High harm, high risk: Working with young people with complex needs in the Secure Estate

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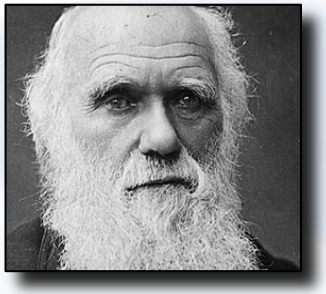
Overview

- Setting the scene – Young People with Complex Needs
- Psychologically Informed Environments (PIE's)
- Attachment/Trauma Meta-Framework
- Implementing into Practice – The Willow Unit
- The Future……



- “It’s not the strongest of the species that survive, nor the most intelligent, but the most responsive to change.” (Charles Darwin)

- "If you meet a teenage mugger on the street one night, the last thing that you will be thinking about is [his] infancy. But the fear and rage evoked in you are probably the same feelings that have been with [him] since babyhood, which have been instrumental in transforming this particular baby into an antisocial 'thug'."
- "The violent children of the future are now babies"

Gerhardt, 2004

- "There is evidence that just one relationship with a caregiver....who is capable of autobiographical reflection, in other words a caregiver who provides a high reflective self-function, can enhance the resilience of an individual. Through just one relationship with an understanding other, trauma can be transformed and its effects neutralised or counteracted" (Fosha, 2003)

Setting the Scene – some observations

- Across 3 systems: Social Care/Mental Health/Criminal Justice System
- Community CAMHS/YOS/LAC Residential/Courts/Secure welfare/Inpatient MH/Secure Estate (LASCH, STC, YOI)
- Core group of young people with complex histories of survival, attachment disruption and trauma
- Present with high risk behaviours (to themselves and/or others)
- Challenge whole systems: Social Care/Education/CAMHS/CJS

Setting the Scene - some observations

- **YP get passed between and within systems : REVOLVING DOOR**
- Majority of young people do not present with a 'mental illness', or fit one diagnostic category, rather a complex mix:
  - CD/ADHD/PTSD/ASD/LD/ATTACHMENT D/BPD/ASPD/ & ? PSYCHOSIS!!
- Same client group, but different 'treatment' systems? – or often cross-systems!
- Difficulties '(re)-emerge', intensify (higher risk) and/or become less 'tolerated' in adolescence (yr 9!!) – c.f. attachment system
- But…..difficulties often identifiable early (with hindsight?)
- Highly resource intensive, difficult to change, frustratingly similar outcomes – prognosis poor and increased likelihood of transition to adult MH/criminal justice/forensic services
- **……? lack of consistency, underpinning therapeutic rationale and co-ordination across services**

PSYCHOLOGICALLY INFORMED ENVIRONMENTS (PIE'S)

Psychologically Informed Environment

- ***'….the definitive marker of a PIE is simply that, if asked why the unit is run in such and such a way, the staff would give an answer couched in terms of the emotional and psychological needs of the [young people], rather than giving a logistical or practical rationale, such as convenience, costs, or health and safety regulations'*** **(pg. 231, Johnson & Haigh, 2012)**
- PIEs are designed to help all staff understand the behaviour of young people within a consistent and coherent psychological framework, and so be able to work more constructively, consistently and creatively with young people to manage any challenging behaviours
- It is important that these changes are measureable in order to review the effectiveness of services and to demonstrate to clients themselves that change is being made

Psychologically Informed Environment

- There is no one right approach to addressing someone's emotional and psychological needs and organisations may decide to use more than one framework (e.g. attachment, child development, complex trauma)
- **However, an explicit psychological framework can legitimise and inform different approaches staff can use and give additional insight into how people behave**
- Training all staff within an agreed framework or combination of frameworks is suggested to help them to work more effectively with young people

Psychologically Informed Environment

- A key element to a PIE is reflective practice. This involves recapturing and analysing actions and processes in order to learn from incidents and improve the responsiveness of services
- It gives staff a perspective on the emotional challenges of their work and helps to develop learning cycles and skills development
- Staff coaching, training and recruitment should explicitly acknowledge the importance of a PIE and dispel any myths and fears about psychological approaches
- Staff will not be acting as 'therapists', but may well develop therapeutic approaches in their work with clients
- Effective staff supervision, both individually and group, is an essential component of a PIE

Psychologically Informed Environment

In summary, there are 6 key areas of a PIE:

- A focus on the psychological & emotional needs of the clients
- Developing a coherent psychological framework
- Utilising the physical and social environment
- Staff training and support
- Managing relationships
- Evaluation of outcomes

AN EXAMPLE OF A PSYCHOLOGICALLY INFORMED 'FRAMEWORK'

Attachment experiences, trauma and effects on the developing brain

- *"Those whose internal systems are less robust because of their early experiences* [of attachment disruption and trauma] *may simply be more vulnerable to adversity and less able to draw on the powers of their frontal cortex* [to process distress and regulate emotion and behaviour]" *(Gerhardt, 2004)*

Therapeutic 'Meta' Framework

- Not suggesting anything particularly NEW... multiple perspectives
- Psychologically informed and multi-systemic: formulation driven
- Meta-theoretical:
  - Attachment *(Bowlby,1998; Crittenden, 2005)*
  - Trauma (developmental trauma & trauma systems) *(Van der Kolk, 2005; Briere & Scott, 2006, Saxe et al., 2007)*
  - Cognitive Neurosciences
  - Systemic theories
  - Behavioural theories
  - Evolutionary/Developmental
  - Biological…….

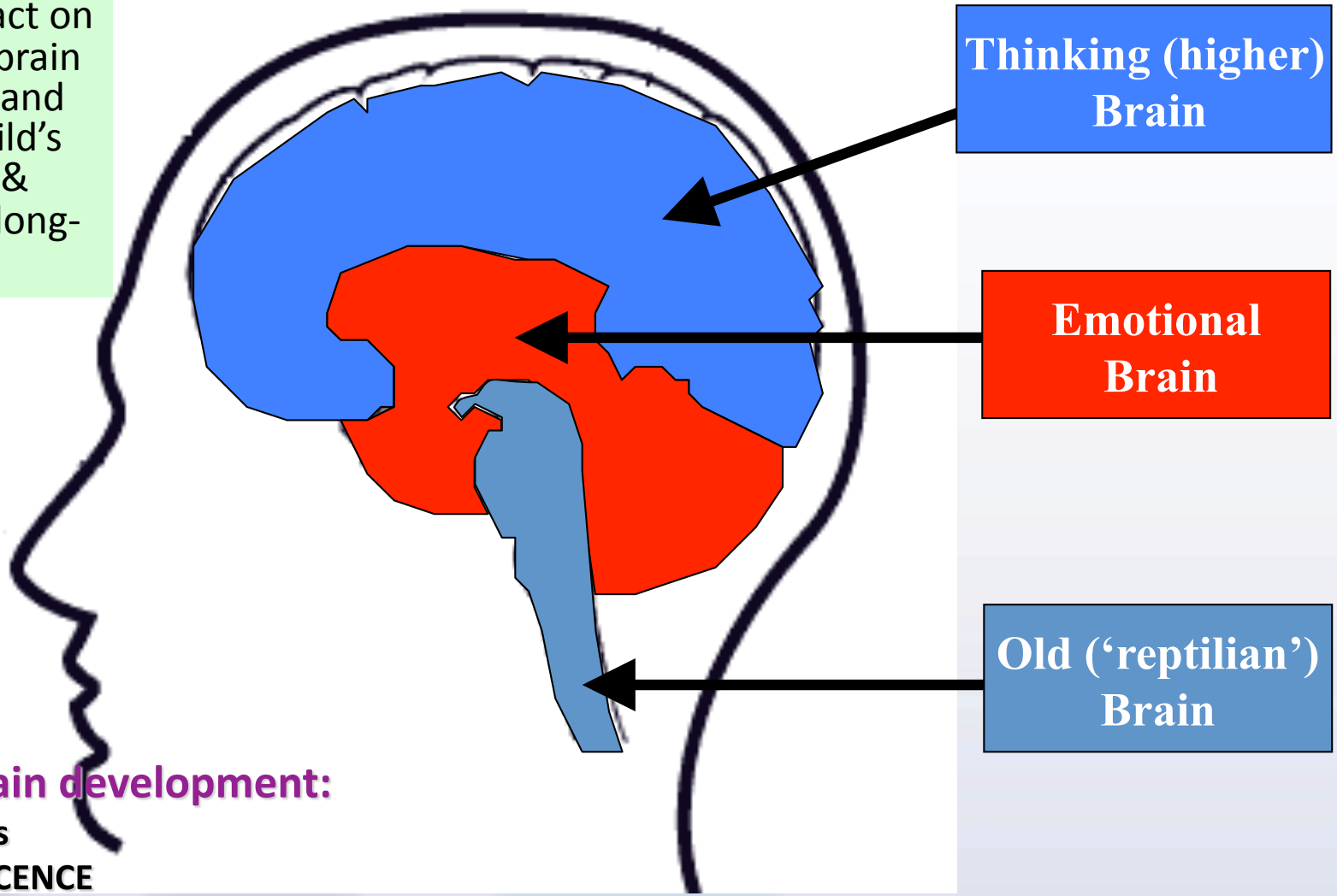
- Emphasis on safety and supporting staff to regulate their own emotions and provide secure, 'therapeutic' care
- Robust risk assessment and **MANAGEMENT**
- FOCUS ON STAFF-YOUNG PERSON RELATIONSHIP
  - Parenting with PACE *(Hughes, 2004)*
  - House model of parenting *(Golding, 2006 & 2008)*
- **Promoting, coaching & modelling attunement, co-regulation *(leading to self-regulation)* and interactive repair in interactions**

