



Interventions for Vulnerable Youth (IVY)

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Ensuring Access to Best Practice Risk Assessment, Formulation and Interventions for Traumatized and Violent Youth.

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Aims and Overview

➤ Aim

- To introduce the IVY model with the aim of demonstrating that the SPJ paradigm of risk assessment and management is achievable in the context of an evidence-based, efficient and effective model of service delivery and that a joint social work and clinical forensic psychology service has added utility

➤ Overview

- Introduction: The population needs and the service challenges
- The pilot project: using best practice to address needs and risks
- Lessons learnt and implications for practice



1. Introduction

Mental Health in Youth Justice

Multiple and complex
MH needs

Prevalence in general
population (UK): 10 –
20%

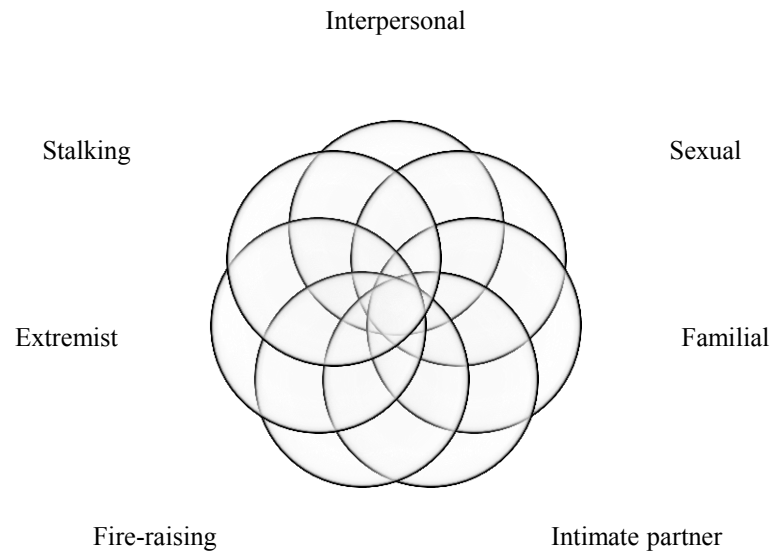
Prevalence in youth
offending population:
80 – 95%

