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Short Article

Words into action: Bridging the gap between theory and practice when supporting young people in secure care

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Abstract:

The authors elucidate Johnstone's ABC Formulation Framework and 6D model for understanding and intervening with young people who display distressed behaviour. This approach equips care professionals with a theoretically informed method of identifying unmet needs that drive harmful behaviours. By simplifying complex psychological theories, the approach empowers practitioners to apply best practices effectively. The authors describe the implementation of this framework in the secure care context at Rossie Young People's Trust, providing a clear account of its transformative impact on both staff and young people.

Introduction

Children in secure care are some of the most vulnerable and at-risk in society, as characterised by their complex, diverse, and challenging needs. Childhood is universally acknowledged as a formative phase, where both positive and negative experiences profoundly influence an individual's future development and achievements. Consequently, exposure to adverse childhood experiences (ACEs), which include traumatic or stressful experiences, increases susceptibility to a myriad of poor outcomes (Asmundson & Afifi, 2019). Young people in secure care are disproportionally exposed to ACEs and, notwithstanding the associated distress these cause at the time, in the long-term it has been shown that exposure to four or more ACEs is predictive of poor outcomes such as substance misuse, cognitive, physical, and mental health difficulties, self-harm, suicide, victimisation, offending, violence, and incarceration (Carnie et al., 2017; Cleare et al., 2018; Felitti et al., 1998; Fox et al., 2015; Hughes et al., 2017; Loudermilk et al., 2018; Marryat & Frank, 2018; Paranjothy et al., 2018; Smith, 2018; Webster, 2022).

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Following Kilbrandon, Scotland's distinctive approach to managing young people who pose a risk of harm to themselves and/or others responds by recognising 'need not deed' and views them as inherently vulnerable. Whilst these children are vastly heterogeneous, many, if not most, will have histories of trauma. However, the complexities surrounding the young people placed in secure care are incredibly diverse, such that a multi-theoretical, multi-dimensional approach is required to ensure appropriate responses. Consequently, a one-size-fits-all approach has little to offer. Whilst trauma theory is core and central, it is important to note that development is impacted by relational, behavioural, cognitive, systemic, and mental health variables. It is only by embracing and responding to the child as a whole that we can progress in supporting vulnerable young people in secure care, providing them with genuine opportunities for hope, recovery, rehabilitation, growth, and ultimately their best possible futures.

Working with this reality, Johnstone (2020) devised an approach to assessing and understanding vulnerable young people that seeks to embrace and work with complexity. By integrating the main developmental theories impacting on children, it is possible to achieve a deep exploration of a child's life history, attachment style, behavioural characteristics, cognitive capacities, trauma experiences, emotional triggers, and coping mechanisms. The purpose of the approach is to achieve an understanding of the intricate interplay of factors, so that the practitioners and young people themselves achieve an understanding of the child that illuminates the roots of their distress and ensures responses are sensitive and targeted to promote change.

What is the ABC Framework?

The ABC Framework (Johnstone, 2020) sets out an approach to achieving a formulation for vulnerable and high-risk youth. Formulation is a nuanced and comprehensive approach to providing working hypotheses for why a person presents with their difficulties at that time (Weerasekera, 1996). In this context, it draws on biopsychosocial theories to describe factors which predispose, precipitate, and perpetuate problems for the individual being considered. It also requires an evaluation of strengths, which are then maximised to develop a personalised treatment pathway that links theory to practice (Butler, 1998). A formulation-led approach moves beyond surface-level symptom management whilst placing the child's experiences and perspectives at the forefront, acknowledging that their past has profoundly shaped their present.

The ABC Framework requires a comprehensive multi-modal and multi-informant assessment spanning a series of steps where key information is gathered and analysed according to the main theories of child development and risk. The framework considers: attachment theory, behavioural theory, cognitive skills, developmental trauma, emotions and mental health, family and systemic factors, and gender-specific needs. The ABC Framework also integrates a structured professional judgement risk assessment protocol, Short Term

