



Mental Health Needs and Effectiveness of Provision for Young Offenders in Custody and in the Community

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Executive summary

Introduction

Although there is growing literature on the mental health needs of adolescents in the youth justice system, there remain many unanswered questions. Epidemiological cross-sectional studies have revealed high levels of mental health and social needs. However, many of these studies have been small, focusing on specific populations – for example, those in secure care. These young people frequently move within the youth justice system between community and secure sites, but there have been few longitudinal studies describing how their needs change. Such studies – although difficult to conduct – are vital when considering what mental health resources are necessary to meet changing needs.

What is also unclear is how the different professional organisations can work together in order to provide effective interventions, both to reduce offending behaviour and also improve the mental health and wellbeing of young offenders.

The research described here was conducted during a period of rapid change in the youth justice system. For example, our previous study commented on the lack of mental health and educational provision in secure facilities (Kroll et al, 2002). At the time of the study, youth offending teams (Yots) had only just been established. However, since then, there have been numerous changes. Yots are now well established, with their own national standards and targets, and the sentencing of young offenders has changed considerably – for example, with the introduction of the Intensive Supervision and Surveillance Programme (ISSP) and Detention and Training Orders (DTOs). There is also increasing emphasis on mental health screening, and providing interventions to reduce offending.

In this context of continuing change, the Youth Justice Board commissioned us to conduct a national study on the mental health needs of young offenders in custody and in the community. We were also asked to describe models of service provision, and to comment on examples of good practice – particularly, what interventions work to reduce mental health needs and offending behaviour. The specific aims of the study were:

- to describe the overall mental health and psychosocial needs of young offenders – both in custody and in the community – and to identify how needs vary according to gender, ethnicity and placement (custody versus community)
- to describe models of mental health provision available for young offenders, and examples of good practice
- to evaluate continuity of care, and how needs change as young offenders move from custody into the community
- to identify whether mental health needs predict future offending
- to assess financial costs for service provision for young offenders
- to evaluate the effectiveness of interventions to reduce offending behaviour and address mental health needs.

This report is divided into three sections.

- a. current models of service provision and principles of good practice

- b. costs and needs data from the research survey
- c. a summary of what works with young offenders in addressing mental health needs and offending behaviour.

Current models of service provision and principles of good practice

Method

Eighty semi-structured interviews were carried out with key stakeholders to ascertain the structures of current service provision, and processes involved in provision and outcome. This included interviews with youth offending staff, managers and staff within secure establishments, and providers of mental health services (child and adult services).

All young offenders were also questioned about their satisfaction with a variety of different services.

Results

The findings have been split into three sections – those relating to the secure estate; community provision (including Yots and child and adolescent mental health services); and, finally, findings that relate to both secure and community sites.

The secure estate (young offender institutions and local authority secure children's homes)

- Provision of mental health services in many secure estate institutions was provided on a sessional basis by mental health professionals who had a personal interest in the area. Continuous provision was subsequently vulnerable to changes in personnel and priorities and, unlike community child and adult mental health services, a multi-disciplinary approach was not common.
- There was no routine mental health assessment on admission to secure sites, but a reliance on previous assessments (*Asses*) accompanying the young person, which was frequently missing.
- There was a lack of appropriate intervention packages available, as well as resource problems in delivering available interventions.
- There was little evidence of appropriate and timely support for staff involved in major incidents, or regular support and supervision for staff.

Community sites

- Child and adolescent mental health services (CAMHSs) were patchy and variable. The perceived reasons for this included lack of resources and funding being the primary obstacle to provision. There were few examples of formal and regular opportunities for consultation between Yots and CAMHSs.
- Health workers were highly valued within Yots when they were in post. However, their experience in mental health was variable and likely to have an impact on service delivery. Few health workers had any clinical supervision from mental health services – although those that did found this valuable.
- Yot managers, whose time was spent principally on strategic rather than operational matters, were more likely to be working with other professionals and agencies at a senior and strategic level.

Secure and community sites

- Good inter-agency working was based on personal relationships and prior experiences of working together. Well-developed links appeared to be connected with less tension between agencies.
- Gaps in mental health services for 16 to 18-year-olds (who are no longer in full-time education) were evident in most sites.
- Vulnerable young people – both those with learning difficulties and those on remand – were of concern to those working with them, and responsible for their care.
- Young people reported a high level of satisfaction with services provided by the youth justice system, particularly from Yots and local authority secure children's homes. They had also found educational services helpful (half of these were provided within custody), but were less clear about the benefits from mental health and social services.
- Continuity of care was a frequent problem, although the use of the Care Programme Approach (CPA) in one secure estate had minimised the barriers to providing continuous care.

Principles of good practice

In summary, we believe the following.

- Continuing investment of resources will be necessary in order to provide equitable and accessible services.
- Structured and continuous assessment of the mental health needs of young offenders is required, using reliable and validated tools – e.g. the Mental Health Screening Interview for Adolescents (SIFA) and the Mental Health Screening Questionnaire Interview for Adolescents (SQIFA).
- There needs to be further development of accredited, evidence-based interventions to reduce offending behaviour, with implementation by trained staff.
- There is a need for tailored educational provision based on individual needs and ability (a quarter of young offenders had learning difficulties) – particularly for those under 16 years of age.
- Staff working within the secure estate and Yots require support and supervision, particularly following major incidents.
- Continuity of care is important, and depends on resources, assessment and the adoption of a CPA-type model.
- The development of a local multi-agency mental health strategy for both Yots and secure establishments is essential for the delivery of effective interventions. Any strategy should incorporate a multi-disciplinary approach.
- There is a need for clear guidelines regarding confidentiality of records across different professional groups within the youth justice system.

Needs and cost data from the research survey

Method

Six geographically representative areas across England and Wales were selected, each containing a Yot and secure establishment. A total of 151 young offenders from secure estate establishments and 150 from the community were interviewed, using assessments of demographics, mental health and social needs. These were: the Salford Needs Assessment Schedule for Adolescents (S.NASA); the Health Economic Questionnaire; and standardised IQ assessments (Wechsler Abbreviated Scale of Intelligence [WASI] and Wechsler Objective Reading Dimension).

Of the secure sample, 75 were reinterviewed an average of nine months later using the S.NASA and the Continuity of Care Questionnaire. All young offenders were also followed up through their case records (Criminal Records Bureau) and telephone interviews with their case managers (Yot workers). The study also evaluated 100 *Asset* forms completed by Yot workers at each of the six sites on a separate sample of young offenders attending the Yots.

Results

- The *Asset* form was not always completed. In the 600 *Asset* forms evaluated, only 15% of young offenders were identified as having mental health problems. This is much lower than the 31% identified as having a mental health need in this national study, using the S.NASA, which is a fully validated mental health screening tool.
- Young offenders were found to have high levels of needs in a number of different areas, including mental health. About half had problems with relationships (peer and family), while a third had significant problems with education or work.
- These young people were found to be a particularly vulnerable group. They frequently had a history of social care placements, family breakdown and school exclusions.
- Almost a quarter of young offenders were identified with learning difficulties (IQ<70), while a further third had borderline learning difficulties (IQ 70–80). However, this finding must be taken in context, in that a number of these young people had missed education. Commonly used psychiatric measures, including the WASI, cannot easily differentiate those with intrinsic learning difficulties from those with low IQ scores secondary to lack of education.
- A third of young offenders had a mental health need. Almost a fifth of young offenders had problems with depression. A tenth of young people reported a history of self-harm within the last month, with a similar proportion suffering from anxiety and post-traumatic stress symptoms (PTSD). Hyperactivity was reported in 7% of young people, and psychotic-like symptoms in 5% of the sample.
- While there was no significant difference in the number of needs by gender or ethnicity, overall, female offenders had more mental health needs than males. Also, young offenders from ethnic minorities were found to have higher rates of post-traumatic stress.
- Young offenders in the community were found to have significantly more needs than those in secure care. Specifically, the numbers of needs were higher in areas of education, risky behaviour (alcohol and drug misuse) and peer and family relationships. There was no significant difference between the groups with respect to the number of mental health needs.
- Needs increased for young offenders discharged from secure facilities back into the community, suggesting that needs are only temporarily reduced while in custody.

- Many of these needs remained unmet, with few young people having any form of intervention for their needs. The most recommended intervention from the S.NASA was the basic requisite for an assessment, particularly for mental health needs.
- Further offending was not predicted by mental health needs or alcohol and drug abuse problems. Male offenders were more likely to continue to offend than female offenders.
- Continuity of care for young people was highly variable. Within the youth justice system, national standards for reviews in custody were often met. However, this was less successful for visits by Yot workers, and delays were frequently reported. Continuity of care was often poor with regard to educational services, but slightly better for those in contact with mental health services and best for alcohol and drug services.

Provision of mental health and substance misuse services was frequently provided by staff within the youth justice system – for example, by health and substance misuse workers within Yots. The remaining mental health provision was provided by a variety of different service providers, ranging from primary care to CAMHSs and adult psychiatry services.

A recent study (Byford and Barrett, 2004) has demonstrated the significant financial burden of young people in the youth justice system, not only to the criminal justice sector, but also to social services departments, the NHS and the education sector. The average cost per year of a young person in the youth justice system was estimated to be £39,120. Costs were significantly higher for those in custody (£55,674), compared with those in the community (£22,456).

Conclusions and recommendations

- Needs for young offenders were often not met, due to a lack of recognition of these needs. This re-enforces the necessity for structured needs and risk assessment procedures. However, this should occur in the context of a mental health screening and training programme within community and secure settings. Within any programme, there should also be clear guidelines for professionals where young offenders screen positive.
- Needs were temporarily lower for those in custody due to the level of supervision provided. There was evidence to suggest that some services were more readily available in secure facilities. Subsequently, there may be further opportunities to provide interventions while young people are in custody.
- A high proportion of young offenders were identified with low IQs and, critically, almost a quarter had IQs below 70 (the normal range is between 85 and 115). We recommend further studies to evaluate the neuropsychological deficits that have been described in these young people and, specifically, whether young offenders have higher rates of learning difficulties, or whether their low IQs are secondary to lack of educational opportunities. We also recommend a review of services provided for this vulnerable group across the different agencies, including youth justice, social services, mental health and, particularly, education.
- Continuity of care was variable – supporting the view that there is a need for a CPA that is recognised and accepted by all four key agencies involved (youth justice, mental health, education and social services).

What works with young offenders in addressing mental health and offending behaviour

Method

The method was based on a literature review of available databases, and consideration of how these findings are applied to the youth justice system.

Results

- An initial structured assessment of risk and mental health needs of the young person is an important basis for planning interventions. It was also clearly evidenced that the most common reason for unmet need was the failure to assess and review the needs of a young person adequately.
- Interventions should be tailored to the young person's needs and abilities (a quarter of offenders were found to have learning difficulties), with a focus on the dynamic aspects of risk.
- Cognitive behavioural and problem-solving skills therapies are most effective, particularly multi-modal approaches that include the individual, peer group and family.
- There is limited evidence for brief uni-modal interventions such as anger management or social skills training.
- There is evidence to support a number of interventions for treating child and adolescent mental health problems, but not all have been fully evaluated on samples of young offenders.
- There is empirical support that cognitive behavioural therapy programmes and problem-solving skills training designed to reduce anti-social behaviour may also have a beneficial effect on mild-to-moderate emotional symptoms (anxiety and depression).
- Young offenders with moderate-to-severe mental health needs should be identified by a structured screening process, and referred to the appropriate professional or agency, as co-existing mental health problems are likely to influence the success of any offence reduction work.

Conclusions and recommendations

- There should be tailored interventions using a cognitive behavioural and problem-solving skills training approach based on assessment of risk, needs and learning abilities.
- There should be a multi-modal approach focusing on the individual, family and peer group.
- Interventions should be evaluated for effectiveness with young offenders and accredited by the Youth Justice Board.
- Those with moderate and severe mental health problems should be identified and referred to the appropriate professional or agency.
- There should be prioritisation at both national and local level for mental health screening with the development of a local mental health strategy.
- It is essential that all interventions are delivered by fully trained staff.

Introduction

Background

Out-of-control children continue to be a source of concern for professionals, politicians and the public. Young people at the boundary between the Criminal Justice System and mental health services are a particularly vulnerable group that face not only the risk of social exclusion but also stigmatisation. However, there is increasing evidence that young offenders are falling between gaps in services.

Additionally, the financial cost of youth crime to society is substantial. The Audit Commission has estimated that public services in England and Wales spend around a billion pounds a year on processing and dealing with young offenders (Audit Commission, 1996). Research to date has tended to concentrate on the cost of dealing with and processing crime carried out by youths, rather than the cost of support, care and education for young people in the youth justice system.

Providing services for this group of young people requires an integrated approach from all the agencies involved in their care, including the Criminal Justice System, social services and mental health services. While 'joined-up working' is essential in providing comprehensive services, there are a number of barriers to this, and services have different aims and different 'languages', which makes this more difficult.

Recent changes in England and Wales, with the introduction of the Crime and Disorder Act 1998 and the Children's National Service framework (2003), have provided a timely mandate for the development of services. There have subsequently been numerous reforms in the youth justice system within the last five years, including the introduction of Yots, and changes to the sentencing of young offenders. However, the effects of many of these changes have not been investigated.

Although there is growing literature on the mental health needs of adolescents in the youth justice system, there remain many unanswered questions. Epidemiological cross-sectional studies have revealed high levels of mental health and social needs (Lader et al, 2000). However, many of these studies have been small, or have focused on specific populations – for example, those in secure care (Kroll et al, 2000). There is subsequently a lack of studies that have investigated the needs of young offenders in the community, or compared them with the needs of those in secure care. Many have also concentrated on male young offenders, and had limited representation from ethnic minorities.

These young people frequently move within the youth justice system between community and secure sites, but there have been few longitudinal studies describing how their needs change. Such studies, although difficult to conduct, are vital when considering what mental health resources are necessary to meet their changing needs.

Many of the studies that have investigated mental health problems in juvenile offenders have historically used psychiatric diagnosis as a measure (Lader et al, 2000). The use of prevalence rates of psychiatric diagnosis, particularly from national studies, are often of limited value in planning mental health services and providing for juvenile offenders. For example, disorders vary in prevalence between areas, depending on the level of deprivation locally. Also, the prevalence of a disorder does not necessarily equate with the level of services required, as this is influenced by a number of factors, including the availability of an effective intervention and a willingness to accept it (Harrington et al, 1999).

Increasingly, therefore, needs assessment is seen as a more useful measure of health problems in children and adults, including juvenile offenders (Marshall et al, 2000).

In this context of continuing change, we were commissioned by the Youth Justice Board to examine, via a national study, the mental health needs of young offenders in custody and in the community, and to describe models of service provision. The specific aims of the study are set out below.

Aims

1. To describe current models of mental health provision and examples of good practice.
2. To examine a national sample to estimate the level of mental health and psychosocial needs of young offenders both in custody and in the community:
 - a comparison of the levels of need for young offenders in custody and in the community
 - to explore whether needs differ according to gender or ethnicity
 - to explore whether needs are met for young offenders
 - to assess the extent to which mental health need is correlated with further offending
 - within a secure sample, to establish how needs change over time, and whether care continues into the community
 - to assess the financial cost of youth crime.
3. To evaluate the effectiveness of interventions to reduce offending behaviour and address mental health needs.

Method

The study was based on six geographically representative areas across England and Wales, each site including a Youth Offender Team and a custodial establishment.

A largely quantitative approach was used in the cross-sectional and longitudinal aspects of the study, while a qualitative methodology was used to examine models of service provision for young offenders with mental health problems. The cross-sectional and longitudinal study concentrated on the needs of young offenders and continuity of care from services. The qualitative study examined the perspectives of those working directly with young offenders, and those involved in service provision. There are a number of advantages in combining quantitative and qualitative approaches in this type of research – for example, the use of a qualitative approach can illuminate quantitative findings.

Models of mental health provision

The method for the case study evaluation was semi-structured qualitative interviews with key stakeholders from different professions representing different sectors (Appendix 1). This method has the benefit of providing multiple perspectives on the advantages and disadvantages of current and developing models of service provision. The interviews concerned three main areas:

- a. structure of current service provision
- b. processes involved in provision
- c. outcome, i.e. perceived advantages and disadvantages of current provision.

Interviews

Eighty detailed interviews were conducted with representatives from young offender institutions (YOIs), local authority secure children's homes (LASCHs), Yots and CAMHSs.

The breakdown of the interviewees was as follows:

- 28 from Yots
- 15 representatives of CAMHSs
- 14 were discipline staff, governors or managers and assistant managers in custodial settings
- 14 worked in health care (including mental health care) in custodial settings
- 3 interviewees from Tier 4 forensic services
- 2 forensic psychologists in secure settings
- 1 counselling, assessment, referral, advice and throughcare (CARAT)¹ worker
- 2 social services managers
- 1 probation officer working in a custodial setting.

At two of the sites, specialist forensic services were located near the Yots and the YOIs involved in the study, and representatives from these services were also interviewed.

All the interviews were audiotaped and transcribed in full, and the interviews lasted between 40 and 95 minutes.

Data analysis

The transcripts were all read twice, and then analysed line by line. Coding categories were developed from identification of themes arising from repeated scrutiny of the interview transcripts and field notes. A coding frame was developed through an iterative process and discussion with colleagues. Some themes were obvious and of predetermined interest. Others emerged in the course of analysing the transcripts.

Cross-sectional survey

Within each site, a random sample of 25 consecutive attendees at a Yot team, and 25 offenders at a secure establishment was selected, with over-sampling from ethnic minorities and female offenders. The total numbers interviewed were:

- 151 from secure facilities (LASCHs and YOIs).
- 150 from the community (Yots).

Each young person was interviewed using quantitative assessments of demographics, mental health and social needs (S.NASA, see Appendix 2), health economics (Health Economics Questionnaire, see Appendix 3) and standardised IQ assessments (WASI and WORD). They were also questioned about their satisfaction with different services in the previous six months. This semi-quantitative approach used a Likert scale (ratings of satisfaction from -3 to +3).

¹ In April 2005, the CARAT service for juveniles was renamed the Juvenile Substance Misuse Service within the Prison Service.

Salford Needs Assessment Schedule for Adolescents (S.NASA)

The S.NASA covers 17 areas of need, including mental health, educational and social needs. The areas covered include:

- social (peer) relations
- family relations
- school attendance
- school performance
- weekday occupation (those over 16 years of age)
- aggressive behaviour to people
- aggressive behaviour to property
- inappropriate sexual behaviour
- alcohol misuse
- drug misuse
- depressed mood
- deliberate self-harm
- hyperactive/attentional problems
- anxiety symptoms
- post-traumatic stress disorder (PTSD) symptoms
- hallucinations and delusional symptoms
- accommodation problems.

The methodology used and its psychometric properties (reliability and validity) have been described previously (Kroll et al, 1999). The interview gathers information from clients and key workers (for each area) on symptom severity over the last month (5-point scale), client co-operation (3-point scale), client perception of the problem (3-point scale) and key worker stress (4-point scale). Information is also gathered about interventions that have been offered recently or not offered. From this information, the S.NASA generates 'needs' and recommended interventions, using a software-supported algorithm. A need is a significant problem that can benefit from an intervention. When a need is identified, it is rated by clinicians, based on available information into unmet need, suspended need (an intervention has been offered recently and, therefore, it is too early to assess whether it has been beneficial) or persistent need despite intervention (PDI).