Complexity = severity
x comorbidity

conduct, emotional,
neurodevelopmental,
disorders, substance
misuse problems

Significant
vulnerability and
treatment needs

Youth Violence: Nature and Scope

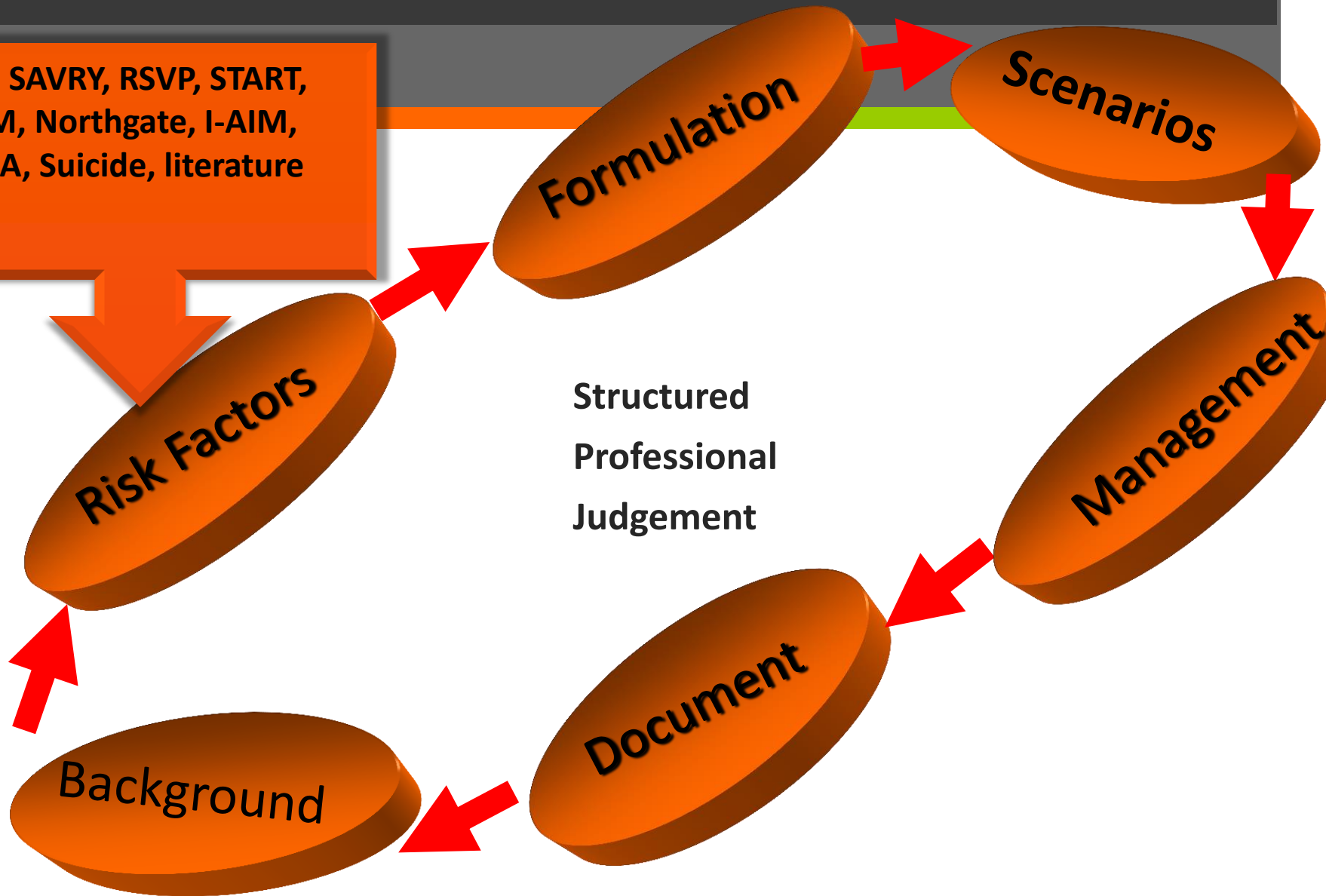


Youth Violence: Developmental Risk Factors



Best Practice Principles: SPJ

e.g., SAVRY, RSVP, START,
SAM, Northgate, I-AIM,
VERA, Suicide, literature



Scotland's Response

A Whole Systems Approach to Getting it Right for Every Child

Early and Effective
Intervention (EEI)
8-15

Diversion from
prosecution

The Children's
Hearing system

Address risks and
needs

Alternatives to
secure care

Supporting YP if
they do go to court,
aid decision
makers

Risk Management
by multiagency
partners

Support
reintegration after
secure care

Use supervision
requirements as
legal status



SCOTTISH CONTEXT

Population: 5, 295,000

32 Local Authorities

Children and Families Social Work

Youth Justice Social Work

Universal Health Care

14 Health Boards

Child & Adolescent Mental Health teams

1 Forensic CAMHS team

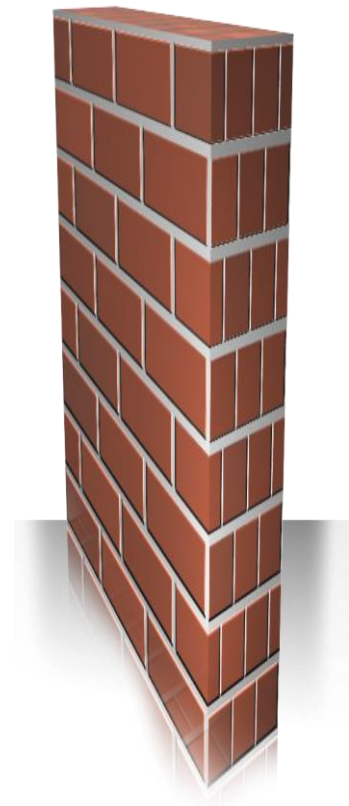
Service Constraints

WHY?

- Conduct Disorder is an exclusion criteria in CAMHS
- Early indicators of forensic psychopathology might not be identified or understood in terms of risk (e.g., paraphilias, violent extremism, etc.)
- Competencies required to assess MH and risk – FMHA not routinely available in the workforce
- Approaches to risk assessment not appropriate
- Only a small proportion of youth present with severe and enduring violence risk...demand?

AND SO,

- Agencies often outsourcing expert assessments at significant cost and for Tier 5 cases, refer to England...only for admission...
- not getting at root cause and not addressing local service provision



Youth Violence – the context

- The health, psychological, social, and financial burdens of crime – and violence in particular - are well established.
- 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).
- 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**.