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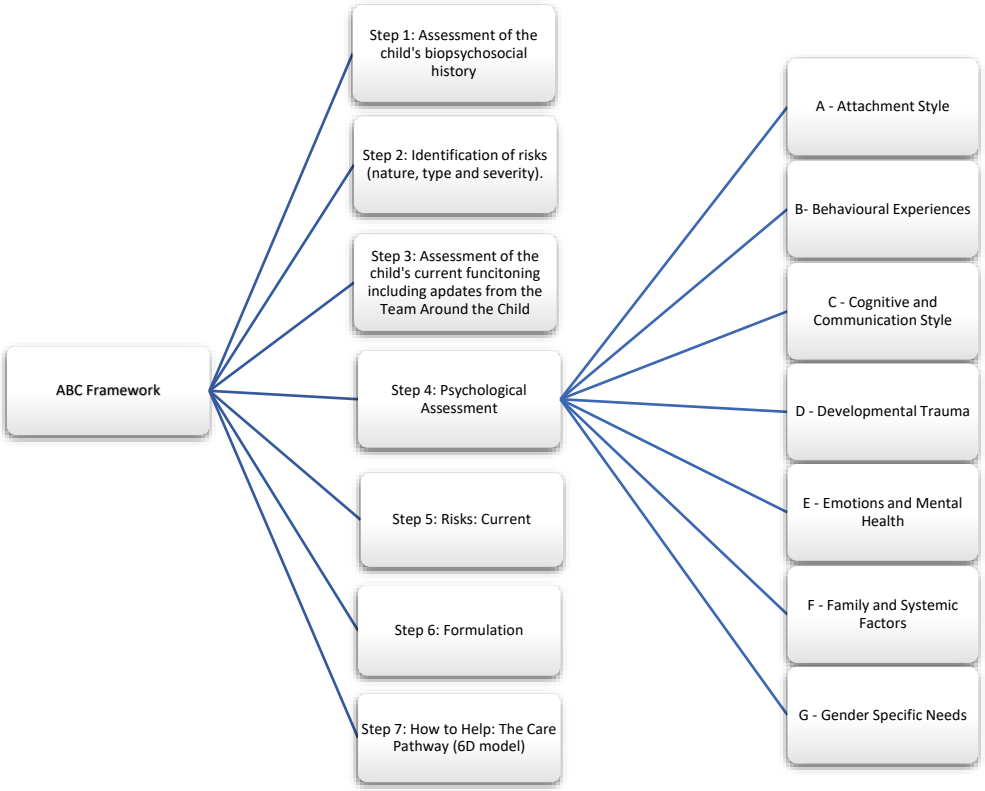
Assessment of Risk and Treatability: Adolescent Version, (Nicholls et al., 2010) which ensures the systematic evaluation of diverse risk outcomes (e.g., risk of self-harm, suicide, absconding, substance use, offending, victimisation, exploitation, violence) whilst also elucidating vulnerabilities and strengths that may be present for the young person being considered. The ABC Framework creates a holistic understanding of the young person and supports the identification and development of evidence-based interventions designed to enhance care and risk management, and aligns with and endorses the principles underpinning GIRFEC (Getting It Right for Every Child) (Scottish Government, 2022) and the SECURE STAIRS framework (Atkinson et al., 2023).

Figure 1: The ABC Framework



Moving on from the formulation, the ABC Framework provides the foundation and roadmap for further interventions that are delivered by psychological practitioners. This includes a range of strategies that care staff can implement to respond to distress behaviours, so that the milieu is therapeutic, whilst also identifying key targets for individual work including low, moderate and highly specialised psychological therapies. This typically adheres to a stepped care model (Mughal et al., 2023), systematically incorporating explicit aims, objectives, and exit points so that progress towards less restrictive care alternatives, such as community-based support services remains a priority.

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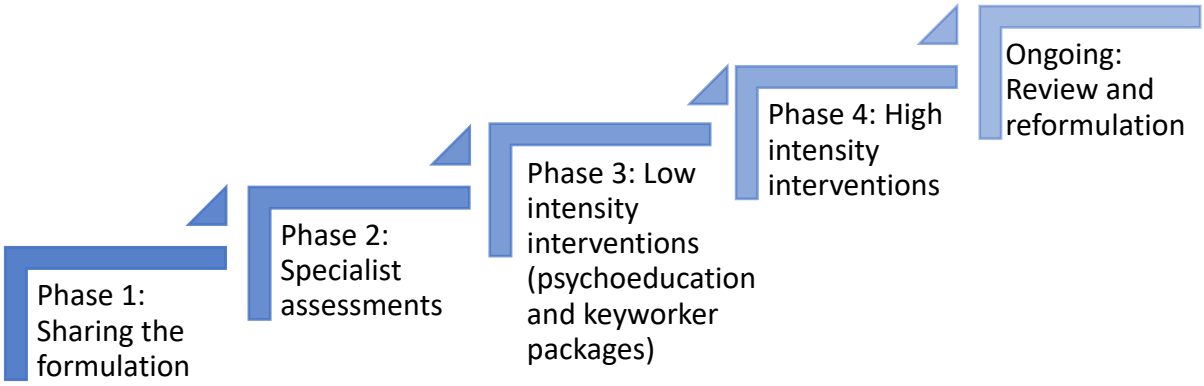
A typical pathway is structured as follows:



