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Space to Think: Lessons and Impact of the IVY Project

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Contents

1. Executive Summary

The Interventions for Vulnerable Youth (IVY) service was developed and commenced in September 2013, aiming to fill the gap in service provisions for high risk young people. It is a nationwide service designed to meet the needs of a much marginalised and challenging group of young people. The project is funded by the Scottish Government and based in the Centre for Youth and Criminal Justice at the University of Strathclyde.

Two years on from the birth of the project, this service evaluation was carried out by the Centre for Youth and Criminal Justice to measure where the project is now and where it will go in the future.

104 referrals have been made over two years, of which 91 were accepted as appropriate for inclusion in the service. These have come from 26 of 32 local authorities across Scotland with 10% of surveyed professionals having used the service on more than one occasion and 100% responding they would use the service again, suggesting that the project is embedded within the mental health landscape.

Overall, 98% of survey respondents were positive about their self-identified aims of involvement being met, with 56% expressing that their aims had been met excellently, 37% that they had been met well and 7% fairly well.

91% of respondents thought the report added a new way of thinking about the potential risk and 94% felt it would influence the young persons' care plan.

In the survey of professionals, 73% reported that the young person had either maintained their current living placements or had moved towards greater independence and 90% of the respondents believed the project had benefitted the young person or family or carers. Additionally, 95% to 98% of respondents rated the Risk Analysis Report as somewhat or very likely to help the young person towards better outcomes in terms of the various SHANARRI outcome indicators.

It emerged that one of the most striking outcomes was providing guidance and support in these complex and high-risk cases to the referrers and other professionals involved in the care of the young people. Put most simply, 'space to think'.

Two main issues were raised by referrers surveyed; the length of the waiting time prior to consultation, and clarity regarding communication between the service and themselves. These are both previously identified issues. To overcome these, two psychological staff have been added to the team in place of the use of consultants (which was required due to difficulties recruiting staff). It is expected that this more consistent staffing model will enable the service to be more responsive to the needs of the referrers.

2. Introduction

2.1 Mental health in Scotland

Improving mental health is a national priority in Scotland. *Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009–2011* (Scottish Government, 2009) committed NHS Health Scotland to work with key stakeholders to develop a set of national indicators to monitor trends in children and young people's (C&YP) mental health (mental wellbeing and mental health problems) and associated contextual factors. Building on previous work to develop a core set of national indicators for adult mental health, NHS Health Scotland finalised and published a similar set for Children and Young People in November 2011 (Parkinson, 2012). The importance of the indicators was highlighted in the latest mental health policy document, *Mental Health Strategy for Scotland: 2011–2015* (Scottish Government, 2011).

Particularly highlighted within the strategy was the issue of how best to tackle conduct disorders. Conduct disorders refer to a broad spectrum of behavioural problems from a relatively mild form of behavioural disturbance to the most severe forms of externalising behaviour, such as extreme violence and sexual offending. The prevalence of conduct disorders increases throughout childhood and has been found to be more common in boys than girls. These conduct disorders frequently coexist with other mental health problems; for example, in some groups more than 40% of children and young people with a diagnosed conduct disorder also have a diagnosis of ADHD. Other coexisting issues have been identified such as substance misuse problems, attachment difficulties, trauma presentations, and mood difficulties. Children with severe conduct problems may need to be looked after away from home, may be subject to youth justice interventions and as a result, be more likely to require intervention from the Children's Reporter and Hearing System. Although conduct disorder does not always lead to offending, studies have shown that the relationship between the two is a strong one. Conduct disorder is also a significant predictor of adversity in adulthood.

The needs of children (and the families of children) who present with severe conduct problems in the form of violent behavioural problems are diverse, complex and require multiple perspectives and input. They are a group of children who have attracted considerable research interest and with developments in forensic mental health and risk assessment, formulation and the linking of trauma to violence, the knowledge base that exists to promote better outcomes for these young people has grown. However, there remains inequity in the provision and accessibility of the requisite expertise to properly support the care and management of this most challenging group of children. Within the NHS, the Child and Adolescent Mental Health Services (CAMHS) have been a key resource working with children and young people up to the age of 18. Whilst the CAMHS workforce has been increased and access improved in recent years, particularly with regards to waiting periods, the reality remains that demand outstrips capacity. Additionally there are differences in resource allocation and accessibility of expertise depending on geography. Conduct disorder – even severe conduct disorder - may or may not be considered in that category and local services differ in terms of their provisions. Within Scotland, there is one, relatively small, Forensic CAMHS team existing to meet the needs of the young people in only one

health board area. This has meant in some local authorities some young people are referred to the adult mental health team, or to support services for older young people. For such a marginalised group, access to the right expertise, in the right place at the right time is critical. It was against this backdrop that the Interventions for Vulnerable Youth (IVY) service was developed.

IVY exists to provide an alternative provision for children and young people that adheres to best practice in risk assessment and management for very high risk youth. It adopts a multi-disciplinary tiered approach to risk assessment, formulation and management for high-risk young people aged 12 to 18 years, who present with complex psychological and mental health needs and high-risk behaviour in terms of their violent conduct. The minimum standard for every referral is a risk analysis report structured around best practice methodologies in assessing risk. Where appropriate and indicated, specialist assessments are also completed and, for a very few exceptionally unusual or challenging cases, individualistic and formulation-led treatments are delivered by highly specialist psychologists. The three levels of intervention offered by the IVY project are; Level 1: Consultation, Level 2: Psychological Assessment and Level 3: Treatment.

IVY is funded by the Scottish Government and based within the Centre for Youth and Criminal Justice at the University of Strathclyde. It is a nationwide service designed to meet the needs of this marginalised group who cannot, or will not, access psychological assessment and interventions necessary to ensure their needs are met.

Two years on from the birth of the project, this service evaluation was carried out to ascertain whether IVY has had any impact. A multi-method audit was completed in order to determine what referrers think of the project, where we are now and where the project will, or at least should, go in the future. The survey examined three main areas: the consultation, the Risk Analysis Report and their wider experience of the IVY service.

2.2 Where IVY sits within the Scottish mental health landscape

IVY provides three distinct but related levels of risk assessment and management using a Structured Professional Judgement (SPJ) paradigm, which is recognised as best practice in risk assessment. This service aims to ensure: a consistent minimum standard for all referrals, that those young people with the highest level of risk and need do not incur any undue waiting times, and that they have access to appropriate resources.

The rationale for developing this service is based upon an awareness that a significant proportion of high risk young people with severe conduct and offending behaviour problems are marginalised within society and may be unable or unwilling to access appropriate resources capable of meeting their complex psychological health needs. Across Scotland, severe conduct disorder/conduct problem is not typically viewed as eligible for CAMHS input, and access to psychological treatments for this population is inconsistent. As such, it is often the responsibility of social work services to resource external supports in the form of commissioned assessments which can be timely and costly but more importantly are limited in scope with no follow-through treatment and/or interventions available.

The service is based in Glasgow at the University of Strathclyde but accessibility can be ensured via teleconferencing and webinars for those referrers who are geographically

distant. IVY also links directly with 'Safer Lives' trainers across Scotland to help embed the work of the service in local practice. Referrals will be arranged, where appropriate, to local CAMHS for follow up.