Longitudinal survey

Half the sample in custody at the time of the initial interview (75 young offenders) were reinterviewed, on average nine months later, using the S.NASA, the Health Economic Questionnaire and a Continuity of Care Questionnaire (see Appendix 4). The Continuity of Care Questionnaire is designed to rate the level of continuity of interventions with the young people (based on the community training plan – the T1: FR) and the rate at which the *Youth Justice National Standards* regarding supervision were being met by Yots.

All young offenders were followed up through telephone interviews with their case managers (Yot worker), on average, eight months later. They were asked for information about mental health, education, and drug and alcohol problems (see Appendix 5). The criminal records data were also obtained for the follow-up period from the Police National Computer through the Home Office).

Results – part one: models of service provision

In this chapter, we discuss the models of service provision that were found to exist at the six sites that participated in the study. They included Yots and secure establishments (LASCHs and YOIs). The qualitative aspect of the study concentrated on the youth justice system and mental health services, although substance misuse services and educational provision are described briefly.

The main findings are illustrated by quotations from interviewees, and demonstrate effective and developing practice. It must be stressed that the findings illustrate services as they were at the time of the study, and do not necessarily represent current models of service provision. The references following the quotation refer to the interviewee reference number and site. Unless otherwise stated, the main findings refer to the community and secure estates.

In addition to interviewing providers of services in the qualitative study, we also questioned young offenders themselves regarding their satisfaction with a variety of different services in the last six months (Likert scale -3 to +3).

Youth justice system

Multi-agency and strategic planning

Good inter-agency working was based on personal relationships and prior experiences of working together, with well-developed relationships linked to less tension between agencies.

Yot managers, whose time was spent principally on strategic rather than on operational matters, were more likely to be working with other professionals and agencies at a senior and strategic level. This was a major advantage when establishing multi-agency and multi-disciplinary working between Yots and other professionals.

The following quotation demonstrates the advantage of having a Yot manager who has developed links with other agencies at a senior level.

We have a good relationship with almost everyone. I sit with the management team in social services. I will take on work [within social services]. I'm particularly impressed by the police. We work in partnership with education on a lot of things – social inclusion programme is all working with education – I think that's partly because we are a unitary authority.

Another Yot manager talked about the competing priorities and pressures on senior staff at all agencies, and the difficulties this could present to developing links between services.

I think that a lot of my time should be spent on strategic work. I think the reality is that a lot of it is spent on operational work just because that comes to you really – links with health have been difficult this year because of the PCTs [primary care trusts] being set up. We've had problems with the two health posts – they've not been able to identify the funding and pass the money over to us to recruit – but there's been a lack of urgency and a lack of priority, and that's unfortunately the children and mental health post. I have offered all sorts of things – like, let me go and speak to your staff at the CAMHS and tell them about what a great place this is and it was kind of: 'No, there isn't really any way that you can speak to them,' and I think it's a great shame because when I meet the CAMHS representative, she's very connected to the whole issue, but she has all sorts of other pressures on her at the moment.

High-quality communication between professionals and agencies was valued by all interviewees. Major barriers to achieving this were related to lack of understanding about roles and responsibilities, different statutory requirements, and interfaces dominated by written rather than verbal communication.

Within Yots, the multi-agency and disciplinary representation among the staff was valued by team members. For example, mental health workers would often provide the link between the young person and CAMHSs, and those with a background in education were better placed to negotiate with schools on a young person's behalf.

Screening and provision

Community sites

Within Yots, a health worker was not always in post and, sometimes, had only recently started. Where health workers were in post, they were valued – although their experience and background were variable and likely to affect service delivery. Many health workers were from a generic health background, and did not feel adequately skilled in both physical and mental health areas. The majority of health workers were seconded, and reported difficulties in their professional identification, as they had little contact with other health professionals.

Some health workers also reported being expected to carry a generic case load, which included offending work with young people, and found this difficult both in terms of the actual number of cases they were expected to hold, and the conflict that this could generate when they were also expected to be available for cases that needed health input and expertise.

It was clear that this referral system, from Yot to CAMHSs, had taken some time to establish, and was the consequence of many meetings and much discussion between the two agencies.

We developed a specialist referral form so that anyone who scores three or more on Asset would be an automatic referral to me, and anyone who had concerns can refer to me. I then liaise with the CAMHS, and ring them up and discuss whether it is a referral or not, and we do the first stage of the CAMHS assessment then. CAMHS have referred to me; we offered a parenting group and a few individual sessions for the young person around consequences. That's the relationship we've got with CAMHSs – I think it's the way to go.

It was evident that health workers without a background in mental health found aspects of their role and responsibilities within the Yot difficult at times.

If I had come from a Yot I'd know what to do – but I have been acute-paediatric trained and then did my community nursing degree; the mental health aspect of this job was something that I was particularly interested in; I applied for an MSc in child and adolescent mental health, and the funding was turned down because they said it wasn't relevant to my job – they don't know what a Yot is I think. I am funded by health, and have three managers and that doesn't help. How they treat me seems to be endemic of how they treat health workers, because there's no standard across them, no national standard – until you utilise people properly, help them, develop them, support them they're going to leave.

The tension between Yots and CAMHSs was evident in the community, with some interviewees from CAMHSs feeling that they were ill-equipped to work with young offenders.

The difficulty of engaging many young people, particularly adolescents, and the fact that many among this population do not attend CAMHS appointments, was a source of concern for Yots and people working within CAMHSs.

Another interviewee from CAMHSs described the absence of effective treatments for the problems many young offenders present.

I'm quite interested in forensic matters; but I could argue that I've got enough work, thank you very much, without trying to engage a difficult bunch who I've got no good treatments for, particularly; who all the evidence suggests that I could bang my head against a brick wall and not do much about – so how could we do it? The models we are looking to develop here are genuine multi-agency, not just multi-disciplinary. We've got a model which we are hoping will be funded; which will have a full-time CAMHSs worker, social worker, input from educational psychology and behaviour support team, and which will be physically based in a family of schools.

A Yot manager described how many people within or alongside the youth justice system are frightened of working with young offenders, and talked about the importance of providing a service that is tailored to the needs of this population.

There are always unpopular groups, aren't there? And whether that's because people think they're undeserving or scary, uninteresting or unresponsive, hopeless. Traditional health services, for example, run a mile, so it's the tuning – working with a service that is tuned to their needs. That's what we lack.

There was a distinct problem reported in being able successfully to commission and receive medical legal psychiatric reports within specific timeframes. This applied to both professionals trying to commission reports, and those asked to provide them. This has clear implications for effective risk management at all levels and for all agencies.

In one Yot, the health worker (mental health trained) either wrote the reports or was able to arrange for them to be written because of contacts with other CAMHSs workers.

When the courts want a report, if there are perceived mental health issues or whatever, then he does them or he knows where to go to get someone to do them. So we count our blessings, and I know that colleagues in other places are in despair with the input from health.

The manager of one Yot described an informal assessment service provided by an adult mental health team. Although this was effective, it relied upon personal relationships and could be vulnerable to changes in personnel.

We've got to know people [criminal adult mental health team]; in an emergency, they will see someone in the cells to see whether they need sectioning or not; but they are not funded to do it, and they do it because they care about people and we've got such a good relationship, that it works. Last year, we had two young people sectioned immediately from police cells.

Secure estate (young offender institutions and local authority secure children's homes)

Crucially, a number of interviewees recognised that young people should have continuous, rather than one-off, assessment, particularly within the secure estate, where screening on arrival was often confounded by the high levels of anxiety, anger and depression as young people adjusted to the change in their environment.

The importance of assessing young people frequently, taking into account context and timing, was highlighted by a manager in a secure unit.

The previous psychiatrist used to make this point often: 'Don't tell me about the first two weeks because, if everything was well in the world, and you locked a child away in an institution away from their family, you should see them kicking off and acting out and being destructive or being withdrawn and quasi-depressed – 'cause that's what normal human beings do, is react to those kind of threats to attachments in that way.' And I like that, 'cause it eases staff anxieties, so I like the CAMHSs team because they will raise those issues and help us to think about care rather than control.

There were resource and training problems in delivering available interventions, and this was particularly evident at YOIs. Tensions between discipline and therapy were also evident at YOIs, although understanding and respect for the roles and responsibilities of colleagues based on personal contact reduced the potential for conflict.

Other respondents talked about the tension (which they all understood the reasons for) between discipline and therapy. These tensions were most evident where there was little understanding between professionals of their roles and responsibilities.

I've been involved in trying to get across this idea of positive reinforcement, rather than taking away this and that. I've had people literally turning red and screaming at you; it is such a heated thing you know – like two perspectives that are just not going to meet. But you know I think there is a lot more receptiveness. But a lot of times, it is that difficult thing between security and discipline and keeping order in the prison and therapeutic change; you might talk about one lad and what is in his best interests, whereas you have to think of the interests of the other kids – it's a tricky balance.

Lack of supervision was evident in accounts of major incidents where appropriate support after the event was often non-existent or inadequate. A number of interviewees talked about the effects of major incidents, and the following quotation refers to a secure establishment that had support available to staff. The speaker was the first person on the scene when a young person had committed suicide.

If it ever happens again, I'm not coming back to my job, because that was horrific – you're not supposed to be pally with the inmates, but you interact with them all every day and you do get to like them. There was another one that really got me, and I ended up with the counsellor next door crying my eyes out.

There appeared to be little communication between the forensic psychology service and other health professionals working in secure estate establishments. This had probably contributed to a lack of understanding about the roles and interventions offered by the forensic psychology service.

In the following example, the forensic psychologist interviewed could give a clear account of his roles and responsibilities.

There are three main roles: work with clients, and the focus tends to be offending behaviour work – we also do coping strategies and work with self-harmers, anxiety management and self-esteem work; research and consultancy; and membership of all prison policy groups, things like anti-bullying, race relations and suicide prevention.

However, it was apparent from other interviews carried out within YOIs that many staff were less clear on the remit of psychology services and their relationship with both health care and discipline staff. This lack of clarity is reflected in the following quotations:

In terms of referrals, it is not very consistent. Some people will refer a lot for certain things, and others, for other things – some are more appropriate than others, and some will want to discuss every referral with you, and others will leave it up to you to sort out. Sometimes, we would make a referral direct to health care, and they would then make the referral to the psychiatrist – relationships between us and them [health care] are not as good as they should be. I think we'd certainly like things to be looser, and there to be a lot more awareness of what goes on; and I think that is down to both of us to actually do that – it's not really that relations are poor, it's just that relations are not really there.

Secure and community sites

There was a lack of appropriate intervention packages available – for both community and secure sites.

It was troubling to note, given the potential impact of unresolved issues on the psychological wellbeing of staff, that provision of adequate and regular supervision for professionals within YOIs and Yots was patchy.

Confidentiality issues within Yots and custody, and between other agencies, were often a barrier to appropriate sharing of information in the best interests of the young person. This is despite recent government initiatives around child protection and risk. Although good inter-personal relationships between agency workers appeared to ameliorate this problem, there is an urgent need for clearer guidelines in this area.

The degree to which confidentiality could compromise the care of a young person was highlighted by a number of interviewees.

Confidentiality issues come up again and again. As an agency, we need to spell out what we mean by confidentiality, and how it benefits the customer when there could well be mental health needs that are not being identified. Do we just give ourselves an easy time by hiding behind that? That would be my worry. It feels that, with confidentiality, a polarisation takes place, and it's moving us from our position of comfort into one where you are confronted with situations that you're not familiar with; some can then say: 'It's nothing to do with me, confidentiality.' End of story.

Vulnerable young people – both those with learning difficulties and those on remand – were of concern to those working with them and responsible for their care, particularly in Yots and YOIs. This study found that a quarter of young people interviewed presented with learning difficulties and, therefore, the scale of the problem is significant.

The young person in question in this example had learning difficulties, and was bullied on the wing. The only feasible option was to move him to health care for his own safety.

We have a young boy in at the moment [health care], as well as an older boy, and they have learning disabilities. We've made him a cleaner, but a member of staff has to be with him to direct him. That can't happen forever, and he's looking at a lengthy sentence; and we'll give him another couple of years, and then he will hit the adult system where he will be absolutely crucified. You couldn't put him anywhere else but here at the moment.

Within YOIs, young offenders with learning disabilities present a challenge, as they are often vulnerable to bullying, and it is also difficult to access services.

The difficulty of getting them a diagnosis that they have learning difficulties is because, if their IQ is over 70, there is no service. I've never been able to get learning disabilities on board; and that's no criticism – everyone is under pressure. You find a lot of people have come through school, and they've never had a statement of special needs at all, which you find incredible.

Continuity of care

At the time of the study, assessments and recommendations that should accompany the young person into custody were often missing. This included any continuous assessments of mental health status and risk to self and others, and is particularly problematic, as young people are not routinely screened within secure sites.

The absence of paperwork was often a problem for secure estate establishments. One interviewee said: “If we're lucky we will get the *Asset* and the pre-sentence reports”.

Continuity of care was a frequent problem, although the use of the CPA in one establishment had minimised the barriers to providing continuous care. The CPA and its advantages are described in more detail in the final chapter of this report.

One YOI was implementing the CPA to try to ensure that all professionals and agencies involved in delivering care to a young person were aware of their roles and responsibilities.

We are trying to implement the CPA; and we're trying to involve the community mental health team. The initiative and momentum at the moment is to get CPA up and running – then links would be better forged.

The importance of re-engaging young people in education was a recurring theme, with many viewing custody as an opportunity to achieve this. However, continuity of provision on release was identified as a significant problem, particularly by Yot workers.

A number of staff at secure sites also raised concerns about young people who were moved from one secure estate to another, or those on short tariffs, as they were unable to carry out adequate assessments and deliver interventions.

Training

A number of interviewees within the youth justice system thought there was a need for additional training for the day-to-day task of working with, and caring for, young offenders. Many respondents also identified the need for mental health training so that staff could make better use of specialist services.

Those interviewed acknowledged that the Youth Justice Board was providing some mental health training. Mental health screening, for example, was welcomed by many – but there was also disappointment that more staff had not been able to attend the specific training due to a lack of availability on courses.

Some of the staff within the YOIs and Yots felt that they did not have the skills to recognise or identify mental health problems in young offenders, as illustrated by the following:

If you were able to recommend, through this, that at least two to three officers per wing go on an in-depth course on dealing with young men who need psychiatry or psychology; then I would say that you would then have to recommend it, because within the system, we have only done short courses here – it's not enough. Yes, I would like more depth, without becoming part of the psychiatric team.

Satisfaction

About two-thirds (66%) of young offenders expressed a high degree of satisfaction (+1 to +3 on the Likert scale) with services provided by Yots and LASCHs, compared with 45% for YOIs. They described staff as helpful in accessing a number of different services, from accommodation to education. Young people were also able to describe positive experiences in custody, from provision of a stable and safe environment, to reducing access to alcohol and drugs.

Mental health services

Screening

There is currently a reliance on previous assessments, including *Asset* and any mental health assessment completed by the Yot, accompanying the young person. As this study has already demonstrated, these do not always happen. In any event, this reliance on past assessments also fails to reflect the changing needs of young people.

Discipline staff within YOIs were concerned about identifying mental health problems, when they were unsure about whether there were any appropriate services available, or how to access them. This raises the recurring dilemma of screening in the absence of appropriate services, as discussed as part of the mental health-screening programme launched by the Youth Justice Board in November 2003.

Some of the interviewees, particularly at YOIs, were concerned that young offenders who were disruptive were more likely to be assessed and, therefore, stood a better chance of receiving some therapeutic input.

I think that every trainee should have the same opportunities for multi-disciplinary input; but it is usually the trainee who is in your head – those boys who are withdrawn and anxious don't come to light; and you normally see them coming back through reception.

Provision

There were considerable differences in the models of mental health provision in secure establishments compared with Yots.

In many secure estate establishments, mental health provision was provided on a sessional basis by mental health professionals who had a personal interest in the area. Subsequently, continuing provision was vulnerable to changes in personnel and priorities. Unlike community CAMHSs, multi-disciplinary input was rare. However, secure estate establishments with multi-disciplinary mental health teams reported comparatively high levels of well co-ordinated input to young people.

One YOI had implemented a multi-disciplinary 'in-reach' mental health service, following extensive discussion between the YOI and local CAMHS. The service is based in the YOI, and has links with staff at operational and strategic levels.

The actual model: we introduced OT [occupational therapy], psychology, psychiatry, psychotherapy, and the prison itself was to provide nursing, GPs, dental care, sexual health – so, essentially, we're trying to replicate a community-style service within the prison, so we've got all the key players all attending. We haven't come to set up our own service in the buildings – it's using their resources and their people; an integrated service. It's linked up and down the line – at referral meetings, anyone with concerns can attend, and there is a steering group that meets monthly. The deputy governor, health care manager, in-reach mental health team manager, and this group reports to the prison health steering group.

Health workers within Yots with mental health training were valuable in the assessment and management of young offenders with mental health problems. However, they were at risk of being overwhelmed and unsupported, and few health workers had any clinical supervision from mental health services, although those who did found it valuable.

From the geographically disparate sites included in the study, the perception of those interviewed was that provision of mental health services across the country was variable and often influenced by local factors – reasons included lack of resources and funding as the main obstacles to provision.

There were few examples of regular opportunities for consultation liaison between Yots and CAMHSs. There was some evidence of joint working between Yot health workers and CAMHSs, but this tended to be informal and based on individual cases.

Many CAMHSs professionals were concerned about the impact that the referral of young offenders with mental health problems would have on a service that is already overstretched and struggling to provide a service for those on their waiting list. A CAMHS worker described the predicament faced by many within CAMHSs concerning the impact that young offenders with mental health problems may have on their service.

I find the response of colleagues quite defensive; there's a lot of worry that the flood gates are going to open, and that we'll have all these hundreds of kids, naughty boys to boot – and even consultants have taken the attitude: 'If they think they're going to do that...'. Similar issue with the Yots kids – these are the kids that we don't engage with, they're not easy to cope with and to manage and to engage with, and we signally fail to assess their mental health needs.

They went on to talk about the reluctance on the part of some of the team to work with young offenders at all, seeing them as the responsibility of the Yot.

It's an interesting dilemma that was highlighted in a meeting; we were looking at a case referred by Yots. Our first reaction is: 'Well, they've got the resources and they're doing much the same as us really.' If you crossed out Yots and put Dr so-and-so, there wouldn't be a question asked. I've got a case now referred to us by Yots, and they asked at the team meeting if this was an appropriate referral. I found out he had been referred last year by his GP – exactly the same issues, and they were sent an appointment and they were given a DNA test.

However, at one site, the Tier 4 specialist forensic adolescent service had provided in-reach to health care, and this had promoted closer working and greater support within the YOI.

