness in promoting parental resilience and reducing harsh practices[50, 51]. Several versions are used in CAMHS services, including the Incredible Years Programme[52] and the 'Triple-P' Positive Parenting Programme[53]. Often they involve multiple or alternative formats (group, individual and self-directed, with guidance by phone), and generally cover limit-setting, consistency, problem-solving, play, praise, and the prioritisation of 'golden' or 1:1 'quality' time with carers. The most effective programmes are collaborative, leave room for parents to relate the teaching to their own experiences, are delivered in tandem with separate family therapy, and are supported by the provision of creches, transport and other practical interventions that enable struggling families to attend. It often proves difficult, however, to engage families in these kinds of interventions, particularly where there are histories of mistrust in services or other circumstances that may act as a barrier. Fairly high rates of attrition and non-attendance in such groups[54] mean that these interventions cannot always reach those who are in the greatest need or at the highest risk. The Lighthouse programme[55], a therapeutic initiative for parents using mentalisation-based treatment (MBT), art and group-based discussion and currently running across various services in the west of England, is a new and promising development in this area.

Child-focused interventions

Structured, often manualised, cognitive-behavioural therapeutic (CBT) interventions for children, delivered in both group and individual formats, have been widely studied and evaluated. With children, CBT for anger-related issues usually involves psychoeducation, relaxation strategies, problem-solving, social skills and conflict resolution training[56] and may involve complementary work with parents. The 'third wave' of cognitive therapies, incorporating (among others) mindfulness and compassion-focused approaches, may enhance the effectiveness of these interventions[57, 58]. Meta-analyses of the effects of group-based CBT for children[59, 60, 61] have generally found that multi-modal, skills-based treatments are the most effective, especially where they include problem-solving components. Dominant CBT programmes include the Anger Coping Program for younger children[62] and Aggression Replacement Training (ART) for adolescents[63].

Many of the more manualised interventions for children and parents assume that skills deficits are the problem, and that the solution can be found in learning more skills, and the control to apply them. As Cochran et al.[41] point out, however, 'the skills tend to be known, but not used, by such youth' (p. 292). All practitioners in this field are familiar with the experience of working with young people who appear more than able to grasp ideas and describe how they can be manifested in positive behaviours but who struggle profoundly to feel any emotional charge in these conversations, or to feel there is any place for such skills in real life. Cochran et al. suggest that 'the self-defeating belief systems and environmental influences have largely solidified by teen years: thus a corrective therapeutic relational experience may be more effective than directives and skill teaching.' Indeed, years of research have repeatedly told us that the therapeutic alliance is a greater predictor of positive change than the manifest content or technique of any therapy[63, 64], and that attention to multiple levels of the child's social ecology is more likely to effect change than focused attention to a specific set of skills.

While there is some evidence that CBT interventions for anger and aggression can be effective, the interventions evaluated in such studies are usually American, group-based and manualised, with male-only samples, and do not necessarily reflect the nature and form of CAMHS work in the UK. Nor are non-cognitive-behavioural approaches such as psychodynamic or family therapy often included in the major studies despite clinicians' experience of their value, which creates the obvious danger of their being disregarded in the allocation of funding, commissioning in services, or further research.

Small-scale studies highlight the value of other approaches such as Mentalization-Based Therapy and Mindfulness-Based Therapy[58, 65] and mind-body approaches such as yoga and biofeedback training, and we would recommend that practitioners in the area remain open and curious about such therapeutic approaches that intuitively, theoretically and anecdotally appear to benefit children showing pain-based behaviour, but are yet to be evaluated on a large scale. Approaches designed for other groups of children, for example those affected by bereavement or loss, such as the Seasons for Growth programme and Tree of Life work[66, 67], may have great applicability to children whose distress is expressed through aggression and violence and who have often experienced significant losses.

Medication

Pharmacological interventions are not recommended in the research literature or in the NICE guidelines[6, 11] for the routine treatment of children presenting with violence or aggression; psychosocial interventions are the first line treatment. However, as Squire et al.[68] suggest, 'due to the lack of psychologically oriented practitioners within services and a predominance of a medical model of understanding behaviour' and, we would add, because often the fear engendered by violent behaviour feels as if it requires a rapid and reactive response which medication easily supplies, 'this guidance is not necessarily followed widely' (p. 124). It is important, nevertheless, to accept that there are occasions when the use of medication may be appropriate. For some children, there may be a co-morbid difficulty that can be addressed by the use of medication; an improvement in this area may then enable them to engage with psychological treatment or to respond to changes in how they are treated by teachers or parents following systemic interventions. When there is thought to be co-morbidity alongside underlying pain-based behaviour, medication may be considered. Treatment of co-morbid ADHD, significant depression and crippling anxiety may be addressed through stimulant medication and SSRIs respectively, in keeping with NICE guidance. Prescribing should only be done by an experienced CAMHS Psychiatrist, preferably as part of a multi-disciplinary response to a good assessment and formulation; it is important that clinicians understand that this is a part of the treatment, and not the sole answer. Within specialist inpatient settings, medication may be used to manage particularly distressed and challenging behaviour; this needs to be done in keeping with local protocols and national guidance around the use of rapid tranquilisation in young people.

Systemic and multi-modal treatments

Functional Family Therapy[70] is a widely used and researched form of family therapy designed to support families to address and resolve aggressive and anti-social behaviour in children. It uses a three-stage programme focusing first on beliefs about change and patterns of relationships within the family, then on behavioural interventions, and finally on generalising change across systems. Early studies of its effectiveness showed promising results but subsequent trials have not shown significant advantages over other forms of intervention[71].

Non-violent resistance (NVR)[72] is a family-based psychological intervention derived from the principles espoused by activists such as Mahatma Gandhi and Martin Luther King. It has been developed by Haim Omer, Peter Jakob and colleagues as a systemic intervention to support families and carers of people whose behaviour is violent or controlling. Delivered in regular sessions, in the form of guidance and coaching and often supported by telephone contact, it aims to redefine and strengthen family relationships and reduce conflict and violence. NVR rests on the idea of parental presence and non-engagement in escalating verbal or physical exchanges. The assumption is that without a violent counter-response, the aggressive child will find that their usual strategies become ineffective, and wear out. It is explicitly relational: violence is not regarded as the inevitable expression of trauma, deprivation, uncontrollable impulsivity or illness, but as a relational phenomenon in which the parents/carers have acquiesced (usually without realising they are doing so) and

continued to provide the means for it to perpetuate. NVR is widely used in Israel, Germany, and increasingly in the UK. In a German study in 2009[73], NVR was compared with TEEN-Triple-P. Improvements were evident among both groups with some advantages found in the NVR group. A more recent UK study[74] found that group NVR improved family relationships and reduced episodes of violence and aggression in the home.

