Mental Health Difficulties in the Youth Justice Population:

Learning from the first six months of the IVY project

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Abstract

This paper considers a marginalised group in our society – young people with severe psychological and mental health difficulties who present a risk of serious harm to others. Their needs will be examined along with what we can do to support them. Gaps in social work and health services will be highlighted and ways to address these issues discussed.

Introduction

Youth violence and offending is a significant social and public concern. According to the World Health Organisation (WHO, 2011): "Youth violence greatly increases the costs of health, welfare and criminal justice services; reduces productivity; decreases the value of property; and generally undermines the fabric of society." As such, effective interventions across the public sector are needed to prevent and remediate against youth violence. This paper is particularly interested in the role that mental health and the associated services play in youth justice.

There is a paucity of research pertaining to the psychological and mental health needs of young people in Scotland who are involved in serious offending behaviour that manifests as risk of harm to others. Nevertheless, the severity and complexity of this population's needs is well established, via epidemiological research, from a variety of other jurisdictions. It is widely acknowledged that this is a hard-to-reach, marginalised and vulnerable population. Based on preliminary findings of the IVY project (Interventions for Vulnerable Youth), this paper summarises the emerging needs of young people with severe psychological and mental health problems in the context of the Scottish youth justice population.

IVY is a Scottish Government funded project established to meet the need of children who often do not meet Child and Adolescence Mental Health Service (CAMHS) criteria (criteria vary by health board, but are usually related to meeting diagnostic criteria for a mental disorder such as depression, anxiety or psychosis), but who present with significant psychological difficulties that are relevant to understanding and managing their violence risk. IVY sits within the Centre for Youth & Criminal Justice (CYCJ), funded by the Scottish Government and hosted by the University of Strathclyde. IVY takes a novel approach to meeting the needs of this group. Preliminary findings suggest that IVY is a promising model which can contribute to meeting and managing the need of this marginalised group of young people. Initial findings pertaining to the first six months of the operation of IVY are presented in this paper.

The mental health and psychological needs of young people: Prevalence rates

Estimates of the psychological and mental health difficulties (in this case meaning symptoms of mental disorders as defined by prevailing ICD-10 (WHO, 1992) and DSM-IV-TR (American Psychiatric Association, 2000) diagnostic classification systems[1]) in children and young people vary, even within the United Kingdom. For instance, in 2006, the Social Work Inspection Agency (SWIA) reported on a study of children and adolescents across Great Britain and found that almost a fifth had a mental disorder, whereas Green et al's (2005) British study estimated that one in ten children had mental health problems. When examining the youth justice population, the prevalence rates for mental health difficulties increases exponentially when compared with the general population. The Mental Health Foundation (2000) suggest that the rate of mental health problems of those in the criminal justice system tend to be three times greater than that of the general population; falling between 25% and 81%, with those in custody having the highest rates. Lader and colleagues (2000) reported rates of mental disorder in the population of young offender's institutes in England and Wales to be 95%. Significant prevalence of mental health difficulties in this population have also been widely reported across a range of countries (Almond, 2012 (England); Chitsabesan et al. 2006 (England & Wales); Collins et al. 2009; Kinner et al. 2013 (Australia); Moore et al. 2010 (Australia); Rogers et al. 2006(United States of America); Abram et al. 2007 (United States of America). Jurisdictions which are seriously committed to promoting the welfare of children and to reducing reoffending must take cognisance of

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[1] The ICD-10 and the DSM-IV-TR are used to describe, classify and diagnose mental disorders. They set the diagnostic criteria that guide clinical judgement in mental health services.

this research if interventions are to be meaningful and effective. However, this is not a straightforward task.

The Nature and Complexity of the Task

The literature suggests that a common theme to understanding the mental health of young people who offend is 'complexity'. The complexity relates to the nature of the disorder, the severity of disorder, the comorbidity of the disorder and the relevance of the disorder to any concerning behaviour. This is further compounded by the fact that childhood is a time of metamorphic change. Children and adolescents are not yet at their full maturational state. Childhood is a time of rapid growth and development. As such, the emotional, social and behavioural manifestations of mental health problems will vary depending on the young person's age.

