



# **The Development of Specialist Support Services for Young People who have Offended and who have also been Victims of Crime, Abuse and/or Violence: Final Report**

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## Executive Summary

### Introduction

1. This report was commissioned to inform the development of support services for young people who have offended and who have prior experience of victimisation, including but not limited to mental, physical and sexual abuse. In 2014, the London Mayor's Office for Policing and Crime secured £400,000 from the Ministry of Justice Victim's Fund to invest in these services which will be delivered through two London Resettlement Consortia (LRC) areas, each comprising six Youth Offending Services (YOSs), one in North East London, the other in South London.
2. The research involved an online survey and follow up interviews with a sub-sample of YOS professionals, a review of existing research and knowledge on the matter and interviews with seven key informants with specialist knowledge of the issues addressed.

### Background

3. Existing evidence from academic and applied policy research shows that children and young people are more likely to be victims than offenders and more likely to be victimised than adults, albeit that these comparisons are not straightforward. Furthermore, children and young people known to have offended are more likely to have been a victim of crime, violence and or abuse than young people with no recorded offending history. Many will have emotional and mental health needs and vulnerabilities linked to such traumatic events and when these occur alongside or in the context of other forms of disadvantage and victimisation, young people are particularly vulnerable and find it more difficult to recover from the experience.
4. Children and young people in the youth justice system also have significantly greater speech, language and learning difficulties relative to the general population, are disproportionately likely to have a diagnosed learning disability and to have had a seriously disrupted education. Neurobiological research suggests that traumatic events in early childhood can have a detrimental impact on a range of cognitive and verbal communication skills and may find it difficult to engage productively with treatments that require a certain level of abstract reasoning such as cognitive behavioural therapy.
5. The prevalence and nature of mental health problems relating to crime, violence and abuse varies by ethnicity and gender. Young black males are over-represented in the criminal justice system and in terms of referrals to mental health services made via the CJS. Young women involved in group-related offending are significantly more likely to be victims of sexual assault.
6. There has been growing awareness and recognition of these issues at a policy level in recent times as indicated by the commissioning of the services to be developed in the LRC areas. At the same time, there is concern at a national level about the real term cuts in funding for Child and Adolescent Mental Health Services and the implications for mainstream service provision.

### The Extent and Range of Needs and Existing Provision

7. The survey returns from YOS professionals indicated that as many as fifty percent of the young people being managed in the community by Youth Offending Services will have had

traumatic experiences and/or been the victim of or witnessed crime, abuse and/or violence. Additionally, a significant proportion of this group, representing 40 percent of young people on a typical YOS caseload, will have emotional and mental health needs that are linked to these experiences. Around a half of this group were said to be receiving some form of support for these needs but provision is variable and stretched to beyond existing capacity at times.

8. Diverse causes and manifestations of trauma associated with victimisation were identified by research participants. Bereavement, bullying, street-based and domestic violence, sexual abuse and the experience of war were all cited as underlying factors. Anxiety, depression, anger, emotional instability, troubled relationships and substance misuse were identified as consequences and as indicators of emotional and mental health needs.
9. Referrals to CAMHS professionals and services were identified by survey respondents as the most common response young people with these needs. In addition, voluntary, third sector provision such as gang prevention projects, mentoring schemes and services for victims-survivors of domestic and sexual violence were also cited as potential sources of support, though there appears to be little consistency in terms of their availability across the LRC sites.
10. The research suggests that new assessment and screening tools currently being rolled out nationally by the Youth Justice Board should be adopted as a matter of priority as existing instruments provided a very limited picture of the level and nature of needs linked to trauma. Relatedly, there is both a need and appetite for training focused on understanding and responding to young people facing these issues.
11. The research found that young people will often not engage with mental health services even where provision is offered. A variety of reasons were suggested including young people not being developmentally and psychologically ready to engage with certain forms of treatment, the social stigma attached to mental health services, resistance based on poor past experiences of interventions and support being unavailable at the right time or place. It is therefore recommended that screening and offers of intervention be undertaken more than once during the time that a young person is with a Youth Offending Service, though this will depend on individual circumstances.
12. Where young people do have EMH needs linked to victimisation and associated trauma, these will often sit alongside a range of other behavioural, educational, familial, practical and social needs and problems. Moreover, this and other research studies indicate that a number of overlapping preconditions may need to have been met in order for therapeutic/clinical interventions to be effective. This include that children and young people should feel safe and secure and able to trust professionals, substance misuse issues are addressed and practical accommodation and nutritional needs met.