Interventions such as Multi-Systemic Therapy (MST)[75] and Multi-Dimensional Family Therapy (MDFT) attempt to address more severe difficulties intensively, at multiple levels of the system (i.e. individual, parents, wider family, school, peer, community). MST is based on ecological systems theory[29] and the understanding that the child is an active participant enmeshed in a series of larger, connected systems that affect his or her experience. It is aimed at preventing children going into custody or other forms of care outside the family home, and at improving the quality of family relationships. MST typically involves considerable therapeutic resources, with teams of specially trained therapists who develop close, collaborative and flexible working relationships with families, staying in daily or even 24-hour, contact, visiting them at home, facilitating engagement with other helpful resources and offering therapeutic intervention at all levels (i.e. in school, with peers) according to the needs and wishes of the family. Interventions typically last several months, and can be extended as needed. Where families remain engaged, these multi-modal, ‘ecological’, flexible, expertly delivered and responsive approaches produce some of the best outcomes[76].

Practice points: Treatment

- Treatment should be based on a thorough and meaningful assessment and a collaborative formulation that considers multiple contributory risk and protective factors across the systems around the child.
- Though Tier 3 CAMHS services are staffed with clinicians with appropriate skills and training to address pain-based behaviour, resource shortages and commissioning priorities mean that children may not be able to access them.
- Parent-focused interventions, including supportive skill-building groups, can be highly effective.
- Child-focused interventions should meet the child at their developmental level, should be engaging, individualised and based on a meaningful and shared formulation of their difficulties. Medication can be helpful in specific circumstances, as part of a wider response.
- Systemic interventions such as MST, FFT and NVR may offer more ecologically valid and meaningful responses that work at multiple levels.
- Therapeutic responses should operate on the principle of developing safe, containing and communicative relationships around the child that foster the child’s developmental integration and positive sense of self and other.

7. Restrictive interventions

Criminalisation and incarceration

The use of 'secure care' to manage and prevent violence in children represents an extreme form of physical containment. The UK's readiness to criminalise children is somewhat mitigated by sentencing guidelines that discourage custodial sentences and promote community orders and welfare interventions. There is a decreasing reliance on incarceration for children, though less so for crimes that involve violence. Since 2008, the number of children in custody in England and Wales has fallen from approximately 2,900 to 860[9]. The Lammy Review (2017)[77] found a disproportionate and rising number of these children are from black and other minority racial and ethnic groups, reflecting the operation of structural racism in UK society and within the criminal justice system (51.9% of those in the YOIs were from minority groups, according to 2021 statistics, relative to 27% in youth custody in 2009, and 18% across the general population[78]). These children are housed in Young Offenders' Institutions (YOIs) (for 15-18 year-old boys), secure training centres (STCs) and secure children's homes (for 12-18 year-old boys and girls), on remand and while serving sentences of varying lengths. 51% of children in custody are detained for violent offences[9]. Over the last ten years the average sentence length has increased from approximately 11 to 18 months, but this statistic disguises the rapidly growing proportion of young people in custody who are serving 'life' sentences (given a minimum tariff by the judge at their sentencing, after which release depends on the approval of the Parole Board, and a lifetime on licence). Minimum tariffs have increased dramatically over the past ten years, a trend Crewe et al.[79] describe as reflecting 'the increased use of forms of expressive punishment designed to communicate moral outrage and a political culture that is less resistant to punitive demands, cultivated by the popular press' (p. 6).

In England, Wales and Northern Ireland, the age of criminal responsibility (ACR; the age at which a child can be prosecuted and punished by law for an offence) is currently 10. This is the lowest ACR in Europe and one of the lowest in the world; it has been criticised by the UN as incompatible with their Convention on the Rights of the Child and '*not internationally acceptable'*[80]. Scotland has recently moved to implement legislation raising the ACR to 12 (The Age of Criminal Responsibility (Scotland) Act, 2019). Mounting neurobiological and psychological evidence has shown that children do not reach emotional, moral or intellectual maturity until far later than 10, particularly where development is disturbed by trauma and adversity. Adolescence is a period in which risk-taking, impulsivity and boundary-breaking behaviour is developmentally and culturally normative[81], after which these behaviours naturally decline[82]. As Dockar-Drysdale[2] notes, 'Roughly, one can equate degree of responsibility with degree of integration as an individual reached by the person who has committed the violent act. Unintegrated people of any age are unable to contain conflict, to make a choice, to feel personal guilt or compassion for others or to accept responsibility' (p. 65). This understanding fundamentally questions the legitimacy of criminalising young people, let alone administering sentences that are sometimes longer than the lives they have already lived and coloured by systemic prejudices.

The fact of coming into custody suggests that containment in the systems of relationships, home, school, community and the community youth justice system has not been adequate. The level of violence or dangerousness that the child is thought to present is now to be met by what we might understand as 'the brick mother'[83]. While nominally preventing violence

to the public, secure settings are notoriously violent places for both young people and custodial staff; in the YOIs, between April 2018 and March 2019, there were 2,400 assaults, roughly equally split between peer on peer and staff assaults[9]. The vengeful paradigm that suggests that incarceration is an appropriate and curative response to violence is not validated by any known research. Reoffending rates for children who have been in custody were last measured at 69.3% in the UK (for the year ending in March 2019)[9], and there is evidence that children who are treated most harshly in custody are the least likely to desist from crime[84].

Balancing popular pressure, the apparent protection of the public, long-established working practices in the prison service, adherence to human rights and standards supporting the humane and rehabilitative care of children, and advancing psychological theory and practice is clearly a complex task. The upshot is a system that struggles to manage and address violence, much like an uncontained parent reacting chaotically to competing pressures; sometimes punitive, sometimes thoughtful, rarely consistent. In response to repeatedly critical reports from the prison inspectorate, HMIP, a damning review by Lord Taylor in 2016[85] and campaigns by the Howard League and other organisations, the Youth Custody Service has introduced a set of reforms aimed at developing a more therapeutic, trauma-responsive system and training a skilled, professional and dedicated workforce, with the planned creation of 'Secure Schools' to replace the YOIs and the STCs in England and Wales. The standard therapeutic offer to children in custody had already expanded over the last ten years, as specialist CAMHS services were increasingly commissioned to operate in secure settings. These brought a clinical perspective to the care children were offered, beyond formerly minimal mental health provision and the (largely cognitive-behavioural) manualised offending behaviour programmes offered by established forensic psychology services. There have been numerous attempts to reduce violence in the youth estate, including staff training in restorative justice and de-escalation techniques, embedding conflict resolution teams, and limiting and supervising contact between the boys, with, unfortunately, limited success.

Promising innovations: SECURE STAIRS

A key element of the new Reform programme across the secure youth estate in England, SECURE STAIRS, is a framework for integrated care, devised, funded and shared jointly between HMPPS, NHS England and the Department for Education. It embodies a set of principles for developmentally sensitive, psychologically-informed work with children and staff in secure settings[86, 87].