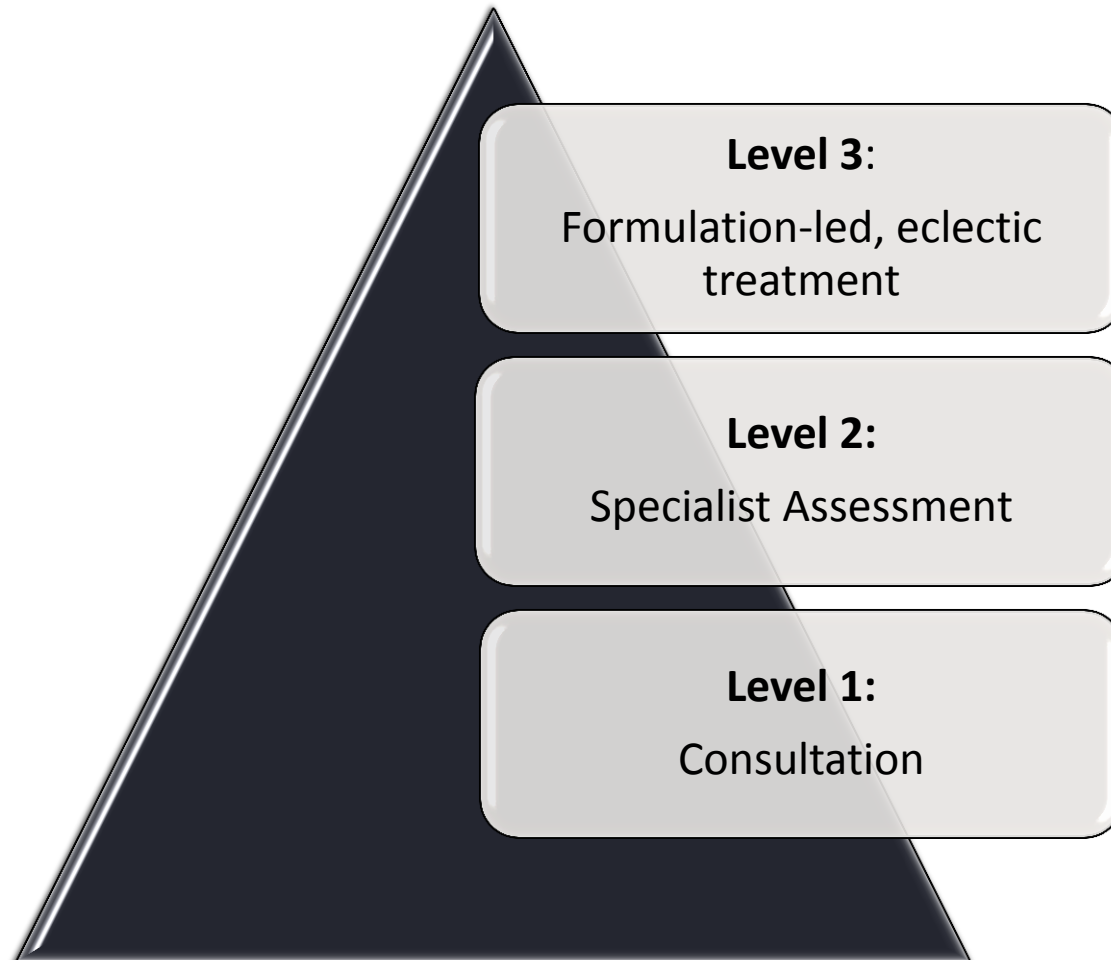
2. The Pilot Project

IVY: A Pilot Project

interventions for
vulnerable youth



IVY Model



IVY: The Team

Four Consultants

- Consultant Clinical and Forensic Psychologist/Research Fellow (Project Lead 0.2 WTE)
- Clinical Psychologist with Formal Training in Forensic Psychology(1.6WTE) (Soon 2.0 WTE)
- Social Work Consultant with expertise in SHB (0.1 WTE)
- Social Work Consultant with expertise in Violence Risk Assessment (0.2 WTE)

Total years working with vulnerable youth/offenders = +60 years

Level 1: Consultation

Who:

All referrals – this is the minimum standard

Referral Form is submitted which provides relevant information on risk, background, mental health, placements, etc.

As long as there is active risk of harm to others, a consultation is offered

Format:

Consultants, who are specialists, assist the consultee(s) to assist with the case; consultants are active agents to achieving solutions (understanding) and strengthening the consultee's competencies to address similar issues in the future

2 hours per case direct time*

Report provided to lead professional within 2 weeks of consultation

Content: All aspects of the SPJ Paradigm

Level 1 and 2: Paradigm

Family composition and functioning
Attachment and parenting
Developmental Hx.
Educational/School
Placements etc.
Mental and Physical Health
Substance Use
Offending
Relationships/Psychosexual
Recreation/Interests, etc.