Difficulties were also highlighted in the provision of mental health services for young offenders aged between 16 and 18 years. The recent introduction of the Children's National Service Framework as a national standard to provide mental health services for young people will, it is hoped, address some of these difficulties. Within this framework and the context of a comprehensive CAMHS, recommendations have been made both for CAMHSs input to Yots, and also for providing services for this particular age group.

Satisfaction

While over a third of young offenders had previously seen a mental health practitioner, very few were in current contact with mental health services. Young offenders who had been in recent contact were less clear on the benefits of such a service, with 52% rating it neither a particularly positive or negative experience (rating of 0 on Likert scale), and 43% rating it more positively (+1 to +3 on Likert scale).

Drug and alcohol provision

Screening

The study also found high levels of drug and alcohol problems, particularly for young offenders in the community. However, recognition of these needs was often variable. Staff within the youth justice system appeared more comfortable enquiring about drug and alcohol misuse than mental health problems.

Provision

Generally, provision of services for young offenders with alcohol and drug abuse problems was found to be good. This may be attributed to a number of factors, including the introduction of CARAT workers within secure sites and substance misuse workers within Yots.

The manager of a CARAT team described the establishment of a new drug and alcohol service in a YOI. This informal approach had led to effective working relationships with discipline staff; as the manager observes:

When the CARAT service was set up, it was brand new so we decided that the best thing we could do was spend time drinking tea with officers, and we did that for three months; and then it turned out we were not a threat, and we really appreciated the environment they were working in – and we see all new officers as part of their induction.

The close working relationships with discipline staff had led to the development of a co-ordinated approach to the assessment and monitoring of young people.

Assessment would be an on-going thing, so we'd be looking at any indication of substance misuse issues and mental health problems. We would keep an eye on them, and tell the wing officer, if we had any concerns regarding their behaviour or their state of health, and we'd always liaise with other people if we had any worries.

Additionally, the position of substance misuse workers within Yots may be more straightforward than that of their health counterparts, as their remit is more defined and circumscribed – with ringfenced funding for their posts. Often, there was also more than one Yot worker within the team with this specialist experience. Workers were both seconded and employed directly by the Yot.

Education services

Provision

There was also good provision of educational services for young offenders within custody. However, services were less comprehensive for those in the community, especially for those under 16 years of age, where non-mainstream alternatives were limited. The introduction of agencies, such as Connexions, has been a helpful resource for a number of young people wanting training and apprenticeships rather than mainstream education. These alternative placements may subsequently provide an opportunity to engage these young people better.

Many of the interviewees considered that inclusion in education was a potentially protective factor in relation to the development of mental health problems. Education workers in Yots were valued by other members of the Yot for their relationships with local schools, and had clearly had an impact on provision for young offenders in the community.

An example of innovative practice is described in the following.

The local secondary schools got together and agreed to try and avoid exclusion of pupils by moving young people from one school to another. If one head felt they had no choice but to exclude, another school would agree to take them, on the understanding that schools who excluded pupils would also have to include others. Sometimes the change of environment, new teachers, peers, etc. would be very positive for the young person. They also involve us [the Yot] when appropriate. It's not easy – but it keeps the young people in education.

It was also apparent that it was often time-consuming and difficult to find schools for young people. In reality, continuity of education provision from secure custody to community was frequently hard to achieve.

There were examples of the difficulties faced by Yot workers, in particular, who struggled to find places for young offenders in education, once they were back in the community.

He became very interested in a particular subject in the YOI, and started to attend education regularly. On his release, he had applied for a place at college and been offered it – but no-one would pay for it; here's a highly motivated young man with a place at college, and we struggled for months to find the money.

Satisfaction

The findings regarding the benefits of education services were further reinforced by the views of the young people. Over two-thirds of young offenders (70%) reported a high level of satisfaction (+1 to +3 on the Likert scale) with educational services, and had found them a helpful resource. However, many of these services were provided while young offenders were in custody and in non-mainstream alternatives. A number of young offenders identified the importance of educational/training or leisure activities in keeping them occupied and away from the company of other anti-social peers.

Implications and recommendations

- There should be adequate resources, and they should be used effectively.
- Structured continuous assessments of mental health needs for young offenders in custody and the community.
- Accredited evidence-based interventions.
- Multi-disciplinary approach to assessments and interventions in both secure and community sites.
- Tailored educational provision based on individual needs and ability, particularly for those under 16 years of age.
- Adequate support and supervision of staff.
- CPA to improve continuity of care.
- Local multi-agency mental health strategy for both Yots and secure establishments.
- Clear guidelines regarding confidentiality of records across different professional groups within the youth justice system.
- Prioritisation at management level for strategic planning in the delivery of assessments and interventions locally.

Limitations

- This research did not include secure training centres.
- No details regarding physical health services and less emphasis on education and substance misuse services.
- Need for more user views from young offenders regarding service provision: although this was assessed within this study, there was a high amount of lost data, due to interview fatigue on the part of the young person – we would recommend a separate study to address this.

Results – part two: epidemiology and needs data

In this chapter, we begin by summarising the main epidemiology and needs findings from the study before describing them in more detail.

Summary

While the study aimed to over-sample female offenders and those from ethnic minorities, in the event, rates of young offenders from ethnic minorities were not dissimilar from rates found within the youth justice system.

There were few differences in the demographic backgrounds of young offenders in custody, compared with the community. Young offenders in custody were significantly more likely to have had a previous custodial sentence or community order. The study also found higher rates of young offenders from ethnic minority backgrounds within custody. This finding has been confirmed by other studies of both juvenile and adult offenders (www.youth-justice-board.gov.uk/publications).

Many young offenders came from backgrounds where the family structure had broken down, and a history of local authority care placements was common. The links between psychosocial adversity and offending behaviour have already been well established.

A history of temporary or permanent school exclusion was also common, and a quarter of young offenders were identified with learning difficulties. Similar high levels of learning difficulties have been found in previous studies of young offenders (Kroll et al. 2002; Lader et al 2000).

With regard to offending history, the mean age of onset for girls was later than for boys (16 years, compared with 12 years). As found in other studies, there were a few frequent offenders who committed the majority of crimes. Thus, the most frequent (median) number of offences per offender was nine; but the mean was 42, due to the influence of these frequent offenders (see Figure 3, p.36). The most common type of offence reported was property offences, with violent crimes the second most common.

Cross-sectional findings

Asset was found to underestimate rates of mental health problems. Of the 600 forms evaluated, only 15% of young offenders were identified with mental health problems. This is much lower than the 31% of young people identified in this national study, using the S.NASA needs assessment tool.

The study found high levels of needs in young offenders, not only in mental health but also within education and social relationships. About half had problems with peer and family relationships, while a third of young people had significant problems with education or work. This is in keeping with the findings of a number of other studies.

A third of young offenders had a mental health need. This was broken down as follows: almost a fifth of young offenders had problems with depression, while a tenth of young people reported a history of self-harm within the last month. Similar rates were found for young people suffering from anxiety and PTSD. Hyperactivity and psychotic-like symptoms were reported in 7% and 5% of young people, respectively.

Rates of mental health and substance misuse problems were high but not predictive of subsequent offending. However, male offenders were more likely to continue offending than female offenders.

The most significant predictor of need was not gender or ethnicity, but location. Young offenders in the community had significantly more needs than those in secure care, particularly within the areas of education, peer and family relationships, and risky behaviour (alcohol and drug misuse). This is likely to be secondary to a number of factors, including: the provision of educational services, increased supervision, and reduced access to alcohol and drugs while in custody. There was no significant difference in mental health needs between custody and community groups.

While total levels of needs were not associated with gender or ethnicity, female offenders were found to have significantly higher levels of mental health needs (depression, deliberate self-harm and post-traumatic stress), while young offenders from ethnic minorities were found to have higher rates of post-traumatic stress.

Needs increased in young offenders discharged from secure facilities into the community, especially within areas of relationships and risky behaviour. This is possibly secondary to reduced opportunity while young offenders were in custody.

Needs were often unmet in a number of different areas due to four main reasons:

- lack of recognition
- lack of an appropriate service
- young person refusing to engage
- poor continuity of care.

Based on the S.NASA, assessment was the most commonly recommended intervention for most areas of unmet need.

This study found that 23% of young offenders had an IQ below 70 (normal range: 85 to 115). However, a criticism of commonly used psychometric measures, including the WASI, is their inability to differentiate easily those with intrinsic learning difficulties from those with low IQ scores because of a lack of education.

Longitudinal findings and continuity of care

Continuity of care for young offenders was highly variable. While national standards for reviews in custody were often met, there were frequent delays – particularly in visits by Yot workers. Continuity of care was poor for educational services, although slightly better for mental health, and best for alcohol and drug services. However, there were long delays for young offenders accessing mental health services.

Provision of mental health and substance misuse services was frequently provided by staff within the youth justice system – for example, by health and substance misuse workers within Yots. The remaining mental health provision was provided by a range of different service providers, from primary care to CAMHSs and adult psychiatry services. These findings must be taken in the context of the recent recommendations made by the Children's National Service Framework (Department of Health, 2003).

Young people reported a high level of satisfaction with services provided by the youth justice system, particularly from Yots and LASCHs. They had also found educational services helpful (half of these were provided within custody), but were less clear about the benefits from mental health and social services.

Cost of youth crime

According to a recent study (Byford and Barrett, 2004), the financial costs incurred by all agencies with regard to young offenders were considerable. The average cost of a young person in the youth justice system was estimated to be £39,120. The primary driver of cost was accommodation, both for young people in custody and in the community. Costs were significantly higher in custody (£55,674 compared with £22,456). Other characteristics associated with greater costs included lower age, history of violence and depressed mood.

Implications and recommendations

- Improved screening, particularly for mental health needs, both in secure and community sites (this should be in the context of a mental health screening and training programme, with clear guidelines for professionals where young offenders screen positive).
- Identify those young offenders who are:
 - vulnerable, i.e. at risk of mental health problems or risk to self (female offenders, previous history of mental health problems/self-harm, multiple social placements and low IQ)
 - at risk of reoffending or violence.
- Tailor interventions to needs and ability, and not prescribe universally.
- Further studies to evaluate the neuropsychological deficits described in young offenders.
- A review of services provided for young offenders with learning difficulties across the different agencies, particularly education.
- Emphasis on motivational work with young people who have unmet needs and who are difficult to engage.
- Using opportunities while young people are in custody to engage them, and to deliver a variety of interventions.
- CPA to improve continuity of care as young offenders move between secure and community sites.

Limitations

- Lack of comparison group of young people with no history of offending behaviour.
- Unable to obtain IQ assessments on 15% of the sample.
- Key worker interview not always possible, particularly within YOIs.
- Small numbers of young people were recommended interventions in the continuity of care data, particularly for mental health problems.
- A few young people were lost track of in the longitudinal telephone follow-up interviews and criminal records data (Police National Computer).

Main findings

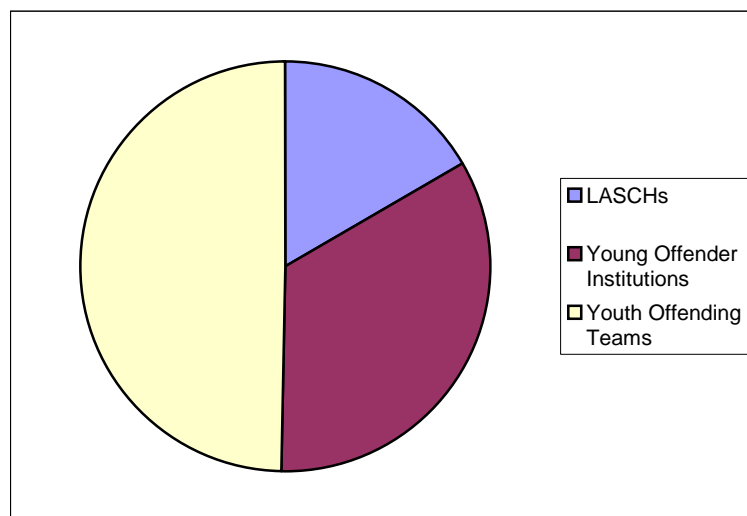
Characteristics of participants and sites

Sites

Originally, two LASCHs and four YOIs were chosen as sites for the study, each paired with a Yot.

However, it was necessary for referrals from both LASCHs and small Yots to expand the chosen sites to include two further LASCHs and three more Yots, in order to achieve the target number of young people. These sites were chosen based on geographical proximity to the original sites.

Figure 1: Location



Participants characteristics

- In total, 301 young offenders were interviewed – 151 in secure facilities and 150 in the community.
- 78% (n=234) were male, and 22% (n=67) were female. It must be remembered that the study specifically over-sampled female offenders. These rates are, therefore, slightly higher than the numbers usually found within the youth justice system (23% in this study, compared with 16%).

The age of young offenders varied between 13 and 18 years, with a mean age of 16 years.

The majority (n=249) of young offenders were white (83%), with 9% (n=26) from an Afro-Caribbean background and 2% (n=7) Asian. Two participants classified themselves as 'other' and were from an Eastern European background, while 5% (n=15) were of Mixed Race. Young offenders from ethnic minorities were also over-sampled in this study, although rates were very similar to those found within the youth justice system (17% in this study compared with 16%).

Table 1 demonstrates the differences between young offenders in custody, compared with those in the community in a number of different areas.

Table 1: Demographic differences between community and custody groups

	Custody n=151 (%)	Community n=150 (%)
Mean age (years)	15.7	15.7
Sex		
Female	33 (22%)	36 (24%)
Male	118 (78%)	114 (76%)
Ethnicity		
White	112 (74%)	138 (92%)
Ethnic minority	39 (26%)*	12 (8%)*
Mean number of offences	44.2	38.9
Age at first offence	12.0 years	12.5 years
Previous custodial sentence	49 (33%)*	28 (19%)*
Previous community order	106 (72%)*	41 (28%)*
Previous care history	65 (43%)	49 (33%)
History of temporary/permanent school exclusion	116 (77%)	111 (74%)

*Significant difference between groups

- There was no significant difference between the groups for a number of different variables, including age, gender, and history of social care placements or school exclusion.
- With regard to offending history, young offenders in custody committed more crimes and began offending at a slightly younger age – although this was not significantly different. However, those in custody were significantly more likely to have a history of previous custodial sentences and community orders.
- The study also found that there was a significantly higher proportion of young offenders from ethnic minorities in custody. This finding has been documented by previous studies.

Cross-sectional findings

At the beginning of this section, we describe the results of the evaluation of 600 *Asset* forms on a separate sample of young offenders, 100 from each of the six original Yots selected to participate in the study.

We also describe the level of need of all 301 young offenders, before exploring individual areas in more detail as follows:

- overall prevalence rates of needs
- offending behaviour
- mental health and substance misuse
- education and IQ
- social needs.

Asset

- In 46 (8%) of cases, *Asset* had not been completed when it should have been. In an equal number of cases (n=46), the files of the young people could not be found to ascertain whether the *Asset* had been completed or not.
- In *Asset*, those identified with mental health problems score a 3 or 4 on the mental health section. Of the 600 *Asset* forms evaluated, only 15% of young people were identified with mental health problems. This is much lower than the 31% identified with mental health needs by this national study using a needs assessment tool.
- *Asset*, therefore, is not sufficiently sensitive in identifying mental health needs in young offenders.

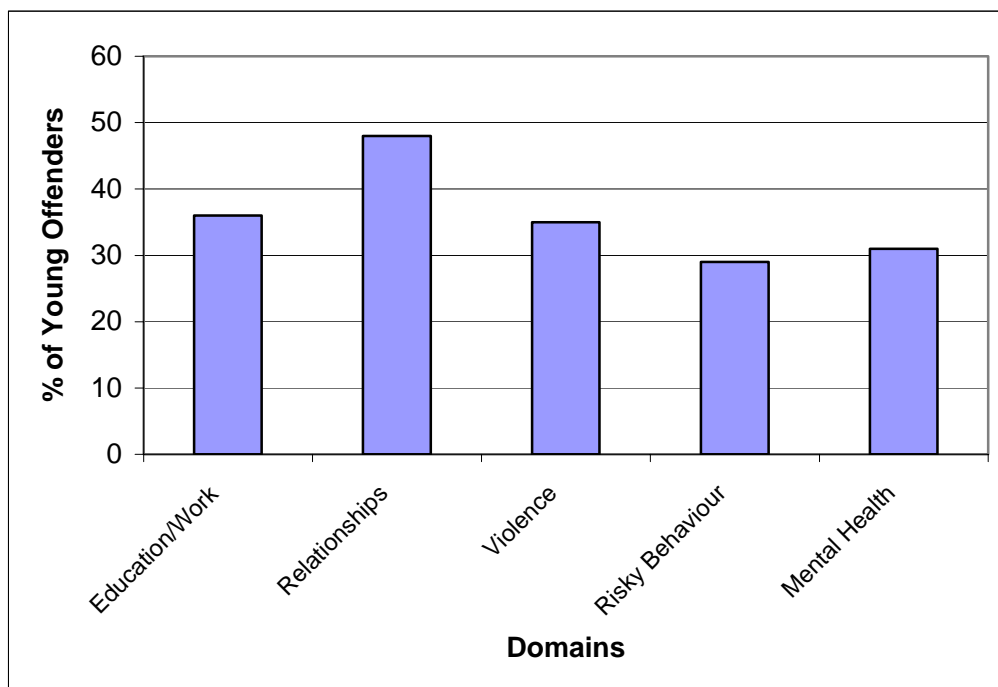
Overall prevalence rates of needs

The 301 young offenders were assessed in 17 different areas. The mean number of needs per individual was 2.6 (standard deviation 2.57, and range 0 to 13). A need is a significant problem that can benefit from an intervention.

Figure 2 displays the needs of young offenders in five main domains:

- education (education attendance, education performance and weekday occupation for young people over 16 years of age)
- relationships (relationships with peers and family members)
- violent behaviour (violence to people and property)
- risky behaviour (inappropriate sexual behaviour, drug and alcohol abuse)
- mental health (depression, deliberate self-harm, post-traumatic stress, anxiety, psychosis and hyperactivity).

Figure 2: Prevalence of need



- Young offenders were found to have high levels of need in a number of different domains.
- Almost a third of young offenders had a mental health problem or problems, accompanied by some form of risky behaviour.
- Almost half the sample had significant difficulties with peer and family relationships.
- Around a third of young people had educational or work needs.

Table 2 outlines the level of needs and recommended interventions broken down into individual categories for all 301 young offenders.

Table 2: Needs by individual categories

	Needs n=301 (%)	Recommended intervention for need
Depression	55 (18%)	Assessment
Self-harm	27 (9%)	Assessment
Anxiety	31 (10%)	Assessment
PTSD	26 (9%)	Assessment
Psychotic-like Symptoms	16 (5%)	Assessment
Hyperactivity	20 (7%)	Assessment
Alcohol abuse	33 (11%)	Assessment
Drug abuse	59 (20%)	Assessment
Sexual behaviour	19 (6%)	Assessment
Violence to people	76 (25%)	Assessment
Violence to property	61 (20%)	Assessment
Social relations	106 (35%)	Coping advice
Family relations	86 (29%)	Supportive counselling
School attendance	56 (19%)	Setting appropriate targets
School performance	52 (17%)	Setting appropriate targets
Weekday occupation	31 (10%)	Advice about seeking work
Accommodation	33 (11%)	Supported lodgings

Influence of gender, ethnicity and location (custody versus community)

Table 3 demonstrates the differences in total levels of need with gender, ethnicity and location.