SECURE STAIRS (an acronym for the key principles of the framework) significantly expanded the funding for NHS therapeutic provision and trauma-informed training and support for custodial officers in youth secure settings, from its inception in 2016. The operationalisation of the framework differs across these settings but involves core components of formulation-based care for young people, and intensive training, reflective practice and clinical-style supervision for custodial staff. Its ambitious aim is the transformation of 'warehouses' to 'greenhouses', re-training custodial staff as

'therapeutic parents' and embedding cultures of benign enquiry, care and reflection in these establishments, drawing on a broadly systemic and psychodynamic understanding of organisational functioning and trauma[88, 89].

The programme draws on ideas from the literature on therapeutic communities to promote stable patterns of communal living and relating, establishing community meetings and valuing the voices of the boys alongside those of custodial staff. The idea of reparation is privileged, where the community offers the potential for forgiveness and reconciliation after damage or violence[90].

The expanded on-site CAMHS teams created by the SECURE STAIRS programme, working with custodial staff, can, when enabled to function within the complexity and rigidity of prison regimes, offer highly specialist, individualised, multi-systemic therapeutic work, and enable 'through-the-gate' transitions with families and community services to address and resolve the systemic anxiety around release or transfer. A multi-site longitudinal outcome evaluation by the Anna Freud Centre is currently in progress.

Physical restraint, Co-regulation and De-escalation

Children and adolescents in extreme states of distress or arousal, particularly when attacking another person, naturally need to be made safe and those around them protected. As a last resort, this may require physical restraint or holding[91]. Restraint must be undertaken by trained staff and must be 'appropriate to the situation, reasonable, proportionate and necessary, used for the shortest period possible[11] (p. 183). During the restraint, 'vital observations are taken and recorded' (ibid), and ideally carried out by a member of staff who is the same sex as the child.

While restraint is rarely necessary in community CAMHS settings, it is more common in in-patient psychiatric and forensic adolescent units, and in secure settings. In the youth secure estate in England between 2018 and 2019, there were 6,300 Restrictive Physical Interventions (a rise of 16% from the previous year), an average of 46.6 incidents per 100 children in custody[9]. Restraint training, guidance and protocols, which include debriefing and multi-agency monitoring of video footage of restraints and the presence of medical staff to monitor the child's condition during and after restraint, are normal practice in these settings.

There is an increasingly strong emphasis on the use of de-escalation techniques as a way of averting violence, and for good reason. Physical restraint poses serious risks of physical and psychological harm to all involved, including death[92, 93]. Its misuse is associated with children's rights abuses[94] and the Committee on the Rights of the Child (2016) has criticised the UK for its lack of related monitoring[95]. Accordingly, young people should always have access to independent advocates and means of raising concerns via complaints or other processes.

In the UK, seclusion and isolation are no longer considered humane ways to deal with children in distress, although recent media reports have suggested that some schools here continue to use such practices. It is increasingly understood that co-regulation - the use of a relational space in which an adult in a caregiving role can help the child to regulate his or her emotions using proximity, vocal comfort and other strategies - is a more therapeutic and naturalistic response. The capacity to co-regulate, however, depends on an environment and a set of relationships that support staff to be able to work in this manner, as well as a knowledge of the child that includes an understanding of any sensory issues. It is also important to acknowledge that building and maintaining the kind of relationships that children can access when they become distressed is sometimes profoundly difficult, particularly when previous experiences have given them good reason to resist and/or test their relationships with adults. Staff should be closely familiar with the individual formulation for each child which should encompass co-produced care plans that anticipate how that child is understood to respond to stressful events, and suggest what may help.

When feelings have built to a level at which they have erupted into pain-based behaviour that poses a serious risk of imminent harm it is essential, first, to remain *in relationship*, maintaining calm receptiveness and making yourself and the relationship as accessible as possible to the child through actively cognitively processing the communicated pain and empathically acknowledging it, even (and especially) as you assess it necessary to physically restrain the child. This can be one of the most complex and demanding requirements of professionals working with children who have chronic and severe psychosocial pain. The second essential component of good related practice (individually and organisationally) is *the provision of meaningful opportunities for understanding, resolution and reparation* afterwards. This has the power to contain and transform feelings of shame, confusion and hurt, and is a crucial part of enabling children to learn to express their pain in less harmful ways.

Physical restraint is one of the most extreme forms of containment that will occur in the settings to which this chapter is addressed. This is the case whether the restraint is carried out as a form of what we might call ‘crude containment,’ or whether it is part of the therapeutic processes theorised by Bion (and others, subsequently), as discussed above. In a large-scale, in-depth, qualitative study of staff and young people’s experiences of physical restraint in residential child care[96, 97], almost half of the 30 young people who shared their experiences of being physically restrained described *some* as having positive effects, either on how they felt afterward or on their relationships with those who restrained them. Young people appeared to experience and make sense of restraints based on the degree of trust they had in the staff who restrained them – trust that staff were trying to avert recourse to restraint, that staff were trying to understand and help them, and that when they were restrained, it was done for the right reasons and in a way that did not deliberately hurt them. For trust to withstand the intense potential for restraint to rupture relationships, the two essentials outlined above come into sharper relief. To be clear, we are not suggesting that physical restraint itself is beneficial. Indeed, in the aforementioned study *all* young people who shared experiences of being physically restrained spoke of negative experiences and/or impacts on their relationships with staff. Thus, it warrants repetition: physical restraint should only be used when less restrictive ways of resuming safety are proving

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ineffective or the immediacy and severity of risk is so great that there is not time to use them. When it is carried out relationally within wider systems and practices that are robustly containing, it can be a part of a wider experience of therapeutic containment.

The Restraint Reduction Network (RRN) has set out to reduce the reliance on coercive practices (including physical restraint) across education, health and social care settings including both children's and adult services. Towards this end, they have developed training standards and a certification scheme, as well as an active network of committed practitioners and a repository of related resources[12].

8. Developing protective factors through legal and ethical practice

Throughout this chapter we have touched on the elements in children's lives that can lead to pain-based behaviour. Most of these - victimisation, abuse, neglect, poverty - are beyond childrens' power to change. Compounding these external influences are internalised beliefs about themselves and others as a result of inadequate attachment relationships and unmet needs which telegraph to children the message that they do not matter. 'These children are sensitive to humiliation; they have been exposed to a catastrophic loss of power…'[98]. The picture can look bleak. However, in Bronfenbrenner's macrosystem there exists a positive, protective, and potentially developmental factor in the form of laws and guidance relating to children. These, in tandem with our professional ethical codes and frameworks, offer opportunities for practice that can plant the seeds of self-respect and agency in children.

Child law in all four nations of the UK takes a strong children's rights perspective with many of its principles grounded in the *UN Convention on the Rights of the Child* (UNCRC), adopted by the UK in 1991. Statutes such as the *Children Acts* set out who has rights and responsibilities with regard to children. Case law such as *Gillick v West Norfolk and Wisbech Area Health Authority* draws on the principles of capacity, consent and privacy in the *Convention* to allow children the right to make choices about their own lives.