Some Basic Principles

- Developmental perspective is paramount
- Attachment and brain development starts before birth – born unfinished
- Our genes are influenced by our environment well into the first years of life
- **ADAPTABILITY IS KEY:**
  - Young people adapt to their environment with survival as the primary goal
  - Young people develop highly adaptive strategies to achieve this goal
  - **Primary question: What strategies has this YP had to develop to adapt to his/her environment? – maximise care / stay safe**
- 2 underlying processes:
  - Attachment (working model) & emotional regulation
  - Alarm & trauma response system
- Effective interventions must be driven by comprehensive psychosocial formulation & **focus on increasing adaptibility**
- EVERY SINGLE INTERACTION WITH A YOUNG PERSON IS AN OPPORTUNITY TO PROMOTE DEVELOPMENT & ADAPTABILITY

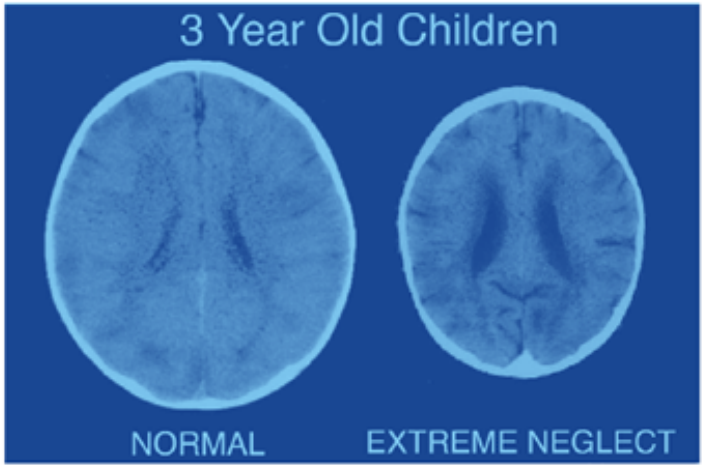
Evolution of the brain

Early experiences will have a major impact on how these three brain regions develop and influence the child's emotional life & behaviour in the long-term.



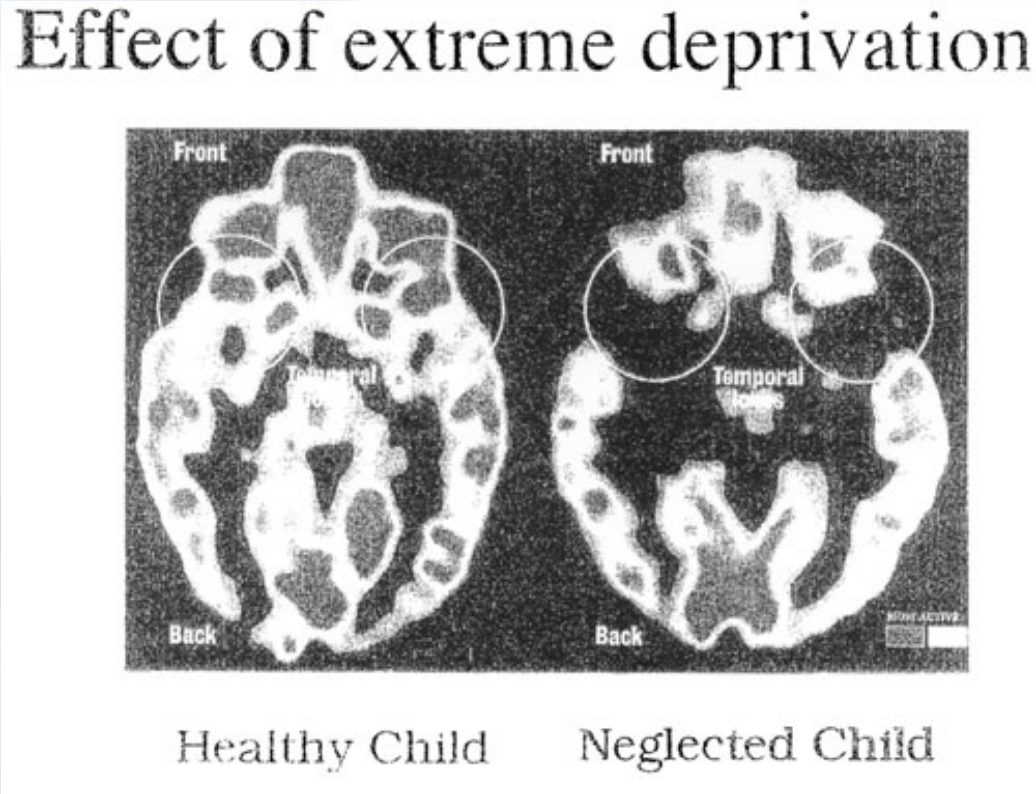
Key times for brain development:

- **0-2 years**
- **ADOLESCENCE**
- **Continuous development well into 20's**



These images illustrate the negative impact of neglect on the developing brain. The CT scan on the left is from a healthy three-year-old with an average head size. The image on the right is from a three year old child suffering from severe sensory-deprivation neglect. This child's brain is significantly smaller and has abnormal development of cortex.

Romanian Orphans' Brains



Why are Attachment Relationships Important?