There is a voluminous literature describing the types of psychological therapies that are appropriate for vulnerable young people (Batien et al., 2020; Epstein et al., 2015; Kramer & Landolt, 2011;Pilling et al., 2020; Skowron & Reinemann, 2005), and for the sake of brevity, these are not detailed in this paper. Rather, the focus is on how formulation and psychological theories can be used by care staff to respond to distressed behaviour and how they can be supported to work in accordance with individualised formulations and care needs, as discussed below.

What is the 6D model?

The 6D model builds on PACE (playful, accepting, curious, and empathetic) (Hughes & Golding, 2012) but expands on the understanding by providing a structured framework for discerning the distinct 'states of mind' a young person may experience leading up to and during moments of distressed behaviours. Furthermore, it identifies evidence-based strategies for providing effective support in these challenging circumstances. Drawing from a mosaic of complex psychological theories and therapeutic approaches, the 6D model encapsulates the holistic spectrum of how children grow, develop, think, feel, and act. Understanding the underlying causes of a young person's behaviour is not always straightforward. Thus, the 6D model provides a diverse range of strategies to guide how staff should respond to a young person in crisis as it assists staff in pinpointing the specific factors driving a young person's behaviour and their current state of mind. This knowledge empowers them to respond in ways that are most likely to have a positive impact, especially when their own tolerance is challenged by the circumstances around them.

The states of mind within the 6D model are tied to the various triggers associated with a young person's attachment style, behavioural patterns, cognitive development and communication style, developmental trauma history, emotions, and mental health needs. Figure 2 provides a visual representation of how these states of mind correspond to pertinent psychological theories.

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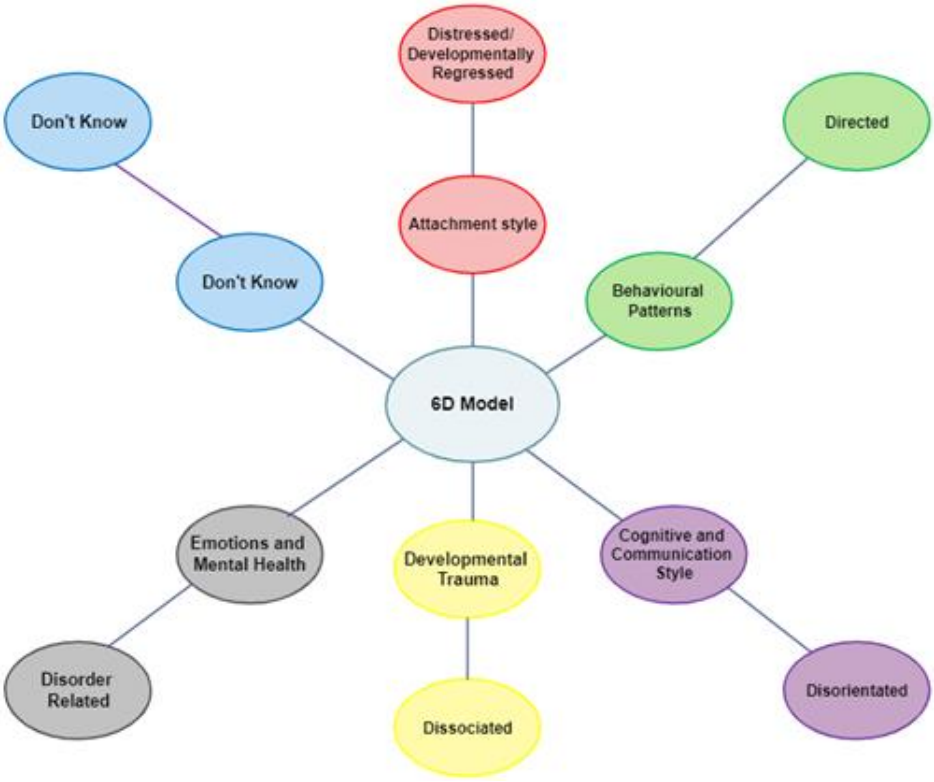
Figure 2: 6D model diagram