### **Potential Approaches and Interventions**

13. A review of best practice models and approaches revealed a variety of strategies designed to address the issues summarised above. There is no magic bullet and no particular form of intervention that emerges as obviously superior, either to plug the gaps and unmet demand identified in the primary research undertaken for this study or on the basis of existing research into EMH needs linked to victimisation and associated trauma and evaluative studies of current practice. However, certain options for intervening at different levels and

in different ways, each with their own strengths and weaknesses, do suggest themselves. Each approach suggested needs to be assessed further, particularly with a view to assessing whether they can be commissioned or embedded within the available timeline.

14. The Enhanced Case Management Practice Project based on the Trauma Recovery Model (TRM) currently being trialled in and by Youth offending Teams/Services in Wales focuses on training and supporting YOS professionals to better recognise and respond to EMH needs linked to prior victimisation and associated trauma. Underpinned by psychological research and theory which suggests that responses to such needs must be tiered according to children and young people's level of cognitive, emotional and behavioural development, the model aims to equip front-line staff to achieve this goal.
15. Diversionary models such as the Swansea Bureau in Wales and the Social Needs Development Programme in Texas, USA have been developed in part because of the substantial evidence that young people who have offended are disproportionately likely to have been victims of crime, abuse and/or violence. Proponents argue that where entry into the youth justice system can be averted or even postponed, this makes reoffending less likely and the offer of professional support to meet EMH and related needs more acceptable to young people. Our findings suggest that at present, referral to CAMHS services in the LRC area operates more as an adjunct than an alternative to youth justice interventions. It may therefore be possible to formalise and/or extend arrangements for diverting more young people who are assessed as having EMH needs to a service that is removed, physically or procedurally, from YOSs.
16. A third option suggested by the review of best practice and innovation is to invest in voluntary sector providers which aim to improve access to mental health services for young people in community settings, using outreach and youth work approaches. The main attraction with this strategy is that it appears to address the problem of non-engagement with CAMHS. It is at least plausible that young people are more receptive to support of this kind when it is offered within settings they have chosen, as opposed to those which they are compelled to attend.
17. Deploying mentors, buddies, advocates, coordinators or brokers to work with and support young people was suggested both by research participants and by existing research into the resettlement of young people leaving custody. In part, the rationale here is similar to that for offering services outside of the YOS context, namely that young people are more likely to trust and accept advice and support from workers whose role is less to monitor and correct their behaviour than to address and help them cope with various problems they face. The related argument is that where there is a need for support from different services, including mental health services but also, potentially, education, and training, accommodation and care providers, there is a concomitant need for individuals who can broker these kinds of support on their behalf and/or in conjunction with them
18. It may be possible to commission a floating service with additional psychiatric or other clinical expertise. This could be shared within and possibly between LRCs. It might provide face to face, telephone or possibly virtual consultations and these could be directly for young people, as part of their treatment plans, or be used to support and supervise YOS practitioners with screening and ongoing support. Indeed services may be for practitioners as well as for young people, not just in terms of clinical debriefing, but also to help them in knowing what is a concerning behaviour or not. For example, this report has not really

mentioned suicide or self-harm but levels of distress are high and clearly feature as part of broader safe-guarding approaches.

19. The options above focus on interventions which seem to address the problems with and barriers to the take-up of mental health services amongst young people identified by YOS professionals in the survey and follow up interviews conducted for this research. It is important to note, however, that much of the research into best practice with young offenders more generally, concludes that holistic and family focused interventions which address the spectrum of needs presented by young people who offend are often the most effective in terms of reducing reoffending. A final option to consider then is the further development of family intervention projects within the YOS context.

## Introduction

In 2014, Police and Crime Commissioners in England and Wales were invited by the Ministry of Justice (MoJ) to bid for one off funding to support *priority* victims of crime, defined in the Victims Code as “victims of the most serious crime; persistently targeted victims; and vulnerable or intimidated victims” (MoJ, 2013: para. 1.1) The London Mayor’s Office for Policing And Crime’s (MOPAC) successful bid focused on developing services for “young people who have offended and who have prior experience of victimisation, including but not limited to mental, physical and sexual abuse” (MOPAC, 2014: 4). The funding is to be channelled through two London Resettlement Consortia (LRC) areas, each comprising six Youth Offending Services (YOSs), one in North East London, the other in South London. The aim of the analysis presented in this report is to inform the commissioning of the new services.