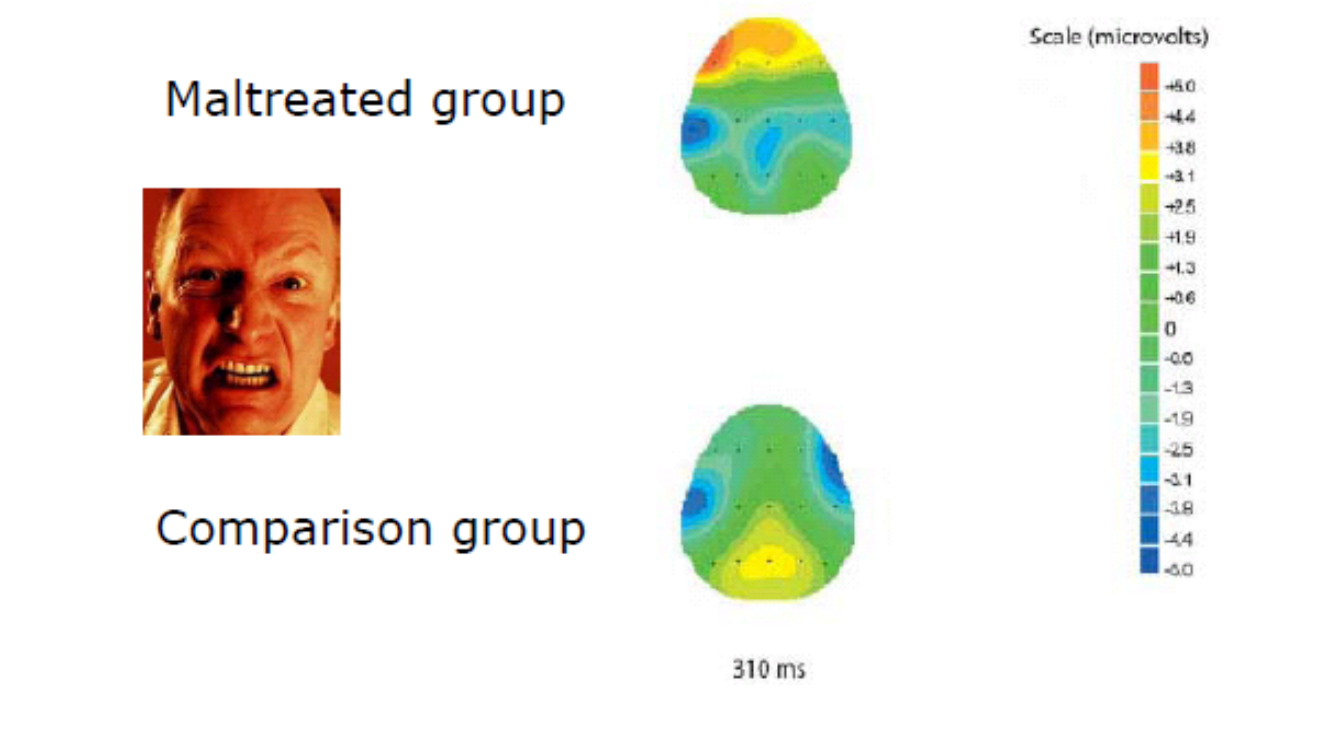
- The very earliest years of a child's life are critical for later development
- Children's development is linked to the quality and character of their close (attachment) relationships
- Relationships with caregiver teaches child about:
  - Their own and others behaviour and emotional experience (e.g. a sense of empathy)
  - Their own worthiness (e.g. self esteem)
  - The emotional availability of others and their ability to provide a 'safe' environment
  - **The ability to recognise and regulate emotion**
    - **co-regulation & self-regulation**
- Positive attachment experiences lead to a sense of safety, development of trust in others, more effective emotional regulation and self-reliance.

Attachment experiences, trauma and effects on the developing brain

- Early experiences of disrupted attachment and 'trauma' (T and t) impact on:
  - 'Hypersensitive' amygdala
  - Unusually high/low cortisol levels
  - Less well adapted pre-frontal cortex
  - Less effective hippocampal function (organising memory)
- Early experiences of disrupted attachment and 'trauma' (T and t) underpin:
  - Our sensitivity to stress/threat (fight/flight/freeze)
  - Our ability to process/interpret social information
  - Our ability to empathise with others
  - Our ability to regulate emotions & behaviour
  - Our capacity to seek support and comfort (co-regulation)

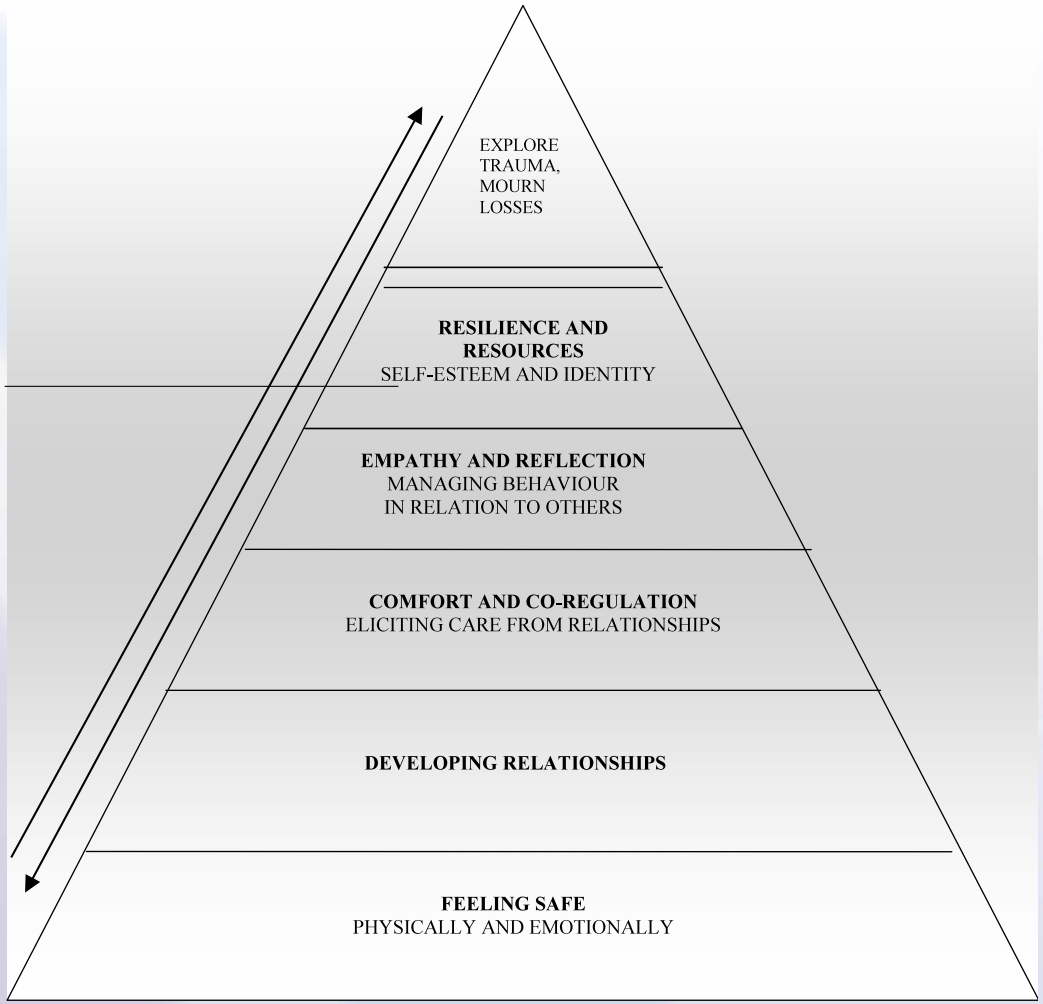
EEG study of the responses of maltreated and non-maltreated children to viewing an angry face

(Cicchetti & Curtis, 2005)