Formulation

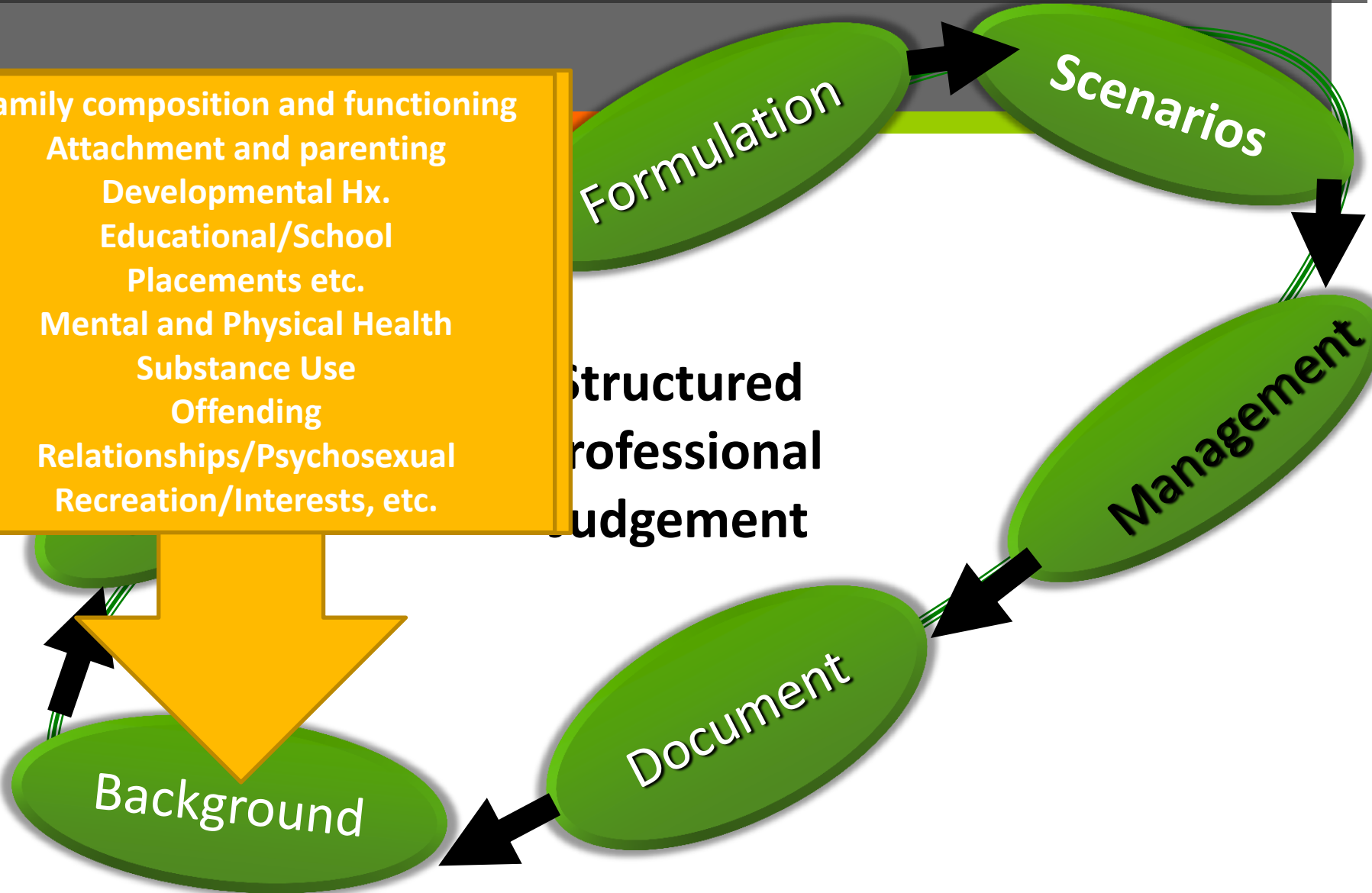
Scenarios

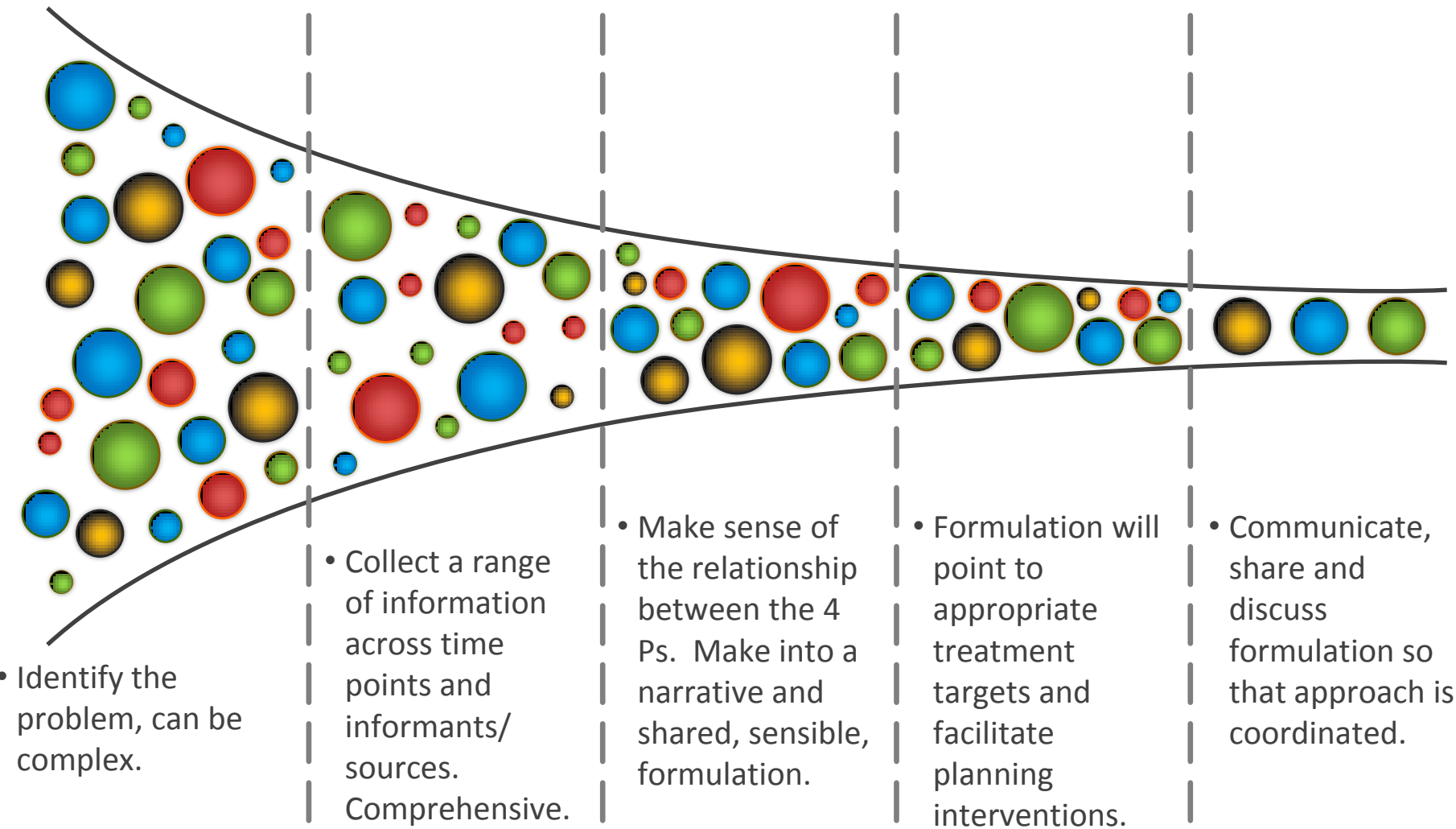
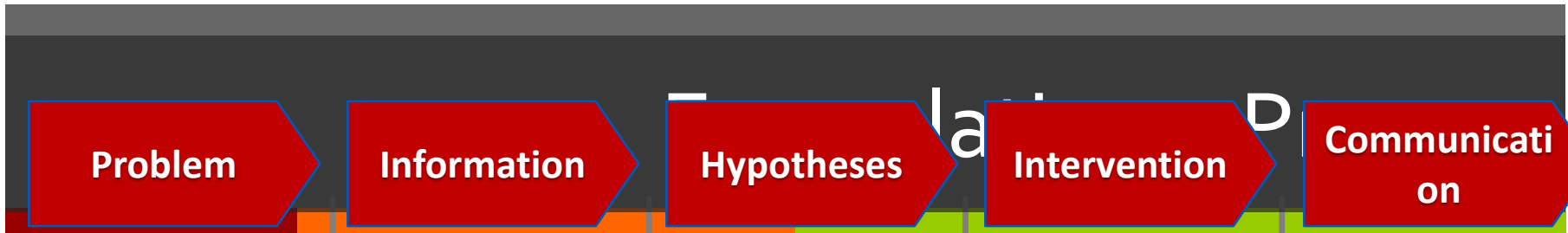
Structured
Professional
Judgement

Management

Document

Background







Predisposing Factors

The diagram is a flowchart illustrating the factors leading to violence. It consists of three stacked rectangular boxes: a green one at the top, a yellow one in the middle, and a light green one at the bottom. Each box is connected to the next by a downward-pointing arrow. Below the bottom box is a large, red, multi-pointed starburst shape containing the word 'VIOLENCE'. To the left of this starburst is a dark grey arrow pointing right, labeled 'Perpetuating Factors'. To the right is a red arrow pointing left, labeled 'Protective/Inhibitors Factors'. The entire diagram is set against a white background with a red horizontal line at the top left and a light green horizontal line at the top right.

Drivers/Motivators

Precipitating Factors/Destabilisers

**Perpetuating
Factors**

VIOLENCE

**Protective/Inhibitors
Factors**



Scenarios

Best Case

Repeat

Twist

Worst Case

Escalation

Improve

Consultation Outputs

WITHIN 2 WEEKS OF CONSULTATION, A DETAILED REPORT:

- Introduction
- Limitations
- Background
- Risk Factor Ratings (for presence and relevance) as per relevant protocol(s)
- Risk Formulation (pragmatically grounded – 4Ps)
- Risk Scenarios
- Recommendations for Risk Management

Level 2: Specialist Assessment

Who:

- Where there are significant information gaps
- Where specialist psychological/mental health assessments are needed such as cognitive, attachment, trauma, diagnostic, personality, psychosexual, etc. evaluations.