2.2.1. Aims and objectives of the project

At a minimum, within the project young people's care plans will be informed by a level of risk analysis typically not accessible within local authorities. This will optimise the ability of teams to intervene and target resources appropriately and ultimately impact upon the effectiveness of risk management. Psychological assessments will be carried out by IVY where there are substantial information gaps or specialist psychological or mental health assessments are required. This will ensure that young people have a fully and properly informed analysis of any significant and unusual complexities in their presentation as well as a full consideration of psychological disorders and mental health problems. This is intended to fulfil unmet need and identify areas of vulnerability previously undocumented. In addition, case specific treatments will be analysed for treatment impact on risk, per se, but also on psychological health and well-being. By engaging with the service, social workers will, through a process of consultation and peer support, be introduced to the stages involved in a fully comprehensive risk assessment and analysis which will aim to impact competency and capability.

3. Methodology

The data collection and analysis was carried out throughout October 2015 by Kristina Moodie, Associate Researcher within CYCJ and Arlene Anderson, an independent researcher who has recent experience of the IVY service having accessed IVY data as part of her recent MSc dissertation.

There are four sources of data that will be utilised throughout this report and they are described below:

a. Ongoing feedback

Since 3 July 2015 feedback forms have been distributed to referrers as they arrive and leave the project on the day of the consultation in order to help identify their aims and objectives from the meeting, and also record their expectations of what the consultation might be able to achieve in their case. The responses collected as they leave the clinic capture an immediate record of how they feel the consultation worked in reality. To date, 22 consultation feedback forms have been completed in respect of 14 young people. When the formulation, in the form of a Risk Analysis Report, has been prepared and distributed to the professionals involved, they are again asked to provide feedback. As part of the ongoing feedback, five Risk Analysis Report evaluations have been completed.

b. Retrospective survey

Professionals involved in the referral of the young person or, who had attended the clinic, were identified and contacted during October 2015 and asked to complete an evaluation survey. This survey contained the same elements found in the feedback forms for both

consultation and Risk Analysis Report, as described above, and, additionally, some questions relating to the service in general. 127 individuals named in the referral application were identified in respect of 71 young people referred to the service and were included in the survey. This survey was initially distributed by email through a link to an online survey website, Qualtrics (Qualtrics, Provo., UT, 2015). However, due to a low response rate the remainder of the referrers identified were contacted by a researcher by telephone and asked to complete the survey verbally.

Within this evaluation report the responses by recent project attendees to the ongoing survey and by previous attendees who completed the retrospective survey will be combined to give an overall view of expectations of the IVY service, experience of the consultation and views on the Risk Analysis Report.

c. Feedback from other stakeholders and project staff

The IVY Project Steering Group consists of members from various local authorities and the Risk Management Authority (RMA). Two members of the steering group have had members of their staff seconded to the IVY Project and one gave their views on the project to date. In addition, two IVY project staff members gave their views regarding their experiences.

d. Project databases

There are two databases used within the project. The Referral Database contains contact information, demographic data and identified risk factors as indicated on the referral form for each case referred to the project. The Risk Analysis Database records information regarding risk assessment measures. Data was extracted from both of these databases and included within this report.

4. The IVY Project

4.1. Stages of the project

Pre-referral stage

Prior to a referral being made, potential referrers often call the project informally to discuss the case and their particular concerns or anxieties. Where the project is not appropriate for a young person, for instance, due to the level of risk being too low (e.g. delinquency as opposed to violence, or self-harm as opposed to risk of harm to others) or due to the age of the young person, then the psychologist or social worker consultant will often give advice or guidance regarding the next steps the referrer might take to move on with the case. Where a case fits the project criteria, the project worker will often recommend that a referral is made and if necessary advises the referrer how to do this.

Level 1 Consultation

Initially the IVY project estimated that there would be fortnightly consultation clinics with two scheduled cases. However, after the first year of the project the decision was made to hold consultation clinics on a weekly basis; this would continue the pattern of having at least four consultations each month. Currently there are six consultations, with an additional clinic being held on two Fridays per month. Emergency clinics can be arranged if a case is deemed particularly urgent.

Urgent cases are usually situations where there needs to be a decision made quickly regarding pending charges against the young person or in relation to a placement where, for example, there is a family breakdown. When an urgent clinic is requested by the referrer, a clinical psychologist will speak to the referrer to gain an understanding of the case and its urgency and give an estimate of the length of the waiting list and when a scheduled place is likely to be available. If the case is viewed by the psychologist as more urgent than the other cases on the waiting list, it can be given priority within the schedule. This enables the flexibility of the project to respond in a timely manner to more urgent cases.

A Risk Analysis Report is subsequently provided to the lead professional/referrer. This report includes information on the young person's background, risk factor ratings, risk formulation, risk scenarios, and recommendations for risk management.

Occasionally follow-up consultations will be held at the Level 1 stage. These are used to address any changes that may occur with the young person. Referrers are informed that they can phone for guidance or advice at any time and sometimes it is felt that a second, or third, meeting would be advantageous in certain cases. These follow-up consultations join the end of the waiting list as before, except in cases where a meeting is deemed urgent.

Level 2 Psychological Assessment

There is often a lot of communication between project staff and referrers at this stage and they are informed where they are on the Level 2 waiting list. This is a more complex stage as the clinical psychologist will travel to where the young person is accommodated and will arrange a location to meet the young person. The assessments, themselves, are often highly specialised and may require several visits to complete. Two of the part-time clinical psychologists carry out this particular stage and appointments are allocated when time permits. Currently there are 12 cases on the Level 2 waiting list and young people are offered appointments by the first available clinical psychologist.

The Government target for all NHS services by the end of 2015 is 18 weeks from referral to treatment and the IVY project aims to fall within this timescale. Waiting list timescales are measured from the date of the consultation where Level 2 intervention was agreed, as it is only at that stage it is known whether the young person has assessment needs. It is common at Level 2 for IVY staff to identify other services to provide the input, particularly in complex cases or when there is a learning disability.

Level 3 Treatment

In this stage of the project the young person, rather than being referred to another service, might receive direct formulation-led diverse work carried out by IVY project staff. Additionally

the project can provide staff group supervision to those working with the high-risk young people. To date, two cases have received this type of input.

4.2.1. Changes over time

As of November 2015, the project will be working at full capacity. In terms of posts filled, the lead consultant psychologist and clinical psychologist will continue to work one day per week and there will be two clinical psychologists working part-time and one working full-time. As a result, a decision has been made to continue with six scheduled consultations each month as standard, increasing the number and speed of responses to referred cases.

In the second year of the project it was decided to add a level of ongoing feedback and dialogue between referrers and the project at two stages of the journey. On arrival at the consultation, attendees are asked to identify what they hope to achieve from the meeting with project staff. Post-meeting they are asked to identify if these aims were met. In addition, once the formulation has been completed by the project staff and the resulting Risk Analysis Report shared with referrers, they are again asked if and in what ways this will help them with case planning. Methods of capturing the young person's voice and experience of the IVY project are also ongoing.

Training provided by project staff in conjunction with CYCJ to date has included an input into a 'violence workshop' in the Highlands, workshops at both the Youth Justice Conference 2015 and the 2015 Social Work Scotland Conference, including keynote speeches from the IVY Project Lead. Mutual training with PREVENT (Scotland) and two practice training days, one in the use of START-AV and one in the use of the SAVRY, provided by the lead psychologist. In addition, there is the ongoing publishing of papers and reports.