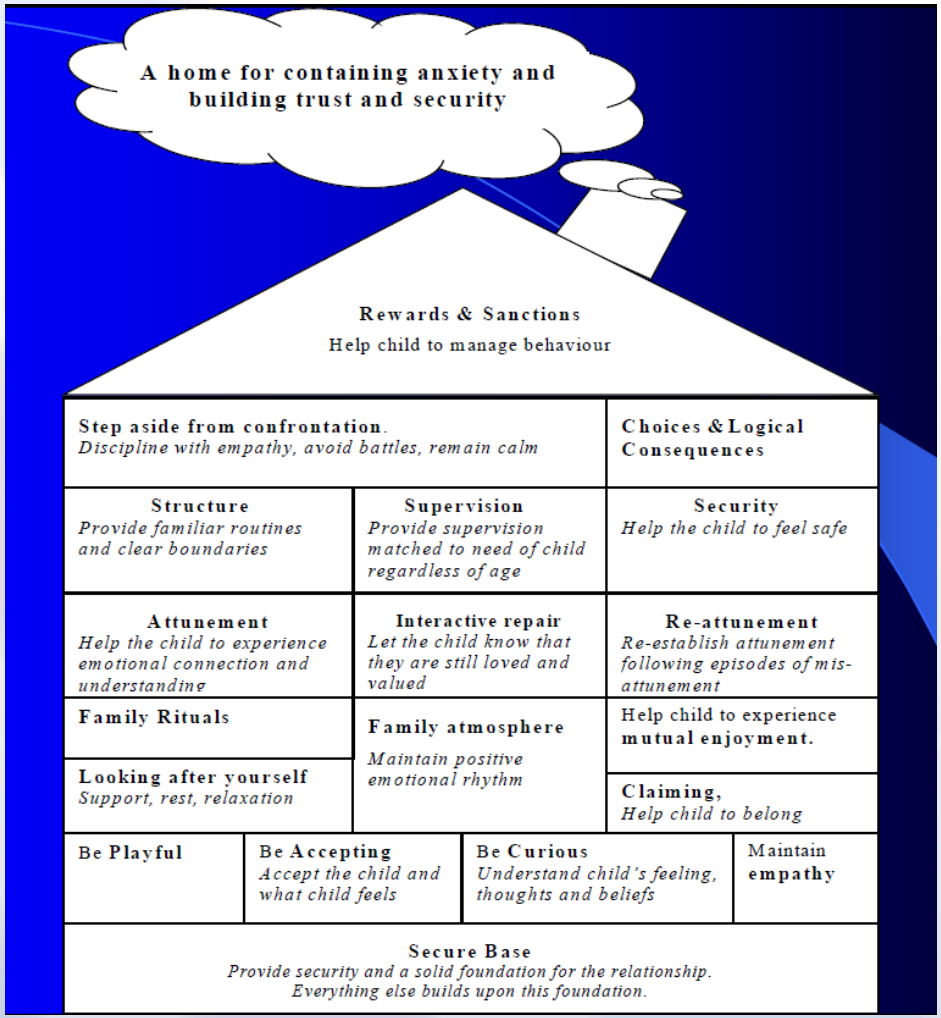
From Fonagy, P www.ucl.ac.uk/psychoanalysis/unit-staff/mbt_training_theory.pdf

Pyramid of Need



Golding, (2006)

House of Parenting



The House Model of Parenting

Golding *et al.* (2006)

'Therapy' in everyday interaction

- **Every** interaction with a YP with complex attachment/trauma presentation is likely to activate attachment system
- **Therefore every interaction has the potential to be therapeutic**
- Attune, co-regulate, interactive repair
- Observe for trauma – what is the threat?
- Important to retain a 'mentalizing' stance
  - Awareness of self
  - **Curiosity**
  - Non-judgemental (genuinely interested in understanding what's going on)
  - Understanding the misunderstanding
  - It's ok to say sorry, to reflect confusion, to get it wrong – it's how you manage this that is the key!

Basic Ideas – complex delivery!

- Not so much **what** you do, but **how** you do it!
  - **FOCUS ON RELATIONSHIP** - (as we suspect with psychotherapy – not the model, but how it is applied and who is applying it)
  - Use psychologically informed approaches to providing developmentally appropriate care:
    - Unless we recognise adaptive attachment processes & address the 'gaps' in the developmental process
    - Unlikely to impact long-term on brain development, regulatory system & nurture more typical developmental processes
    - Unlikely to have prepared the YP for the emotional challenges of effectively processing traumatic memories
    - **Treatment needs to incorporate intervention strategies that promote a return to normal development and engagement with age-appropriate activities (Marmar, Foy, Kagan & Pynoos, 1993).**

Basic Ideas – complex delivery!

- Avoid 'recreating' earlier maladaptive attachment experiences
- PRIMARY INTERVENTION MUST BE WITH CARE-GIVER(s) (Parent/ YOT worker/social worker/Prison officer)
- …….then add specialist 'technologies' / offence-focused intervention
- 'Good enough' – long-term approach
- Dosage/frequency/timing – important considerations
- **Emotionally attuned & regulated systems → emotionally attuned and regulated people**
- **REAL LIFE EVALUATION**
- **ABSOLUTELY MUST BE IN CONTEXT OF WIDER PATHWAY – GENERALISATION TO MAIN LOCATION AND COMMUNITY – TRANSITION PLANNING**
- Emotional & Mental health is **everyone's** business

IMPLEMENTING INTO PRACTICE; THE WILLOW UNIT EXPERIENCE

Broader context

- Change in policy landscape;
  - Access to healthcare in prisons
    - DH, 1999
    - NHS Executive Working Group, 1999
  - Cooperation between prisons and healthcare providers
    - DH, 2001
  - Service provision for young people
    - DH, 2004
    - DfES, 2005
- Change in commissioning arrangements (2005)

- Following changes in the commissioning and delivery of healthcare in the secure estate, a need assessment demonstrated that mental health services in Hindley YOI were not configured to meet the needs of the population, particularly young people with complex needs. Key stakeholders (commissioners, providers and prison governors) worked together to develop and deliver a new model based on therapeutic parenting, delivered on a residential unit using a collaborative approach between discipline staff and mental health staff.