The report draws on the following sources of information:

- An online questionnaire survey of (65) professionals working in the twelve Youth Offending Services that comprise the North East London and South London resettlement consortia;
- Follow up telephone interviews with a sub-sample of nine professionals who had previously completed the online survey;
- Face to face and telephone interviews with seven key informants with specialist (academic and professional) knowledge of the issues addressed in this research;
- A review of relevant academic and policy literature.

All research has its limitations. This study was completed within two and a half months from the point of commissioning, in late December 2014. More survey responses and further interviews would have been desirable, so as to secure a more even spread of returns and perspectives from across all twelve YOS areas. Whilst the map of existing services is accurate, more time would have permitted development of a more nuanced and comprehensive picture of service provision.

The next section of the report outlines the broad context in which the new services will be developed, summarising research into the needs of young offenders who have been victims of crime, violence and/or abuse, and providing a brief outline of recent policy developments. The report is then organised according to the substantive aims of the research which are as follows:

- the number of young people who might potentially benefit from new services within the resettlement consortia and the range of needs they present with;
- the use and effectiveness of existing assessment and screening tools, alternative measures and associated training needs;
- existing service provision in the LRC areas for the client group in question with a particular focus on gaps and levels of unmet need;
- alternative models of best practice and innovation for meeting the complex emotional and mental health needs of young people being managed by Youth Offending Services in the community.

## Background

“There is a wealth of evidence to indicate that the majority of children and young people in the youth justice system in England and Wales come from the most deprived and disadvantaged families and communities and their lives are characterised by disruption,



neglect and impoverished social landscapes. Many have experienced abuse and neglect and those who move through both the welfare and youth justice systems into custodial institutions tend to have particularly complex needs” (OCC, 2009: 24)

Children and young people in general, are ‘more sinned against than sinning’ as Hartless et al. (1995) titled their report into a survey of young people about crime. In the many subsequent surveys that have asked children and young people to report on whether or not they have offended and whether or not they have been a victim, researchers have consistently found higher levels of victimisation than offending (Wood, 2005; Wilkstrom & Butterworth, 2006; Roe & Ashe, 2008; Anderson et al, 2010). Whilst the circumstances in which children and young people experience crime and the nature of this activity make comparisons with crime against adults problematic (Millard & Flatley, 2010), the evidence suggests that younger people are disproportionately likely to be victims. Males aged 16-24, for example, are more likely to report being a victim of violent and property crime than other age categories and those aged between 10-15 years are more likely still to be a victim of a personal crime (NACRO, 2009) whilst “females aged 16 to 19 years... are the age group at highest risk of being a victim of a sexual offence” (MoJ et al 2013, cited in Beckett and Warrington, 2014: 2). This disproportionality is evident in spite of research indicating that children and young people are less likely to report being a victim than adults, not least because to receive official recognition, incidents have to be reported to ‘gate-keeping’ adults (Morgan & Zedner, 1992; Finkelhor et al., 2001; Beckett and Warrington, 2014), but also because to do so can be felt to be a sign of personal weakness as can admitting to the traumatic impact of having been a victim (Lemma & Young, 2010), or conversely, because exacting revenge directly will enhance status amongst peers and so boost self esteem (Victim Support, 2007).

As with crimes such as theft and interpersonal violence between children and young people, child abuse and neglect is both widespread and underreported.

“Radford et al. (2013), for example, observe that the child maltreatment rates observed in their 2011 study were 7 to 17 times greater than those substantiated cases recorded by ... child protection systems” and that around a quarter of young people aged 11-24 they surveyed “had experienced some form of abuse or neglect at some stage in their childhood” whilst approximately a third of 11–17 year olds had experienced physical violence and/or emotional abuse within the past year (Beckett & Warrington, 2014: 10).