4.2.2. Project staffing

The staffing levels of the IVY project have fluctuated over time due to some issues in attracting appropriately qualified psychologists to a service with short-term funding. As a result the project has offered part-time positions and more recently sought out professionals who can be seconded from their posts for a period of time. Going forward it is clear that the project would benefit from longer contracts and consistent staffing.

Table 4.1 Project staffing during 2014-2015

Project Staff	Days per week	Responsible for:
Project lead – Consultant Clinical and Forensic Psychologist	1	Chairs all consultations. Supervising all psychological staff and oversees all reports. Training delivery.
Project Manager (Service in kind from CYCJ)	1	Overseeing all aspects of the project including promotion of the service. Providing supervision. Securing funding.
Clinical Psychologists	3	Level 1 reading and preparation. Consultation, formulation and report writing, Level 2 specialist assessments and Level 3

		direct work, operational tasks.
Psychological Consultants	1	Level 1 reading and preparation. Consultation. Formulation and report writing.
Social Work Consultants (Including two half-day consultants, service in kind from North Lanarkshire Council)	2.5	Level 1 reading and preparation. Consultation, writing Risk Analysis Report with supervision.
Assistant Psychologist	1	Database management
Project Administrator	2	All admin duties

These staffing levels will change in November 2015 with the addition of two new Clinical Psychologists increasing capacity to an additional 7.5 days a week (one full-time post and one part-time post). The Project Administration post has also been increased to three days a week

5. Findings

5.1.1. Demographics

The project works with young people aged between 12 and 18 years of age, who are presenting with complex behavioural issues that the current professionals involved in their care are struggling to cope with or manage.

To date there have been 104 referrals made to the IVY project although it is worth noting that many potential referrals are discussed prior to a written referral being made. Where a referral is not appropriate and/or does not fit the criteria then alternative advice is given by project staff. Of the referrals made, 91 have been accepted by the project and thirteen were rejected as not fitting the project criteria, as discussed below.

Of the 91 young people accepted onto the project the mean age was 15 years and the majority were young males (84%) and 16% young females. The mean age of the young females is slightly lower at 14.67 years compared to 15.12 years for the young males. Referrals came from a total of 26 local authorities: the majority of the accepted referrals came from South Lanarkshire (11%), Falkirk (10%), Dumfries & Galloway (9%) and North Lanarkshire (9%). Nearly three-quarters (73%) were not currently attending mainstream education and just over half (51%) were recorded as having received police charge(s). The majority of the young people were living outwith the family home at the point of referral. With research identifying that looked after children have significantly poorer mental health than the rest of the population, this is perhaps not surprising. In total, 29% of the young people referred to the project were living with family at the time of referral whilst the remainder were accommodated in various other settings as shown in table 5.1 below.

Table 5.1 Young people living circumstances at point of referral

Living Circumstances	Count	%
Residential Setting	34	37.4%
Family Home	26	28.6%
Secure Setting	13	14.3%
Foster	5	5.5%
Supported Accommodation	5	5.5%
Alternative Family Placement	3	3.3%
Own Tenancy	2	2.2%
Scottish Prison Service	1	1.1%
Young Offender Institution	1	1.1%
Homeless Unit	1	1.1%
Referral Total	91	

Table 5.2 Legal status of the young person at point of referral

Legal status	Count	%
Compulsory Supervision Order (CSO)	46	51%
Voluntary Supervision	8	9%
Permanence Order	6	7%
Interim Compulsory Order	4	4%
Other	3	3%
Community Payback Order (CPO)	2	2%
Parental Responsibilities Order	1	<1%
Information pending	2	2%
Not recorded	19	21%
Referral Total	91	

Just over half of young people were subject to a compulsory supervision order, when this information was recorded. The majority of referrals (72%) were made by social workers, with a further 19% from CAMHS or Health, 6% from residential workers, 2% from Education and 1% referred by the Police.

In 46 referrals, there was a record of the young people being charged with an offence and an indication of the types of charges each young person was facing. Thirty-eight of the young

people with recorded offences were young men and eight were young women. The majority of offences committed by both genders were offences of violence (20 of the young males and seven of the young females were reported to have been charged with these), thirteen of the young males had been charged with sexual offences and two had been charged with both sexual offences and offences of violence. Four young people were charged with offences of vandalism or fire-raising (three of these were young males and one was a young female).

5.1.2. Declined referrals

The project is funded to work with a very distinct group of young people presenting with specific needs. They must be aged between 12 and 18 years of age and present a danger to others.

Thirteen referrals were made who did not match the criteria of the project and therefore could not be accepted. In six cases the young people were under 12 years old, in four cases they were over 18 years old, in two cases they were not deemed high-risk and one case already had Forensic CAMHS involvement which was felt to be adequate. In each of these cases guidance was given by the clinical psychologist within the project regarding possible next steps.

5.2. Referrer aims

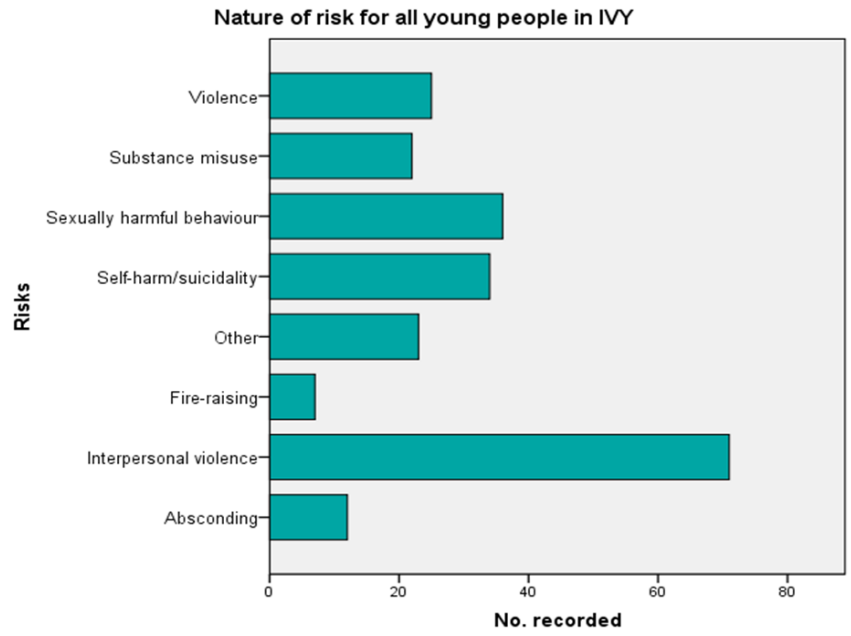
5.2.1. Referral/application to project

The most commonly emerging aims of the consultation as reported within the referral to the project were risk assessment, risk management and informing the care plan. One or more of these aims were identified in 60 referrals of the 72 where there is a documented record. Discussing potential options and a need for a second opinion were also identified, as was hope for greater understanding of the young person's behaviour and planning for the young person's future. Other identified needs were recommendations for alternative placements, to discuss the future direction of the case management and for the young person's cognitive capacity to be examined.

Emerging from these applications, however, is a general sense of needing to 'share' the case at the consultation; for example, in order to get a second opinion, to 'offload', or to get confirmation that accurate and appropriate assessments and plans have been made and appropriate action has been taken.