Table 3: Influence of gender, ethnicity and location

	Mean number of needs per person
Sex	
Male	2.5
Female	3.0
Ethnicity	
White-British	2.8
African-Caribbean	1.7
Asian	1.9
Mixed race	2.3
Other	0.5
Location	
Custody	1.9*
Community	3.3*

*Significant difference between groups

■ **gender**

- Girls had more needs than boys, but there was no significant difference.
- Girls had significantly higher levels of mental health needs, particularly in areas of depression, deliberate self-harm and post-traumatic stress.

■ **ethnicity**

- There was no significant difference in the total level of needs between young people from different ethnic groups.
- Ethnic minorities had higher rates of post-traumatic stress.

■ **secure versus community care**

- Young offenders in the community had significantly more needs than those in custody.
- Rates of needs were higher in areas of education, risky behaviour and relationships – as evident in Table 4.
- Needs were likely to be lower in custody, due to a number of different factors including increased access to educational interventions and less access to drugs and alcohol.
- Additionally, admission to custody removes these young people from their families – so, possibly, reducing some of the stress on family relationships that is often reported.
- The intensive supervision and structure provided within secure facilities may also reduce difficulties in peer relationships.

Table 4: Custody and community differences in needs

Category	Custody (n=151) %	Community (n=150) %
Depression	19%	18%
Self-harm	8%	10%
Anxiety	11%	10%
PTSD	11%	7%
Psychotic-like Symptoms	5%	6%
Hyperactivity	6%	7%
Alcohol abuse	6%*	16%*
Drug abuse	11%*	28%*
Sexual behaviour	3%*	9%*
Violence to people	24%	27%
Violence to property	15%*	26%*
Social relations	23%*	48%*
Family relations	21%*	36%*
School attendance	11%*	26%*
School performance	16%	19%
Weekday occupation	3%*	17%*

*Significant difference between custody and community groups

Levels of unmet need

When a need is identified, it is rated by clinicians, based on available information into: unmet need; suspended need (an intervention has been offered recently and, therefore, it is too early to assess whether it has been beneficial); or persistent need despite intervention.

- Few young people had any type of intervention for their needs. There appeared to be little difference for social, educational or mental health needs (see Appendix 6).
- Subsequently rates of unmet need, i.e. the rate of those with a need and no suitable intervention was very high.
- By combining quantitative and qualitative research findings, we were able to identify four important factors in meeting the needs of young offenders:
 - recognition of needs
 - accessibility of services
 - client co-operation
 - continuity of care.
- Findings from the qualitative study suggest a number of difficulties associated with screening and identifying problems in young people.
 - There is inadequate training of staff, and there is no health worker in post at the Yot.
 - Young people moving within the youth justice system are often transferred without their documentation (e.g. Asset forms) accompanying them.

- A number of staff, particularly within Yots and YOIs, were concerned that assessments of young people were only undertaken on referral or admission to their service. Subsequently, these assessments were not adequately reflecting the fluctuating needs of young people over time.
- With regard to non-referral for a service, reasons provided by staff from the qualitative study included:
 - a lack of appropriate services available locally
 - concerns about the imminent transfer of the young person within the youth justice system that would disrupt any intervention offered
- In certain cases, even with identification of a need and the availability of local services, the young person had refused any intervention.
- We explored this further for two categories of need, mental health and alcohol and drug abuse. Those with unmet needs in these areas at baseline were identified and assessed for any subsequent interventions in the follow-up period. Table 5 (below) displays the reasons for unmet need in these two categories.
 - For unmet mental health needs, the single most important factor appeared to be inadequate screening and, therefore, under-recognition of these needs.
 - For young offenders with unmet alcohol/drug abuse needs, the most common reasons for unmet need included inadequate screening and the young person refusing any intervention. This group of young people are increasingly seen as a hard-to-engage group. However, there may be opportunities – for example, while young people are in custody, to engage them and better address these needs.

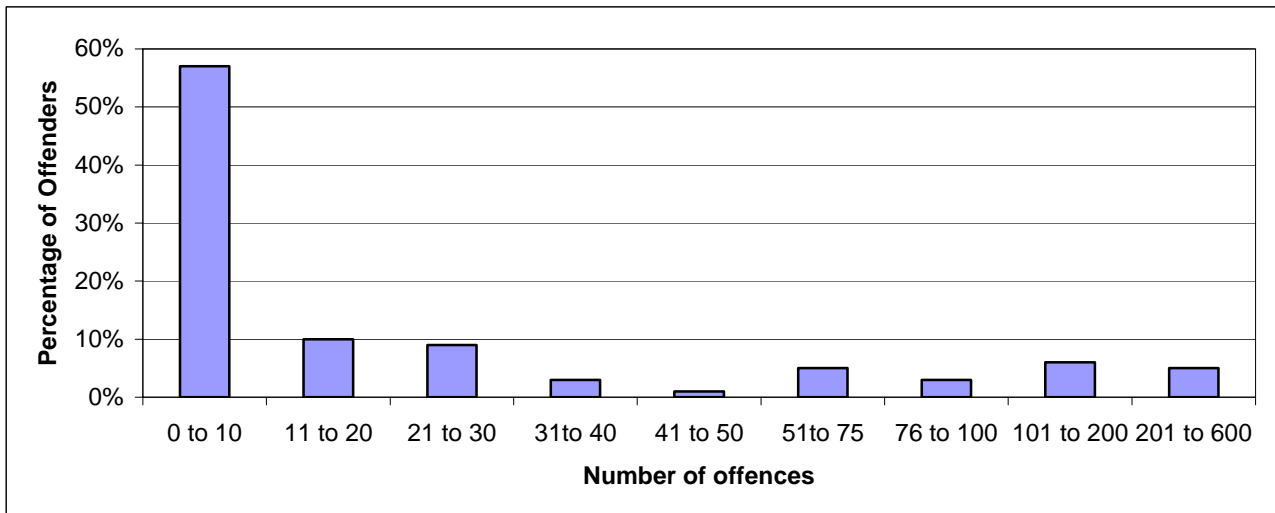
Table 5: Reasons for unmet need (examples mental health and alcohol/drug abuse)

Reason	Mental health (n=73) %	Alcohol/Drug abuse (n=53) %
Inadequate screening	78	45
Non-referral to services	10	10
Young person refuses	7	28
Missing/Lost to follow-up	5	17

Offending behaviour

- According to the S.NASA, a quarter of young offenders were found to have problems with aggressive behaviour towards people, with a fifth having problems with aggressive behaviour to property (Table 2, p.32).
- Only a third of young offenders were having some form of intervention for their needs, with the most recommended intervention from the S.NASA being the need for assessment.
- The study found that there were a few frequent offenders who were responsible for the majority of the crimes committed (see Figure 3, overleaf). The number of offences committed by young people was, therefore, not normally distributed; this is reflected in the discrepancy between the mean number of offences (n=42) and the median (n=9).

Figure 3: Number of offences committed



- The mean age of the young person when they committed their first offence was 12 years. It was slightly older for girls (16 years), compared with boys (12 years).
- The most common type of offence reported by young people was property offences (90%), with violent crimes the second most common (71%). Serious violent crimes and public order offences were committed by 15% of offenders, with 21% committing driving offences. Sexual and fraud offences were the least common (2% each).
- Young people in custody and in the community were on a number of different types of orders. The most common custodial order was the Detention and Training Order, while the most common community order was the Supervision Order.
- Those in custody² had, on average, spent four months in secure facilities, and had been given, on average, a sentence of 15 months.
- About a quarter of young offenders had served a previous custodial sentence, while just over a third had been given a previous community order. Those in custody were significantly more likely to have had a previous community or custodial sentence.

Association with subsequent offending

- Mental health needs, including alcohol and drug abuse at baseline, were not significantly associated with subsequent offending during the follow-up period.
- However, gender was associated with future offending, with male offenders significantly more likely to continue offending than female offenders.
- We were unable to obtain from the Criminal Records Bureau the criminal records for 24 of the 301 young offenders in the study.

Mental health and substance misuse

- Rates of mental health problems were high in a number of different categories, although there was no significant difference for young offenders in custody, compared with the community.

² For those on DTOs, for the purposes of these calculations, length of sentence includes the community element.

- Almost a fifth of young offenders had problems with depression, while a tenth of young people reported a history of self-harm within the last month. Similar rates were found for young people suffering from anxiety and PTSD. Hyperactivity and psychotic-like symptoms were reported in 7% and 5% of young people respectively (Table 2, p.32).
- Girls had significantly higher levels of mental health problems than boys, particularly for depression (35%, compared with 13%), deliberate self-harm (17%, compared with 7%) and PTSD (19%, compared with 6 %).
- Young offenders from ethnic minorities were also found to have higher rates of PTSD, compared with non-ethnic minority offenders (16% against 7 %).
- As already described, levels of unmet mental health need were high. The most common recommended intervention from the S.NASA was the need for assessment.
- Almost a quarter of young people reported a previous history of self-harm at some point in their lives, and two-fifths reported previous contact with either a mental health practitioner (psychiatrist or psychologist), or with mental health services.
- Substance misuse rates ranged from 11% of young people with alcohol abuse problems, to 20% with drug abuse problems. Similar high rates have been found in a number of other studies of young offenders.
- Rates of alcohol and drug abuse needs were significantly higher in the community (Table 4, p.34). With regard to alcohol problems, this was a problem for 16% of young offenders in the community, compared with 6% in custody; and for drug misuse, 28% of young offenders in the community, compared with 11% in custody.
- More young offenders were having some form of intervention for their alcohol misuse compared with their drug abuse. It is unclear at this stage whether this is related to better screening or motivation from the young person to engage in interventions. The need for assessment was again the most recommended intervention from the S.NASA for substance misuse problems.

Education and IQ

- With regard to education, school attendance and performance needs were seen in 19% and 17% of young offenders respectively; while 10% of those over 16 years of age had difficulties with weekday occupations (Table 2, p.32).
- Young offenders in the community had significantly more needs than those in custody (Table 4, p.34). For those under 16 years of age, school attendance needs were seen in 26% of those in the community, compared with 11% in custody; while occupation difficulties (of those over 16 years of age) were seen in 17% of young offenders in the community, compared with 3% in custody.
- More young offenders were having some form of intervention for their needs, compared to other areas. The most recommended intervention from the S.NASA for school-based needs was the setting of appropriate targets, while advice about seeking work was the most recommended intervention for those over 16 years.

- Almost a quarter of young offenders (23%) in the study sample met the criteria for learning difficulties (IQ<70), while a third had borderline learning difficulties (Table 6, overleaf). Male offenders had significantly lower IQs than female offenders (IQ of 77, compared with 84). The study also found that young offenders in the community had significantly lower IQs, compared with those in custody (an IQ of 77, compared with 81).

Table 6: IQ of offenders

IQ range	IQ classification	n (%)
69 and below	Extremely low	60 (23%)
70–79	Borderline	93 (36%)
80–89	Low average	60(23%)
90–109	average	38 (15%)
110–119	High average	5 (2%)
120–129	Superior	1 (<1%)

*Data were not available in 44 cases

- Over three-quarters of young people had a reading age (83%) and reading comprehension age (92%) below their chronological age. The mean reading age was 11.3 years (range 6 years to 17 years) and reading comprehension age, 10 years (range 6 years to 17 years). This is significantly lower than the mean chronological age of the study sample (16 years).
- Three-quarters of young offenders reported a history of temporary or permanent school exclusion.
- Poor levels of school attendance were also found, with a tenth of young offenders aged 16 years or below failing to attend.
- Many young offenders of all ages were accessing education outside mainstream establishments, particularly while in custody.

Social needs

- Over a quarter of young people described difficulties with family relationships, and a third had problems with peer relationships (Table 2, p.32).
- This was significantly higher for young offenders in the community, compared with those in custody (Table 4, p.34). For example, with peer relationship needs, this was a problem for 48% of young offenders in the community, compared with 23% in custody; and for family relationship needs, this occurred in 36% of those in the community, compared with 21% in custody.
- Unmet need was again high; coping advice for peer relationship needs and supportive counselling for family relationship needs were the most recommended interventions from the S.NASA.
- Over three-quarters of young offenders were currently living with their family (immediate and extended), or had been living with them before their custodial sentence.
- With respect to those accommodated by social services, 4% of young people were living in foster care, while 6% were in children’s homes.
- However, over a third of young offenders had been in care at some point in their life.

- Almost two-thirds of young offenders came from families where the family structure had broken down, with only a third of biological parents still married or living together.

Longitudinal findings and continuity of care

In this section, we report the key findings from the follow-up data. There were two methods used. The first involved direct interviews with young offenders and professionals, while the second was via telephone interviews with the case manager (Yot worker) and, therefore, less robust.

Direct interviews with the young person (secure sample)

Half the secure sample (75 young offenders) were reinterviewed, on average, nine months later (range 5 to 13 months). They did not differ significantly in background characteristics, compared with the remaining 75 young offenders from the secure sample. These young people were interviewed using the S.NASA, a Health Economics Questionnaire and a Continuity of Care questionnaire. The Continuity of Care questionnaire was designed to rate the level of continuity of interventions with the young person from different services, and was based on recommendations made on the young person's community training plan (TI:FR). It was also used to assess if DTO and section 53/91 standards for supervision, as set out in the Youth Justice Board's *National Standards for Youth Justice Services*, were being met. These recommend that, while in custody, a young person should be the subject of three-monthly reviews and monthly visits from his or her Yot worker. Meanwhile, section 53/91 standards recommend a review every three months, while in custody, and monthly for the last three months. On release, national standards recommend twice-weekly community contact with the Yot worker in the first 12 weeks.

Telephone follow-up with case managers

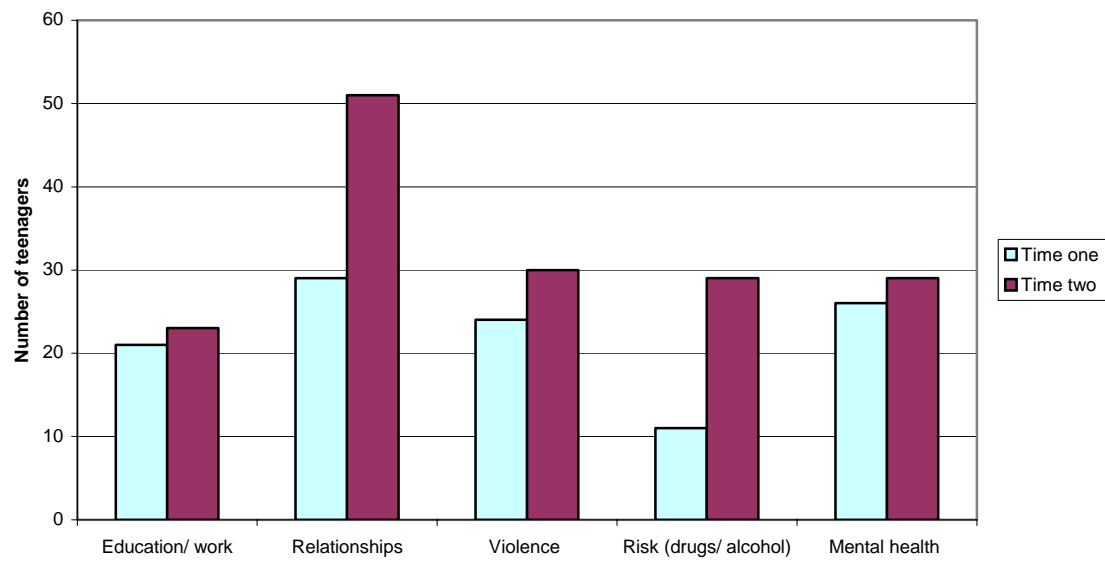
All 301 of the young offenders in the study were followed up through telephone interviews with their case managers (Yot workers) in which they were asked for information about mental health, education and drug and alcohol problems. These were conducted, on average, eight months after the initial interview (range 5 to 13 months). Seven young people were no longer in contact with Yots and information was not known on one young person.

Direct interviews (secure sample follow-up)

■ **Change in needs**

- Half the young people in custody were followed-up and reassessed, on average, nine months later (range 5 to 13 months).
- The mean number of needs for each individual was significantly higher at follow-up (3.1, compared with 2.1).
- Figure 4 displays the changes in needs in different domains between baseline (Time 1) and follow-up (Time 2). This increase in needs was attributable to significant changes in areas of risky behaviour (alcohol and drug abuse problems) and relationships (peer and family).

Figure 4-Changes In Needs Between Baseline and Follow -up



- Table 7 (overleaf) displays the prevalence rates of needs at follow-up, and can be compared with those at baseline (Table 2, p.32).
- While prevalence rates of a number of mental health areas increased on follow-up, this was not significantly different (Table 7).
- There was little difference at follow-up for the most recommended intervention from the S.NASA. The need for assessment continued to be the most recommended intervention for those with unmet need (Table 7).