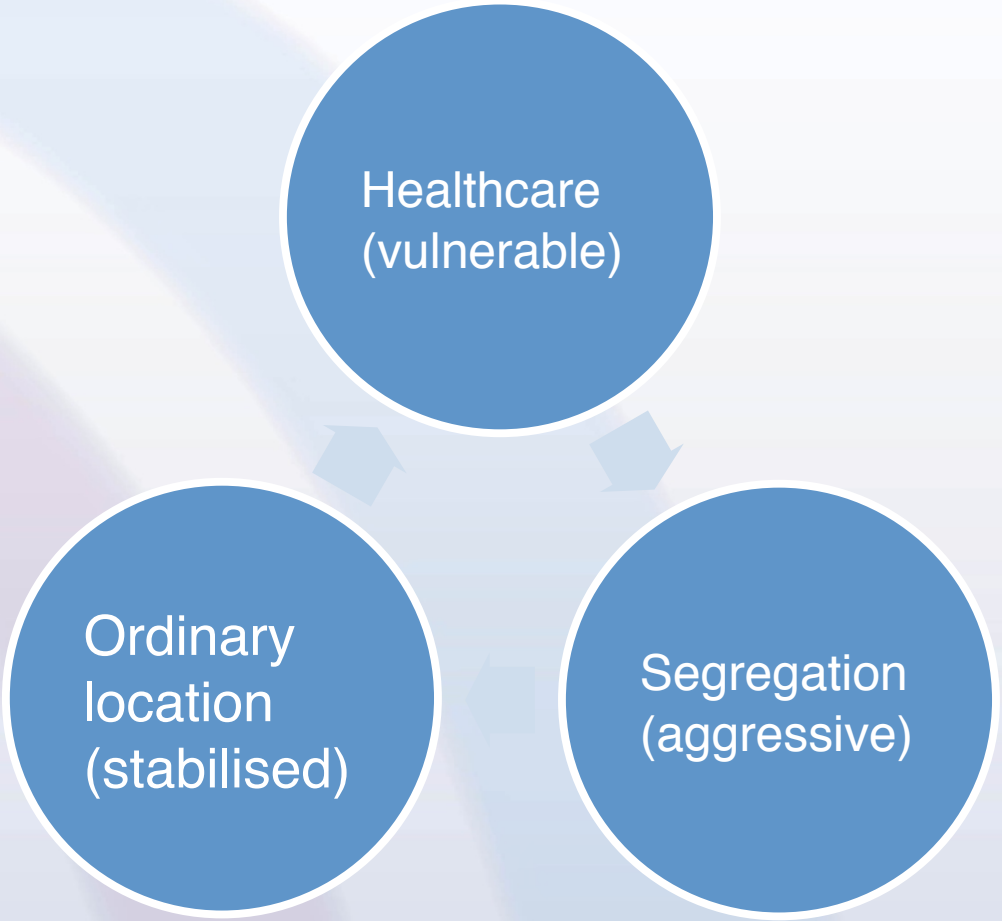
Local context

- Healthcare provision based around a hospital wing with accommodation for up to 19 young people and access to some primary care services
- Limited mental health provision
- Review of reasons for admission over a two year period (early version of "Health Needs Assessment") identified that;
  - Average bed occupancy of 8 young people
  - 50/50 split between "clinical" and "behavioural" needs
  - Clinical included
    - Small proportion of physical health needs and detoxification
    - Small proportion of serious mental illness
    - High proportion of emotional regulation problems, including self harm in the context of mental illness
  - Behavioural included
    - Emerging PD
    - Aggression
    - Self-harm not associated with mental illness
    - Learning Difficulties
    - Poor coping and vulnerability
  - Average bed occupancy based on clinical need; **2**

Local context

- High level of “complex need” (i.e. need in more than one area, such as vulnerability *and* aggression)
- Many caught in revolving door, depending on which need was prominent at any one time
- Resources allocated to manage this group restricted resources available to meet mental health needs across the establishment

Revolving door



Background within Secure Estate

- Consequences of this approach
  - Original needs are still not met
  - Discontinuity of care
  - Does not solve the prison's "problem" (or the young person's difficulties)
  - Original needs are often made worse
    - Deterioration in emotional wellbeing →
    - Increasing problems in emotional dysregulation →
    - Breakdown in relationships with staff →
    - Behavioural problems increase
- Most young people admitted to the healthcare unit had complex needs, not serious mental illness

Local response

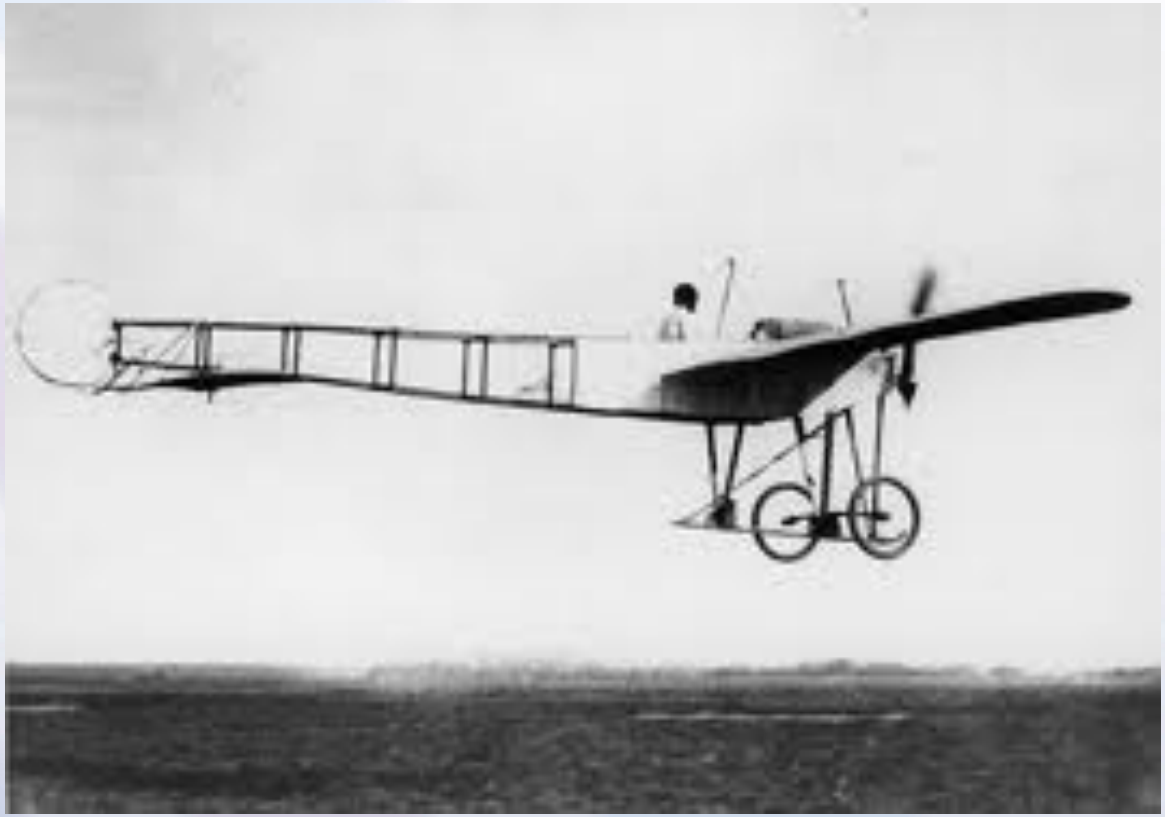
- Business case to re-profile resources within the prison
  - Community mental health service to meet needs of overall population
    - Screening
    - Stepped care approach
    - Emergency beds
  - Complex needs service based on hospital wing
    - Discipline staff supported by mental health
- All underpinned by high level of commitment from key stakeholders
  - Prison
  - Health commissioners
  - Health providers