'Presenting risks', as they have been identified by referrers, are specified within the application also. This information is not always provided, however; frequently more than one risk is identified and it is not uncommon to have several risks listed. The data is based on the information available about the young person at the point of referral and not on an individual assessment carried out by IVY: as such, it serves as a guide. The risks identified have been recoded into groupings of similar risk types and these 'presenting risk types' are shown in chart 5.3 below. The category of 'other' includes risks such as internet offending, gang violence and extremism.

Chart 5.3 Risk 'types' identified at referral



5.2.2. Needs of the young people

The young people referred to the IVY Project represent a group of individuals with complex needs, which are characterised by neurodevelopmental, emotional and interpersonal difficulties. The majority of the young people referred have needs which would meet psychiatric criteria for a formal mental health diagnosis, as per the prevailing ICD-10/DSM-V diagnostic classification systems. Table 5.4 below details the neurodevelopmental, mental health and behavioural difficulties relevant to the 72 young people discussed at consultation for whom there is information available. As before, it is important to note that this information is not based on having assessed young people directly on an individual basis, but on background information provided by referrers at consultation. It is acknowledged that partitioning out needs is not always clinically meaningful, particularly with respect to the young people in the IVY project whose many needs are often interconnected. The data is presented in this manner only in order to show the variation and combinations of needs identified and the clinical complexity in this client group.

Of the 72 young people for whom this data was available, 23% had no needs identified, 29% presented with a single identified need(most commonly this was ADHD or ASD). In the majority of cases, however, 48% presented with more than one identified need.

Table 5.4 Needs identified on application

Presenting needs identified	No. of young people
ADHD	10
ADHD and ASD (Autistic Spectrum Disorder)	1
ADHD, ASD, Autism	1
ADHD, Asperger's Syndrome, suspected Foetal Alcohol Syndrome	1
ADHD, Attachment Disorder	1
ADHD, Conduct Disorder, Reactive Attachment Disorder	1
ADHD, Insecure attachment with parent	1
ADHD. Oppositional Defiance Disorder (ODD)	1
Anger, Substance Misuse Difficulties (Alcohol/Drugs)	1
Anxiety, ASD	2
Anxiety, low mood, disrupted sleep pattern, self-harm	1
ASD	5
ASD, ADHD, Dyslexia, Dyspraxia, developmental concerns	1
ASD, Borderline Learning Disability, Attachment Disorder	1
ASD, possible OCD	1
ASD, Tics, Tourette's Syndrome	1
Suspected Asperger's Syndrome, Dyslexia, Dysgraphia, Dyspraxia.	1
Cerebral Palsy, ADHD, Conduct Disorder	1
Deliberate self-harm	3
Deliberate self-harm, trauma and attachment problems.	1
Deliberate self-harm, Substance Misuse Difficulties (Alcohol/Drugs), ASD	1
Deliberate self-harm, ADHD, Trauma.	1
Developmental delay, Dyspraxia, self-harm, chronic soiling	1
Foetal Alcohol Syndrome, slight learning difficulty, Attachment Disorder	1
Global Developmental Delay, Epilepsy	1
Suspected learning disability from head injury	1
Low mood, ASD	1
Neonatal Abstinence Syndrome, Foetal Alcohol Syndrome	1
ODD, sensory and motor difficulties, night terrors	1
PTSD, ADHD	1
PTSD, Anxiety	1
Substance Misuse Difficulties (Alcohol/Drugs)	1
Substance Misuse Difficulties (Alcohol/Drugs), deliberate self-harm, Reactive Attachment Disorder, PTSD	1
Substance Misuse, ADHD, ODD	1
Tourette's Syndrome, Foetal Alcohol Syndrome, developmental delay, heart murmur	1
Trauma	1
Trauma, attachment issues	2
Trauma, self-harm, suspected ADHD	1

None identified	17
Total	**72**

Of the 91 referred and accepted young people, 81 completed Level 1 (69 of these have received a Risk Analysis Report to date). Seven of the remaining ten are awaiting a consultation date. On one occasion the referral was moved straight to Level 2. In two cases the referrer pulled out of the project prior to Level 1 getting underway. On one occasion this was due to a change in post, in the other this was due to disengagement on the part of the referrer. In both of these cases, despite being formally discharged, an open invitation was extended to them to access the service at another time.

5.2.3. Risks identified through psychological assessment

The IVY project has offered psychological assessment to 44 young people in the first two years of the service with 32 having received this input to date. Of these, nine are ongoing cases and 12 young people are waiting for assessment to be scheduled. On six further occasions the assessment identified was recommended to be undertaken by services already involved with the case and on two occasions a recommendation for further psychological assessment was not taken up by the referrers.

The most prevalent risk protocol used by the IVY Project is the Structured Assessment of Violence Risk in Youth (SAVRY; Borum, Bartel and Forth, 2006) (42 cases). Other protocols and risk assessment tools used to date are the Risk for Sexual Violence Protocol (RSVP; Hart et al., 2003) (used in eight cases), Early Assessment Risk List for Girls (EARL-21G; Levene & Child, 2001) (used in three cases) and the Violent Extremism Risk Assessment 2 (VERA-2; Pressman and Flocton, 2010) (used on two occasions).

The EARL-21G is a structured clinical risk assessment device that provides a comprehensive framework to evaluate 21 risk factors known to influence young girls' propensity to engage in future antisocial behaviour.

The RSVP is a structured professional judgement risk assessment instrument which guides evaluators in assessing risk of sexual violence and in making risk management plans to prevent sexual violence.

VERA2 is a structured professional judgement tool to assess the risk of violent political extremism.

The SAVRY is a comprehensive assessment of violence risk for use with adolescents aged between 12 and 18 years. SAVRY includes both risk and protective factors for violent recidivism and is relevant for interpersonal, instrumental and sexual violence risk. Is it the most widely used assessment within the IVY project having been used with 42 young people. The risks identified using this tool are represented in Table 5.3.

Table 5.3 Risks identified within the SAVRY

Historical Risk Factors	High	Moderate	Low	Not Rated
1. History of violence	38	4	0	0
2. History of nonviolent offending	26	8	7	1
3. Early initiation of violence	23	13	4	2
4. Past supervision/intervention failures	21	13	4	4
5. History of self-harm or suicide attempts	9	17	15	1
6. Exposure to violence in the home	28	4	6	4
7. Childhood history of maltreatment	28	4	7	3
8. Parental/caregiver criminality	21	6	12	3
9. Early caregiver disruption	28	11	2	1
10. Poor school achievement	29	8	2	3
Social/Contextual Risk Factors				
11. Peer delinquency	22	8	9	3
12. Peer rejection	28	9	4	1
13. Stress and poor coping	38	3	0	1
14. Poor parental management	31	7	2	2
15. Lack of personal/social support	20	17	4	1
16. Community disorganisation	13	6	16	7
Individual/Clinical Risk factors				
17. Negative attitudes	33	7	1	1
18. Risk taking/impulsivity	34	3	3	2
19. Substance use difficulties	17	4	19	2
20. Anger management problems	34	4	2	2
21. Low empathy/remorse	29	3	1	9
22. Attention deficit hyperactivity difficulties	13	4	23	2
23. Poor compliance	31	9	0	2
24. Low interest/commitment to school	20	14	5	3

The most prevalent historical risk factor within this group is a history of violence. High contextual risk factors identified within the sample are stress and poor coping skills.