The Mental Health Foundation (2000) suggested that the most common disorders for both the general population and the population of young people who offend are conduct disorders, emotional disorders, attentional disorders, and substance misuse problems. In essence, this captures the full range of emotional, social and behavioural difficulties. The complexity within the offending population is the higher frequency, greater severity and comorbidity; as the prevalence rates would suggest. This translates to significant vulnerability and treatment needs and suggests that consideration of the full spectrum of mental health difficulties is needed. In 2000, the Mental Health Foundation reviewed the literature and reported that research suggesting the detection of mental health problems in young people who offend was imprecise, and tended towards underestimation, particularly with regard to internalising (anxiety and mood etc.) disorders, or those not characterised by extreme behaviour. Similarly, a recent study (Smith et al., in prep) investigating the needs of institutionalised young people who offend in Scotland suggested that information relating to their psychological and mental health status is patchy at best. They suggest that even at a basic level of screening and identification of mental health difficulties, the practice is inconsistent. Similar concerns were recently raised in the English context by Young Minds (2013) who reported that despite the complex mental health needs of young people who offend, services remained "woefully inadequate" (p. 4). In the Scottish context, evidence of sub-optimal service provision is apparent in that local CAMHS teams tend not to see severe conduct disorder or violence risk as their remit, or tend not to accept cases that present where there is no acute psychiatric or mental state disturbance – services are weighted towards the medical model of mental health. Despite the Mental Health Strategy giving its unequivocal commitment to promoting positive psychological health, CAMHS teams can still

find themselves in a position where they need to confine their finite resource to dealing with a small section of young people in need. Similarly, for those extremely rare cases that require an in-patient admission, currently there are no secure forensic adolescent inpatient beds available in Scotland. Young people who require secure forensic inpatient services are placed in units in England. Whilst this paper is not necessarily advocating the creation of such a facility – indeed it could be argued that to do so in the absence of robust community services is premature and misguided – there is recognition that among the services where key expertise might exist, young people are not able to consistently access and benefit from resources in an equitable manner.

Predisposing and Perpetuating Factors

Building on the above, the onset and development of psychological and mental health problems in young people do not develop or occur in a vacuum. Vulnerability and recovery are influenced by biological, psychological, social and environmental phenomena. For instance, Ruffolo and colleagues (2004) found that girls in community based closed residential units had experienced more adverse life events; had significantly higher levels of depression; reported more sexual abuse; had more disruptions in their living circumstances; exhibited more delinquent behaviours; and used more negative coping strategies even when compared with other clinical samples. Epps (1997a) described a population of young people involved in offending as having "long-standing emotional problems resulting from the experience of physical, sexual and emotional abuse" (p.548). Indeed, there are common predisposing factors. Findings from the Mental Health Foundation (2000) suggested that the original risk factors that contributed to offending also predicted mental health problems in the general population. For example, inconsistent or erratic parenting, over-harsh discipline, or hyperactivity as a child.

Clinically speaking, emerging findings from IVY suggest that young people referred are likely to have been exposed to domestic violence, and experience attachment difficulties secondary to interpersonal trauma in the form of childhood maltreatment. Physical, sexual and emotional abuse are therefore highly relevant, as are physical and emotional neglect. Reiterating the above, it would be wrong to 'medicalise' abuse. That said, the impact of trauma can lead to mental health problems that are amenable to mental health and psychological treatments. In terms of maintenance of difficulties, interactions with the justice system – and indeed the care system - can be highly stressful and may on their own lead to anxiety and depression, via a number of psychological mechanisms. This might be especially pertinent around times of custody and transition. Environmental stressors, family

dysfunction, ongoing rejection, interpersonal problems, poor coping skills, and low self-esteem are some examples of common clinically identified perpetuating factors.

The Risks

The health, psychological, social, and financial burdens of crime – and violence in particular - are well established. Crime committed by young people is no exception. Youth crime is a significant public health problem. Young people are most likely to be the victim of youth crime, however, victims can include peers, parents, siblings, strangers, professionals, intimate partners and vulnerable others. Youth homicides account for 41% of the formal figures and homicide is a leading cause of death among adolescents (World Health Organisation, 2011). Youth violence is not just limited to interpersonal aggression. The nature of the crime can be as diverse as the range of victims and can include serious and life threatening interpersonal violence, fire-setting/arson, theft, vandalism and various behaviours considered to be antisocial. Indeed, adolescents account for a disproportionate amount of perpetrated rapes and child abuse (Radford et al, 2011; Vizard et al, 2007).

In order to intervene with this population, it is essential to assess and understand the nature of the risk posed and the factors that contributed to the onset, development and maintenance of the problems. Contemporary practice guidelines advocate the use of formalised risk assessment approaches.