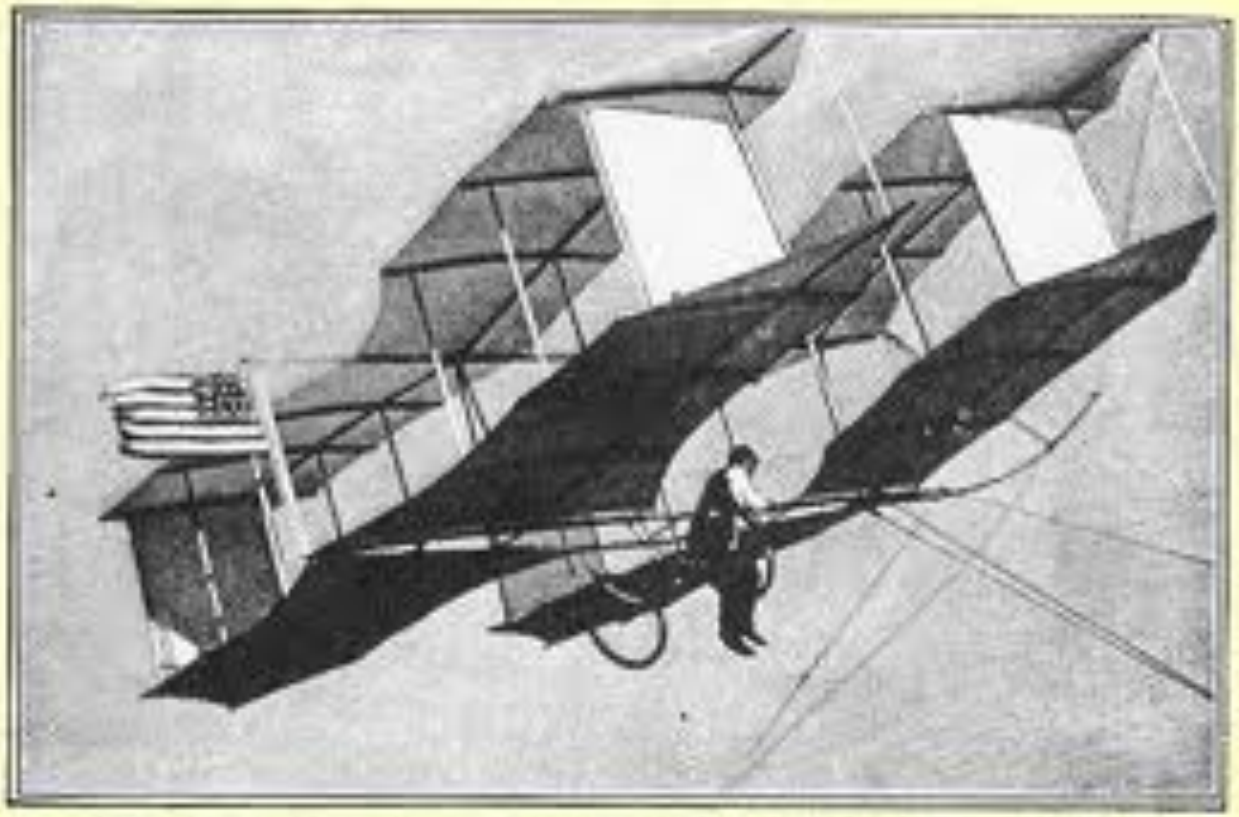
Joint commitment from the prison and mental health at three levels

Commissioning	Partnership Board
Organisational	Steering Group
Operational	Weekly meetings

Question

- What would “good” look like?





MR. FRED BICKFORD ASCENDING IN A LAMSON KITE IN 1897.

Willow Unit: Aims

- Collaborative approach between prison and mental health
  - Meet the psychological needs of young people with the most complex needs and reduce frequency of "moves"
    - Promote mental wellbeing
    - Facilitate emotional regulation
    - Promote pro-social relationships with staff and peers
    - Facilitate self-regulation of behaviour
  - Improve the overall prison regime by reducing disruption on other units

Service model

- Small-scale environment with high level of consistency from selected and trained staff group
- Mental health input embedded
- Regime specific to unit – including education and programme staff
- Individualised care supported by multidisciplinary review process
- Robust pathway through unit
- Emphasis on socialisation, promoting resilience and reintegration
- Overview and support at commissioning and organisational level

Therapeutic Milieu

- Meta-framework:
  - Attachment *(Bowlby,1998; Crittenden, 2005)*
  - Trauma (developmental trauma & trauma systems) *(Van der Kolk, 2005; Briere & Scott, 2006, Saxe et al., 2007)*
- Emphasis on safety and supporting staff to regulate their own emotions and provide secure, 'therapeutic' parenting
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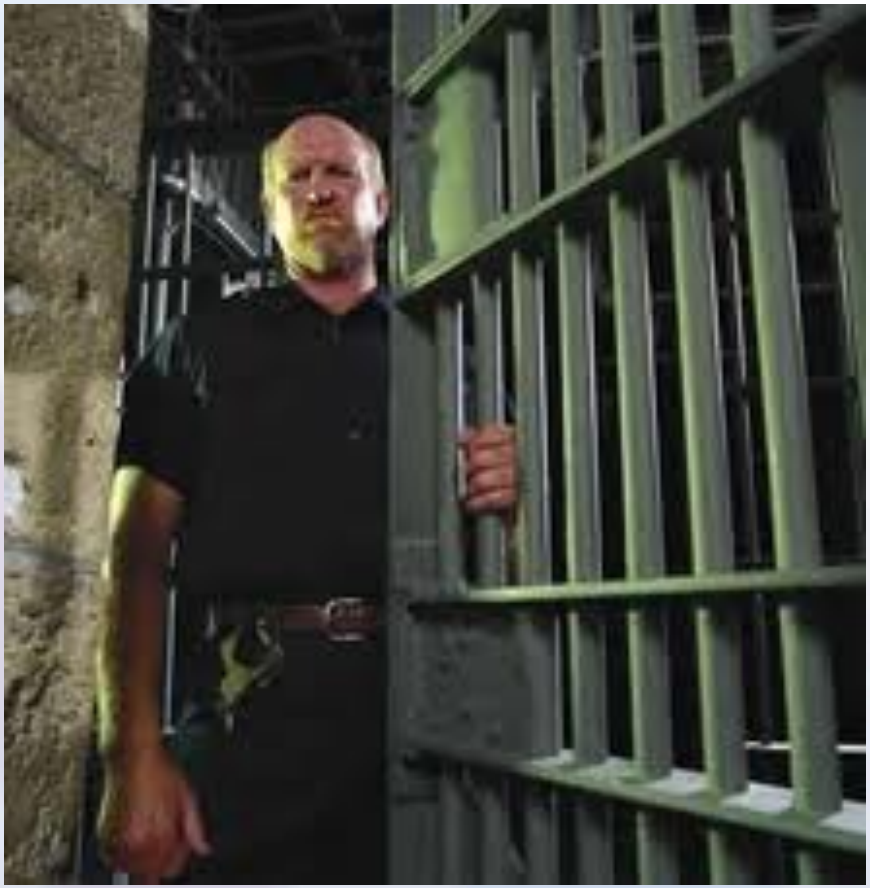
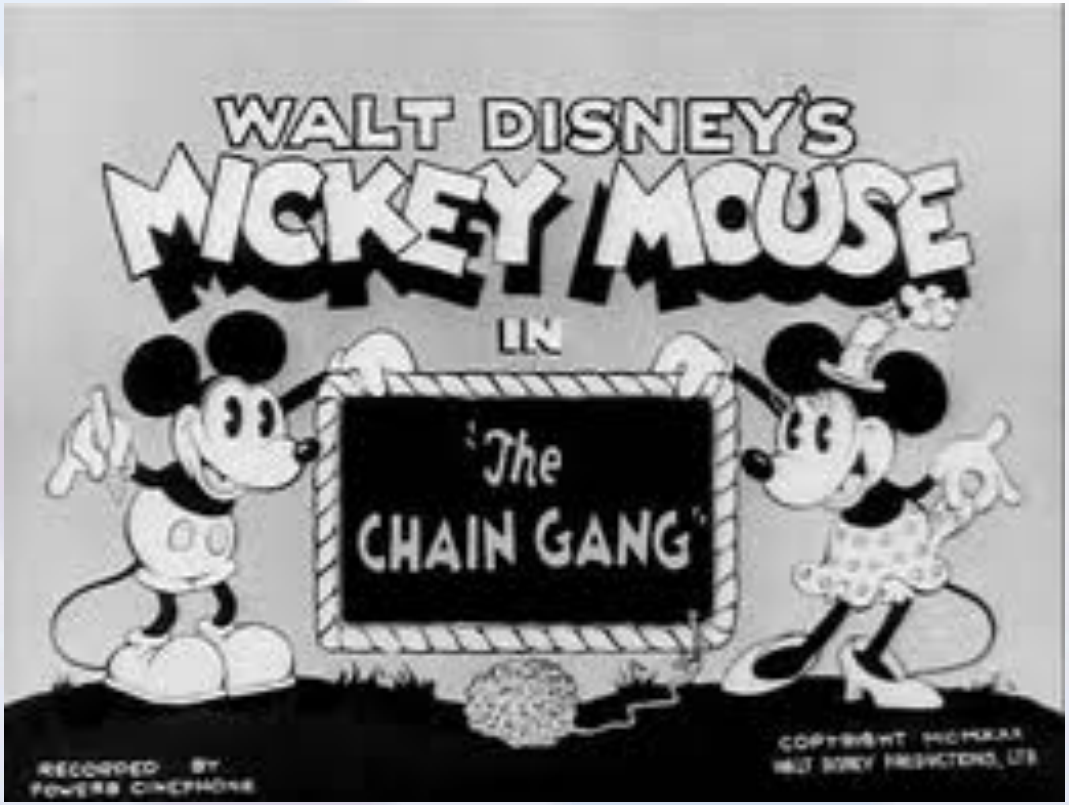


The End?