Individual risk factors identified include anger management problems, high levels of risk taking and impulsivity and negative attitudes.

5.2.4. Direct work by IVY project

To date, three cases have received a Level 3 intervention by the project. In one of the two current cases, there were initially three consultations plus further psychological assessments. A decision was made in November 2014 for one young person to receive direct work. This required a service level agreement with the local authority teams in both health and social work. The work was actioned in January 2015 and continues to date. This process involved a great deal of indirect preparatory work by project staff.

In a second case, escalated harmful behaviour concerns at a second consultation led to a Level 3 intervention. In this case the team already working with the young person required further support and the project had provided this. In a third case, the work has primarily been aimed at supporting the multi-agency team tasked with managing an extremely high risk and unusual case of attempted matricide.

5.2.5. Timescales of the project

The number of young people that fit the criteria for the IVY project is greater than the capacity of the project. This has resulted in an average waiting time from referral to consultation of 55 days, or around eight weeks. Over the two years that IVY has been operating this length of time has increased from 47 days in Year 1 to nearly 62 days in Year 2. Due to the time taken to write the formulation and Risk Analysis Report there is also a waiting period once the consultation has taken place: on average it takes a further 41 days (around six weeks) for receipt of the Risk Analysis Report. Over the life of the project this has reduced taking on average 43 days for receipt in Year 1 and 39 days in Year 2.

Clinic dates are allocated generally on a first come/first served basis, however the urgency of the case and availability of the staff involved to come together at a suitable time can affect this.

5.3. Survey responses

5.3.1. The project referrers

An email regarding an IVY survey was sent to 127 practitioners in respect of 71 young people. Seven of these surveys were completed online using an online survey tool, Qualtrics. Follow-up telephone calls were made to those for whom we had or could trace telephone numbers, which prompted a further 28 completed responses. Twenty-two of these were noted by the researcher and inputted into Qualtrics; the remaining six were completed by respondents online. Further follow-up individual case-specific emails were sent to 68 practitioners which prompted a further 17 surveys completed online.

Including feedback from the on-going survey, a total of 68 surveys were completed from a possible 129 participants giving a 53% response rate.

Referrers came from diverse occupations including social work, residential care, police, education and mental health practitioners. The majority of referrers (51%) were social work practitioners and included 11 who were in a senior position. An additional four referrers worked in residential care, all in senior positions. Nine of the respondents were mental health practitioners of different levels of seniority. Eight referrers were employed in education and one respondent was a detective sergeant. Job title was not provided for 11 respondents.

The following discussion of the results should be read in the context of the limitations of the review. Just over half of the practitioners surveyed responded (53%) and the views were confined to practitioners and, therefore, did not include the views of the young people and their families.

5.3.2. Consultation aims and outcomes

In order to identify whether the IVY consultation met the aims of attendees, respondents were asked to indicate their three main aims of attending the IVY consultation and how well these aims were met. Two respondents failed to detail any aim and 24 respondents did not itemise all three aims. In all, 159 aims were specified. After initial coding, the aims were split into seven categories. These were consistent themes throughout the survey. These were:

- Care plans
- Advice and support
- Clarification of behaviours
- Access to resources
- Risk Assessment, risk management, risk planning
- Multi-agency information sharing
- Information regarding the IVY service

Advice and support was the most frequently cited (48), risk assessment, management and planning was second (36), access to resources was third (22), followed by clarification of the young person's behaviours (18), consideration of care plans (17), multi-agency information sharing (12) and information relating to IVY (6). The second biggest category 'risk', perhaps not surprising given the nature of the service, underlines the importance that workers give to balancing the needs of the young person versus safety to the general public. The third category, 'access to resources' indicates the general difficulty regarding availability of resources for these young persons.

> *"The staff [were] extremely helpful and approachable; they valued the opinion of all involved in the consultation process. It also led to an appropriate and proportionate risk management plan being implemented for the young person." (Practitioner)*

> *"Really valuable service – essential when you don't have support in the local area. IVY provides an opportunity to have a discussion with people with more experience and provides an opportunity to have 'cross-fertilisation' of different professionals in the field. IVY focused on the young person and understands the needs of the young person as opposed to the service available in our area, which is an adult service. IVY expands our thinking to balance what is best for the young person versus likely risk." (Practitioner)*

Overall, reports were positive about aims being met; respondents thought that 56% of their aims had been met excellently, 35% had been met well and a further 7% fairly. Analysis of the results showed that five respondents (*n=55*) felt unable to comment fully on their aims being met as the work with the young person was seen as a work-in-progress; partly because it was too early to judge the success of the intervention but also because of the delay in service provision. To assess their experience further, respondents (*n = 68*) were asked to rate to what extent the consultation had helped their understanding and how helpful the IVY recommendations were to the management of the case. The majority noted that it had aided understanding well (29 excellent, 29 good and 8 fair) and responses were very similar with regard to recommendations (29 excellent, 31 good, six fair).

For each of the above questions regarding the consultation, only two respondents gave indications that they felt aspects of the service was "poor", further examination of the data indicated that, in one of the cases, the respondent believed that the referral to IVY had been unnecessary as an appropriate assessment of the young person had been conducted already by another agency and, in the other, the respondent's expectations around the purpose of the consultation had not been met. Overall, however, respondents were very positive about their experience of the consultation with 90% of respondents responding that it was good or excellent (17 good, 44 excellent), only one respondent thought it was poor and six thought it was fair.

Analysis of additional comments revealed respondents' overall appreciation of IVY consultants' objective expertise and their insight into the high-risk behaviours of young persons.

> *"It was great to have an expert and fresh perspective on the young person's problems, along with very practical suggestions." (Practitioner)*

> *"Communication was excellent, formulation was very clear and intervention prompt, supportive and appropriately challenging." (Practitioner)*

Respondents also noted the part that the format of the service and consultation played in meeting their main aims.

> *"I found the whole experience extremely beneficial as a worker using the experience for the first time. I felt listened to by the staff in attendance and the advice given was specific to the young person. I felt we were given time to thoroughly discuss the concerns and strategies used to support the young person and reduce risks around for her and to ask questions to assist us in our understanding and expectations of the young person." (Practitioner)*

> *"The staged model of working – consultation with all involved professional parties, followed by assessment with young people – was very useful in terms of meeting the three aims. " (Practitioner)*

> *"The consultation provided positive reassurance to the professionals that the planning was robust and also a realistic discussion on outcomes and expectations of the plan." (Practitioner)*

A consistent thread of feedback from respondents was how supportive the service was. All of the respondents (n =68) confirmed that they were made to feel comfortable and supported to a great extent by IVY when sharing their information at the consultation (16% good; 84% excellent).