Table 7: Needs at follow-up

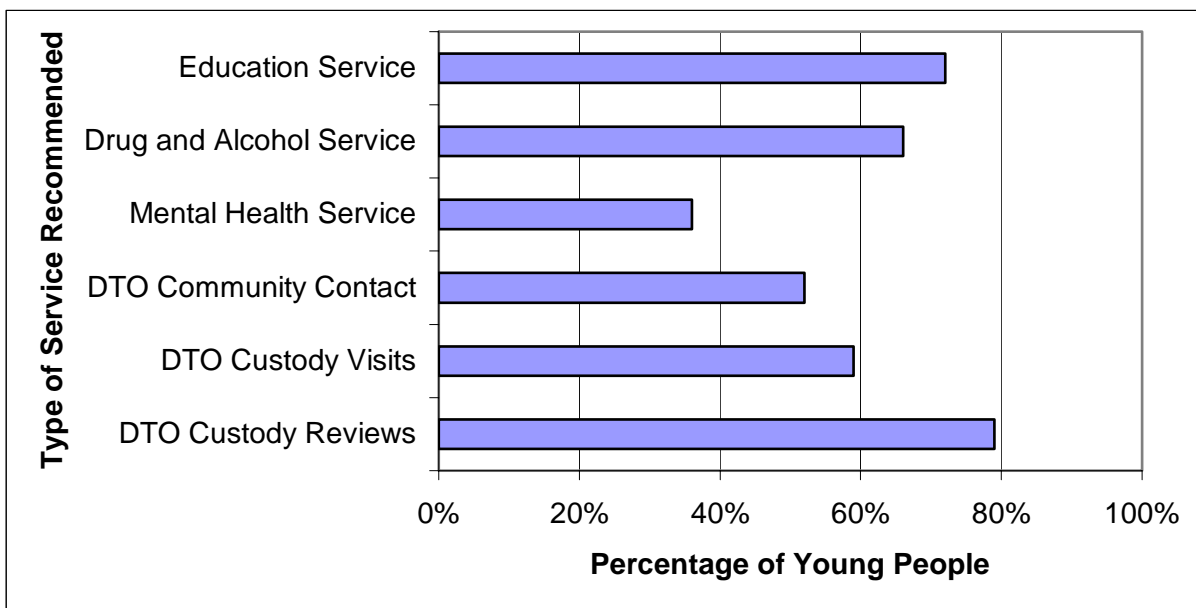
Category	Needs n=75 (%)	Recommended intervention for need
Depression	20 (27%)	Assessment
Self-harm	5 (7%)	Assessment
Anxiety	10 (13%)	Assessment
PTSD	10 (13%)	Assessment
Psychotic-like symptoms	4 (5%)	Assessment
Hyperactivity	6 (8%)	Assessment
Alcohol abuse	17 (23%)	Assessment
Drug abuse	18 (24%)	Assessment
Sexual behaviour	5 (7%)	Assessment
Violence to people	24 (32%)	Assessment
Violence to property	15 (20%)	Assessment
Social relations	41 (55%)	Coping advice
Family relations	37 (49%)	Coping advice
School attendance	3 (4%)	Setting appropriate targets
School performance	2 (3%)	Setting appropriate targets
Weekday occupation	19 (25%)	Advice about seeking work
Accommodation	14 (19%)	Supported lodgings

■ **Continuity of care**

- The 75 young offenders in custody who were reinterviewed were also assessed for continuity of care with youth justice services, as well as for mental health, education, and alcohol and drug services, based on the recommendations made on the community training plan (TI:FR). In some areas, such as mental health, these findings must be taken in the context of the low numbers of young offenders recommended for such an intervention. The numbers from this interview do not correspond to the needs assessment interviews, as different methods were used (direct interview of the young person using a needs assessment tool, compared with youth justice assessment on the TI:FR).
- Within the youth justice system, *National Standards for Youth Justice Services* were met for reviews in over three-quarters of cases – although this fell to just over half for continuity visits and community contact (Figure 6, p.43). In half the cases, reviews and visits were delayed – on average, by a month.
- Of the 15% of young offenders recommended a mental health intervention on the TI:FR, only a third received it (Figure 5, overleaf), with frequent delays, on average, of three and a half months. Failures and delays for services were secondary to a number of different factors, from the Yot to the young person and the service provider. Continuity of care on the part of mental health services for young offenders was variable (Figure 6, p.43), although the reasons for this were unclear.

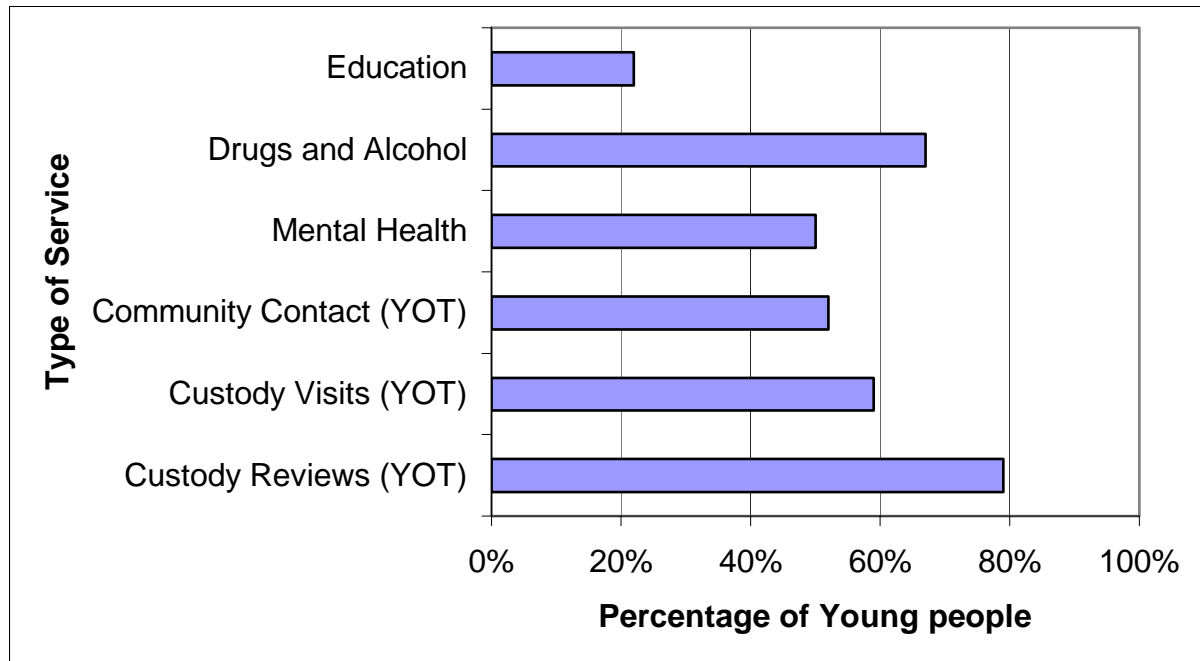
- Almost half the young people were recommended a drug/alcohol intervention on discharge from custody, and two-thirds of young offenders received this service (Figure 5, below). Delivery of the intervention was often delayed (the mean length of delay was 1.8 months), although there was appropriate continuity of care from drug and alcohol services for two-thirds of young offenders (Figure 6, overleaf).
- Of the 81% of young offenders recommended an educational or training service, almost three-quarters received this (Figure 5, below), although this was at times delayed (mean length of delay was 1.8 months). Continuity of care was poor for three-quarters of these young people (Figure 6, overleaf).

Figure 5: Service received



Appropriate continuity of care with different services is summarised and illustrated in Figure 6.

Figure 6: Appropriate continuity of care



Telephone follow-up (all young offenders)

■ **Mental health services**

- During the follow-up period, case managers (Yot workers) identified 70 young people (23%) with mental health problems.
- Of those identified, 53 young people (76%) were having some form of assessment or intervention for their problems.
- Table 8 (below) outlines which agencies were providing this service. Almost half the young people were receiving a mental health intervention directly from Yots via the health worker. The remaining provision was provided by a range of different service providers, particularly from Tier 3 CAMHSs.

Table 8: Mental health service provider

Service provider	Number of offenders N=53 (%)
CAMHS/Psychiatrist	16 (30%)
Adult psychiatry services (out-patient)	3 (6%)
Hospital admission (adolescent/adult in-patient services)	4 (8%)
Primary care services	5 (9%)
Yot health worker	25 (47%)

- **Alcohol and drug services**

- 139 young people (46%) were identified with alcohol and drug misuse problems during the follow-up period.
- Of those identified with problems, 112 young offenders (81%) received some form of assessment or intervention.
- Two-thirds of young people were receiving this service from substance misuse workers within Yots, while the remainder of services were either provided from primary care or within custody (Table 9).

Table 9: Substance misuse service provider

Service provider	Number of offenders N=139 (%)
Inpatient admission for treatment (drug services/adult psychiatry)	2 (1%)
Primary care	20 (18%)
Substance misuse workers (Yot)	77 (69%)
CARAT workers in custody	13 (12%)

Cost of youth crime

Method

Economic data were collected from all 301 young offenders during the initial interview, using the Health Economics Questionnaire (see Appendix 3). The questionnaire collects data on the use of all health, education, social, voluntary, private and criminal justice sector resources over the six months before interview. Total costs were calculated by multiplying the number of contacts for each service by an appropriate unit cost (see Byford and Barrett, 2004).

Results

- The average cost per year of a young person in the youth justice system was estimated to be £39,120.
- Costs per year were significantly higher for those interviewed in custody (£55,674), compared with those in the community (£22,456).
- The main cost was accommodation. This included secure care and YOIs for young people in custody; and foster, residential, supported, and temporary accommodation in the community.
- However, young people in the community also incurred significantly higher social service, education and voluntary sector costs.
- Therefore, for young offenders in custody, the greatest financial burden fell on the criminal justice sector, which bore 86% of the total costs, compared with young offenders in the community, where the greatest burden fell on social services (44% of total costs). The NHS incurred 1% (young offenders in custody) to 3% (young offenders in community) of all costs.
- Individual characteristics at baseline that were found to have a positive impact on future cost included: younger age, history of a violent offence, and depressed mood.

- Costs were perhaps greater among those in younger age groups because they require more intensive support in the community, and are more likely to receive a custodial sentence in a secure unit than a YOI.
- Individuals with a history of violent offending are perhaps more likely to receive a custodial sentence, generating higher costs.
- The relationship between depression and high cost is likely to be indirect. Depression may be reflective of people who have more serious problems – for example, abuse and multiple local authority placements.

Results – part three: effectiveness of interventions for young offenders

A large number of different treatments have been used to reduce anti-social behaviour and, in this chapter, we have summarised the evidence-base for these interventions. In this chapter, anti-social behaviour relates to aggressive behaviour and, therefore, not necessarily offending behaviour. However, many of the interventions and principles described can be applied to young offenders.

We have primarily focused on psychological and pharmacological treatments, as youth justice approaches have been reviewed elsewhere (Powell, 2004; Youth Justice Board, 2001; Youth Justice Board, 2004).

We will also review the effectiveness of interventions to address the mental health needs of young offenders. Addressing the mental health needs of young offenders is important, not only to improve their wellbeing; it is also likely to affect the motivation and ability of the young person to engage with offence reduction programmes. Finally, we will briefly discuss the application of these findings to the youth justice system.

This review is based on a literature review of available databases and peer-reviewed journals. The reporting of many trials fell short of CONSORT (consolidated standards for reporting trials), and few interventions were found to be effective in multiple studies by independent research groups.

Interventions to reduce anti-social behaviour

Meta-analysis of treatment approaches reviewing 400 studies published since 1950 have produced reasonably consistent findings (Lipsey et al, 1995). The main finding was that there was an overall reduction of 10% in offending rates in treatment groups, compared with untreated comparison groups.

There was considerable variation in the results of individual studies. We look at four different approaches:

- psychological treatments
- pharmacotherapy
- systemic/family therapy
- multi-modal treatments.

Psychological treatments

Parent management training

Parent management training is one of the best-researched therapy techniques for the treatment of anti-social behaviour in young people (Kazdin, 1993). The available evidence, however, suggests that parent management training is not particularly effective for adolescents with behaviour problems, unlike younger children.

Cognitive problem-solving skills training

Problem-solving skills training attempts to develop interpersonal cognitive problem-solving skills. Their core characteristics include helping young people approach situations in a more structured way. By generating and selecting a range of different solutions to the interpersonal situation being confronted, they also develop more social behaviour as part of the process of solving difficulties.

Problem-solving and cognitive approaches are promising treatments, as there is supportive evidence that anti-social young people have maladaptive thinking processes. While an advantage is that these interventions exist in manual form, it is important to ensure adequate training and to reduce drop-out rates, which can be high (Kazdin and Holland, 1997).

The conclusion that cognitive-behavioural and skills-orientated methods were likely to be relatively effective was supported by a UK Home Office research study report (Vennard et al, 1997).

Anger management

This is a related group of interventions focusing on teaching young people anger management. Although it is widely used in the youth justice system, there is little evidence of its effectiveness. As aggression is determined by many factors, it is unlikely that any intervention simply targeted at one problem, such as anger, will be sufficiently effective. However, if such an intervention is made, it should be of adequate intensiveness and duration (McGuire and Priestley, 1995).

Pharmacotherapy

Pharmacological treatments are rarely effective alone, and any short-term benefits will need to be balanced against potential short- and long-term side effects (Campbell and Cueva, 1995).

There is some limited evidence to suggest that pharmacological treatments (mood stabilisers and neuroleptics) may reduce aggressive behaviour in adolescents with learning difficulties in the short term. However, current opinion is that, on present evidence, pharmacological therapies by themselves are unlikely to be an effective treatment for behavioural problems in adolescents; although they do have a role in treating co-morbid mental illness such as Attention Deficit Hyperactivity Disorder (ADHD), psychotic illnesses and depression.

Systemic/Family therapy

Family therapy approaches conceptualise juvenile anti-social behaviour from the standpoint of the purpose the behaviour serves within the family system. Functional family therapy is a promising treatment for anti-social behaviour in young people, with several studies producing consistent effects.

While a significant advantage of family therapy is that family therapy skills and training are widely available within CAMHS settings, they are not available within youth justice settings, where it might be more acceptable and less stigmatising for young people and families.

Multi-modal treatments

Multi-systemic therapy is a multi-modal intervention (Henggeler et al, 1996). As the name suggests, it is a systemic approach to treatment, in which the child is viewed as part of wider systems, including the family, peer group, school and neighbourhood.

It includes a programme of interventions, including several family therapy approaches as well as parent management training, marital therapy, parental advice and individual cognitive behavioural therapy with the young person.

There have been a number of trials of multi-systemic therapy that have been promising in reducing offending behaviour – although many have been conducted by the research group (Borduin, 1999). The strengths of multi-systemic therapy include possible long-term effects and a low drop-out rate. However, the challenge is that it requires therapists to be experts in several different modalities, which can be difficult to achieve in routine practice.

Interventions for co-morbid mental illness

The relationship between specific mental health disorders and anti-social behaviour in young people has already been established and described elsewhere (Bailey, 2002; Tiffin and Kaplan, 2004). There is empirical evidence to support a number of interventions for treating child and adolescent mental health problems in those who also display anti-social behaviour.

Impact of treatments for anti-social behaviour

While many studies of treatment on anti-social behaviour do not report measures of behaviour that is not anti-social, studies that do have found beneficial outcomes. Multi-systemic therapy has demonstrated improvements in parental psychiatric symptoms and adolescent behaviour including substance misuse (Borduin, 1999). Cognitive behavioural programmes for reduction of anti-social behaviour have also shown benefits for emotional symptoms, particularly internalising symptoms such as anxiety and depression (Kazdin et al, 1997).

Treatment for co-morbid mental illness

Attention Deficit Hyperactivity Disorder

The relationship between anti-social behaviour and attention deficit disorder is particularly important, as studies have shown a poorer prognosis compared with anti-social behaviour alone. There is now unequivocal evidence that stimulants are effective as a short-term treatment for attention deficit and hyperactivity symptoms (MTA Co-operative Group, 1999a, 1999b).

The MTA study of children with ADHD showed that stimulant medication alone was significantly more effective than psycho-social intervention alone. However, a combination of medication and psychosocial interventions has been advocated for those with co-morbid behavioural problems and complex needs.

Depression and suicidal behaviour

Many different psychological therapies have been used for the treatment of depression in young people – but the most promising is cognitive behavioural therapy (Harrington et al, 1998).

There is significant evidence that individual cognitive behavioural approaches are effective in mild and moderately severe depressive disorders. Although most of the studies have been based on non anti-social samples, at least one trial has shown it may be effective for depression in anti-social young people (Rohde et al, 2001). This is particularly important, given the high number of young offenders with depressive symptoms who are found in this study.

Pharmacological treatments for depression in young people have recently been extensively reviewed in light of concerns regarding increased suicidal thinking. The current government and expert committee guideline is that only fluoxetine has been shown to be effective, and it is the only recommended anti-depressant drug for those under 18 years of age.

With regard to suicidal behaviour, while family therapy was not found to be effective, a group-delivered treatment with many cognitive behavioural treatment elements was found to reduce significantly the risk of repetition (Wood et al, 2001). The trial included many young people from disadvantaged backgrounds, with two-thirds having a co-morbid behavioural disorder.

Anxiety and post-traumatic stress

There is evidence that cognitive behavioural interventions are helpful in adolescent anxiety, although it is unclear whether this can be extended to young people with anti-social behaviour.

Pharmacotherapy also appears to be effective (Research Unit on Paediatric Psychopharmacology Anxiety Study Group, 2001).

PSTD among young people may be helped by cognitive-behavioural approaches. There is also evidence that, following abuse, PTSD will also respond to psychological treatment (Perrin et al, 2000).

Substance misuse

While there are many studies evaluating treatment interventions in adults, they cannot be assumed to apply to adolescents. Individual treatments have been primarily based on cognitive behavioural or problem-focused principles (Myers et al, 1993). There is also evidence for family therapy, particularly structural family therapy where substance abuse is seen in relation to family dysfunction (Stanton et al, 1997).

Community-based interventions with a focus on family problems may also be effective. Studies of multi-systemic therapy have shown reductions in substance abuse as well as deviant behaviour (Henggeler et al, 1990).

A framework for how services should be delivered for young offenders with substance misuse problems has been described using a multi-systemic approach (Bailey and Marshall, 2004). This study has also highlighted difficulties in engaging young people with substance misuse problems in interventions. There is growing evidence for the use of motivational work with young people in this context (McCambridge and Strang, 2003, 2004).

Application to the youth justice system

We focus on assessments and interventions both to reduce anti-social behaviour and to address the mental health needs of young people within the youth justice system.

Offence reduction

Assessment

Since its creation in 1998, the Youth Justice Board has aimed to develop and introduce a structured risk-assessment profile. Within the Criminal Justice System, risk prediction tools for adult offenders have been available for some time – although the introduction of OASys as a common tool for prison and probation services is a further development (Home Office, 2003)..

We review two risk assessment tools for young offenders, *Asset* and the Structured Assessment of Violence Risk in Youth (SAVRY).

■ **Asset**

- introduced in April 2000, allowing a common structured assessment profile across the youth justice system

- contains 13 sections focusing on the dynamic and static factors relating to risk and reoffending
- *Asset – Risk of Serious Harm* assessment is expected to be completed, if the *Asset* indicates that there is risk of the young person committing serious harm to themselves or others
- encouraging findings on reliability and validity (Baker et al, 2003).
- assessment of predictive accuracy for reoffending (67%) is comparable to other assessment tools used with adult offenders in the UK (Baker et al, 2003).
- **SAVRY**
 - designed to assess violence risk in adolescents (Bartel et al, 2000)
 - has its origins in historical/clinical risk management 20-item scale (HCR-20) routinely used within adult forensic mental health services
 - based on a structured professional judgement model, which allows for appropriate consideration of developmental factors, and emphasises the dynamic and often contextual nature of risk
 - SAVRY’s 30-item scale designed to aid in the identification of risk for violence in youth; consists of three risk scales and one protective scale – historical risk factors; social/contextual risk factors; individual risk factors; and protective risk factors
 - also used for monitoring progress and planning interventions and, therefore, supports a CPA.
 - initial evaluation of reliability and validity is promising although limited for female offenders (Borum, 2003)
 - used within forensic CAMHSs for young people with mental health problems and risk of violence (Bartel et al, 2000; Borum, 2003).

Interventions

One of the main aims identified by the Youth Justice Board is to “assess the needs of young people and the degree of risk they pose, and to then match intervention programmes to their assessed need” (Youth Justice Board, 2000). Interventions should be based on risk assessments, focusing on changing the dynamic aspects of risk:

- environment – housing and leisure activities
- peer influences and family relationships
- education and training
- enhancing skills, coping strategies and consequential thinking.

From the evidence available, offence reduction programmes should combine cognitive behavioural and problem-solving principles using a multi-modal approach. However, interventions should not be prescribed universally, but tailored to the young person’s needs and ability.

A quarter of young offenders in this study were found to have learning difficulties. They are, therefore, likely to respond less well to cognitive-based interventions, and may benefit more from a behavioural approach and increased levels of supervision.