Format:

- Clinical psychologist completes the evaluation
- Revises formulation and risk assessment report
- Can span several weeks/months
- Updated report/supplemental report

Level 2: Examples

- Specialist assessment of cognitive functioning, e.g., WISC-4 or WAIS-4
- Specialist in-depth assessment of psychosexual functioning e.g. SSKATT or emerging paraphilias
- Specialist assessment of attachment and family functioning
- Assessment of violent ideation, fantasies
- Assessment of personality styles such as PCL:YV*

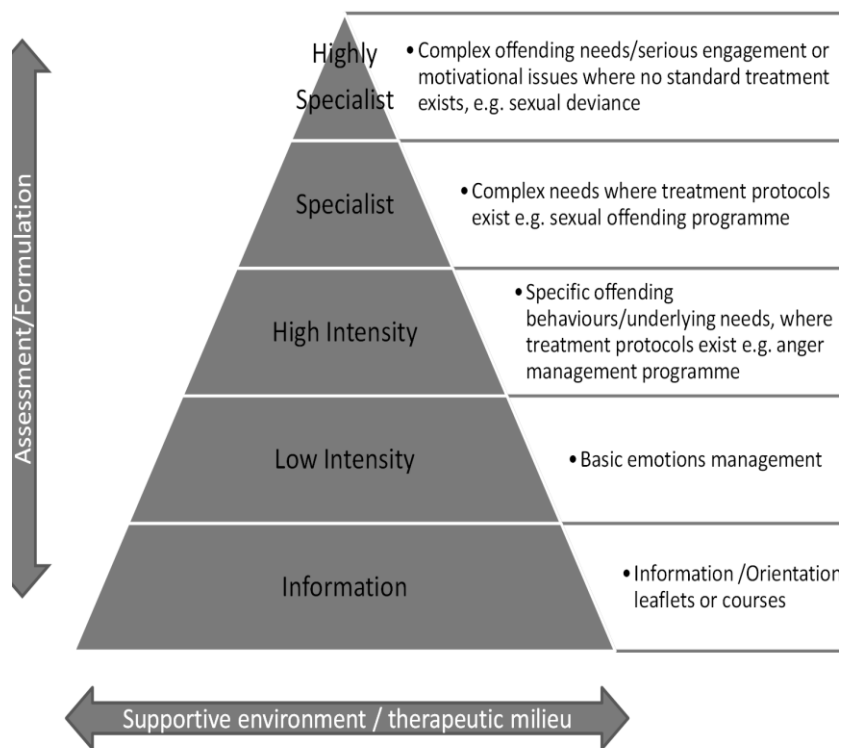
Consultation Outputs

REVISED SECTIONS/REPORT:

- Additional/new background information
- Revised Risk Factor Ratings (for presence and relevance) as per relevant protocol(s)
- Revised Risk Formulation (pragmatically grounded – 4Ps)
- Any new or change to Risk Scenarios
- Additional Recommendations for Risk Management

Level 3: Formulation-led Tx's.

Eclectic Model



Format

- Treatment proposed as per stepped care pathway
- Where specialist intervention is required, this would be delivered by clinical psychologist

Principles of Treatment

- Guided by individualised formulations
- Informed by mental health, offender behaviour and developmentally based literatures
- Accounting for low base rate presentations and limitations in extant research

Principles of Treatment

Modalities

- Individualised
 - Engagement and Education
 - Basic distress focused work
 - Mental health work
 - Violence and offence focused work
- Family
- Systemic
- Situational
- Staff
- Carers