Organisational challenges

- Getting the level of staffing right (not enough staff to facilitate programme)
- Getting the regime right (too much activity on the unit – dependence)
- Getting the mental health support right (too many different people involved)
- Getting the model right (lack of clarity in model)

Organisational challenges

- Getting the level of staffing right (not enough staff to facilitate programme)
  - Changes to staffing to support regime
- Getting the regime right (too much activity on the unit – dependence)
  - Reduction in regime on unit, greater emphasis on reintegration
- Getting the mental health support right (too many different people involved)
  - Allocate specific staff members to ensure consistency of input to young people and support for staff
- Getting the model right (lack of clarity in model)
  - Adoption of attachment/trauma model to support formulation process and care planning

Clinical challenges

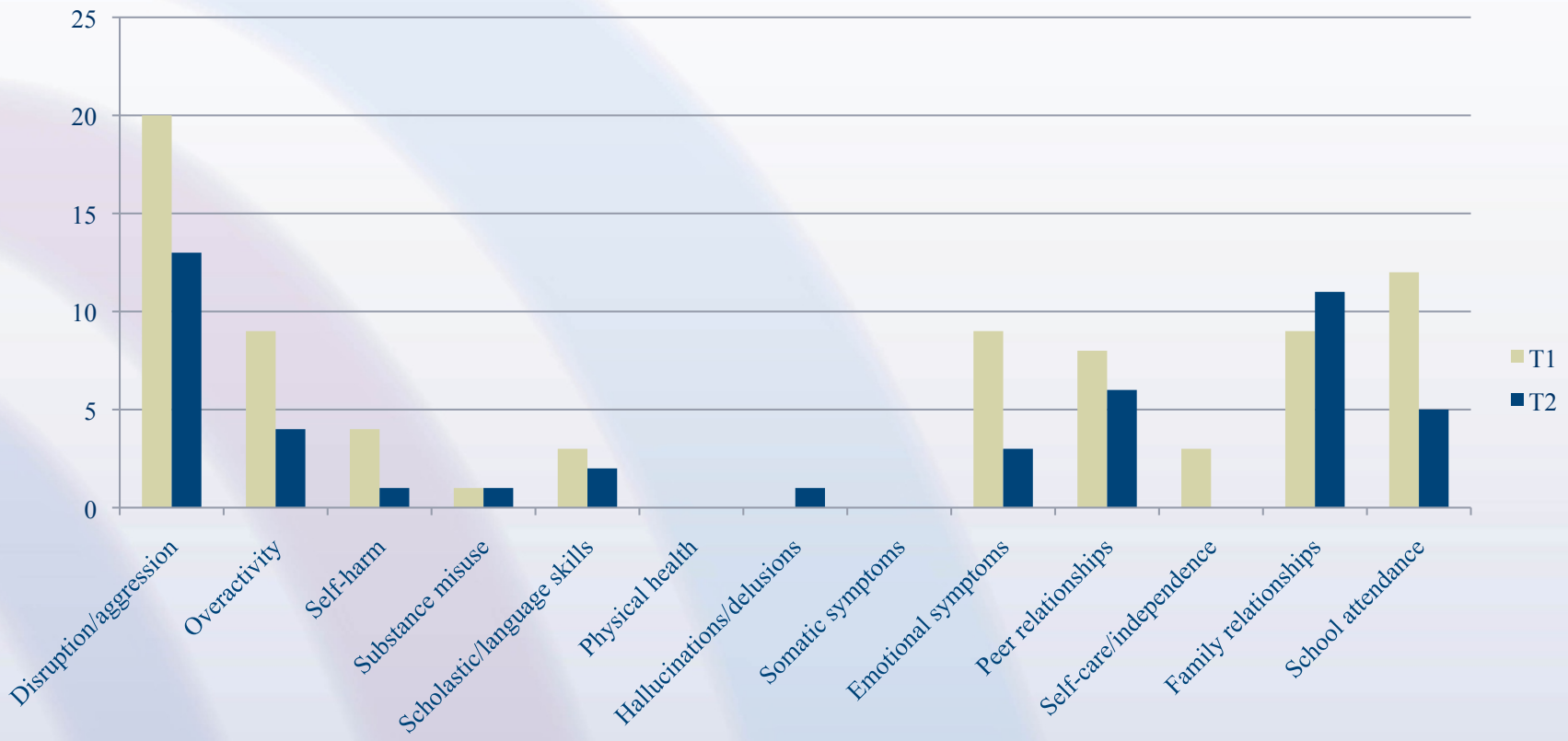
- Selection criteria (identifying young people likely to benefit)
- Creating dependence (on high level of support and small scale of unit)
- Staff fatigue and vicarious traumatisation
- Splitting (discipline or therapy? authority or nurture?)