According to *Psychological Interventions in Child and Adolescent Mental Health Services*[99], the competence framework for child and adolescent mental health services, one of the core competences for work with children and young people is 'knowledge of legal frameworks related to working with children/young people'. The competence required includes knowledge of capacity and informed consent, parental rights and responsibilities, participation, child protection, mental health, education, data protection and equality. These topics sound dry but they represent a vital and living resource for practitioners seeking to establish growth-enhancing relationships with children.

Capacity, informed consent and confidentiality

In the UK, a child under 16 can consent to medical treatment if s/he understands the risks and benefits of what is being proposed. This right is found in the *Age of Legal Capacity (Scotland) Act 1991* in Scotland and in *Gillick v West Norfolk and Wisbech Area Health Authority* in the rest of the UK. There is no lower age limit for consent, although in Scotland

there is a presumption of capacity at age 12. A relational (and therefore developmental) approach to assessing children's capacity makes it a collaborative process of informing children about their treatment in child-friendly language, checking their understanding, answering their questions and upholding their decisions. A parent cannot overturn the wishes of a child who has capacity in Scotland. In the rest of the UK, parents must make a request through the courts.

A child who has capacity and has given his or her consent to treatment is entitled to confidentiality within certain limits based in the child's right to protection. This right to confidentiality is found in case law *(Axon v Secretary of State For Health (The Family Planning Association: intervening) [2006])* and in Article 16 of the UNCRC which says that children are entitled to privacy. Maintaining confidentiality and, when sharing information, requesting consent and discussing with the child what is being shared demonstrate respect for the child and can help to build trust.

Participation

Legal frameworks endorse a child's right to have a view when adults are making decisions that concern them, and for that view to be taken into account. This principle of participation is also articulated in Article 12 of the UNCRC: 'States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.' In practice, this means routinely consulting with children throughout your relationship with them, making sure that their wishes are understood and implemented in accordance with their capacity.

Child Protection

Children have a right to be protected. This is a universal, ethical, moral and legal right. In legal terms, the responsibilities that pertain to safeguarding and child protection can be found in the *Children (Scotland) Act 1995* and the *Children and Young People (Scotland) Act 2014* in Scotland and in the *Children Act 1989* and *Children Act 2004* in the rest of the UK. The principle of protection is found in Article 19 in the UNCRC and addressed in detail in child protection guidance at national and local levels.

When practitioners take action to protect children it should be done with care and compassion; informing them, consulting them, respecting their choices as far as possible, supporting them throughout the process and acknowledging the impact of any loss or change that results.

Data Protection

The *General Data Protection Regulation* (GDPR) entitles children to the same data protection rights as adults, with additional specific rights:

- Children of any age may share their personal data in order to access free online preventive or counselling services.
- Children must be provided with clear child-friendly information presented in plain, age-appropriate language about how you will process their data.
- You must explain to children why you require the personal data you have asked for, and what you will do with it - including when and how you will share it - in a way which they can understand.
- You must tell children what rights they have over their personal data in language they can understand.

In relational terms this might take the form of writing case notes together with a child or young person at the end of sessions, using session rating outcomes measures with them or keeping a shared treatment diary.

Equality

Discrimination and unfair treatment of children can go unnoticed simply because they do not know their rights or because having a protected characteristic means that they become used to habitual bullying and day-to-day discriminations, like lack of wheelchair access, for example. Under the *Equality Act 2010*, children have the same protections as adults in all categories except age discrimination. Children are only protected from age discrimination in employment or, if under age 18, when using, or trying to use, services.

Living with a protected characteristic - and the resulting sense of difference - can be especially difficult for children and young people, for whom fitting in with their peers is important. A relational approach to equality means not making assumptions about the impact of a protected characteristic and instead taking time to understand the meaning of it for the individual child, valuing the child as a whole person and asking the child how they would like you to work with them.

Codes of practice and ethical guidelines

The Royal College of Psychiatrists' *Good Psychiatric Practice: Code of Ethics* (2014)[100] sets out twelve principles for good professional practice. These principles do not distinguish between adults and children and are not limited by age except Principle 5 which addresses issues of capacity and consent. According to the *Code*, all patients shall have their essential humanity and dignity respected. They shall have their consent sought, their confidentiality maintained, and be enabled to make the best available choices about their treatment. The *Code* describes collaborative practice with patients, referring to ethical principles of beneficence, non-maleficence, justice and autonomy common to professional codes of practice across most of the helping professions. While recognising that children's autonomy and ability to self-determine can be limited by their age and circumstances, developmental practice endeavours to see the opportunities for growth in every encounter with them.

The law respects children's ability to make choices within the limits of their capacity, takes their views into account, protects them from harm, safeguards the information they share

with us and ensures that they are treated equally and fairly. Ethical frameworks for good practice articulate the values that we hold as practitioners and that we bring to our work with children and young people: among these are a commitment to treating them with care, respect and fairness, and supporting them to discover what they are capable of. Together, the law and ethics represent a powerful resource for developing protective factors in children such as self-worth, empathy and social competence.

It is perhaps too much to expect a child who has experienced little or nothing of these values and principles to suddenly, and miraculously, embrace them or to trust the person who offers them. It takes consistency, patience, trustworthiness, hope and even a degree of stubbornness to stick with the personhood of a child who has lived with pain and expresses it through behaviour: 'A good enough therapist [for children] has a dash of a caring grandmother combined with the forensic discipline of a scientist and the compassion of a spiritual leader, humbled to the healing powers of love and time'[98].

9. The impact of COVID-19

At the time of writing (early 2021), COVID-19 and the associated restrictions continue to affect the lives of young people in the UK and on the provision of healthcare for them and their families. The pandemic seems to have provoked creative approaches to providing care and unexpected opportunities but has also highlighted, exacerbated and, in some cases, been used to justify the reinforcement of existing inequalities.

CAMHS teams have largely moved to providing assessment and therapy online, which seems to have had both advantageous (widening access to some, enabling greater flexibility) and disadvantageous effects (narrowing access to others, limiting the provision of specialist assessments, providing a different and potentially less 'real' experience of relating, raising confidentiality and privacy issues), and Social Care and Youth Offending Services were able to monitor children less closely. School closures affected children differently, with some children increasingly exposed to harm at home, others retreating with anxiety, and many of those with social, communication and other neurodevelopmental needs no longer able to access specialist provisions.

Anecdotal evidence from clinicians and Youth Offending Teams suggested concerns about some of the most vulnerable young people disengaging, others waiting so long for treatment that they turned 18 before provision or transition to adult services could be arranged, and young people 'going missing' more than usual during the pandemic, potentially involved in county lines drug dealing and exploitation by criminal gangs. A joint report by organisations working with children affected by youth violence (RedThread, Street Doctors and MAC-UK[101]) on the impact of COVID-19 highlighted the loss of statutory support and rising feelings of depression, anxiety and isolation among the young people they interviewed.