Providing timely interventions to high risk young people is essential. For some, it will need to reflect proactive early intervention; for others, it will need to be reactive or crises led.

Psychological and Mental Health Needs of High Risk Young People

Whilst high rates of mental health problems have been identified in offending populations, a clear causal link between mental disorder and offending has not been established (Johnstone, 2013).   Much of the research in this area has focussed on adult populations with a psychotic illness. This sample is not representative of a youth offending cohort.

Out with the psychosis literature, empirical evidence in this regard lacks specificity, in that attempts have not been made to study the effect of different sub-types of mental health difficulties on different subtypes of violence (Johnstone, 2013). The relationship between mental health and offending behaviour is complex and idiosyncratic, and often the diagnostic label (e.g. conduct disorder) merely describes the offending behaviour rather than facilitating understanding of the mechanism of risk. Given the inability of the empirical evidence to inform our understanding in this regard, it is suggested that the relationship

between psychological and mental health presentation and risk be understood via individualised formulations, generated on a case by case basis. This method is arguably the most appropriate given what we know about the complexity and co-morbidity of mental health concerns in this population. Only the structured professional judgement (SPJ) paradigm provides an appropriate methodology for reaching such conclusions.

The Challenge

Service challenges in terms of high risk youth vary, for instance, depending on whether the task is preventative, early intervention or more crises led intervention responses. A range of promising and evidence based preventative interventions are implemented nationally, such as the family nurse partnership, various parenting programmes and work focussed on infant mental health. Such services hope to improve the experience of vulnerable young children who are at risk by promoting secure attachments and limiting the potential for maltreatment. However, the present focus is on the challenges faced by health and social services when trying to intervene directly with young people, especially in adolescence.

There are significant challenges for all agencies with regard to engaging this group, and it is apparent that services often struggle to overcome these barriers. Despite their significant needs, the young offending population are the least likely to access services (Khan, 2010). This is concerning given that in the absence of successful treatment, research suggests that further offending and worsening mental health problems are likely to develop, placing young people and others at further risk (Mental Health Foundation, 2000).

> *"A lack of provision of mental health services exacerbates offending behaviour in young people who are in touch with the criminal justice system, and leads to further marginalisation from society and greater hopelessness" (Young Minds, 2013, p.8)*

It is clear that meeting a young person's psychological and mental health needs is critical if youth offending is to be addressed. Yet assessing, understanding and managing the very complex and diverse needs of young people who offend can be a significant challenge for services. These challenges include, but are not limited to, the following:

(1) young people may not exhibit impairment of a nature or degree which enables them to access local NHS CAMHS services – they may not meet referral criteria and consequently fall out with CAMHS remit – therefore at times early indicators of mental disorder or very rare forms of psychopathology might go undetected and the young person can be excluded from services;

(2) assessing and formulating violence risk, and intervening with high risk young people with mental health difficulties is a specialist skill. These skills, and training and supervision of same, are not equitably dispersed across the country and thus represent an obstacle to service provision;

(3) the typical models of assessment and intervention used to assess child and adolescent mental health problems (i.e., relying on direct assessment of the young person, having access to reliable family assessment/information, etc.) are not always successful with this group (Johnstone & Dyer, 2013). The demand placed on services by high risk youth, in terms of clinician time and intermittent engagement, may be greater than the capacity of the service.

(4) the young person may be living between local authorities and there can be challenges associated with accessing psychological therapies based on Health board boundaries and organisational barriers, especially with short-term placements, etc.;

(5) the young people typically do not require medical management. Psychopharmacological interventions are rarely effective in preventing offending. The young peoples' needs are usually complex psychological, emotional and behavioural problems. As such, Lead Professionals/Authorities can find it difficult to access the right resource and the paradox is that young people in the community often do not have the access to adequate resources (Johnstone & Dyer, 2013).

Young Minds (2013) highlighted barriers to service provision. Lengthy waiting lists; poor provision for transition between adolescent and adult mental health services; and, mental health treatment, when it was offered, largely consisting of medication. Inconsistency in terms of the reviewing clinician was also felt to be a barrier to effective therapeutic alliances. They recommended that in order to improve engagement, mental health services should: strive for consistency of clinician; provide input to staff that can facilitate the identification of mental health problems; improve coordination between services; have a lead individual identifiable to the young person; and provide young people with accessible information.