McGuire (McGuire, 2000) identified eight principles for effective programmes:

- sound theoretical base
- risk assessment and allocation
- focus on criminogenic needs
- responsiveness to individual learning styles
- structured, directive approach
- community setting
- use of cognitive behavioural methods
- monitoring of programme integrity.

Within the youth justice system, there are a number of different intervention packages that are routinely used based on these principles; for example, the Star Programme (McGuire and Priestley, 1995) and Enhanced Thinking Skills Programme. Evaluation of these intervention programmes, however, is limited, primarily focusing on sex offenders and persistent offenders (Feilzer et al, 2004a).

A recent review of effective practice for young offenders in secure facilities also highlighted similar concerns (Youth Justice Board, 2001) – in particular, the lack of age-appropriate programmes, which has led to the adaptation of existing programmes, for example, prison service programmes within YOIs. Additional issues raised, included a lack of work with families of young offenders, as well as the need to facilitate closer links between secure facilities and Yots.

Subsequently, there are no accredited interventions within the youth justice system that have been evaluated for effectiveness with young offenders. While the Youth Justice Board does not advocate accreditation, it does recommend the *Key Elements of Effective Practice* guidance booklets, which describe the features of an effective service in a number of different areas.

This study and previous studies (Little and Bullock, 2004) have highlighted concerns regarding the continuity of care for young people within the Criminal Justice System. A commissioning framework for children and young people with complex needs, and who are at serious risk to themselves and others, has advocated a CPA (North West Regional Steering Group, 2004).

The CPA was introduced in 1991 to provide a framework for effective mental health care. It is routinely used by adult mental health services (NHS Executive, 1996; Kingdon, 1994) and has started to be introduced within Tier 4 CAMHSs as a model of good practice. It has four main elements:

- systematic arrangements for assessing the needs of people, particularly health and social care needs
- the formation of a care plan which identifies the care required from a variety of providers
- the appointment of a key worker to keep in close touch with the service user and to monitor and co-ordinate care
- regular review and, where necessary, agreed changes to the care plan.

The CPA is drawn up in consultation with the user and has two levels of care:

- **standard CPA**

This is for those who pose little risk to themselves or others, and have mild mental health problems. They only require the support or intervention of one agency or discipline, and are more likely to maintain appropriate contact with services, and are not high risk if they lose contact with services.

- **enhanced CPA**

This is for those with moderate-to-severe mental health problems that are a risk to themselves or others. They may be difficult to engage and have multiple care needs requiring the involvement of a number of different agencies.

An example of a CPA form is provided in Appendix 7.

Mental health needs

Assessment

The assessment of mental health and the promotion of the mental wellbeing of young people within the youth justice system is integral to the delivery of effective youth justice services.

A health screening tool for adult offenders that covers mental and physical health is already available and being used in prisons (Grubin et al, 2002). Initial assessment of its reliability and validity, based on the results of a pilot study, has been promising. It is being evaluated on a larger scale, where issues regarding implementation will also be paramount.

Within the youth justice system, the mental health screening programme was launched nationally in November 2003 (Kroll et al, 2003).

This two-stage screening programme is triggered by scores on the mental health screening section of *Asset* (section 9), and includes screening assessments completed by the Yot worker (the Mental Health Screening Questionnaire Interview for Adolescents [SQIFA]) and the health worker (the Mental Health Screening Interview for Adolescents [SIFA]). Within this programme, there is also clarity of process for young offenders who screen positively.

Training of Yot and health workers in the use of the tools has already begun. However, the challenge that exists is not only in the practical implementation of these tools within routine use, but the continuing training of staff, as this study has found.

The SIFA is a mental health needs assessment tool based on the S.NASA (Kroll et al, 1999), and has the advantage of also assessing the motivation of the young person to engage in treatment. It has been evaluated and shown to be a reliable and valid assessment tool (Myatt et al, unpublished). The importance of using reliable and valid tools has already been established.

In practice, this screening programme has been launched within the Yots, but not within secure facilities. Clearly, this is a necessary requirement to provide comprehensive services, as this study has already highlighted that needs are different for young offenders in secure sites, compared with the community. Such a mental health screening tool would also need to be closely linked to existing screening tools – for example, *Asset*, SIFA and SQIFA.

Additionally, the mental health screening programme has not currently been incorporated into the *National Standards for Youth Justice Services* set by the Youth Justice Board (Youth Justice Board, 2004). Staff within the youth justice system frequently have a long list of competing priorities and it is, therefore, unlikely to be prioritised at a local level.

Interventions

Interventions can be targeted at two levels:

- mild-to-moderate mental health problems
- moderate-to-severe mental health problems.

Mild-to-moderate mental health problems

By addressing environmental and educational factors affecting the young person, there can be secondary influences on their wellbeing. Cognitive behavioural and problem-solving based packages for offence reduction and mental health needs share common principles. Therefore, interventions that improve self-esteem may also have an effect on depressive symptoms.

Moderate-to-severe mental health problems

Those with more moderate-to-severe mental health problems first need to be identified using a universal screening process within community and secure sites. Referral to an appropriate agency is than necessary for further assessment and intervention. Young offenders who have serious mental illness and who are also high risk to others should be referred to specialist forensic CAMHSs.

The development of a local mental health strategy by both Yots and secure establishments with appropriate agencies is essential for the delivery of effective mental health services. The planning of service delivery can be best informed by a needs assessment of the young offenders each establishment works with. While such needs assessments have been carried out within YOIs, this is not routine practice within other secure facilities and Yots. Yots do have the opportunity to use the *Asset* and the mental health screening tools as a basis for planning services and interventions.

Evidence-based interventions for mental health problems in adolescents are already available, although not all have been evaluated on young offenders. This would benefit from continuing investigation in the future to help inform effective practice.

Interventions to reduce offending behaviour and address mental health needs

Implications and recommendations

A comprehensive service for young offenders to reduce offending behaviour and mental health co-morbidity, therefore, needs to include a number of different factors:

Assessment

This should include:

- using reliable and valid assessment tools to assess both mental health needs and offending behaviour
- a mental health screening programme for both custody and community sites that reflects the dynamic nature of needs, and has clear guidelines for professionals when young offenders screen positive
- for young offenders identified with complex/severe needs, assessments incorporated into a CPA that includes:
 - a care plan outlining needs and specific interventions
 - identified key worker

- a review process.

Interventions

These should include the following:

- evaluation for effectiveness with young offenders and accredited by the Youth Justice Board
- adaptation to the young person's individual circumstances, using a cognitive behavioural and problem-solving skills training approach based on assessment of needs, severity, motivation and ability – and not prescribed universally
- a multi-modal approach focusing on the individual, family and peer group
- motivational work to engage young people in interventions
- delivery by trained staff
- identification and referral of those with moderate and severe mental health problems to the appropriate professional or agency.

Strategic planning

This should include:

- prioritisation at management level for strategic planning in the delivery of assessments and interventions locally, and continuing evaluation of their effectiveness
- prioritisation at both national and local level for mental health screening
- for services such as mental health and education not delivered by staff within the youth justice system, a local strategy with appropriate agencies for effective delivery of these services.

Limitations

The reporting of many trials fell short of CONSORT, and few interventions were found to be effective in multiple studies by independent research groups. Furthermore, the study did not evaluate educational or youth justice approaches to reduce offending

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Appendix 1: Interview schedule for all professionals

Category	Question	Interview content checklist
<p>Behaviour and experience (what, how and why?) or Structure and process of service</p>	<p>What kind of assessment process do you use?</p> <p>Can you describe the services provided for young offenders with mental health problems?</p> <p>Could you describe two recent cases One which you felt went well (i.e. where they engaged and you were able to access appropriate services). One which you felt, in spite of everyone's efforts, did not go well.</p>	<p>How is the assessment documented?</p> <p>Where are the documents kept? Who has access to them?</p> <ol style="list-style-type: none"> 1. Services provided within young offender institution? – Who provides/what skills/kind of problems dealt with/kind of interventions provided? 2. Interface work institutions/Yots/CAMHSs/social services/education? Who provides/what skills/kind of problems dealt with/kind of interventions provided? 3. Consultation/liaison? Training and education? Who provides/what skills/kind of problems dealt with/kind of interventions provided? 4. Referral process to CAMHSs (both routine and out of hours) How long is the waiting list? 5. Services in the community? 6. Other? <p>How is information shared between agencies? Relationship between secure and Yot workers? Comparisons between work undertaken in secure accommodation and in the community (contact time/intensity/consistency in content)?</p>
<p>Behaviour and experience (what, how and why) or Structure and process of service</p>	<p>What has informed and facilitated this model of service delivery? (How did this model of service delivery come about? What helped it to develop?)</p> <p>What has impeded these developments?</p>	<p>Why was the service developed, where did impetus come from? Why and how funded? How long is funding for? What was happening before this service was developed? What have been the barriers to setting up this service? What has happened/ changed as a result of this service being available?</p>
<p>Knowledge</p>	<p>How confident do you feel about your ability to deal with mental health problems in young people?</p> <p>What knowledge have you gained from doing this kind of work?</p>	<p>What training have you had? How frequently is it rerun/updated? What could be provided to enhance skills further? How have you developed the skill required for this type of work? What is your background? How would you rate your knowledge of local services on a scale of 1 to 10?</p>

Subjective evaluation or Outcome	What are the strengths and weaknesses of the model of service delivery?	What is working well? Why? What is not working? Why? Does this service meet the needs of young people?
Opinion and Belief or Outcome	How do you think this service should develop in the future?	What do you believe this work should consist of/what should be done? Are there gaps in provision? How can the service be improved? What are the funding/resource/input from other agencies implications?
Opinion and belief	How do you see your current role in the management or treatment of young people/offenders with mental health problems? What do you think your role should be? How do you currently see the role of CAMHSs in the management or treatment of young people/offenders with mental health problems? What do you think their role should be? How do you currently see the role of social services in the management or treatment of young people/offenders with mental health problems? What do you think their role should be?	How can an effective and consistent service between custody (or Yots depending on interviewee) and community (CAMHSs, social services, education, voluntary) be achieved? Which agency should take the lead in case management/co-ordination (e.g. secure, Yots, CAMHSs)?
Feelings	Overall, how do you feel about this way of working?	
Background/ Demographic	Factual Information already collected or to be collected as appropriate.	Numbers of professionals involved. How young people are assessed Types of mental health problems presented Take up/completion rates of interventions Number of cases seen Waiting times

Appendix 2: Salford Needs Assessment Schedule for Adolescents

The Salford Needs Assessment Schedule for Adolescents

S.NASA

Research Version 3 (July 2002)

CLIENT INTERVIEW

Adolescent Forensic Services

Salford Mental Health Trust

Developed by

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(1) Peer/Social relationships

Consider the child's **ability to form and sustain** satisfying peer relationships. **Consider** school and social settings.

If a child has few friends, is socially avoidant in some situations but is genuinely happy with his/her peer relationships and seems to be able to form new relationships if desired, then this should not be rated as a problem.

Rate peer problems irrespective of the causes of problematic peer relationships. Rate associated problems in respective areas. **Do not rate sibling.**

Tell me about your friends. Do you have many friends, some, or just a few? How old are they?

(If no friends then): do you want to have friends?

(If some friends): have you got a close friend that you can trust and tell your troubles to?

Do your friends get in to trouble or do things against the law?

Do your friends take advantage of you (use you), or do you do this to them?

Are you bullied or are you a bully? Have they ever made you do something you didn't want to do?

Do you feel left out or lonely?

Do you change friends a lot? **If yes:** Why?

Do you fall out with your friends a lot? How does it make you feel?

- | | |
|----|--|
| 1. | No problem. |
| 2. | Mild problem, infrequent transient arguments, occasional social withdrawal. |
| 3. | Moderate problem, distress due to social withdrawal, or social rejection. Some relationships provide satisfaction, even though these relationships may not be sustained. |
| 4. | Marked problem, frequent distress, (anger, upset, sadness) over making and losing friendships. Relationships may be possessive, exploitative, or conflict ridden in quality. |
| 5. | Severe problem, person has hardly any friends, or has superficial friendships that provide no satisfaction or support. |

if 1 or 2, ask has it ever been a problem. If applicable, ask reason for improvement.

Does this bother you?

Ask or confirm to everyone.

Not at all	A bit of a problem	A big problem

If help was on offer would you consider it?

No	Maybe	Yes

Do you think people have tried to help with this? *Remind re: definition of help*

What help have you had from professionals? E.g. coping advice, group social skills, family therapy or social skills programme at residential/day/educational unit

Any help from friends/family?

Effectiveness

Help Scale ↓

--	--

(2) Family relationships and functioning

Consider child-carer and child-sibling relationship problems, including those not confined to home setting, e.g. separated parents/siblings. Carers are usually parents, foster parents, social workers/teachers in residential placements.

Rate problems such as poor communication, arguments, verbal or physical hostility, criticism and denigration, parental neglect, sexual and/or physical abuse.

Rate parental personality problems, mental illnesses, marital difficulties affecting family relationships.

Overall how do you get on with:-

Your parents, brothers and sisters, the rest of your family?

Do you have rows in your family? Is this the usual falling out or more than that?

Can you chat with your parents about problems, friends, your future, school, etc?

Is there someone in your family that you confide in?

If some disharmony, what is the worse that family difficulties have been?

- | | |
|----|--|
| 1. | No problem of this kind. |
| 2. | Mild problem, transient and balanced by acceptable family/carers relationships at times. Person usually has one supportive relationship. |
| 3. | Moderate problem, occasional episodes of neglect and/or hostility. There may be occasional episodes of threatened or actual family/carers breakdown or reorganisation. |
| 4. | Marked problem, frequent threatened or actual family/carers breakdown or reorganisation. Person feels unsupported within the family/carers. |
| 5. | Serious problem, person feels or is being victimised, blamed, abused or seriously neglected by family or carer. Person seriously isolated from or hostile to the family. |

if 1 or 2, ask has it ever been a problem. If applicable ask reason for improvement.

Does this bother you?

Ask or confirm to everyone.

Not at all	A bit of a problem	A big problem

If help was on offer would you consider it?

No	Maybe	Yes

Do you think people have tried to help with this? remind re: definition of help

What help have you had from professionals? E.g. family advice, family/marital therapy, parent skills training or coping advice to YP

Any help from friends/family?

Effectiveness

Help Scale ↓

--	--

(3) Educational attendance

Consider school attendance/training placement problems (if <16yrs and college if >16yrs) for whatever reason, e.g. physical illness or disability, family problems, temporary exclusion from school, school refusal etc. If child attending a form of planned intermittent schooling, rate attendance at planned sessions.

Do you miss any schooling/training?

Ever felt anxious, about going to school/training, so much so that you felt ill?

Ever played truant, how often, when, what happens?

Ever been off school/training for more than 2 weeks at a time, can you tell me a bit about it?

- | | |
|----|--|
| 1. | No problems of this kind. |
| 2. | Mild problem, occasional non-attendance. |
| 3. | Moderate problems, such as significant proportion (25%) of school days lost. |
| 4. | Marked problem, over 50% school days lost. |
| 5. | Severe and/or continual problems, almost never in school. |

if 1 or 2, ask has it ever been a problem. If applicable ask reason for improvement.

Does this bother you?

Ask or confirm to everyone.

Not at all	A bit of a problem	A big problem

If help was on offer would you consider it?

No	Maybe	Yes

Do you think people have tried to help with this? remind re: definition of help

What help have you had from professionals? E.g. setting targets, EWO, key staff member to monitor, family education, educational resource centre or special schooling

Any help from friends/family?

Effectiveness

Help Scale ↓

--	--

(4) Educational performance

Consider persistent academic/training under performance due to poor motivation or lack of interest, excessive fluctuations or deterioration.

Rate the actual performance compared with ability, performance may be affected by physical or mental or emotional/behavioural problems.

Do not rate if problems caused by school attendance difficulties. Rate performance here and attendance under section 3.

How is your learning?

How do you manage the work?

- | | |
|----|---|
| 1. | No problem. |
| 2. | Mild problem, infrequent but subject usually catches up. |
| 3. | Moderate problem, intermittent motivation and interest in school work on some days. |
| 4. | Marked problem, markedly poor motivation or marked disinterest in school work on most days. |
| 5. | Severe problem, serious concern by others almost every day about school performance. |

if 1 or 2, ask has it ever been a problem. If applicable ask reason for improvement.

Does this bother you?

Ask or confirm to everyone.

Not at all	A bit of a problem	A big problem

If help was on offer would you consider it?

No	Maybe	Yes

Do you think people have tried to help with this? remind re: definition of help

What help have you had from professionals? E.g. setting targets, EWO/ key professional support, class room support worker, educational resource centre or special schooling

Any help from friends/family?

Effectiveness

Help Scale ↓

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(5) Weekday occupation

Rate here if left school (16-18yrs) and not in further education.

Are you at work/training scheme/college?

How is it going?

Are your employers/tutors pleased with your work? Are you?

Would you like to get a job?

- | | |
|----|--|
| 1. | No problem, full- or part-time regular employment. |
| 2. | Mild problem, need help such as supported work scheme, youth training, sheltered work. |
| 3. | Moderate problem, only occasional employment, but reasonable standard of behaviour and punctuality at work, or actively seeking work but no success as yet. |
| 4. | Marked problem, infrequent work, often out of work because of poor standard of work or behaviour or punctuality. |
| 5. | Severe problem, has rarely worked over the last six months but, if worked, has rapidly stopped work because of person's unreasonable expectations or behaviour. |

if 1 or 2, ask has it ever been a problem. If applicable ask reason for improvement.

Does this bother you?

Ask or confirm to everyone.

Not at all	A bit of a problem	A big problem

If help was on offer would you consider it?

No	Maybe	Yes

Do you think people have tried to help with this? *Remind re: definition of help*

What help have you had from professionals? E.g. advice about seeking work, work placement

Any help from friends/family?

Effectiveness

Help Scale ↓

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(6) Destructive behaviour

Consider behaviour directed towards property. If there is clear intention to harm others, such as fire-setting with intent to harm others, rate under section 7 as well.

Have you smashed anything up (not broken something by accident)?
Or threatened to?

How often has this happened?

Do you think you have put yourself or others at risk by this behaviour?

Have you ever set things on fire, what happened?

- | | |
|----|---|
| 1. | No problem. |
| 2. | Mild problem threatens to destroy property occasionally but has not actually done so. |
| 3. | Moderate problem, frequently threatens to destroy property and some moderate damage but not putting themselves or others at risk during these destructive behaviours. |
| 4. | Marked problem, marked damage to property, e.g. broken windows, furniture, walls, lights, minor firesetting episodes. Severity of destructive behaviour could inadvertently put others or themselves at risk. |
| 5. | Severe problem, severe and/or frequent damage to property, major fire, persistent and directed destruction of property. Other people's health/safety put at risk. |

if 1 or 2, ask has it ever been a problem. If applicable ask reason for improvement.

Does this bother you?

Ask or confirm to everyone.

Not at all	A bit of a problem	A big problem

If help was on offer would you consider it?

No	May be	Yes

Do you think people have tried to help with this? *Remind re: definition of help*

What help have you had from professionals? E.g. assessment, coping advice, family therapy, community supervision or admission to residential/ secure care to reduce risk

Any help from friends/family?