Young victims of crime, abuse and violence are not evenly distributed throughout the population. As noted above, there are significant gender differences in the level and form of victimisation which also tends to be concentrated within areas of relative deprivation and those communities, notably minority ethnic groups most likely to live in such areas (Lea & Young, 1986; Ecorys UK & Fitzgerald, 2014). Most significantly for this study, children and young people known to have offended are more likely to have been a victim of crime, violence and or abuse than young people with no recorded offending history (Wood, 2005; Victim Support, 2007; Rowe & Ashe, 2008; NACRO, 2009; Anderson et al., 2010; Heber, 2014). Relatedly, research focusing on the characteristics and personal histories of young people who offend, especially those who do so persistently and/or commit more serious offences, has consistently found them to have emotional and mental health needs and vulnerabilities linked to past experiences of abuse, violence and/or traumatic events such as bereavement (Kroll et al., 2002; Harrington & Bailey, 2005; Chitsaben et al., 2006; Mezey, 2007; OCC,

2011; Jacobsen et al., 2010; Vaswani, 2014; Vizard, 2014). One indicator of this is the high proportion of young people in custody who have previously been in care (Blades et al., 2011; Haines et al., 2012). Evidence further suggests that children and young people who have been victims of particular traumatic events, such as child sexual abuse, alongside or in the context of other forms of disadvantage and victimisation, such as material poverty or domestic violence, are particularly vulnerable and less likely to recover from the experience (Whitelock et al., 2013). Further, personal responses to these events such as running away, compound their proneness to further victimisation and abuse (Bender et al., 2013). McAra & McVie, reporting on the findings from the Edinburgh Study of Youth Transitions, observe that:

“violent offenders were significantly more likely than non-violent youths to be: victims of crime and adult harassment; engaged in self-harming and para-suicidal behaviour; exhibiting a range of problematic health risk behaviours including drug use, regular alcohol consumption, disordered patterns of eating, symptoms of depression and early experience of sexual intercourse; having more problematic family backgrounds; and, *for girls* in particular, coming from a socially deprived background” (2010: 185, emphasis in original).

Critics argue that state responses such as criminalisation and imprisonment can be viewed as ‘punishing disadvantage’ (Jacobsen et al., 2010; and Wacquant, 2004) which can result in further victimisation as well as self harm and, on occasion, suicide (Goldson, 2002; OCC, 2011). The recent fall in the number of young people entering the youth justice system and custodial institutions (Ministry of Justice, 2015, a & b) has been welcomed by reform groups with the caveat that: “...System contraction might be driven at least in part by financial imperatives, associated with a perceived need for austerity, rather than by a considered assessment of how the wellbeing of children in conflict with the law might best be promoted” (Bateman, 2014: 2).

Children and young people in the youth justice system also have significantly greater speech, language and learning difficulties relative to the general population and are disproportionately likely to have a diagnosed learning disability (OCC, 2011) which sits alongside well documented evidence that young offenders typically have very disrupted educational histories (YJB, 2006; Powell et al, 2012). Additionally, neurobiological research suggests that traumatic events in early childhood can have a detrimental impact on a range of cognitive and verbal communication skills (Creedon, 2004). This has implications for intervention with children and young people affected by trauma who may find it difficult to engage productively with treatments that require a certain level of abstract reasoning such as cognitive behavioural therapy, an issue to which we will return.

The prevalence and nature of mental health problems relating to crime, violence and abuse are mediated by ethnicity and gender. In a context where young black males are heavily over-represented in the criminal justice system:

“The Bradley Commission notes that people from BAME communities tend to follow unduly ‘coercive pathways’ into mental health services via a CJS gateway. African and Caribbean men experience the greatest disparities and often have a ‘deep mistrust’ of mental health services, which researchers have attributed to fraught relationships between black men, the police and other institutions. The Centre for Mental Health believes it to be highly likely that people from BAME communities with learning disabilities are also over represented within

the CJS, and the T2A Alliance point to the fact that young people involved in the CJS are very likely to have mental health problems” (Young 2014).

As regards, girls and young women, the All Parliamentary Group on the Women in the Penal System (2012: 3) report that offending amongst young women may signify underlying welfare needs and note that “outcomes for children brought into contact with the penal system, however well-meaning, are poor”. Research into the experiences of women in relation to male gang violence has revealed the (hidden) extent of victimisation and records that “their lack of confidence in services to respond appropriately to the sexual violence they experienced within and outside of criminal gangs meant that they would rather keep such issues to themselves” (ROTA, 2011:47; see also Beckett et al., 2013).