For young people in custody, remand time lengthened as the courts shut, leaving some young people detained for extended periods. Attempts to promote early release in order to ease crowded conditions in custody resulted in few expedited releases. New entrants into

custody - those known to be at the greatest risk of suicide - were segregated for 10-14 days, in order to limit transmission. There was an immediate reduction in violence, mainly because boys were only unlocked in small 'household' groups, and were confined in their cells for much longer periods than usual. Family visits were stopped, then reinstated on a restricted basis (with no physical contact allowed) and video calls made available. HMIP 'scrutiny' inspections determined that the boys felt safer, but also raised concerns about their access to fresh air, education and services. For some, confinement paradoxically provided an opportunity for them to establish more trusting and consistent relationships with officers stationed on their units but, for others, boredom and loneliness were acute. With low staffing, restrictions on face to face work, the withdrawal of the Independent Monitoring Board and most agencies working within the YOIs (apart from NHS physical and mental health care), services available to the boys were comparatively limited, and the usual levels of safeguarding scrutiny reduced.

10. The impact of pain-based behaviour on practitioners and systems

Working with children expressing pain through their behaviour demands a great deal from practitioners, not least because the experience of facing pain-based behaviour can itself be traumatising and arouses individual and organisational defences that can then get in the way of doing the work of care and containment. This is well documented in the psychoanalytic literature on violence and systems[102, 103] and, frequently, tragically enacted in the scandals of abuse and neglect in care homes, psychiatric hospitals and secure settings that regularly surface in the media. In order to do this work safely and therapeutically, staff must be well-trained, closely supervised, given reflective spaces in which to process the impact of the work, and supported by systems of management - and, beyond this, political ideologies and cultural narratives - that understand, enable and value good work.

The central theme in this chapter is the value of understanding and working with children through a developmental, relational lens; paying attention to their social ecology and planning therapeutic work accordingly. Safeguarding - protecting and promoting the child's safety and that of those around them at all times - is central. Working at multiple levels means that multi-disciplinary teamwork, good information-sharing and liaison and joined-up work with other services and agencies is crucial. Staffing must be at a level to meet these needs, both in terms of the size and the diversity of therapeutic teams, and in the care and containment provided to practitioners in order for them to do this very challenging work with humanity and integrity. As Dockar-Drysdale[2] reminds us, 'We have to be careful that children find *us* when they reach out, and that they do not again find defences instead of people' (p. 62).

In settings where we are dealing with pain-based behaviour, good systems of containment are particularly important, as painful and violent dynamics will otherwise be played out between staff or parts of the wider system, or in relation to the children. The greater the frequency, severity and duration of uncontained states experienced by children, the more likely the disruption to practitioners' and organisations' capacity to think clearly and respond helpfully. In offering a containing space for staff working with young children with

severe disabilities, Mawson[103] noticed that 'workers would frequently feel depressed, despairing of being able to make a worthwhile difference in these children's lives… they would sometimes feel intensely persecuted by these feelings, even to the extent of experiencing at some level a measure of hostility towards the children themselves' (p. 67).

The Healthy Organisation Model[21, 89] offers a framework for thinking about how processes of containment can operate in teams. Stokoe suggests that healthy functioning depends on several factors; first, clarity about the primary task and the shared principles that underlie the task. These may be represented through a mission statement, an operational policy, and a team ethos that is mutually understood and agreed. Then, the organisation requires a decision-making system that delegates authority down through the hierarchy and welcomes and accepts the resultant anxieties up through the system as a source of valuable information. The provision of opportunities to discuss and work through these anxieties - in this case, through supervision, learning, reflective practice and other team meetings - and the organisational commitment to a position of curiosity and benign inquiry are essential to continuing healthy functioning as well as adaptation and the containment and transformation of the anxieties that naturally arise in the course of the work. In organisations in which these factors are not in place, or are endangered by the operation of external and internal pressures (e.g. painful experiences with children in their care, changes in institutional priorities, losses of funding, increases in workload), anxiety can become located in individuals and relationships causing a toxic, blame-focused culture, rather than understood as an inevitable and meaningful signifier of a systemic problem and worked through together.

11. Conclusion

Our intention in this chapter has been to set out key principles and good practice in assessment, formulation and treatment, inviting practitioners to consider violence in children from a relational perspective where behaviour is understood to be a pain-based response to situations, settings and systems. We want to encourage those who encounter pain-based behaviour to see these children in context and to respond to them from a position of humanity and empathy, while bringing all of the professional knowledge, experience and skills we have to contain them, to provide the right care for them (and for ourselves as we support them) and to walk alongside them as they take steps towards fulfilling their potential.

Abbreviations

NatSCEV – National Survey of Children's Exposure to Violence
CAMHS – Child and Adolescent Mental Health Services
F-CAMHS – Forensic Child and Adolescent Mental Health Services
NSPCC – National Society for the Prevention of Cruelty to Children
ADHD – Attention-Deficit/Hyperactivity Disorder
NICE – National Institute for Health and Care Excellence
RRN – Restraint Reduction Networks
NHS – National Health Service

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FAIV - Framework for Assessment and Intervention
PRU – Pupil Referral Network
MBT – Mentalisation-Based Therapy
CBT – Cognitive Behavioural Therapy
ART – Aggression Replacement Therapy
NVR – Non-Violent Resistance
MST – Multi-Systemic Therapy
MDFT – Multi-Dimensional Family Therapy
FFT – Functional Family Therapy
YOI – Young Offenders' Institution
STC – Secure Training Centre
ACR – Age of Criminal Responsibility
UNCRC – United Nations Convention on the Rights of the Child
HMIP – Her Majesty's Inspectorate of Prisons
GDPR - General Data Protection Regulation
MAC-UK – Music and Change – United Kingdom

References

(1) Anglin, JP. Creating "Well-Functioning" Residential Care and Defining Its Place in a System of Care. Child & Youth Care Forum. 2004; 33: 175–192. Available at https://doi.org/10.1023/B:CCAR.0000029689.70611.0f [Accessed 27.4.2022]

(2) Dockar-Drysdale, B. The Management of Violence. Residential Treatment For Children & Youth. 1998; 16 (3): 61-74.

(3) Rivara, FP. Understanding and preventing violence in children: Editorial. Archives of Pediatric Adolescent Medicine. August 2002: 156.