Effectiveness

Help Scale ↓

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(7) Hostile behaviour to persons

Consider hostile or physically aggressive contacts including verbal or physical hostility. Only rate if it is inappropriate or more extreme than the situation demands.

Are you ever hostile or abusive to others? (verbal or physical)

If yes, was it somebody your own age or was it somebody in authority?

Do you hurt people or animals? Why? (Was this enjoyable?)

Did you ever get so mad that you threatened to or actually tried to hurt or kill someone?

- | | |
|----|--|
| 1. | No problem, contacts are nearly all appropriately friendly. |
| 2. | Mild problem, mainly verbal hostility. |
| 3. | Moderate problem, incidents of inappropriately hostile verbal threats. Occasional mild and unsustained physical incidents on others. |
| 4. | Marked problem, frequent physical incidents. More serious and sustained violent episodes towards others. |
| 5. | Severe problem, frequent or episodic potentially life threatening or disabling attacks on others. Some episodes judged so serious that without intervention the attack would have a grave outcome. |

If 1 or 2, ask has it ever been a problem. If applicable ask reason for improvement.

Does this bother you?

Ask or confirm to everyone.

Not at all	A bit of a problem	A big problem

If help was on offer would you consider it?

No	May be	Yes

Do you think people have tried to help with this? *Remind re: definition of help*

What help have you had from professionals? E.g. assessment, coping advice, family therapy, community supervision or admission to residential/ secure care to reduce risk

Any help from friends/family?

Effectiveness

Help Scale ↓

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(8) Inappropriate sexual behaviour

Rate sexual activity directed towards another person.
Rate aggressive component, (if present) under section 7.
Rate here reckless sexual activity beyond adolescent sexual experimentation among peers, possibly with multiple partners.

Have you ever upset anyone by being too sexually personal towards them? Either because of something you said or did?

Is anyone concerned about your sexual behaviour? Are you?

Do you feel that you are in any danger because of sexual activity? E.g. pregnancy, STDs, or being with people who might be dangerous (e.g. violent)?

Do you ever lead people on/make people interested in you sexually?

1. No problem, no inappropriate sexual behaviour or talk.
2. Mild problem, person is somewhat preoccupied with sexual matters (e.g. once or twice talked about sex in an inappropriate context in past month).
3. Moderate problem, person often exhibits inappropriate behaviour (e.g. makes infrequent unwelcome sexual advances), or exhibits sexualised behaviour.
4. Marked problem, person exhibits frequent behaviour and / or inappropriate sexual behaviour frequently. This may include sexually abusive episodes towards children and/or adults, or dangerous or reckless behaviour.
5. Serious problem, episodes of frequent behaviour and/or the person's behaviour is sufficiently serious (abusive) to cause problems in his or her community. Sexual behaviour often persistent if given the opportunity and may be reckless.

If 1 or 2, ask has it ever been a problem. If applicable ask reason for improvement.

Does this bother you?

Ask or confirm to everyone.

Not at all	A bit of a problem	A big problem

If help was on offer would you consider it?

No	May be	Yes

Do you think people have tried to help with this? *Remind re: definition of help*

What help have you had from professionals? E.g. assessment, sex education, sex offender group, coping advice, family therapy, community supervision or admission to residential/ secure care
 Any help from friends/family?

Effectiveness

Help Scale ↓

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(9) Substance Misuse

Consider here substance misuse; e.g. all drugs e.g. solvent abuse, stimulants, cannabis, heroin and tranquilizers (diazepam, temazepam)

Do you use drugs? Tell me about your use? How many days a week do you use?
 What drugs do you take? How much? How do you take drugs? How do you pay for it? Do you buy your own? Do you have your own dealer?
 Do drugs affect your daily life (stop you doing things) or got you into trouble?
 Have you missed things in the morning because you've had too much the night before e.g. school, Yots appointments?
 Do you use more than you plan to, do you lose control and can't stop?
 Have you had blackouts / memory loss / bad comedowns / mood swings?
 Have you done anything dangerous while on drugs e.g. driving, climbing, took any risks, other dangerous behaviour, including fighting?
 Have you tried to stop taking drugs? What happened? (Did they experience headaches, paranoia, feel anxious, depressed, need to take more drugs to make themselves feel better?)
 Does the thought of stopping drinking make you worried, angry or depressed?
 Do you need to use more drugs now to get the same effects?
 Do you plan your day around drug use?

- | | |
|----|---|
| 1. | No problem. |
| 2. | Mild problem, occasional drug use (cannabis, recreational use, (e.g. once a week) but not affecting overall functioning at home, work or in education. |
| 3. | Moderate problem, excessive drug use, with moderate social consequences, such as problems in school or work as a result of use, loss of control of drug usage, using excessively (most days of week), but no dependency symptoms (see 4). |
| 4. | Marked problem, psychological dependence on drugs, with major social and recreational consequences, such as not attending school or giving up hobbies because of preoccupation with drug using or obtaining drugs. Criminal behaviour associated with drug use or to obtain money to buy drugs. |
| 5. | Severe problem, physical and psychological (as in 4) dependence. Person needs to use more to obtain desired effect, unsuccessful attempts to cut down; person may need to have a use to reduce withdrawal symptoms. Continued severe social, recreational and work/educational problems as a result of uncontrolled drug use. |

If 1 or 2, ask has it ever been a problem. If applicable ask reason for improvement.

Does this bother you?

Ask or confirm to everyone.

Not at all	A bit of a problem	A big problem

If help was on offer would you consider it?

No	May be	Yes

Do you think people have tried to help with this? *Remind re: definition of help*

What help have you had from professionals? E.g. Education, coping advice, medication, detox programme, community supervision to reduce use. Any help from friends/family?

Effectiveness

Help Scale ↓

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(10) Alcohol Misuse

Consider all alcohol use here: **Do not rate** social experimentation normal in teenagers.

Do you drink? Tell me about your drinking?

How many days a week do you drink?

What do you drink? How much? How do you pay for it?

Does / has alcohol affected your daily life or got you into trouble?

Have you missed things in the morning because you've had too much to drink the night before e.g. school, Yots appointments?

Do you drink more than you plan to, do you lose control and can't stop?

Have you had blackouts/memory loss/hangovers/mood swings?

Have you done anything dangerous when drinking e.g. driving, climbing, took any risks, other dangerous behaviour, including fighting?

Have you tried to stop drinking? What happened? (Did they experience headaches, feel anxious, depressed, need to drink to make themselves feel better?)

Does the thought of not using make you angry, worried or depressed?

Do you need to drink more than double the amount to become drunk to the same level?

Do you plan your day around alcohol?

1.	No problem.
2.	Mild problem, occasional heavy drinking, (e.g. once a week) but not affecting overall functioning at home, work or in education.
3.	Moderate problem, excessive alcohol use, with moderate social consequences, such as problems in school or work as a result of alcohol use, loss of control of drinking, drinking excessively (most days of week or binge drinking twice a week), but no dependency symptoms (see 4).
4.	Marked problem, psychological dependence on alcohol, with major social and recreational consequences, such as not attending school or giving up hobbies because of preoccupation with drinking and obtaining alcohol. Criminal behaviour associated with heavy alcohol intake or to obtain money to buy alcohol.
5.	Severe problem, physical and psychological (as in 4) dependence. Person needs to drink more to become intoxicated, unsuccessful attempts to cut down, person may need to have a drink in morning to reduce withdrawal symptoms. Continued severe social, recreational and work/educational problems as a result of uncontrolled drinking.

If 1 or 2, ask has it ever been a problem. If applicable ask reason for improvement.

Does this bother you?

Ask or confirm to everyone.

Not at all	A bit of a problem	A big problem

If help was on offer would you consider it?

No	May be	Yes

Do you think people have tried to help with this? remind re: definition of help

What help have you had from professionals? E.g. Education, coping advice, medication, detox programme, community supervision to reduce use. Any help from friends/family?

Effectiveness

Help Scale ↓

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(11) Depressed Mood

Rate congruent and incongruent delusions due to mood problems here.

Rate associated problems in appropriate sections.

Do not rate suicidal acts/ideas here, rate under section 12

Any problems with:-

- feeling sad? - how bad? how often?
- losing interest in things? e.g. friends, school, appearance
- concentrating?
- feeling tired all the time?
- sleeping?
- appetite?

Do you know why you feel down?

Do you feel bad about things that have happened in the past? Are these things actually your fault?

How do you feel about yourself as a person? Do you ever hate yourself?

- | | |
|----|---|
| 1. | No problem. |
| 2. | Mild problem, gloomy or transient mood changes associated with life events. |
| 3. | Moderate problem, definite depression and distress, preoccupied with feelings of guilt, loss of self esteem. May be irritable at home or school, or with peers. |
| 4. | Marked problem, marked peer and other social difficulties. Inappropriate self blame, physical or mental slowing, sleep or appetite disturbance. |
| 5. | Severe problem, retardation (stupor at most severe) or agitation, severe guilt, self accusation, critical thoughts. |

If 1 or 2, ask has it ever been a problem. If applicable ask reason for improvement.

Does this bother you?

Ask or confirm to everyone.

Not at all	A bit of a problem	A big problem

If help was on offer would you consider it?

No	May be	Yes

Do you think people have tried to help with this? *Remind re: definition of help*

What help have you had from professionals? E.g. assessment, medication, family advice/ therapy, coping advice, individual/group psychotherapy

Any help from friends/family?

Effectiveness

Help Scale ↓

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(12) Deliberate self-harm

Consider deliberate self-harm behaviour such as hitting self or self-injury caused by cutting, overdoses, hanging, drowning, use of firearms.

Rate associated symptoms in respective areas, such as depression, anxiety, PTSD (areas 11, 13, 14)

Have things got so bad that you have thought of hurting yourself e.g. after an argument, or when you're very angry, or when something bad has happened to you?

People hurt themselves in many different ways such as cutting, scratching, burning, banging head on walls or punching walls. Have you tried this? How often?

Have you ever made plans or tried to kill or hurt yourself? How often? What happened? Did you want to kill yourself? Do you still feel like this?

1.	No problem.
2.	Mild problem, infrequent (once a fortnight) threats, gestures (obtaining pills, ligatures), but no actual harm to self.
3.	Moderate problems, infrequent (more than once a fortnight) threats, gestures (obtaining pills, ligatures), and some definite acts, but not life threatening, (e.g. superficial scratching or taking a few tablets).
4.	Marked problem e.g. a significant overdose or cutting episode, or an attempted hanging episode requiring medical attention. This might occur only once, or repetition is infrequent (2 episodes in 6 months)
5.	Severe problem, repeated episodes of self harm usually life threatening and needing frequent medical intervention. Motivation to self-harm persists in individual after life threatening episode.

If 1 or 2, ask has it ever been a problem. If applicable ask reason for improvement.

Does this bother you?

Ask or confirm to everyone.

Not at all	A bit of a problem	A big problem

If help was on offer would you consider it?

No	May be	Yes

Do you think people have tried to help with this? *Remind re: definition of help*

What help have you had from professionals? E.g. assessment, coping advice, individual psychotherapy, family advice/therapy or admission to day/residential unit. Any help from friends/family?

Effectiveness

Help Scale ↓

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(13) Anxiety symptoms

Worries cover a wide range of problems such as

- Phobias (social, fear of spiders, closed spaces)
- Panic attacks, (breathlessness, palpitations, fears of physical problems (heart attack))
- Generalized worries (about themselves or someone they care for (parent, friend))
- Obsessional fears (fears of dirt, contamination, harm, with checking or washing rituals)
- Worries associated with other problems (hallucinations, depression, post-traumatic stress disorder) **rate in respective sections**

Consider here general anxiety and panic attacks.

Do you ever worry? Are you worried about anything at the moment? How often? How much of the day?

Do you worry about things before they have happened?

Is there anything on your mind, e.g. court appearances, school, your offence?

Are you so uptight that you can't relax even if you tried?

Can you stop worrying? Can you put it out of your mind?

Do you get headaches, stomach aches, aches and pains, feelings of restlessness, easily tired, worn out, no energy, can't concentrate, do you have any problems sleeping? How often?

Do you get panic attacks, heart racing, breathless, shaky, thoughts that something bad will happen, such as having some form of physical problem?

Do worries stop you from doing things, or interfere with how well you get on with your friends or family?

1.	No problem.
2.	Minor problem. Worries appropriate to the situation, such as worries about future education, court appearance, parental ill health
3.	Moderate problem, panic attacks at least once a month, with worries about having another one, or general anxiety at least three times a week. Person has some control of symptoms (panic or general anxiety) but needs prompting and reassurance.
4.	Marked problems, symptoms frequently present (more than 3 times a week, panic attacks more than once a month), with great difficulty controlling symptoms, may be overwhelmed by panicky or anxious feelings leading to marked reduction in daily activities (school, work)
5.	Severe problems, symptoms dominate overall function on most days of week, often incapacitating person. Loss of control of symptoms, with often symptoms such as problems sleeping, difficulty concentrating, restless and keyed up (person does not have to have all of these symptoms).

If 1 or 2, ask has it ever been a problem. If applicable ask reason for improvement

Does this bother you?

Not at all	A bit of a problem	A big problem

If help was on offer would you consider it?

No	May be	Yes

Do you think people have tried to help you with this? remind: definition of help

What help have you had from professionals? E.g. assessment, medication, coping advice. Any help from friends/family?

Effectiveness

Help Scale ↓

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(14) Post-traumatic stress problems

Consider events or situations that are exceptionally stressful, frightening or life threatening. Anxiety symptoms occur, but are related to the traumatic event.

Do not rate anxiety or depression symptoms unrelated to the event, rate in the appropriate sections
Have any of these ever happened to you?

- Serious and frightening accident e.g. car accident? Been in a fire? Have you been attacked or threatened? Have you been physically hurt in any way?
- Some young people have been hurt by others in different ways such as being hit, touched in a way that makes them feel uncomfortable or a sexual attack, has this ever happened to you?
- Have you ever seen family members being violent towards each other e.g. dad hitting your mum or brother hitting your mum?
- Have you ever seen anybody being severely attacked or threatened or witnessed a sudden death, suicide, an overdose, serious accident, a heart attack?
- Any other distressing or very frightening experiences?

If yes to one of the above then ask:

Do you think about this event a lot, do you ever get images of the event, such as flashbacks/vivid memories? How often?

How does thinking about the event make you feel?

Do you have trouble sleeping, being irritable or difficulty concentrating?

Have you had nightmares or bad dreams about the event?

Have you got upset if anything happened that reminded you of the event?

Do you avoid certain places or things that remind you of the event?

How does this affect your daily living? Can you control these things?

1.	No problem, no event, or no symptoms following a traumatic event.
2.	Minor problem, some very mild symptoms, but person states that symptoms resolved or controllable
3.	Moderate problem, definite symptoms in last month, but intermittent presence, and person has some control of symptoms if prompted or well motivated to control symptoms. Person avoids certain situations that remind them of event, have recurrent thoughts/nightmares or flashbacks, and have physical symptoms of anxiety associated with event (sleep, concentration, extra vigilant, very jumpy).
4.	Marked problems, person often loses control and feels overwhelmed by symptoms, can get very tearful, angry or frightened. Significantly affects daily function at work/ home or school.
5.	Severe problems, symptoms dominate daily function, often incapacitating and preoccupying person daily. Symptoms uncontrollable almost all of the time.

If 1 or 2, ask has it ever been a problem. If applicable ask reason for improvement.

Does this bother you?

Ask or confirm to everyone.

Not at all	A bit of a problem	A big problem

If help was on offer would you consider it?

No	May be	Yes

Do you think people have tried to help with this? *Remind re: definition of help*

What help have you had from professionals? E.g. assessment, medication, coping advice

Any help from friends/family?

Effectiveness

Help Scale ↓

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(15) Hallucinations, delusions and paranoid beliefs

Consider here psychotic illnesses, such as mania or schizophrenia.

Rate hallucinations - hearing own thoughts spoken out aloud, hearing voices talking to the person or about the person, visual hallucinations.

Rate paranoid ideas, such as strong beliefs that people are looking at or talking about them.

Do not rate beliefs based in reality e.g. real and immediate threats

Do not rate aggressive or destructive symptoms, rate under sections (6 and 7). If symptoms are induced by drug or alcohol misuse and are only present when intoxicated rate under (9 and 10). If persistent beyond drug usage, rate here.

Do you ever hear voices when you are alone; have you seen things, or smelt things?

What things?

Do you have any unusual thoughts that other people don't have? What?

Have you felt controlled by a force or power outside yourself, controlling your thoughts or actions?

Has anyone being plotting against you? How do you know?

Do you feel you have special powers? What?

1.	No problem, no evidence of hallucinations or delusions.
2.	Mild problem, mild paranoid beliefs not in keeping with reality.
3.	Moderate problem, definite paranoid beliefs, delusions or hallucinations, with mild to moderate distress to the person.
4.	Marked problem, preoccupation with delusions or hallucinations, causing much distress and/or markedly bizarre behaviour.
5.	Serious problem, the person is seriously and adversely affected by delusions or hallucinations causing severe distress.

If 1 or 2, ask has it ever been a problem. If applicable ask reason for improvement.

Does this bother you?

Ask or confirm to everyone.

Not at all	A bit of a problem	A big problem

If help was on offer would you consider it?

No	May be	Yes

Do you think people have tried to help with this? Remind re: definition of help

What help have you had from professionals? E.g. assessment, medication, coping advice

Any help from friends/family?

Effectiveness

Help Scale ↓

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(16) Hyperactivity

Consider here hyperactivity, particularly hyperkinetic disorder. Include overactive behaviour associated with any cause such as severe attachment disorders, chaotic or abusive parenting hyperactivity associated with learning disability.

Do not rate here if symptoms are induced by drug or alcohol miss-use and are only present when intoxicated rate under sections 9 or 10.

On observation during the interview

- Does the YP have any problems with inattention, overactivity or acting without thinking?
- Does the YP have problems with impulsive behaviours, doing things without thinking, not being aware of consequences, speaking out in class, being excessively impatient, being unable to wait turn, interrupting an adult, like a teacher?
- Is the YP overactive, restless e.g., such as being always on the go, out of seat, fidgeting, can't sit still, excessive running and climbing, not needing much sleep?
- Does the YP show inattentive and distractable behaviours, such as being disorganised in academic work or at home, being unable to finish a project or piece of work, moving onto a new activity before finishing the first, requires constant supervision or reminding to keep on required task, finding it hard to listen to instructions?

1.	No problem.
2.	Minor problem, overactive and easily distracted, but if prompted can control behaviour and sustain attention on task
3.	Moderate problem, symptoms present mostly in large group settings such as mainstream class, or youth group. This leads to definite impaired functioning such as removal from class for brief periods, poor completion of work, inability to finish straightforward tasks such as short pieces of homework due to inattentiveness. When on own, symptoms can be controlled by prompting and young person can modify and partly control symptoms.
4.	Marked problems, symptoms frequently present in all settings, group and on own. Symptoms have impact on others such as stress on carer, teacher and family members. Person mostly seems to have lost control of symptoms despite prompts and extra supervision.
5.	Severe problems, symptoms dominate daily function, often incapacitating person (repeated loss of friends, education, and work). Almost total loss of control of symptoms, unable to concentrate for even a few minutes, restless and on the go all the time. Major impact on others trying to help person.

if 1 or 2, ask has it ever been a problem. If applicable ask reason for improvement.