There has been growing awareness and recognition of the issues summarised above at a policy level. The former government’s (2003) Every Child Matters framework, the YJB’s (2005) review of risk and protective factors, Lord Bradley’s (2009) review of services for offenders with mental health problems or learning disabilities, two reports from the Commission for Healthcare Audit and Inspection and Her Majesty’s Inspectorate of Probation (‘Actions Speak Louder’ - 2006 and 2009) and the Coalition Government’s (2010) ‘Breaking the Cycle’ Green Paper have each addressed the problem of emotional and mental health and made recommendations for improving access to, and the effectiveness of, services. Although attention has mainly focused on closer working between health and youth justice services and especially access to Child and Adolescent Mental Health Services (CAMHS), the government has also committed to rolling out the Youth Justice Liaison and Diversion Scheme, first piloted between 2008 and 2012 (Newman et al., 2013). In essence the aim of this scheme is “to facilitate help for children and young people with mental health and developmental problems, speech and communication difficulties, learning disabilities and other similar vulnerabilities as soon as they enter the youth justice system.” (Haines et al., 2012). How and to what extent these developments are affected by the real term cut in funding for CAMHS since 2010 (Buchanan, 2015, Sedghi, 2015) is unknown. A number of participants in the primary research for this study, to which the report now turns, expressed concern about the broad context of austerity in governmental expenditure and its implications for mainstream service provision. More than one suggestion for investing in ‘new’ services involved re-instating people whose posts have been recently cut.

### **Locating Victimisation: the extent and range of needs within the LRC**

In order to obtain a local perspective on the kind of support services that might be developed, between December 2014 and January 2015, MOPAC undertook a survey of professionals working in the twelve youth offending services that together make up the two resettlement consortia. Sixty four returns were completed, thirty eight from professionals in the North East London consortium and twenty seven from those in the South London Consortium. Although there was a slightly higher response rate from those working in the North East, the general pattern of results was similar across the two areas as is reflected in the commentary that follows.

The survey asked respondents to report on, first, the number of young people currently on their individual caseload, secondly, the number scoring 2+ on ASSET for Emotional and Mental Health (EMH) needs, thirdly, the number they judged to have EMH needs linked to trauma and fourthly, the

number currently receiving support in respect of these needs. Before presenting the aggregated results to these questions, it is important to note the considerable variation amongst individual respondents in their answers. For example, individual caseload numbers ranged from 2 to 20 and whilst a majority of respondents judged fewer young people as having emotional and health needs linked to trauma than scoring 2+ on ASSET, one in four judged this number to be higher. On the second point, it is difficult to know if it reflects real differences amongst the emotional and health needs of clients on different workers' caseloads or, alternatively, shows how variable assessments of such needs can be. However, there is no observable correlation between respondents' answers to these questions and possible explanatory variables such as their professional role in the YOS or where they work so at least the 'inconsistency' in these responses appears to be consistent across the sample.

One or two further complications need noting. In four of the returns, one from Redbridge and all three from Greenwich, respondents provided details not of individual caseloads but of those for the YOS as a whole. So as not to distort the results, these figures are not included in the quantitative analysis that follows. Relatedly, as there was no return from Croydon YOS, there is no data to report on there. As above however, we have no good reason to believe that the pattern of results that emerges from the overall data is not broadly representative of the situation in the consortia as a whole or within the individual YOS areas.

Table One presents the raw numbers of young people reported on by respondents in answer to the caseload questions, broken down by YOS and by Consortia. As an example of what the data means, the eleven respondents from Enfield YOS reported a total caseload between them of 86 young people, of whom 49 had scored 2+ on ASSET (for EMH), 31 were judged as having EMH needs linked to trauma and 11 are currently receiving support.