These '6D' states of mind (Developmentally Regressed; Directed or Deliberate; Disorientated; Dissociated; Disorder or Diagnosis Related; and Don't Know) serve as a simple heuristic to aid staff in identifying the underlying and unexpressed needs communicated by the young person. By mapping these theoretical concepts onto practical manifestations, the 6D model provides valuable insights into the intersections of human experience, particularly during moments of distress. For example, attachment theory suggests that attachment patterns significantly shape how someone will perceive and interact within relationships (Bowlby, 1969). In the context of the 6D model, behaviours triggered by attachment would manifest as a developmentally regressed state of mind, and a range of attachment-based interventions are suggested. Conversely, behavioural states will result in a directed state of mind, reflecting efforts to achieve desired outcomes or mitigate perceived threats (Bandura & Walters, 1977; Pavlov, 1927; Skinner, 1971). When distressed behaviours appear to reflect maladaptive learning, behavioural principles are applied. When a young person's cognitive limitations are leaving them disorientated and unable to understand and navigate their environment (Leve, 2022), staff are required to reduce demand and simplify the environment. Additionally, experiences of developmental trauma may result in the young person being in a dissociated state of mind, leading to feelings of disconnect from their direct environment and experiences (Gregorowski & Seedat, 2013) and the child will be offered a range of interventions to enable them to achieve a sense of safety. If a young person's distress behaviour is a result of neurodevelopmental disorder or mental health difficulties, they can be understood as being in a disorder or diagnosis

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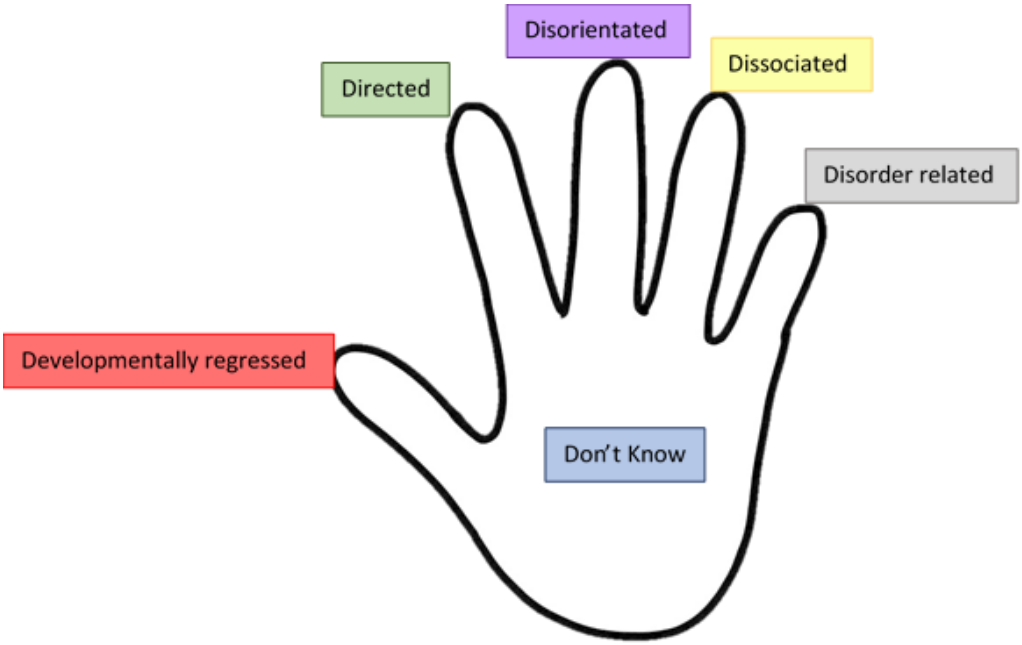
related state of mind and specific recommendations are provided to respond to their unique symptoms. Finally, the sixth 'D' is simply labelled 'Don't Know' and recognises that there may be times when it is unclear, and practitioners need to know how to avoid negative responses.

In recognition that distressed behaviours in children can raise anxiety in staff, the 6D approach has been made practical and accessible. Staff are encouraged to remain grounded and pragmatic by using their hand (see figure 3) to guide them through the potential states of mind to select the most appropriate response.

Figure 3: 6D model in practice



When staff use their fingers while attempting to identify the driver for behaviour, they are utilising their senses to ground themselves. This, in turn, enables staff to make use of the neurosequential model (Perry, 2019) whilst responding to distressed behaviours that create risk by effectively regulating, relating to, and reasoning with the young person whilst nurturing a trusting relationship and creating a sense of safety and security.