"There were a few professionals there. It was informal and people got the best out of everyone. We were listened to. Questions were asked and handled sensitively. We were put at ease." (Practitioner)

"Social worker and me were very comfortable. IVY unpicked our concerns and made us think about things as well as sharing their expertise and knowledge. They gave direction regarding going forward and were proactive and consulted CAMHS to get them to provide their support. Three consultations – good environment." (Practitioner)

"I think this case could have gotten 'inside me' to an extent and the help to think has been invaluable to my work with this boy, who ultimately deserves the best the world can offer after such difficult early experiences but also invaluable to me as a person doing a job that centres on thinking and feeling. It has created a space for emotional health and safety, which has been so important to me. " (Practitioner)

"As a professional working with the challenges of the unknown I found the process informative, reassuring and therapeutic." (Practitioner)

As well as highlighting the interpersonal skills of the experienced IVY consultants, these remarks seem to indicate a certain level of vulnerability that workers dealing with these high-risk young people feel in terms of their own emotional responses to the high-pressured environment in which they work and in terms of uncertainty that the risk management plan that is embarked upon is correct. To this extent, IVY appears to help allay fears of practitioners and provide reassurance that their decision-making is defensible.

5.3.3. Views on the Risk Analysis Report

Forty-one respondents gave some feedback about their use of the Risk Analysis Report although not all of them responded to every question. Ninety-eight per cent of respondents found it very accurate with one respondent (2%) thought that it was somewhat accurate. The majority of respondents (90%), very much agreed with the risk factor ratings while the four remaining respondents (10%) agreed with it somewhat. Again the majority of respondents (81%) found the risk scenarios section very helpful, the remainder somewhat. Seventy-one per cent of respondents thought that the risk management recommendations were very helpful and the remaining 29% thought that they were somewhat helpful. Significantly then, all of the respondents recognised the utility of the Risk Analysis Report to a greater or lesser extent, with the majority finding it very helpful.

"[I] was very impressed with the report. It was very thorough and very informative with the appropriate theory." (Practitioner)

"It provided timely planning and intervention for the future and very robust plans to safeguard the young person and the general public. It highlighted the positive

– often these types of reports can be negative. This focused on what would work well for the young person instead of what not to do. I wish that I could come and do all my cases" (Practitioner)

Although the value of the report was recognised by all respondents, when asked for further comments, some practitioners expressed frustration at the length of time that it took to receive the report, whilst recognising that this may be due to lack of resources.

"It would be really useful to get to the end of the process – still waiting for the report – received an interim, which was useful." (Practitioner)

"Only regarding the frustration regarding the time it has taken for the report but I understand that it is a resource issue." (Practitioner)

Thirty-eight of the 42 (91%) respondents thought the report added a new way of thinking about the potential risk and 37 of 39 (94%) respondents felt it would influence the young persons' care plan. The responses were similar with respect to how practitioners viewed the young person moving towards better outcomes, using SHANARRI indicators as a measure (see table 5.6 below). The seven indicators were identified and respondents asked to rate to what extent they felt the report would help the young person towards that outcome indicator, 95% to 98% of respondents rated the report as somewhat or very likely to help the young person towards the various SHANARRI outcome indicators.

Similar responses were given with respect to the extent to which practitioners believed that the Risk Analysis Report enabled families or carers to understand and manage the young person's behaviour ('very' 15, 'somewhat' 16 and 'not at all' 2, n = 33). The data indicates, therefore, that the vast majority of respondents found the Risk Analysis Report useful in a multitude of ways.

Table 5.6 Rating usefulness of the Risk Analysis Report in respect of SHANARRI wellbeing indicators

No.	Rate the extent to which the content of the report might help move the person towards better outcomes in terms of being:	Very	Somewhat	Not at all	Total Responses
1	SAFE (e.g., placement better informed, different monitoring, etc.)	26	15	1	42
2	HEALTHY (e.g., understanding of the young person's mental health and psychological difficulties)	23	18	1	42
3	ACHIEVING (e.g. improved knowledge about what an appropriate level of expectation	19	19	2	40

	is for the young person)				
4	NURTURED (e.g., understanding of attachment and dynamics and obstacles impacting on nurture)	22	18	1	41
5	ACTIVE (e.g., accessing age appropriate activities in a safe and appropriate manner)	14	23	1	38
6	RESPONSIBLE AND RESPECTED (e.g., is aware of the nature of concerns and care plan, is encouraged to take part in interventions aimed to address difficulties)	22	16	1	39
7	INCLUDED (e.g., is able to access interventions to address any particular inequalities or barriers)	23	16	2	41

Further analysis of comments made by respondents reveals that the division of responses between 'very' and 'somewhat' may be due to the fact that practitioners, many of whom were experts in their own field, felt that they had an understanding of the issues already; in many cases they were simply seeking confirmation or solutions to the issues that they were facing.

"It highlighted what we knew already but gave us confidence in our own assessment. Nothing came us a big surprise to us..." (Practitioner)

With regards to helping families and carers to understand the issues, a large number of respondents interpreted the question to exclude local authority carers: Responses were given in respect of families only and some reflect the lack of involvement by families of high-risk young people.

"Difficult to engage family although every effort made." (Practitioner)

"Family was not party to the report at the request of the young person who is effectively estranged from his birth family." (Practitioner)

On the other hand, there was evidence that some families (5, n=43) had benefitted from the Risk Analysis Report. When a practitioner was asked "to what extent did the Risk Analysis Report better enable the young person's families/carers to understand and manage the behaviour of the young person?" he replied,

"Absolutely. Mum […] said, "for the first time in 16 years I know my son. Very powerful." (Practitioner)

5.3.4. Psychological assessment and direct work

As indicated, relatively few young people have progressed to Levels 2 or 3. The majority of respondents (48) indicated that the young person had not received a Level 2 service (n = 67*).* From the 19 affirmative responses, only 18 respondents described the types of assessments carried out by the IVY team. Four were unable to say what the assessments were, seven indicated psychological assessments, one mentioned discussions with staff and six indicated risk assessments.

Fourteen respondents thought that the assessments were helpful to a greater or less extent ('very' 12, 'somewhat' 2 and 'not at all' 1, n = 15); 15 thought that they expanded their own assessment and understanding of the case ('very much so' in 11 cases, 'somewhat' in four cases and 'not at all' in one case, n = 16); and 14 believed that they had influenced or would influence the young person's care plan ('very much so' in 10 cases, 'somewhat' in four cases and 'not at all' in one case, n = 15).

Seven respondents indicated that the young person had received treatment as part of the IVY service. Of these, two responses seem to indicate that a Level 3 service was provided by IVY, with the others indicating an outside agency, mental health assessment, risk assessment, or not known.

5.3.5. Views on the project

One hundred per cent of respondents indicated that they would be happy to use the service again. Seven respondents (10%) indicated that they had used the IVY service before, reflecting the relative youth of the service and specialised service that it provides. Respondents who had indicated that they had experienced long waiting times or had felt the communication could be improved, still affirmed that they would use the service again. This seems to indicate that although there are improvements which can be made, the need for such a service is recognised amongst practitioners working with vulnerable young people and offenders.

Eight respondents were able to identify some alternative resources for IVY, such as highly specialist units for Looked After Children, CAMHS and Education Inclusion services. Several respondents indicated that the children's needs were met already, implying no need for the IVY service, and two young people had been moved to secure accommodation. In the majority of cases, however, respondents could not identify a suitable alternative to IVY for the young person they were working with; or, if there was an alternative they believed that it would not have led to such a beneficial outcome and a likely route for the child was secure accommodation.

Responses seemed to indicate that available resources were scarce for this extremely vulnerable group of young people and the multi-agency forum that IVY provides is the most expedient way for those practitioners to share information.