(4) Finkelhor, D, Turner, H, Ormerod, R, Hamby, S, Kracke, K. Children's Exposure to Violence: A Comprehensive National Survey. Juvenile Justice Bulletin. October 2009. Available at: https://www.ncjrs.gov/pdffiles1/ojjdp/227744.pdf [Accessed 27.4.2022]

(5) Office for National Statistics. Child abuse extent and nature, year ending March 2019, Crime Survey for England and Wales. 2020. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/childabuseextentandnatureenglandandwales/yearendingmarch2019 [Accessed 27.4.2022]

AAM

(6) National Institute of Clinical Excellence. Antisocial behaviour and conduct disorders in children and young people: recognition and management. Clinical guideline [CG158] Published: 27 March 2013 Last updated: 19 April 2017. Available at https://www.nice.org.uk/Guidance/CG158 [Accessed 27.4.2022]

(7) Lochman JE. Cognitive-behavioral intervention with aggressive boys: Three-year follow-up and preventive effects. Journal of Consulting & Clinical Psychology. 1992; 60: 426-432.

(8) Piquero, AR, Carriaga, ML, Diamond, B, Kazemian, L, Farrington, DP. Stability in aggression revisited. Aggression and Violent Behavior. 1992; 17(4): 365–72.

(9) Youth Justice Board/Ministry of Justice. Youth justice statistics 2018/19: England and Wales. London: Ministry of Justice, 2020. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/862078/youth-justice-statistics-bulletin-march-2019.pdf [Accessed 27.4.2022]

(10) Johnstone, L, Gregory, L. Youth Violence Risk Assessment: A Framework. In Rogers, A., Harvey, J. & Law, H. (Eds.) Young People in Forensic Mental Health Settings: Psychological Thinking and Practice. Basingstoke: Palgrave Macmillan; 2015.

(11) NICE. Violence and Aggression: Short-term management in mental health, health and community settings, updated edition, NICE Guideline NG10. 2015. Available at: https://www.nice.org.uk/guidance/ng10 [Accessed 27.4.2022]

(12) Restraint Reduction Network [online]. Available at: https://restraintreductionnetwork.org/ [Accessed 27.4.21]

(13) Goodman R. Psychometric properties of the strengths and difficulties questionnaire. J Am Acad Child Adolesc Psychiatry. 2001 Nov; 40(11): 1337-45.

(14) Achenbach, T. Manual for the Child Behavioral Checklist/4–18 and 1991 profile. Burlington, VT: University of Vermont Press; 1991.

(15) Spielberger, CD. State-Trait Anger Expression Inventory. Orlando, FL: Psychological Assessment Resources; 1988.

AAM

(16) Beck, AT, Beck, JS, Jolly, J, Steer, R. Beck Youth Inventories – Second Edition For Children and Adolescents (BYI-II). Pearson; 2005.

(17) Barzman DH, Brackenbury L, Sonnier L, Schnell B, Cassedy A, Salisbury S, et al. Brief Rating of Aggression by Children and Adolescents (BRACHA): Development of a tool for assessing risk of inpatients' aggressive behavior. Journal of the American Academy of Psychiatry and the Law Online. 2011; 39: 170-79.

(18) Bartel, P, Bourm, R, Fourth, A. Structured assessment for violence risk in youth (SAVRY). Consultation edn. Tampa: University of South Florida; 2000.

(19) De Vries-Robbe, M, Geers, M, Stapel, M, Hilterman, E, de Vogel, V. SAPROF – Youth Version manual. 2014.

(20) Sukhodolsky, DG, Cardona L, Martin A. Characterizing aggressive and noncompliant behaviors in a children's psychiatric inpatient setting. Child Psychiatry and Human Development. 2005; 36: 177-93.

(21) Stokoe, P. The Curiosity Drive. Phoenix: London; 2020.

(22) Duke, NN, Pettingell, SL, McMorris, BJ, Borowsky, IW. Adolescent violence perpetration: Associations with multiple types of adverse childhood experiences. Pediatrics. 2010; 125(4), e778–e786.

(23) Blake CS, Hamrin V. Current approaches to the assessment and management of anger and aggression in youth: a review. J Child Adolesc Psychiatr Nurs. 2007; Nov; 20(4): 209-21.

(24) Crick, NR, Dodge, KA. A review and reformulation of social information processing mechanisms in children's social adjustment. Psychological Bulletin. 1994; 115: 74-101.

(25) Espejo-Siles, R, Zych, I, Farrington, DP, Llorent, VJ. Moral disengagement, victimization, empathy, social and emotional competencies as predictors of violence in children and adolescents. Children and Youth Services Review. 2020; 118, 105337.

AAM

(26) Broidy, L, Cauffman, E, Espelage, DL, Mazerolle, P, Piquero, A. Sex differences in empathy and its relation to juvenile offending. Violence and Victims. 2003; 18(5): 503–516.

(27) Contreras, L, Cano, MC. Social competence and child-to-parent violence: Analyzing the role of emotional intelligence, social attitudes, and personal values. Deviant Behavior. 2016; 37(2): 115–125.

(28) Lösel, F, Farington, D. Direct Protective and Buffering Protective Factors in the Development of Youth Violence. American Journal of Preventive Medicine 2012; 43 (2; 1).

(29) Bronfenbrenner, U. The ecology of human development. Cambridge, MA: Harvard University Press; 1979.

(30) Gharabaghi, K, Stuart, C. Life-space intervention: Implications for caregiving. Scottish Journal of Residential Child Care. 2013; 12(3): 11-19.

(31) Bronfenbrenner, U. Making human beings human: Bioecological perspectives on human development. Thousand Oaks, CA: Sage; 2005.

(32) Morgan, W. Violence among Young People: A Framework for Assessment and Intervention. In: Rogers A., Harvey J., Law H. (eds) Young People in Forensic Mental Health Settings. London: Palgrave Macmillan; 2015.

(33) Dudley, R, Kuyken, W. Case formulation in cognitive behavioural therapy: A principle-driven approach. In Johnstone, L and Dallos, R. (Eds.) Formulation in Psychology and Psychotherapy: Making sense of people's problems, 2nd ed. Hove: Routledge; 2014: 18-44.

(34) Johnstone, L, Boyle, M, with Cromby, J, Dillon, J, Harper, D, Kinderman, P, Longden, E, Pilgrim, D, Read, J. The Power Threat Meaning Framework: Overview. Leicester: British Psychological Society; 2018.

(35) Bion, WR. Learning from Experience. London: Karnac; 1962.

(36) Ainsworth, MDS, Bowlby, J. An ethological approach to personality development. American Psychologist 1991; 46: 331-341.

AAM

(37) Bowlby, J. Attachment and Loss, Volume 1: Attachment. New York: Basic Books; 1969.

(38) Winnicott, DW. The Maturation Process and the Facilitating Environment. London: Hogarth Press; 1965.

(39) Hanna, FJ, Hanna, CA, Keys, SG. Fifty Strategies for Counseling Defiant, Aggressive Adolescents: Reaching, Accepting, and Relating. Journal of Counseling & Development 1999; 7: 395-404.

(40) Vygotsky, LS. Mind in society: The development of higher psychological processes. Cambridge, Mass.: Harvard University Press; 1978.

(41) Cochran, JL, Fauth, DJ, Cochran, NH, Spurgeon, SL, Marinn Pierce, L. Person-Centered and Experiential Psychotherapies. 2010; 9(4): 290-301.