> *"Effective mental health intervention can improve the health of some of our most excluded people in our communities and address some of the factors that contribute to offending behaviour. Improved awareness, support and evidence-based training for criminal justice professionals can also improve the experience of people with mental health problems accessing the criminal justice system either as a victim or a witness" (Young Minds, 2013, p.34)*

A Way Forward – Interventions for Vulnerable Youth

In view of the complex needs outlined above, and in light of the Scottish Government's commitment to ensuring that all young people have equitable access to services, Interventions for Vulnerable Youth (IVY) was created. This is an innovative and pioneering pilot project designed to address an unmet need and to bridge a notable gap between social and psychological models of care. The project provides a clinical forensic psychology service – in partnership with other agencies - that delivers a range of interventions to lead professionals/authorities. The project incorporates and increases accessibility to dual trained mental health and forensic practitioners as well as those who are expert in the Children's Hearing System, Social Work Practice and Legislation. The project is comprised of psychology and social work expertise and is organised around the principles of CAMHS consultation models to ensure best practice in terms of provision and governance.

IVY reflects a multi-disciplinary tiered approach to risk assessment, formulation and management for high risk young people who present with complex psychological disturbances and high risk behaviour in terms of their violent conduct. It exists to contribute to the response to the mental health and risk assessment needs of a marginalised group of young people who, by virtue of their social circumstances, placement issues or sub-threshold level of psychopathology, struggle to access services, or perhaps to access them at the right time. The SPJ paradigm approach to risk assessment provides the core practice principles to the process. Organised around consultation methods, there are three distinct but interlinked levels to the IVY project:

Level 1 (the consultation clinic). This takes place on a fortnightly basis. A dual trained consultant clinical and forensic psychologist, a clinical psychologist and two social workers form a panel with whom the lead professional (and other professionals where appropriate) will present the case and in collaboration with the panel, identify the presence and relevance of risk factors for on-going risk. This information is used to form the basis of the clinical formulation (a narrative of the person's presentation), risk scenarios and recommendations for risk management.

Where further assessment or intervention is required, the referral will progress to level 2 and on occasion level 3.

Level 2 (specialist clinical forensic psychology assessment). For cases where there is a level of complexity and/or psychological factors that need to be assessed in order to inform case

management, a level 2 assessment is conducted by the clinical psychologist under supervision of the clinical forensic psychologist. These are case specific in form but include psychometric assessment, interviews and observations – as per typical clinical psychology practice.

Level 3 (specialist treatment): Where a level 1 and 2 analysis reveals that a case requires an eclectic treatment intervention and/or where the young person presents with particular responsivity factors requiring specialist input, the clinical psychologist can design and deliver individualised treatment.

This project offers multiple potential benefits. At the individual level, young people will have access to psychological assessments which will include an in-depth assessment of the risk that they pose, and will incorporate an analysis of their presentation from a mental health and psychological perspective. Where appropriate, this will direct intervention. There is therefore a real potential to reach and manage the most vulnerable young people in our society, from which the young people, their families, and the communities in which they live will benefit. Secondly, from an organisational perspective, the defensibility of decision making in risk assessments undertaken by social workers is enhanced by being supplemented with the theory led, transparent and testable risk management recommendations provided by the clinic panel. This in turn provides decision makers with access to more comprehensive assessment information on which to base their risk management decisions. Thirdly, the project develops reports and materials for practitioners that supports them with their work by building capacity and competence. In addition, the consultation model allows services to access specialist advice without unnecessarily introducing additional professionals to already well-established multi-agency groupings. Finally, the project is likely to offer significant potential cost savings by minimising the need for additional speciaist reports, preventing placement breakdowns or the need for placements, and limiting the costs associated with reducing or minimising offending (police, courts, etc.)

Preliminary findings

In the first six months since its inception IVY has accepted referrals for 25 young people from all over Scotland. Nineteen of those referred were male and six were female. The age range of young people was 12 to 17. The mean age was 15.5, with the most frequent age being 16. All of those young people considered thus far at consultation stage had input from social work services, and looked after status. In terms of early life experience, 76%

were exposed to domestic violence and 88% experienced some other form of maltreatment during childhood.