> *"There is a limited range of services available to young people who require assessment or management of offending behaviours and have possible mental disorder – very little specialist forensic CAMHS provision (area dependent), no secure adolescent provision in Scotland and frequently a difficult*

compromise/debate as to whether adolescent services or forensic services should manage the case." (Practitioner)

"We would have found it very difficult to access the level of risk assessment provided – if we had been required to devote all clinical time to this, the therapeutic work done with this child and carers would not have been possible alongside." (Practitioner)

We would have to attend the social work department and medical professionals individually and explain what we thought the problem was. With IVY we were

able to speak as a group, explain our area of business and work out what we deemed to be the best approach to the risk. Not only did it save time, it was a more sound way of doing it." (Practitioner)

5.3.6. Outcomes

Overall, 90% of the respondents believed that IVY had benefitted the young person or family or carers ("very" 45%, "somewhat" 45%, "not at all" 9%). Some respondents did not know whether the young person's involvement with IVY had been beneficial either because they were no longer involved with the young person, work was ongoing or the lengthy wait for IVY service had impeded the progress of the young person; however, the vast majority of respondents indicated that there had been either a direct or indirect benefit. Benefits identified included the young person or the family gaining insight into behaviours, an increased access to resources and the implementation of appropriate interventions, improvement of carers' and workers' understanding and expertise and greater ability to inform the various agencies involved in providing care or a service for the young person, such as schools, CAMHS and the Children's Panel.

"There is a distinct lack of facilities available for vulnerable children and young people in Scotland and the services that IVY provide not only benefit the young people themselves, but have particularly helped us as a service in terms of offering guidance, help and support when it was needed. I know from other colleagues' experiences of IVY that their expertise is hugely beneficial and have been of considerable benefit to us as a service." (Practitioner)

"Has ensured that appropriate care placement will be given on transition to adult services and prevent a secure hospital placement which would have been the only alternative but unnecessary. He should continue the progress he has made in his current placement and avoid an escalation of risk and long-term institutional care. Clinically I would have made similar recommendations but these are back up by the IVY report and therefore more likely to be implemented." (Practitioner)

Given the age of the service there are no metrics available for longer-term outcomes for the young people provided a service by IVY; however, a comparison by IVY in March 2015 of current living circumstances and those at the time of referral was conducted to give an indication as to whether there had been any positive or negative change. Examples of transitions include residential unit to home, home to residential open unit, or supported

placement to own tenancy. That analysis found that 65% of the young people had been maintained in their accommodation or had moved to a more independent form of accommodation. A similar comparison was conducted in the present survey. Some of the young people's living circumstances were unknown (4), some responses were unclear (4) and in one case not applicable. In some cases (6), the young people were moved to a less independent form of accommodation, however, the majority had either been maintained in their accommodation (31) or they were now living in accommodation where they were afforded more independence (7). This equates to 73% of the young people, referred to IVY, for whom there is accommodation data (n = 52).

As identified in the earlier comparison, this data must be interpreted carefully as it is often subject to multifarious influences and any changes to accommodation, whilst apparently positive, may not have that effect (for example, one young person is now living with a friend due to eviction from supported accommodation). In addition, it is difficult to pinpoint underlying reasons for change as their living circumstances may be entirely fortuitous and they can often be subject to multiple multi-agency interventions.

5.4. Staff and steering group views

Five members of staff and two professionals who sit on the IVY project steering group were contacted and asked to complete a short survey regarding their views of the project, how it has changed and how it might evolve over time. This survey was completed by three respondents and their combined responses are described below.

In terms of what the project does well for the young people involved, the individualised, flexible approach was identified, as well as engagement with young people who have difficulties trusting others which gives them the opportunity to make more positive choices for their future.

For the referrers, it was suggested that the opportunity to have to space to reflect and think, while being supported to understand the complexities of the case with which they are working, enables a growth in confidence. In addition, having their experience validated was highlighted as of particular use to the professionals who attend the IVY project.

Staffing has been an unavoidable issue in the last year of the project, with only part-time staff and consultants, therefore the service was not working to full capacity due to unfilled vacancies. Clearly this has impacted on the service offered to clients and was identified by respondents as an issue. Specifically the length of the waiting lists for both consultation and for further assessment was acknowledged as an issue, particularly with complex urgent cases. The staffing shortfall has also meant investing in personal development such as specialist training has not been prioritised within the project, nor has there been as much direct support or training provided to other professionals as would have been liked and would be possible with greater staff numbers. The short-term funding was highlighted by all respondents as a barrier to successful working.

However, the motivation and commitment of the IVY project team was regarded as key to the service. In addition, the combination of disciplines within the team enables a more comprehensive and holistic assessment of risk and needs and treatment recommendations. It was identified that agencies have trusted the project with their complex cases and this had contributed to the way in which the project has developed.

In terms of filling a gap or standing out from other services, respondents felt the broad referral criteria and the fact that the project provides a national service identified it as unique; mention was made of the high demand that it incurs. The collaborative composition of the project team, containing both psychologists and social work was also identified as one of its biggest strengths.

It was suggested that many of the young people referred to the project would otherwise be detained in secure care or custody as the only alternative to managing their high risk behaviours, both to others and in some cases to themselves. There was also concern that private but expensive psychological assessment might be the only way to have their needs and risks assessed.

6. Value for money

The IVY project is situated within the Centre for Youth and Criminal Justice and hosted by the University of Strathclyde, however, it has separate funding arrangements. The costs of running the service are recorded as £272,903 over the two year period, but in order to fully examine the cost-effectiveness of the service it is not as straightforward as simply dividing the cost of the service by the number of cases taken up each year. Project staff carry out other duties outwith consultation and formulation, specialist assessments and treatment. Staff, therefore were asked to complete a work diary to indicate the time that is spent on each type of task and ancillary undertakings.

For example as part of a 'Level 1' intervention there are multiple stages: examining referral documentation and preparing for the consultation, the consultation itself, completing the formulation and writing the Risk Analysis Report while following up other emails and communications associated with the case. In 24 cases there were return consultations where further information had been collated or to discuss ongoing or changing issues with the young person; in one case there were three consultations relating to one young person. Depending on the complexity of the case and the experience of the allocated worker these aspects can take varying lengths of time to complete and therefore the costs to complete them vary from case to case.

The full Risk Analysis Report that IVY undertakes for each young person referred to Level 1 and 2 of the service would have cost the local authority/health boards £720 000 over the past two years (103 young people at Level 1, £515,000, and 41 at Level 2, £205,000). This is based on figures from the Risk Management Authority of 50 hours at £100 per assessment. For Level 3 assessments, this cost would increase considerably. As well as reducing the use of other core services (A&E; substance misuse etc.), if the IVY service also prevented even one young person from entering into a secure facility for a year, a further £200,000 per person would be saved.