(42) White, M. The externalizing of the problem and the re-authoring of lives and relationships. In M. White (Ed.), Selected Papers (pp. 5-28). Adelaide, Australia: Dulwich Centre Publications; 1988/9.

(43) Hagell, A, Lamb, S. Developing an integrated primary health care and youth work service for young people in Lambeth: learning from the Well Centre. Journal of Children's Services. 2016; 11(3): 233-243.

(44) Borgwald, K, Theixos, H. Bullying the bully: Why zero-tolerance policies get a failing grade. Social Influence. 2013; 8 (2-3): 149-160.

(45) Perera, J. How Black Working-Class Youth are Criminalised and Excluded from the English School System: A London Case Study. Institute of Race Relations. 2020.

(46) Sundius, J, Farneth, M. Putting kids out of school: what's causing high suspension rates and why they are detrimental to students, schools and communities. Open Society Institute – Baltimore. 2008. Retrieved 10 October 2020 Available https://www.opensocietyfoundations.org/publications/putting-kids-out-school-whats-causing-high-suspension-rates-and-why-they-are-detrimental [Accessed 27.4.2022]

AAM

(47) Fisher, H, Gardner, F, Montgomery, P. Cognitive-behavioural interventions for preventing youth gang involvement for children and young people (7-16). Cochrane Database of Systematic Reviews. 2008.

(48) Esbensen, F-A, Osgood, DW. Gang Resistance Education and Training (Great): Results from the National Evaluation. Journal of Research in Crime and Delinquency, 1999; 36 (2): 194–225.

(49) Cook, A, Williams, S. Enabling Environments Quality Improvement Process. 2019. Available at https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/enabling-environments-ee/the-enabling-environments-process-document-2019.pdf?sfvrsn=10b4616c_2 [Accessed 27.4.2022]

(50) Scott, S. National dissemination of effective parenting programmes to improve child outcomes. British Journal of Psychiatry 2010; 51(12): 1331-1341.

(51) Furlong, M, McGilloway, S, Bywater, T, Hutchings, J, Smith, SM, Donelly, M. Behavioural and cognitive-behavioural group-based parenting programmes for early-onset conduct problems in children aged 3 to 12 years. Cochrane Database of Systematic Reviews. 2012. Available at: https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD008225.pub2/full [Accessed 27.4.2022]

(52) Drugli, MB, Fossum, S, Larsson, B, Morch, W-T. Characteristics of young children with persistent conduct problems 1 year after treatment with the Incredible Years program. European Child and Adolescent Psychiatry 2010; 19(7): 559-65.

(53) Sanders, MR. The triple P-positive parenting program as a public health approach to strengthening parenting'. Journal of Family Psychology. 2008; 22(4): 506-17.

(54) Scott, S, Spender, Q, Doolan, M, Jacobs, B, Aspland, H. Multicentre controlled trial of parenting groups for childhood antisocial behaviour in clinical practice. British Medical Journal. 2001; 323: 194–7.

(55) Byrne, G, Sleed, M, Midgley, N, Fearon, P, Mein, C, Bateman, A, Fonagy, P. Lighthouse Parenting Programme: Description and pilot evaluation of mentalization-based treatment to address child maltreatment. Clinical Child Psychology and Psychiatry 2019; 24(4): 680-693.

AAM

(56) Sukholdolsky, DG, Scahill, L. Cognitive behavioural therapy for anger and aggression in children. Guildford: New York; 2012.

(57) Thompson, M, Gauntlett-Gilbert, J. Mindfulness with Children and Adolescents: Effective Clinical Application. Clinical Child Psychology and Psychiatry. 2008; 13(3): 395-407.

(58) Lee, J, Semple, RJ, Rosa, D, Miller, L. Mindfulness-Based Cognitive Therapy for Children: a pilot study. Journal of Cognitive Psychotherapy. 2008; 22(1): 15-28.

(59) Sukhodolsky, DG, Kassinove, H, Gorman, BS. Cognitive-behavioural therapy for anger in children and adolescents: a meta-analysis. Aggressive and Violent Behaviour. 2004; 9: 247-269.

(60) Candelaria, AM, Fedewa, AL, Ahn, S. The effects of anger management on children’s social and emotional outcomes: A meta-analysis. School Psychology International. 2012; 33(6): 596-614.

(61) Ho, BPV, Carter, M, Stephenson, J. Anger Management Using a Cognitive-Behavioural Approach for Children with Special Education Needs: A literature review and meta-analysis. International Journal of Disability, Development and Education 2010; 57(3): 245-265.

(62) Lochman, JE, Wells, KC. The Coping Power Program for Preadolescent Aggressive Boys and Their Parents: Outcome Effects at the 1-Year Follow-Up. Journal of Consulting and Clinical Psychology 2004; 72(4)P: 571-578.

(63) Goldstein, AP, Glick, B. Aggression replacement training: Curriculum and Evaluation. Simulation & Gaming. 2004; 25(1): 9-26.

(64) Martin, DG. Clinical Practice with Adolescents. Pacific Grove, CA: Brooks/Cole. 2003.

(65) Horvath, AO, Del Re, AC, Flückiger, C, Symonds, D. Alliance in individual psychotherapy. Psychotherapy. 2011; 48(1), 9–16.

(66) Ingley-Cook, G, Dobel-Ober, D. Innovations in Practice: group work with children who are in care or who are adopted: lessons learnt. Child and Adolescent Mental Health. 2013; 18(4): 251-254.

(67) Ncube, N. Tree of Life Practitioners Guide. Johannesburg: Phola. 2017.

(68) Riley, A. Exploring the effects of the 'Seasons for Growth' intervention for pupils experiencing change and loss. Education and Child Psychology. 2012; 29(3): 33-53.

(69) Squire, B, Jefford, T, Swenson, CC. Whole Systems Approaches. In Rogers, A, Harvey, J, Law, H. (Eds.): Young People in Forensic Mental Health Settings: Psychological Thinking and Practice. Basingstoke: Palgrave Macmillan. 2015.

(70) Alexander, JF, Parsons, BV. Functional Family Therapy: Principles and Procedures. Carmel, CA: Brooks/Cole. 1982.

(71) Sexton, T, Turner, CW. The effectiveness of functional family therapy for youth with behavioral problems in a community practice setting. Journal of Family Psychology. 2010; 24(3), 339-348.

(72) Omer, H. (2004) Non-violent Resistance. Cambridge: Cambridge University Press.

(73) Ollefs, B, Von Schlippe, A, Omer, H, Kriz, J. Adolescents showing externalising problem behaviour. Effects of parent coaching (German). Familiendynamik. 2009; 3: 256-265.

(74) Newman, M., Fagan, C. & Webb, R. (2014) Innovations in practice: The efficacy of nonviolent resistance groups in treating aggressive and controlling children and young people: A preliminary analysis of pilot NVR groups in Kent. Child and Adolescent Mental Health 19 (2), 138–141.