Table One: Number of Young People on Caseload, scoring 2+ on ASSET for EMH, judged as having EMH needs linked to trauma and currently receiving support, by Consortia and YOS

	Total Caseload reported	Total Asset 2+ for EMH	Total EMH Needs	Total receiving EMH Support
<b>North (37)</b>	<b>380</b>	<b>173</b>	<b>135</b>	<b>64</b>
Enfield (11)	86	49	31	11
Hackney (3)	28	8	10	2
Islington (9)	107	52	39	20
Newham (8)	101	39	31	20
Redbridge (2)	19	8	7	3
Waltham Forest (4)	39	17	17	8
<b>South (23)</b>	<b>209</b>	<b>124</b>	<b>120</b>	<b>48</b>
Croydon				
Greenwich				
Lambeth (3)	45	31	35	19
Lewisham (8)	81	56	44	15
Southwark (5)	39	12	17	4
Wandsworth (7)	44	25	24	10
<b>All (60)</b>	<b>589</b>	<b>297</b>	<b>255</b>	<b>112</b>

Table Two: Average Number of Young People on Caseload, scoring 2+ on ASSET for EMH, judged as having EMH needs linked to trauma and currently receiving support, by Consortia and YOS

	Average Caseload Reported	Average Asset 2+ for EMH	Average EMH Needs	Average receiving EMH Support
<b>North</b>	<b>10</b>	<b>5</b>	<b>4</b>	<b>2</b>
Enfield	8	4	3	1
Hackney	9	3	3	1
Islington	12	6	4	2
Newham	13	5	4	3
Redbridge	10	4	4	2
Waltham Forest	10	4	4	2
<b>South</b>	<b>9</b>	<b>5</b>	<b>5</b>	<b>2</b>
Croydon				
Greenwich				
Lambeth	15	10	12	6
Lewisham	10	7	6	2
Southwark	8	2	3	1
Wandsworth	6	4	3	1
<b>All</b>	<b>10</b>	<b>5</b>	<b>4</b>	<b>2</b>

To simplify the picture, Table Two presents the data in the form of mean averages. Thus, in Enfield, the average caseload per worker (even though in reality this varied from three to fifteen) is eight, the average number scoring 2+ for EMH needs on ASSET is four and so on. As can be seen, although there is considerable variation in the average numbers by YOS, the overall picture for the two consortia and across the sample is similar. It suggests that the notionally 'typical' YOS worker has a caseload of ten young people, of whom five score 2+ on ASSET for EMH needs, four are judged to have EMH needs linked to trauma and two are currently receiving support. If we apply this figure to the wider population, it suggests that 40 percent of young people on YOT caseloads in the London Resettlement Consortia are judged by its professionals to have EMH needs linked to trauma and around a half of this group, or 20 percent of all clients, are currently receiving some form of support to try and address these needs. It may be added that whilst, for reasons given above, the returns from the three professionals in Greenwich YOS had to be excluded from Table One, they did identify the proportion of clients receiving support at present and, with one reporting this to be 20-30 percent and two reporting it to be 10-20 percent, this was in line with the general pattern.

These findings are consistent with those from three existing studies that also included ASSET scores as an indicator of mental health needs. First, Gyateng et al. (2013) analysed the administrative records of 1,245 children of young people in custodial institutions and found that 65 percent of those in Secure Children's Homes, 64 percent in Secure Training Centres and 46 percent in Young Offender Institutions had been scored 2+ on ASSET for emotional and mental health needs. Secondly, an examination of the YOT case files of 117 prolific (25+ offences) young offenders undertaken for the YJB in Wales revealed that 52 percent had an Asset score of 2 or above in this area (Cox, 2010). Thirdly, the Commission for Healthcare Audit and Inspection and Her Majesty's

Inspectorate of Probation (2009) record from an analysis of over 2000 case files of young people on community orders that 43 percent of them had been scored 2+ for emotional and health needs.

Existing research would also seem to indicate that whilst relatively few young people in the youth justice system have a formally diagnosed mental health disorder, a significant number are perceived to have mental health problems.

“Only a small number of children and young people in custody have severe or diagnosable mental health problems which would need treatment by specialist CAMHS services. However, all the evidence – confirmed by the staff we spoke to – indicates that the majority of children have poor emotional and lower level mental health needs and poor self-esteem. Children with such problems could benefit from appropriate mental health interventions. “ (OCC, 2009: 50)

This point was reaffirmed by YOS professionals in follow up telephone interviews who said that they could think of relatively few clients who would meet the criteria for Tier 3 type interventions but many who would nonetheless benefit from some form of therapeutic support. Indeed, some frustration was expressed on this issue to the effect that CAMHS support was effectively unavailable precisely because the threshold for intervention was not met. In their evaluation of the Youth Justice Liaison and Diversion Pilot Scheme, Haines et al. arrive at a similar conclusion:

“Taken together, as indicated above and below and elsewhere in this report, there is evidence of an identifiable group of children and young people with a myriad of difficult circumstances and vulnerabilities relating variously to: socio-economic hardship; problematic familial and/or social relations; disrupted education pathways; social welfare needs; safeguarding issues; alcohol misuse; behavioural problems; anger management issues; unresolved questions deriving from bereavement, grief and loss and bullying and victimization. A significant proportion of the children and young people interviewed have no apparent mental (ill) health diagnosis, however. On the other hand, many have been referred to CAMHS for assessment and/or treatment - mostly to generic services but in a small number of cases to forensic services - and several of the conversations during interview alluded to learning difficulty, anxiety, depression, ADHD, OCD, autism, hearing voices and other ‘disorders’.” (Haines et al., 2012: 147)

The implication of this is that responses to the emotional and health needs of the considerable number of clients identified in this and other research are not going to come from within those higher level CAMHS services that exist *outside* of Youth Offending Services and provide support to young people with clinically diagnosed mental health disorders such as Post Traumatic Stress Disorder. There will continue to be a small minority of young people who do need this kind of support and there are some forms of provision, as detailed below, available in most YOS areas.

Before turning however to existing service provision and take up, it is important to consider the nature of young people’s needs. In the follow-up interviews, a distinction was drawn between where these needs come from and how they present themselves. As to the former, the aetiology of emotional and mental health distress and trauma was explained in a range of ways including, having been:

- The victim of or having witnessed domestic violence – physical, emotional and sexual;
- The victim of or having witnessed street level violence amongst young people including assaults, stabbings and shootings resulting in serious injury;
- The victim of sexual abuse from an adult, including online sexual abuse and grooming;
- The victim of rape and other forms of sexual assault, including those committed within and/or by single or multiple perpetrators;
- Bereaved or witnessed death and other serious violence, including sexual violence, through war;
- Bereaved of a family member or friend, in the UK and/or overseas;
- Repeatedly bullied at and/or outside of school (including online bullying).

All of the above are recognised in trauma literature as potential causes and none appear to be peculiar to particular YOS areas. As to how they manifest themselves in young people's behaviour, a range of identifiable cues were reported in the interviews, again familiar from the existing literature:

- Difficulty in controlling emotions and outbursts of anger and violence (sometimes formally diagnosed as Conduct Disorder);
- Problematic and unstable relationships with family and peers;
- Fatalism – an acceptance that 'shit happens' and a normalisation of abnormal levels of violence;
- A fear of public space beyond certain very limited geographical areas;
- Anxiety and Paranoia;
- Difficulty in concentrating, in holding attention (sometimes formally diagnosed as ADHD or ADD);
- Low moods bordering on depression ;
- Problems sleeping;
- Substance misuse – as a coping mechanism.

In identifying these kinds of indicators of emotional and mental health needs, both the YOS professionals and the key informants who participated in this project emphasised both that young people may cover up or deny having such problems and that they may only become manifest as relationships and trust develop over time, something with implications for assessment and screening (see below). A related point, again one that is frequently made in relation to trauma more generally, is that Conduct and Attention disorders may be recognised and diagnosed before underlying developmental and mental health problems are acknowledged or recognised. Interviewees also made reference to communication and learning difficulties and suggested that these children and young people may not have the emotional or literal vocabulary to express how they are feeling. Again this is consistent with previous literature and demonstrates the general awareness of the importance of these issues when considering the complex needs with which young people present..

Two further points can be made. First, in an analysis of the relationship between offending and victimisation, Victim Support (2007) observe that the former may well be caused in a more or less direct fashion by the latter as when young people seek to take revenge on the perpetrator of an offence against them. This in turn relates to a distinction made by psychologists between responses to trauma that are expressed outwardly through for example offending, aggression or impulsivity or inwardly in the form of anxiety, depression or self harm. The second point is that these differential

responses may have a gender dimension, with boys more likely to 'lash out' and girls more likely to 'bottle up' their feelings. This said, it is also widely recognised that individual resilience to traumatic events belie any simple classification and that how and why some people appear better able to cope in ostensibly similar circumstances remain, as one YOS professional put it, something of a mystery.