3. Lessons Learnt

Demographics – Age & Sex

AGE	n
12	2
13	2
14	6
15	10
16	9
17	9

N= 38

Mean age = 15.3

Mode = 15

Range 12-17

Male = 29

Female = 9

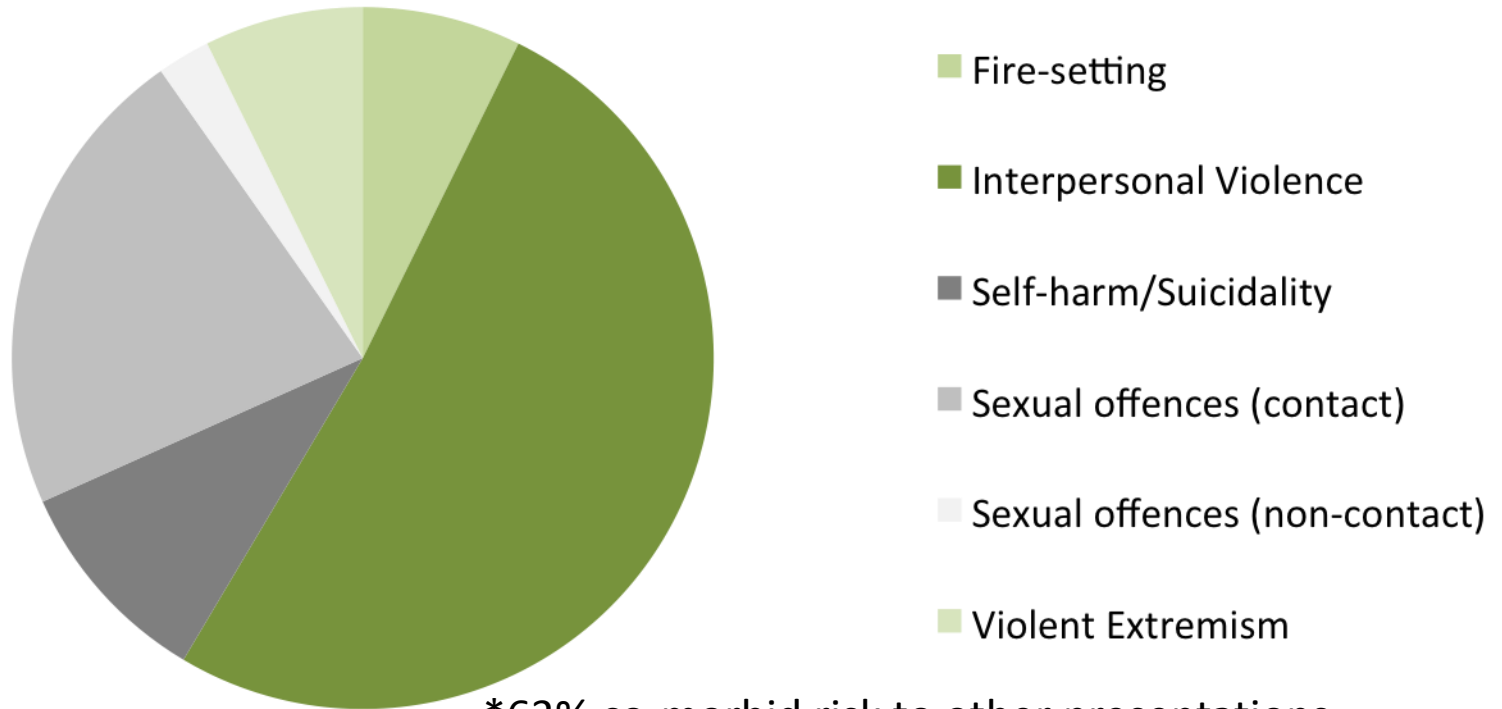
Psychological/Mental Disorders

Diagnosed or Suspected Difficulty	n
Anger	9
Anxiety	3
Autism Spectrum Disorder	12
Attachment Disorder	7
Attention Deficit Hyperactivity Disorder	10
Communication Disorder	2
Complex Post Traumatic Stress	12
Deliberate Self-Harm	12
Dissociation	3
Eating Difficulties	3
Emotional Dysregulation	7
Learning Disability	3
Low Mood	2
Oppositional Defiant/Conduct Disorder	2
Psychosis	2
Sleep Difficulties	2
Substance Misuse Difficulties (Alcohol/Drugs)	15
Suicidal Ideation/Action	8
Thought Disorder	1
Toileting Difficulties	3
Tourette's Syndrome	1
Unusual perceptual experiences	4

N=30

MEAN = 4

RISK PRESENTATION



*63% co-morbid risk to other presentations

*approx 30% suicide/self-harm

*approx 25 % concerns about victimisation

SAVRY - Historical

Item	Low (%)	Mod. (%)	High (%)
History of Violence	0	19	81 (1)
History of Non-violent Offending	21	16	63 (5)
Early Initiation Violence	15	25	60 (6)
Past Supervision Failures	11	26	63 (5)
History DSH/Suicidality	31	32	37 (7)
History Exposure to Violence	15	10	75 (2)
History Childhood Maltreatment	0	28	72 (4)
Parental Criminality	58	10	32 (8)
Early Caregiver Disruption	10	16	74 (3)
Poor School Achievement	5	32	63 (5)

SAVRY - Contextual

Item	Low (%)	Mod. (%)	High (%)
Peer Delinquency	10	30	60 (4)
Peer Rejection	10	15	75 (3)
Stress and Poor Coping	0	5	95 (1)
Poor Parental Management	10	11	79 (2)
Lack of Practical Support	11	42	47 (5)
Community Disorganisation	35	30	35 (6)

SAVRY - Individual

Item	Low (%)	Mod. (%)	High (%)
Negative Attitudes	0	15	85 (2)
Risk Taking/Impulsivity	5	5	90 (1)
Substance Misuse	25	20	55 (6)
Anger Management Problems	10	10	80 (3)
Low Empathy	16	5	79 (4)
ADHD	56	11	33 (8)
Poor Compliance	0	25	75 (5)
Low Interest in School	10	45	45 (7)