(75) Henggeler, SW, Schoenwald, SK, Borduin, CM, Rowland, MD, Cunningham, PB. Multisystemic Therapy for Antisocial Behaviour in Children and Adolescents. London: Guilford Press. 2009.

AAM

(76) Schaeffer, CM, Borduin CM. Long-term follow up to a randomized clinical trial of multisystemic therapy with serious and violent juvenile offenders. Journal of Consulting and Clinical Psychology. 2005; 73(3): 445-453.

(77) Lammy, D. The Lammy Review: An independent review into the treatment of, and outcomes for, Black, Asian and Minority Ethnic individuals in the Criminal Justice System. HMG, Government of the United Kingdom. 2017.

(78) Ministry of Justice. (2020). Youth Justice Statistics. Available at: www.gov.uk/government/statistics/youth-justice-statistics-2019-to-2020 [Accessed 27.4.2022].

(79) Crewe, B, Hulley, S, Wright, S. Life Imprisonment from Young Adulthood: Adaptation, Identity and Time. Palgrave Macmillan: London. 2020.

(80) Houses of Parliament: Parliamentary Office of Science and Technology (2018). Age of Criminal Responsibility. Postnote, 577, June 2018.

(81) Steinberg L, Icenogle G, Shulman EP, et al. Around the world, adolescence is a time of heightened sensation seeking and immature self-regulation. Developmental Science. 2018, Mar; 21(2).

(82) Farrington, DP. Age and Crime. In Tonry, M, Morris, N. (Eds.) Crime and Justice: An Annual Review of Research, Vol. 7, p.189-250. Chicago: University of Chicago Press. 1986.

(83) Rey, H. Universals of psychoanalysis in the treatment of psychotic and borderline states. London: Free Association Books. 1994.

(84) Howard League for Penal Reform. The Carlile Inquiry 10 years on: The use of restraint, solitary confinement and strip-searching on children. 2016. Available at: https://howardleague.org/wp-content/uploads/2016/06/Carlile-Inquiry-10-years-on.pdf [Accessed 27.4.2022]

(85) Ministry of Justice. Review of the Youth Justice System in England and Wales. 2016. Available at

AAM

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

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/577105/youth-justice-review-final-report-print.pdf [Accessed 27.4.2022]

(86) Sadie, C, Stokoe, P. Creating therapeutic environments in youth custody: the SECURE STAIRS programme. Monitor. 2020 (March): 20-23.

(87) Taylor, J, Shostak, L, Rogers, A & Mitchell, P. Rethinking mental health provision in the secure estate for children and young people: a framework for integrated care (SECURE STAIRS). Safer Communities 2018; 17(4): 193-201.

(88) Bloom, SL. The sanctuary model of organizational change for children's residential treatment. Therapeutic Community: The International Journal for Therapeutic and Supportive Organizations. 2005; 26(1): 65-81.

(89) Stokoe, P. The healthy and the unhealthy organization: How can we help teams to remain effective? In Rubitel, A, Reiss, D. (Eds.) Containment in the community: Supportive frameworks for thinking about antisocial behaviour and mental health, 237-259. The Portman Papers, Karnac: London. 2011.

(90) Shnabel, N, Nadler, A. A needs-based model of reconciliation: Satisfying the differential emotional needs of victim and perpetrator as a key to promoting reconciliation. Journal of Personality and Social Psychology. 2008; 94(1): 116-132.

(91) NICE 2019 surveillance of violence and aggression: short-term management in mental health, health and community settings (NICE guideline NG10) Surveillance report. Available at: https://www.nice.org.uk/guidance/ng10/resources/2019-surveillance-of-violence-and-aggression-shortterm-management-in-mental-health-health-and-community-settings-nice-guideline-ng10-pdf-9097015205365 [Accessed 27.4.2022]

(92) Nunno, MA, Day, D, Bullard, L. For Our Own Safety: Examining the Safety of High-Risk Interventions for Children and Young People. Child Welfare League of America. 2007.

(93) Nunno MA, Holden MJ, Tollar A. Learning from tragedy: a survey of child and adolescent restraint fatalities. Child Abuse and Neglect. 2006 (Dec); 30(12):1333-42.

(94) National Childrens bureau making a difference. Report on the Use of Physical Intervention across Children's Services. London: NCB. 2004. Available at https://www.ncb.org.uk/sites/default/files/uploads/files/physical_intervention_across_childrens_services.pdf [Accessed 27.4.2022]

(95) UN Committee on the Rights of the Child (CRC), General comment No. 20 (2016) on the implementation of the rights of the child during adolescence, 6 December 2016, CRC/C/GC/20. Available from: https://www.refworld.org/docid/589dad3d4.html [Accessed 27.4.2022]

(96) Steckley, L. Containment and holding environments: Understanding and reducing physical restraint in residential child care. Children and Youth Services Review. 2010; 32(1): 120-128.

(97) Steckley, L. Catharsis, containment and physical restraint in residential child care. British Journal of Social Work. 2018; 48(6): 1645-1663.

(98) Batmanghelidjh, C. (2004). Therapy: a pretension too far? Counselling in Education Journal, Summer 2004.

(99) University College London. Psychological Interventions in Child and Adolescent Mental Health Services. Welcome to the competence framework for child and adolescent mental health services. Available at https://www.ucl.ac.uk/pals/research/clinical-educational-and-health-psychology/research-groups/core/competence-frameworks-11 [Accessed 27.4.2022]

(100) Royal College of Psychiatrists. Good Psychiatric Practice: Code of Ethics. 2014. Available at: https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr186.pdf?sfvrsn=15f49e84_2 [Accessed 27.4.2022]

(101) Russell, L, Poyton, J, Lake, J, Rennalls, S. Living Through a Lockdown. 2020. Available at: https://www.redthread.org.uk/living-through-a-lockdown/ [Accessed 27.4.2022]

(102) Adshead, G. Mirror Mirror: Parallel Processes in Forensic Institutions. In Adlam, J. Aiyegbusi, A, Kleinot, P, Motz, A, Scanlon, C. (Eds.) The Therapeutic Milieu Under Fire: Security and Insecurity in Forensic Mental Health. Jessica Kingsley: London; 2012.

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

(103) Mawson, C. Containing anxiety in work with damaged children. In Roberts, V. & Obholzer, A. (Eds.) The Unconscious at Work. Routledge, Oxon: 1994.

Webster-Stratton, C. & Taylor, T. (2001). Nipping Early Risk Factors in the Bud: Preventing Substance Abuse, Delinquency and Violence in Adolescence Through Interventions Targeted at Young Children (0-8 Years). *Prevention Science* 2, 165-92.

Children's Charter:
https://www.webarchive.org.uk/wayback/archive/20150220023530/http://www.gov.scot/Publications/2004/04/19082/34411a

AAM