Mental Health and Psychological Needs Profile

The young people referred to IVY represent a complex group characterised by neurodevelopmental, emotional and behavioural difficulties. In short, the majority of the young people referred would likely meet the criteria for several mental disorders. Table 1 below details the neurodevelopmental, mental health and behavioural difficulties relevant to the 17 young people seen at Level 1 and is based on the information available about young people at that time. An averaging suggests that each young person had 4.4 diagnoses. It is important to note that this information is not based on having individually assessed young people, but rather on background information provided by referrers at consultation. As such, it serves as a guide rather than a comprehensive diagnostic review. It is acknowledged that partitioning out diagnoses is not always helpful clinically. This exercise is considered crude and is done here merely to capture the complexity in a brief manner.

Table 1: Neurodevelopmental, Emotional and Behavioural Difficulties Referred Young People (N=17)

Diagnosed or Suspected Difficulty	Number
Anger	7
Anxiety	1
Autism Spectrum Disorder	6
Attachment Disorder	5
Attention Deficit Hyperactivity Disorder	6
Communication Disorder	1
Complex Post Traumatic Stress	6
Deliberate Self-Harm	7
Dissociation	2
Eating Difficulties	2
Emotional Dysregulation	6
Learning Disability	2
Low Mood	2
Oppositional Defiant/Conduct Disorder	2
Psychosis	2
Sleep Difficulties	2
Substance Misuse Difficulties (Alcohol/Drugs)	7
Suicidal Ideation/Action	6
Unusual perceptual experiences	3

Risk

IVY relies on individualised risk formulation and scenario planning, as per the SPJ approach. As such, the risk posed by young people who have been referred to the clinic cannot be quantified with numbers. For the majority of young people the concerns were about the risk of harm they posed to others. There were a small number where the risks were primarily about the young person's vulnerability and some cases where the concerns were about both vulnerability to harm and risk of harm.

In terms of risks posed to others, the young people referred had a diverse range of previous offending (the following information does not relate to charges or convictions, but serves as a description of the behaviour): aggressive conduct; serious sexual offending to younger children and peers (contact and non-contact); voyeurism; viewing and producing child pornography; assault and robbery; assault and injury; intimate partner violence; violence towards a child; arson/fire-setting; property destruction; attempted murder; threatening with a weapon; and extremist violence.

The areas of vulnerability primarily noticed were: deliberate self-harm; suicide; vulnerability to exploitation or victimisation (sexual, violence, financial, substances). The imminence, likelihood and severity of risk ranged from moderate to severe. Some of the cases were considered as representing a risk that required highly specialist interventions.

Table 2 below outlines the nature of primary and secondary risks, as well as the number of cases where there were co-morbid risks. For the purposes of this table the data on self-harm and suicidality differ from that presented above. This is because Table 2 pertains to cases in which self-harm or suicidality were a primary or acute concern and therefore the reason for referral, rather than a historical or chronic issue. There were several cases for which there was more than one primary concern in terms of harmful conduct, and some of the cases had multiple risks.

Table 2: Nature of Risk in Referred Young People (N=17)

Nature of Risk	n = Primary Risk	n = Secondary Risk
Fire-setting	1	1
Interpersonal Violence	10	3
Self-harm/Suicidality	3	3
Sexual offences (contact)	5	0
Sexual offences (non-contact)	1	1
Victimisation	1	5
Violent Extremism	1	0
Cases of co-morbid risks	9	

This data underscored the complexity of the client group and the competing priorities that practitioners face in terms of intervention. All referrers received a comprehensive minute detailing the nature of the risks posed, risk factor ratings (presence and relevance), a risk formulation, details of the most likely scenarios to be managed, and recommendations for ongoing risk management. The panel 'approved' these minutes before dissemination thus, the content reflected an expert view. These were completed within two weeks of the consultation meeting and were both time and cost-efficient.

Summary and conclusions

As can be seen, high risk young people – that is, young people who present a risk of serious harm to others - are a disadvantaged and disempowered group. They constitute a population that can fall between service thresholds and who can find it difficult or impossible to access resources. They are typically of a profile that reflects issues of deprivation, neglect, trauma and abandonment, exposure to antisocial role modelling, lack of social support and exposure to the care system. They can manifest a range of emotional and behavioural difficulties and they typically show early precursors of mental disorders known to place them at risk of persistent offending. By funding the IVY project, the Scottish Government is helping to better meet the needs of this group of young people. Although more needs to be done, IVY presents an efficient and cost-effective way forward. It provides a timely and much needed opportunity to gain further insight into the needs of this vulnerable population in Scotland, and an opportunity to consider whether this model might contribute to significant service improvements for high risk youth.

For more information on the project and a referral form go to www.cycj.org.uk

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