SAVRY - Protective

Item	Present (%)	Absent (%)
Prosocial Involvement	20	80
Strong Social Support	26	74
Strong Attachment Relationships	23	77
Positive Attitude to Authority	6	94
Strong Commitment to School	12	88
Resilient Personality Traits	12	88

Common Themes

Transition

LAAC

**Multiple
Placements**

**?Attachment
Difficulties***

?ADHD

**?Autistic
Spectrum**

**Vulnerability
victimisation**

**Unmet
treatment
need**

**Difficulties
with
engagement***

**Absence of
friendships**

**Childhood
Maltreatment
– 88%**

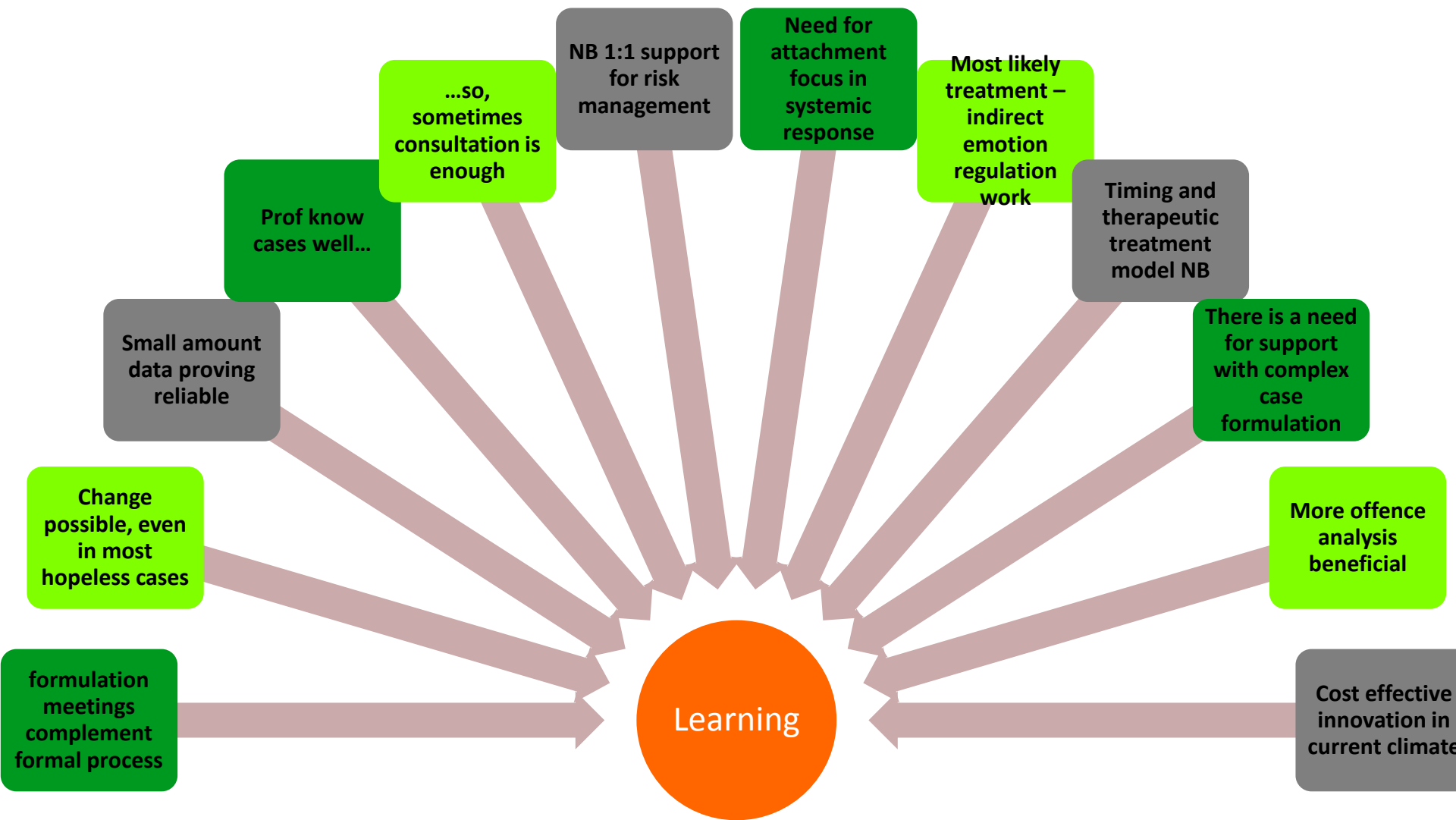
**Domestic
Violence –
76%**

**Parental subs
misuse**

**Long standing
behaviour
problems**

**Poor school
attainment**

**Little sense of
the future**



interventions for
vulnerable youth



www.cycj.org.uk/ivy