Clinical challenges

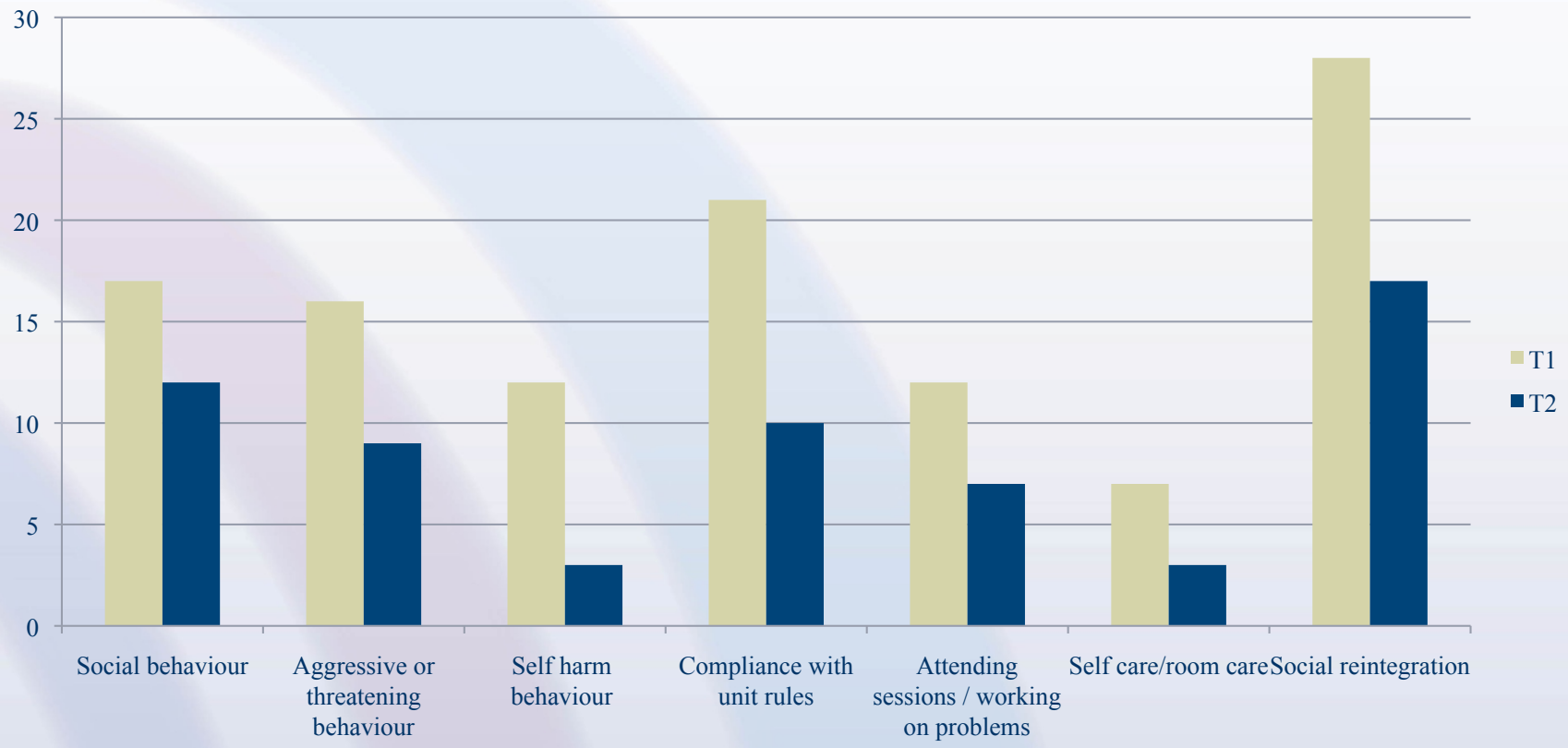
- Selection criteria (identifying young people most likely to benefit)
  - Improve referral/assessment pathway to identify young people most likely to benefit (not necessarily those who want to be there)
  - Maximise inclusivity but ensure effectiveness
- Creating dependence (on high level of support and small scale of unit)
  - More activities provided off the unit, reintegration plans, aftercare from personal officers
- Staff fatigue and vicarious traumatisation
  - Support and training, develop culture of openness and reflection
- Splitting (discipline or therapy? authority or nurture?)
  - Use of formulations, adherence to model, ensuring commitment at all levels, recognition of gender dynamics

Factors at time of admission to unit	
Violence	
To other prisoners	21 (51%)
To staff	14 (34%)
Damage to property	10 (24%)
Self-harm	
Cutting	11 (27%)
Ligature	7 (17%)
Burning	3 (7%)
Minor self-harm	2 (5%)
Contact with mental health team	39 (95%)
Not in mainstream education	18 (44%)
Communication problems (language/speech/hearing/literacy)	12 (29%)
Serious substance misuse	28 (68%)

HoNOSCA scores at admission and discharge



Willow assessment (SABER) scores at admission and discharge



	Prior to admission	During admission	t	Sig
Number of adjudications	4.77 (5.51)	3.74 (4.65)	1.32	0.20
Days on IEP status				
Basic	8.68 (15.41)	3.82 (9.22)	1.42	0.16
Standard	33.00 (31.33)	48.64 (35.54)	−2.57	0.02
Enhanced	7.16 (34.56)	13.70 (39.57)	−0.61	0.55

Discharge outcomes

Discharge outcome	N (%)
Return to ordinary location	14 (34.1)
Release direct to the community	9 (22.0)
Transfer to another prison	7 (17.1)
Transfer to Care and Separation Unit	7 (17.1)
Admission to mental health bed	1 (2.4)
Missing	3 (7.3)
Total	41 (100)

Case Example

- 15 year old boy with I.O. possession of weapon (gun) / assault * 3
- 24 month sentence
- Presenting difficulties:
  - Extreme levels of violence towards staff & young people
  - ? 'hearing voices'
  - Refused to come out of room – deemed 'unmanageable'
  - Reported 'lack of empathy' & poor emotional vocabulary
  - High anxiety / OCD type symptoms
  - Collecting pieces of metal (e.g. screws) - used as weapons
  - Sleeping with light on / poor sleep
- Background History (brief):
  - Early domestic violence
  - Exposure to violence within community
  - Neglect (particularly emotional)
  - ? Specific trauma aged 12 years (suspected)
  - Long history of violent offending behaviour – domestic and community
  - Family conflict

Case Example

- Formulation
  - Avoidant attachment – dysregulated, but suppressed emotional world / poor development of emotional repertoire
  - High anxiety / hyper-vigilance to threat
  - Managed by suppression of emotion, OCD type symptoms and repeating cognitions relating to violence
- Intervention
  - 18 months
  - Therapeutic milieu – House of parenting / parenting with PACE
  - Development of emotional world – individual sessions, relationship based & developmentally (not chronologically) appropriate
  - CBT informed interventions (focus on recurring violent thoughts)
  - Work with parent/grandparent & community agencies – shared multi-systemic formulation and approach
- Outcome
  - Significant reduction in frequency and intensity of violence (no incidents in final 6 months of sentence)
  - Placement maintained
  - Improvement across all presenting difficulties – as reported by unit staff, parents, professionals & young person
  - Improved relationships with family
  - Successful return to community placement – medium term view to moving back home

Lessons learned

- Stakeholder buy-in essential
  - Need for inter-agency cooperation at all levels
- Perfect Preparation Prevents....
  - Important but have to make a start at some point....and then
- Hold your nerve
- Underlying principles important but resilience also comes from flexibility

THE FUTURE…….CHALLENGES & OPPPORTUNITIES

Challenges & Opportunities

- Early days - very complex & highly challenging
- Emerging support - and only PART of the jigsaw
- Operationalising theory into practice with different environmental constraints
- Time & realistic expectations
- Dealing with the toxic nature – managing vicarious trauma
- Negative attitudes: “difficult/challenging/damaged”
- Getting drawn into their world
- Replicating past relationship patterns
- ‘Managing’ difficult/risky behaviour rather than effective interventions to tackle it

Future….Challenges and Opportunities

- **REALISTIC OPTIMISM: Adolescence is a huge window of opportunity e.g. Brain development, developmental tasks, unfinished models, receptive to change**
- **It is possible to place alternative attachment models alongside other (mal)adaptive models!….and then resolve unprocessed traumatic experience**
- Recognising the small steps….. setting your sights at an appropriate level
- **ABSOLUTELY MUST BE IN CONTEXT OF WIDER PATHWAY – GENERALISATION TO MAIN LOCATION AND COMMUNITY – TRANSITION PLANNING**
- Support from YJB and NOMS e.g.
  - Prison officer training
  - Possibility of further 'complex needs' units across the estate

Questions

- Who are the young people with "complex needs" in the justice system?
  - Are they all the same?
  - Are there identifiable sub-groups?
- What are the pathways for them within the broader youth justice system?
- What are the transitional pathways for them into adult services?

Questions

- How do metal health services add the most value within the youth justice system?
  - Generic services or specialist services in the secure estate?
  - Mental health input to YOTs
  - The role of forensic services (community and in-patient)
- What should a comprehensive range of services look like?

Overview of the pathway

Tier	Community	YOT	Secure Estate	In-patient	Transition to adult services
Tier 4: highly complex	CAMHS in-patient	Community forensic CAMHS	Complex needs services	Adolescent forensic in-patient	Adult forensic Service / PIPES
Tier 3: multi-disciplinary	CAMHS MDT	Referral to CAMHS	CAMHS in-reach MDT		CMHT / Early Intervention / Prison in-reach MHT
Tier 2: single practitioner	CAMHS practitioner	YOT health worker	CAMHS in-reach worker		Primary care MH / Prison primary care MH
Tier 1: front-line agencies	Everyone!	Everyone, including YOT	Discipline staff etc.		Probation etc

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