Chart 6.1 Example Level 1 + 2 case

Level 1:

Pre-referral telephone call with social worker = 25 mins (Clinical Psychologist)

Reading for consultation = 2 x 45 minutes (Lead Psychologist and Social Work Consultant)

Consultation = 2 x 2 hours (attended by Lead Psychologist and Social Work Consultant)

Risk Analysis Report (including provisional SAVRY) = 18 hours (2 hrs. Lead Psychologist, 16 hrs. Social Work Consultant)

Est. total cost of Level 1 (based on hourly rates): £1050
Est. total cost of Level 1 equivalent in local authority = £2400

Level 2:

5 x 1.5 hours assessment appointments (Clinical Psychologist)

Travel = 7 x return journeys from project base to secure unit = 7 hours travel (this includes travelling to two assessment sessions that the young person refused to attend once the psychologist had arrived) (Clinical Psychologist)

File review = 4 hours (Clinical Psychologist)

Meeting with social worker = 2 hours (includes 1 hour travel) (Clinical Psychologist)

Telephone liaison with multi-agency workers and parent = 2.5 hours (Clinical Psychologist)

Clinical notes and admin = 4.5 hours (Clinical Psychologist)

Report writing = 21 hours (Clinical Psychologist)

Supervision (Lead Psychologist and Clinical Psychologist)

Est. total cost of Level 2 (based on hourly rates): £1215
Est. total cost of Level 2 equivalent in local authority = £5000

The figures in the example above refer to only one case; however, they represent the workload of an average Level 2 case. When these figures are examined the cost of this case to the IVY project in terms of salary alone is estimated to be £1050 plus £1215, totalling £2265. Even with overheads and other outgoing costs such as training, telephone, travel, printing and events this is less than the cost to the local authority/health board. To carry out the work themselves, based on time estimated by the RMA, it would cost the local authorities or health boards an average of £10,000 per case.

7. Conclusion/discussion

The referrers who responded to the survey were clear that they felt the young person's outcomes had improved as a result of the IVY project involvement in the case: project staff have had anecdotal or informal feedback to this effect. More than 95% of eligible respondents felt that the young person they referred would be moved towards better SHANARRI indicators of well-being as a result of the Risk Analysis Report received during Level 1. Similarly in terms of benefiting the families of the young person, although responses were few regarding this, those who did respond felt that parents had benefited both directly and indirectly, with increased knowledge, understanding and access to resources for the young person.

Respondents to the professionals' survey felt supported by their involvement, felt that the care plans had improved as a result of the project and all of those who responded to the survey have stated they would use the service again.

What emerged from many of the survey responses was a feeling of vulnerability on the part of the professionals and in some cases an emotional involvement in the cases referred, this was both alleviated and supported by the consultation at Level 1. All survey respondents indicated that they felt comfortable and supported by the project staff at the consultation. Although not all respondents had received a copy of the Risk Analysis Report at the point when they were surveyed, those who had generally found it to be helpful with 90% agreeing very much with the risk factor ratings, 81% finding the risk scenarios very helpful and 70% finding the risk management recommendations very helpful.

One potential short-term outcome measure involved examining the changes in living circumstances of the young people. Although this data was not available for all young people who have used the service, for those where the information was recorded, 73% of young people had either maintained their accommodation from point of referral or else had been moved to a less secure placement.

Despite some criticism from referrers regarding timescales and in some cases a concern regarding communication between the project and themselves all respondents who completed the survey said they would use the service again. This feedback suggests that there is clearly a need for the work the project does and that the support, guidance and expertise of the IVY project is appreciated by the professionals who refer their cases.

In terms of the costs of providing this service, from the example figures shown in section 6 of this report there is clearly a cost benefit to local authorities or health boards in making use of the project. The value of the service in terms of money, however, is only one aspect. What the IVY project provides is a multi-disciplinary team with particular expertise in this area. The staff are committed to the work they do while the design of the project enables open discussion, sharing of information and particularly valuable reassurance and guidance in the initial stages. Within stages 2 and 3 there is the addition of access to specialist assessments and ongoing direct work with the young person.

8. Recommendations moving forward

The title 'Space to Think' was a theme identified by both project staff and those who use the project. This reflection time is vital when working with this type of client group and a potentially undervalued and occasionally unrecognised aspect. At two years on this is also an appropriate 'time to think' for the IVY project itself - a period of time to reflect on what works well within the project and what needs refreshing or adjustment in moving forward.

• In terms of data collection within the two project databases there is a need for further refinement. Although this has improved and streamlined over the two years since the project began there is still some way to go to ensure that there is a base level of referral data and more long-term data.

• Information provided at the referral stage is more robust than previously and this has helped the consultation progress more smoothly. There is ongoing feedback regarding referrer aims collated on the day of the consultation itself which has also added clarity to the discussion and ensuring that expectations are understood.

• In line with best practice, thought should be given as to how to capture the experience of the young people who are provided with a service from IVY. As well as helping improve the service delivered to young people, it may help engender trust in the service and any support provided.

• Overall, service users were very happy with the type and quality of the services that IVY had provided but the issues regarding service delays were still extant. Even with the acknowledgement that this may have been due to resourcing issues, there was frustration around the delay between referral and consultation, consultation and receipt of the Risk Analysis Report, and consultation and receipt of further services. An analysis carried out regarding the time taken between these services may help set service users' expectations of time-scales in advance. This is something habitually practiced by project staff during Level 2 and this should filter through each stage of the project.

• A small number of referrers reported some issues about communication, an issue that was raised in the previous survey. As the respondents of this survey include those who took part in a previous survey completed in March 2015, it is not surprising to find that communication was raised as an issue again. Comments were generally positive and respondents in the main were appreciative of the opportunity provided for multi-agency information sharing although one dissenting opinion indicated that it was difficult to work on an inter-agency basis. Some comments indicated that there had been a breakdown of communication. This could be avoided by inserting a clearer communication protocol for all service users into the process.

• In some cases, IVY recommendations had not been able to be followed through, for example, through lack of resources. Although it is unlikely that it would be feasible for IVY to follow-up every case after the risk formulation has been made, practitioners could be advised to contact the service again if more support is required. This may not necessarily take the form of a full consultation.

• Ongoing evaluation of the service is essential and express agreement to provide feedback on the perceived utility of the service is required on the referral form. Nevertheless, obtaining feedback remains a difficulty for IVY for various reasons. Improvements are in hand already, such as contemporaneous evaluation forms at the consultation, to overcome this; however, further thought should be given as to how to capture feedback that is current and relevant.

• Further consideration should be given to how metrics for longer-term outcomes should be assessed. Currently, partly because of the infancy of the service and the paucity of available quantitative data this is not carried out. However a comparison of living circumstances of the young persons does not provided conclusive data. A multi-agency database may provide the answer.

• Relationships are vital between the project and other services and local authorities, particularly within Levels 2 and 3. These relationships should be maintained and where possible enhanced to ensure the smooth running and reduction of delays during these levels of the project. This is something that should be prioritised with the new staffing arrangements.

• Funding for the project remains an ongoing tension: short-term funding for projects provides an additional layer of complication and stress. This has been reflected in this project with the issue of staffing which unfortunately has resulted in longer periods of waiting time for referrers and young people. Attracting highly experienced clinical psychologists to a project that has less than a year of guaranteed funding is always going to prove difficult. As a result, staff vacancies have temporarily been unfilled and current staff have had increased workloads to maintain the level of service the client group needs. Consultants have been used to meet the needs of service users which has placed more financial pressures on the service. Project staff have also been unable to take part in as much professional development as desired: this type of development helps maintain the high levels of work they produce on an ongoing basis. Similarly there has been less opportunity to provide different types of risk assessment training or workshop input to fellow professionals as they would have liked. Ultimately these issues lead directly back to under-staffing, which leads directly from the funding arrangements. In the future the project needs to secure longer term funding that would enable IVY to provide the level of high quality consistent service on an ongoing basis.

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