How has the 6D model been embedded into practice at Rossie?

Rossie Young People's Trust caters for young people who are looked after and require intensive supports and/or secure care. In the dynamic field of child-centred care, the practice of introducing theory to staff at Rossie through regular training sessions has become a foundational pillar. As part of ongoing service development, the ABC Framework and 6D model have been introduced through a series of implementation phases.

Firstly, training sessions were offered to care staff during which staff gained a deeper understanding of critical areas such as child development, psychological approaches and models, trauma-informed care principles, and formulation

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before addressing the 6D model training sessions. The aim of these sessions was to provide staff with an understanding of the approach so they could then translate the ABC and 6D approach into actionable strategies that are attuned and responsive to the lived experiences and unique needs of the young people they are caring for. Thereafter, this framework is used to provide a common language which is used in the multidisciplinary (MDT) context to achieve a shared understanding.

Thus, the second key process of implementation involves MDT discussions. MDT discussions provide a critical forum for information sharing and collaboration when it comes to formulating plans for the young people at Rossie. These discussions foster an environment where professionals from diverse fields—care, education, social work, health, and specialist intervention services—converge, each contributing their unique expertise and insights. Through these dialogues, the multidisciplinary team shares observations, assessments, and the wealth of knowledge amassed from their interactions with the young person. These collective insights, founded on both theoretical understanding and practical experience, weave together to form a holistic and nuanced perspective on the young person's needs, triggers, and priorities for intervention. The young person’s voice is central to this process and all young people are encouraged to contribute to their formulation document and 6D plan. They are encouraged to identify strategies that they know are helpful for staff supporting them through different experiences and challenges. This is critical for ensuring collaboration and a shared sense of responsibility and commitment to the well-being of the young person.

As the formulation evolves, the 6D care plan emerges and the young person receives a consistent and individualised approach to care, ensuring their unique profile of need is understood and met as they progress through their care journey. This collaborative and adaptable approach promotes therapeutic consistency and a sense of security and predictability for the children, as well as a sense of confidence in the staff.

Ongoing support is also critical. Once each young person has their formulation and 6D care plan, staff can access interventions workers (mental health, social work, and psychology) from the Specialist Intervention Service (SIS). The SIS provides an essential resource through the implementation of drop-in sessions, creating a space where staff can reflect, clarify, and seek assistance and guidance, when facing difficult situations. These are typically delivered as drop-in sessions and are therefore easily and timeously accessed. This collaborative approach reinforces the practitioners’ confidence and competence but also promotes a culture of continuous reciprocal learning and improvement, ultimately benefiting the well-being and development of the young people.

Impact on care at Rossie?

Following the delivery of ‘6D’ workshop sessions, staff were asked to provide feedback on both their understanding of the framework and their confidence to deliver the strategies encapsulated within it. Overall, staff reported a marked improvement in their ability to apply the strategies outlined in the 6D model.

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Moreover, they also expressed a new-found confidence in discerning the underlying motivations driving a young person's behaviour and in understanding the rationale behind their chosen intervention strategy.

Likewise, young people conveyed a sense of being better understood by staff and perceived them as more equipped to assist them during times of distress. This is supported by consistent feedback gathered through post-incident reflection discussions, six-weekly wellbeing indicators, and weekly therapeutic discussions with young people.

The impact on the care provided to young people at Rossie was reflected in the commendable Care Inspectorate (CI) results, with Rossie achieving impressive scores of five and six during the 2023 inspection (Care Inspectorate, 2024). The CI highlighted that staff felt supported and empowered to learn about the young people's complex needs through clearly written formulations, staff training days, individualised supports, and ongoing assistance from the SIS.

Conclusion

In conclusion, the integration of the ABC Framework and 6D model has demonstrated significant positive outcomes for both staff and young people at Rossie. By providing a structured framework and an easily accessible heuristic to support the delivery of evidence-based strategies, staff have reported increased confidence and competency in delivering therapeutic interventions tailored to the complex needs of each young person in their care.

Moreover, young people themselves have expressed feeling better understood and supported by staff, indicating a positive impact on their overall well-being. A sentiment that is reinforced by independent evaluations.

Moving forward, the successful implementation of the ABC Framework and 6D model sets a promising precedent for the ongoing enhancement of trauma and psychologically informed practices within residential and secure childcare settings. By prioritising the voices and needs of young people, and by equipping staff with the necessary tools and support, Rossie is poised to continue fostering an environment where healing, growth, and resilience flourish.

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