Does this bother you?

Ask or confirm to everyone.

Not at all	A bit of a problem	A big problem

If help was on offer would you consider it?

No	May be	Yes

Do you think people have tried to help with this? *Remind re: definition of help*

What help have you had from professionals? E.g. assessment, medication, coping advice

Any help from friends/family?

Effectiveness

Help Scale ↓

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(17) Living Situation

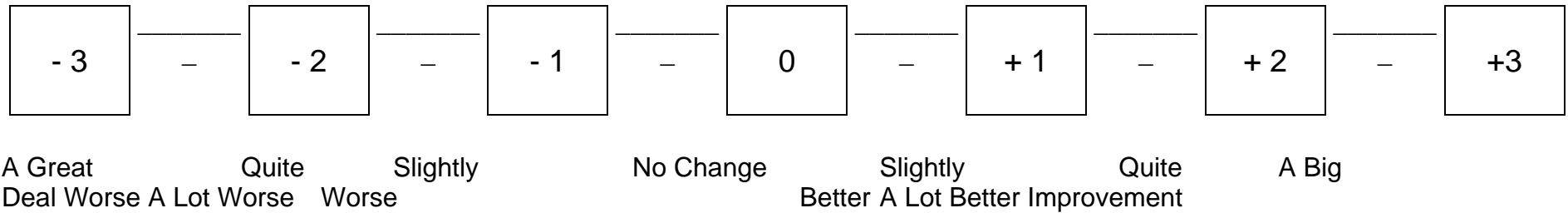
If living in the community or in secure accommodation

Decision support algorithm:

1. What type of accommodation does the person currently live in and how long have they lived in this accommodation?
2. Does the person want to move and why do they want to move?
3. Where does the person want to move to and why?

SATISFACTION WITH SERVICES QUESTIONNAIRE

You have been asked a number of questions about the services that you have been in contact with. Overall how satisfied have you been with the help that you have received from the different services?



DID IT MAKE THINGS BETTER OR NOT? OR WORSE?

Type of Service (9= not applicable)

- 1) Education _____
- 2) Mental Health Services _____
- 3) Social Services _____
- 4) Yots _____
- 5) YOIs _____
- 6) Secure Care _____
- 7) Voluntary Agencies _____

Appendix 3: Health Economics Questionnaire

YOUNG PEOPLE IN CUSTODY AND IN THE COMMUNITY

SERVICE-USE QUESTIONNAIRE

Young person's use of services over the previous six months

ID number:

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Date of interview:

--	--	--	--	--	--

Respondent:

Young person

Key worker

Completed by (initials):

INSTRUCTIONS:

This questionnaire should be given in interview.

The questionnaire covers the young person's use of services over the six months prior to interview.

The young person should be the primary respondent. Where this is not possible, key workers should be consulted.

HOSPITAL CONTACTS:

INPATIENT STAYS

HOSPITAL	Speciality	Reason/notes	Length of stay		
					Nights
					Nights

OUTPATIENT ATTENDANCES

HOSPITAL	Speciality	Reason/notes	No. of attendances		
					No.
					No.
					No.

DAY PATIENT ATTENDANCES

HOSPITAL	Speciality	Reason/notes	No. of attendances		
					No.
					No.

ACCIDENT AND EMERGENCY ATTENDANCES

Hospital	Reason/notes	No. of attendances		
				No.
				No.

COMMUNITY HEALTH SERVICES:

<u>SERVICE</u>	<u>Notes</u>	<u>NUMBER OF CONTACTS</u>			<u>AVERAGE DURATION OF EACH CONTACT</u>		
					No.		Mins
General practitioner					No.		Mins
Practice nurse					No.		Mins
Community psychiatric nurse					No.		Mins
Psychologist					No.		Mins
CAMHSs team member					No.		Mins
Counsellor/individual therapist					No.		Mins
Family therapist					No.		Mins
Other - please specify:					No.		Mins
Other - please specify:					No.		Mins

SOCIAL SERVICES:

Service	<u>NOTES</u>	<u>NUMBER OF CONTACTS</u>	<u>AVERAGE DURATION OF EACH CONTACT</u>
Social worker	<input type="text"/>	<input type="text"/> No.	<input type="text"/> Mins
Family support worker	<input type="text"/>	<input type="text"/> No.	<input type="text"/> Mins
Leaving care worker	<input type="text"/>	<input type="text"/> No.	<input type="text"/> Mins
Foster care	<input type="text"/>	<input type="text"/> Days	
Residential care	<input type="text"/>	<input type="text"/> Days	
Other - please specify:	<input type="text"/>	<input type="text"/> No.	<input type="text"/> Mins

TYPE OF EDUCATION:

<i>TYPE OF SCHOOL/SUPPORT</i>	Attended (y/n)	Number of months attended in last 6	Number of days per week attended	Number of hours per day attended	Ratio of teacher to pupils
<i>REGISTERED WITH</i>					
State day school (mainstream)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
School in custody	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
PRU/other exclusion service	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Residential school	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
LD/EBD school	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Home tuition	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Classroom support	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
College/university/training	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other - specify:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

PRU = Pupil referral unit; LD = learning difficulties; EBD = emotional and behavioural difficulties

EDUCATION SERVICES:

Service	<u>Notes</u>	<u>NUMBER OF CONTACTS</u>		<u>AVERAGE DURATION OF EACH CONTACT</u>	
School doctor			No.		Mins
School nurse			No.		Mins
Education welfare officer/ education social worker			No.		Mins
Educational psychologist			No.		Mins
Other - please specify:			No.		Mins
Excluded from school in last six months?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
Statement of special needs in last six months?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	

VOLUNTARY SECTOR SERVICES:

Service	<u>Notes</u>	<u>NUMBER OF CONTACTS</u>		<u>AVERAGE DURATION OF EACH CONTACT</u>	
Day centre/drop-in centre			No.		Mins
Homestart or other family support service			No.		Mins
Safe in the City or other youth homelessness service			No.		Mins
Housing association or other housing support agency			No.		Mins
Citizen's Advice Bureau or other advice service			No.		Mins
Childline/Samaritans or other telephone helpline			No.		Mins
Other - please specify:			No.		Mins
Other - please specify:			No.		Mins

YOUTH JUSTICE:

Service	<u>NOTES</u>	<u>NUMBER OF CONTACTS</u>	<u>AVERAGE DURATION OF EACH CONTACT</u>
Youth offending team worker		<input type="text"/> No.	<input type="text"/> Mins
Contacts with solicitor or other legal representative	■	<input type="text"/> No.	<input type="text"/> Mins
Contacts with police	1.	<input type="text"/> No.	<input type="text"/> Mins
For each contact, give reason and outcome e.g. arrest, warning, caution. Include witness to and victim of crime.	2.	<input type="text"/> No.	<input type="text"/> Mins
	3.	<input type="text"/> No.	<input type="text"/> Mins
	4.	<input type="text"/> No.	<input type="text"/> Mins
Court appearances	1.	<input type="text"/> No.	<input type="text"/> Mins
For each separate episode, give reason, type of court, type of crime and outcome. Include witness to and victim of crime.	2.	<input type="text"/> No.	<input type="text"/> Mins
	3.	<input type="text"/> No.	<input type="text"/> Mins
Crimes committed	1.	<input type="text"/> No.	<input type="text"/> Mins
For each crime committed, specify type of crime	2.	<input type="text"/> No.	<input type="text"/> Mins
	3.	<input type="text"/> No.	<input type="text"/> Mins
Youth custody	1.	<input type="text"/> Days	
For each, specify location:	2.	<input type="text"/> Days	
	3.	<input type="text"/> Days	
Police custody		<input type="text"/> Days	

PRESCRIBED MEDICATION:

This section should include prescribed medication only.

Please ignore all other medication, e.g. over the counter medicines.

MEDICATION	DOSAGE	DATE OF FIRST DOSE	ONGOING	DATE OF FINAL DOSE																								
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Appendix 4: Continuity of Care Questionnaire

Continuity Measure DTO National Standards YP + Yot Contact

SERVICE OFFERED	SERVICE RECOMMENDED IN DISCHARGE PLAN	SERVICE RECEIVED	TIME LAG DISCHARGE – RECEIPT	APPT/MTG MADE NOT YET RECEIVED	NO CONTACT REASONS -CLIENT -CASE MGR -PROVIDER	FREQUENCY COMMUNICATION Case mgr-provider	FREQUENCY CONTACT YP-provider
ACCOMODATION							
HEALTH -physical -mental -drug/alcohol							
EDUCATION/ALT -ed placement -training -job -careers							
SOCIAL -peers -family							

CUSTODIAL VISITS	NATIONAL STANDARD MET	TIME LAGS	PARENT/CARER CONTACT
	12mths – 1 per month > 12 mths – 1 every 2 months	visits - client or Yot related	Maintained after each visit
DTO UP TO 12 MONTHS			
DTO > 12 MONTHS			

COMMUNITY CONTACT	NATIONAL STANDARD MET	TIME LAGS
	Up to 12 weeks – 2x week After 12 weeks – every 10 working days	- client or Yot related
DURING FIRST 12 WEEKS		
AFTER 12 WEEKS		

YOUTH JUSTICE BOARD EFFECTIVENESS OF MENTAL HEALTH PROVISION IN CUSTODY AND IN THE COMMUNITY

Yot Respondent

Data from SO/Yot case holder and file

1) What services were recommended as part of the training plan?

2) When were the recommended services received?

3) Why were these services not received?
Client, Yot or provider related

YOUTH JUSTICE BOARD EFFECTIVENESS OF MENTAL HEALTH PROVISION IN CUSTODY AND IN THE COMMUNITY

FOLLOW-UP STUDY Continuity of Care for Young People Leaving Custody in to the Community

Young Person Respondent

1) How well informed about services proposed on training plan?

2) How accessible were the services offered you?

Information, understanding of what involved

Able to attend appointments/meetings

Support from professionals

3) Case manager/ Provider consistency.

Number of staff involved with during DTO, for each:

-Yot – SO, paired Yot staff member

-Provider services-

-LASCH/YOI- keyworker, SO

4) Time out of contact with Yot and service provider. Why? client or system related

Appendix 5: Follow-up pro forma

ID NO	Length of follow-up	Mental Health Problems Y/N	Assessment/ Intervention (see list)	Alcohol/Drug Problems Y/N	Assessment/ Intervention (see list)	Accommodation Y/N	Education/ Training/Work Problems Y/N

Follow-up pro-forma

Mental Health Problems (see SNASA for prompts)

Ask about anxiety, depression, PTSD, Deliberate self harm, Hallucinations or other psychotic symptoms (paranoid delusions) and hyperactivity (ADHD type symptoms)

Rate as a problem if positive for any of these areas – use clinical judgement or discuss

Assessment/intervention options: (more than one option possible)

- Assessment
- Medication
- Coping Advice
- Individual Psychotherapy
- Group Psychotherapy
- Family Advice/family therapy
- Medication and individual/family work
- Admission to CAMHSs day unit/inpatient unit

Alcohol/Drugs (see SNASA for prompts)

Assessment/intervention options: (more than one option possible)

- Assessment
- Education
- Coping Advice
- Medication
- Detox Programme e.g. methadone

Accommodation

Questions to Consider:

- What accommodation does the person currently live in?
- Does the young person want to move and where to?
- Are there reasons why the Yot worker/carer feels either the young person should or should not move?

Depending on answers to above – provide a Needs status

Options – Need or no need (for those in secure care they should only move if there are health/mental health reasons to do so)

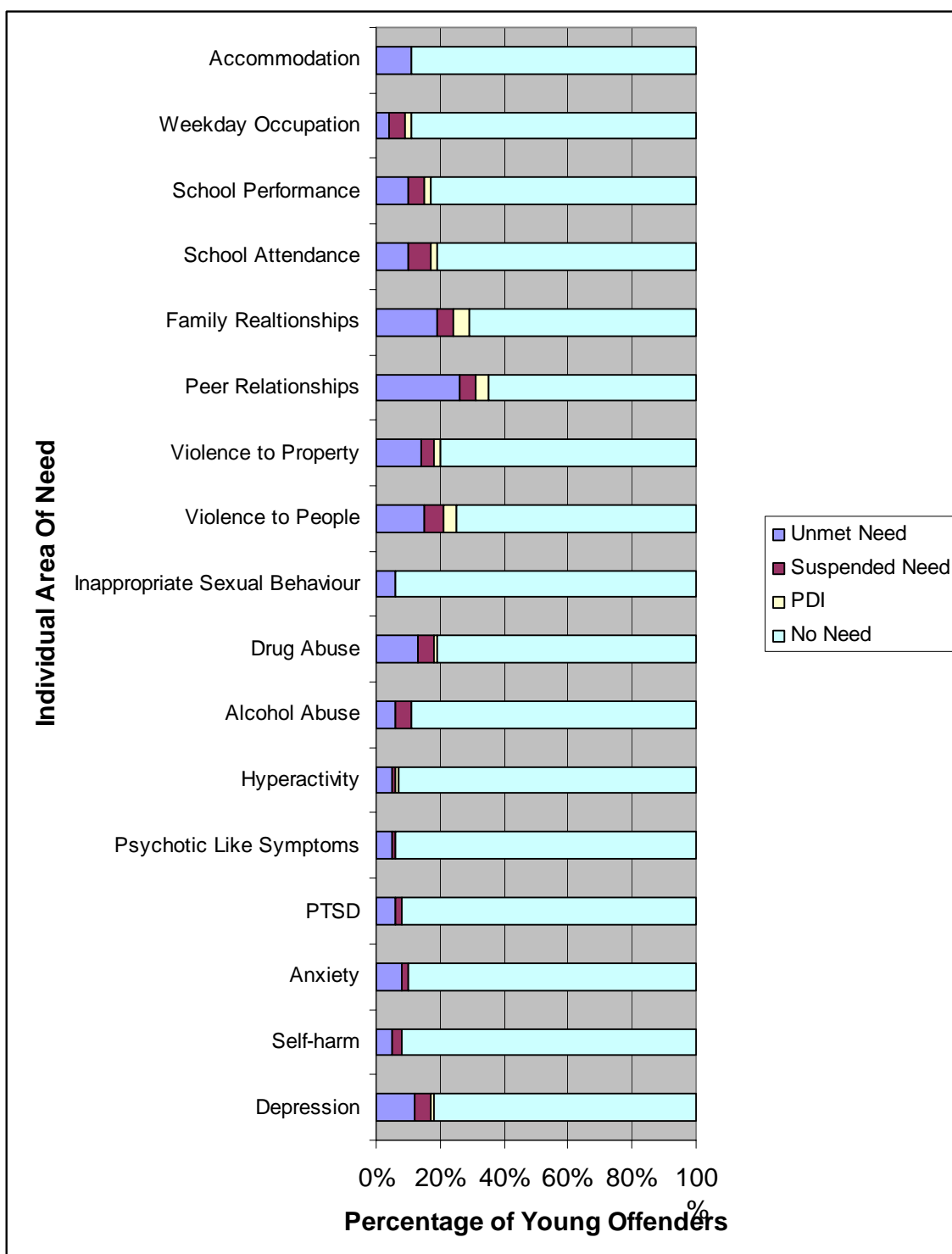
Education/training and work

Assessing attendance and performance together give a rating of ‘yes’ a problem (scores 3 to 5) or ‘no’ problem (scores 1 and 2)

If 16yrs or younger should be in regular education and if older should either be in education/training placement or work

1. No problem – regular attendance
2. Mild problem – occasional non-attendance or needs help e.g. youth training, supported work scheme
3. Moderate Problem – 25% non-attendance, intermittent motivation or only occasional employment but reasonable standard or actively seeking work
4. Marked Problem – over 50% non-attendance and poor motivation. Often out of work because of behaviour
5. Severe problem – Almost no attendance in education/training. Rarely worked or stopped work quickly

Appendix 6: Prevalence of need by individual area



Appendix 7: Care Programme Approach (CPA) form

CLIENT DETAILS			
Name		NHS Number	
DOB		Gender	
Marital Status		Ethnic Origin	
Preferred Language		Tel No	
Address			

REVIEW DETAILS			
Type of Review		Date of Review	
CPA Level		Date Assigned	
MHA / Legal Status		Date Assigned	

CURRENT MEDICATION
Please list all current medication:

CURRENT DIAGNOSIS

ICD-10 Diagnosis: (for each diagnosis please indicate whether 'Principal', 'Concurrent' or 'Provisional')

--

INVOLVED PROFESSIONALS/CARERS

Care Co-ordinator				
Invited		Attended		To Receive Copy
Consultant				
Invited		Attended		To Receive Copy
C.P.N.				
Invited		Attended		To Receive Copy
Art Therapist				
Invited		Attended		To Receive Copy
Yot's				
Invited		Attended		To Receive Copy
Social Worker				
Invited		Attended		To Receive Copy
G.P.				
Invited		Attended		To Receive Copy
Main Carer				
Invited		Attended		To Receive Copy
Other				

Invited		Attended		To Receive Copy	
Has a carer assessment been carried out?	No		Yes	If yes, date	
<i>Others in Attendance:</i>					

CPA CARE PLAN

NEED AREAS					
1. Impact Physical Illness	6. Educational Performance	11. Psychological Distress	16. Self Care	21. Cultural/Racial Identity	
2. Communication Problems	7. Destructive Behaviour	12. Inappropriate Sexual Behaviour	17. Diet/Food	22. Substance Misuse	
3. Autistic Features	8. Hostile Behaviour to Persons	13. Family Relationships and Functioning	18. Living Situation	23. Weekday Occupation	
4. Learning Difficulties	9. Oppositional Behaviour	14. Peer/Social Relationships	19. Hallucinations, Delusions and Paranoid Beliefs	24. Money/Benefits/Allowances	
5. Educational Attendance	10. Deliberate Self Harm	15. Leisure/Activities	20. Depressed Mood		
Area Need No	Summary of Need	Objectives	Action Plans Relating to Need	By Whom	By When
				Therapist Therapist Key worker Therapist or Key worker	Immediately As soon as possible As soon as possible As soon as possible

UNMET NEEDS

Please give details of any unmet needs. (An unmet need is an assessed need, which cannot be met because of unavailable resources, thereby significantly impairing the care programme).

--

CRISIS PLAN									
In an emergency please contact (please state name/address/tel no):									
Early warning signs/relapse indicators:									
Strategies that have helped in a crisis before are:									
RISKS									
Please indicate by placing an 'X' in the appropriate box which, if any, of the risks below should be taken into account in a crisis.									
Self-Harm		Self-Neglect		Vulnerability		Harm to Others		Harm to Carer or Children	
DETAILS OF NEXT REVIEW									
Date of Next Review									
Type of Next Review									
Venue									

SIGNATURES/COMMENTS			
CARE CO-ORDINATOR			
Signature:		Date:	
Comments:			

CLIENT			
Signature:		Date:	
Comments:			
CARER			
Signature:		Date:	
Comments:			