Reflecting on these issues, one expert interviewee observed that it is helpful to think of children and young people in this context as presenting with a spectrum of needs, that will vary over time and to accept that there is no magic bullet which will help all of them, all of the time. This leads to the question of assessment and screening.

### **Assessment and Screening**

In the survey of YOS professionals, respondents were asked how often they use different assessment tools and how useful they find them. The results are presented in Figures One and Two. Almost all respondents said they always use ASSET in conducting assessments. The Screening Questionnaire Interview for Adolescents (SQIFA) was also used regularly - by 38 respondents. The Comprehensive Assessment Tool (CHAT) and the Screening Interview for Adolescents (SIFA) were used by less than a quarter of respondents, reflecting the fact that these assessments would more often be undertaken by specialist staff and the relative novelty of CHAT. Other forms of assessment identified were those conducted by CAMHS staff (using a variety of further tools) and general 'assessment interviews' to inform, for example, pre-sentence reports.

Each of these different assessment tools were rated as either very or fairly useful by a clear majority of respondents, though 29 percent of those who had used it, rated SQIFA as either not very or not at all useful. Likewise, most respondents who used them said they were either very or fairly confident in doing so. Asked how confident they feel that assessments about young people with emotional and mental health needs linked to trauma are correct or accurate, 80 percent of respondents said they were very or fairly confident in doing so.

Follow up interviews with YOS professionals largely reinforced the results of the survey. Normal practice, as per YJB national standards, is for all children and young people to be assessed using ASSET in the first instance with further assessments of emotional and mental health needs being conducted where a score of 2+ on the relevant ASSET section has been made. There is some variation amongst different YOSs, however, in who conducts the second assessment. In some (we think a minority of) cases, YOS workers will do this whilst in general, this task is routinely undertaken by the CAMHS worker attached to the service. Where it is the responsibility of YOS workers, SQIFA is the standard tool used whilst CAMHS staff are more likely to use either SIFA, CHAT or an alternative instrument including bespoke tools developed locally.

A point made frequently in interviews with both YOS professionals and key informants was that assessment is best conceived as an ongoing process, reflecting the prevalent view that an understanding of the needs of clients requires time and a degree of trust that builds up as the relationship with the worker is established. There was also consensus that a proper clinical assessment of children and young people's psychological wellbeing cannot be achieved using any standardised tool (and certainly not a tick box questionnaire such as SQIFA) but instead requires an interview with a qualified clinician.



Figure One: Use of Assessment Tools (% of Respondents; n=65)

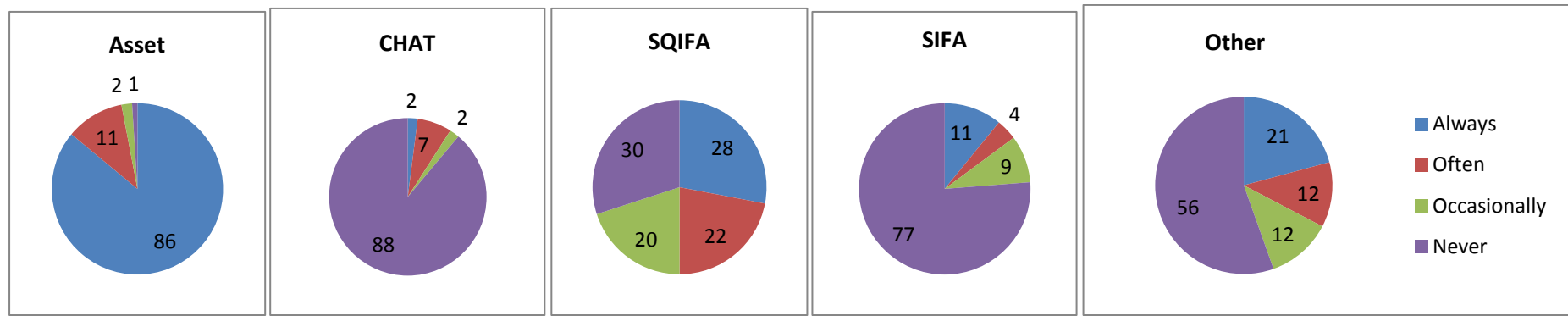
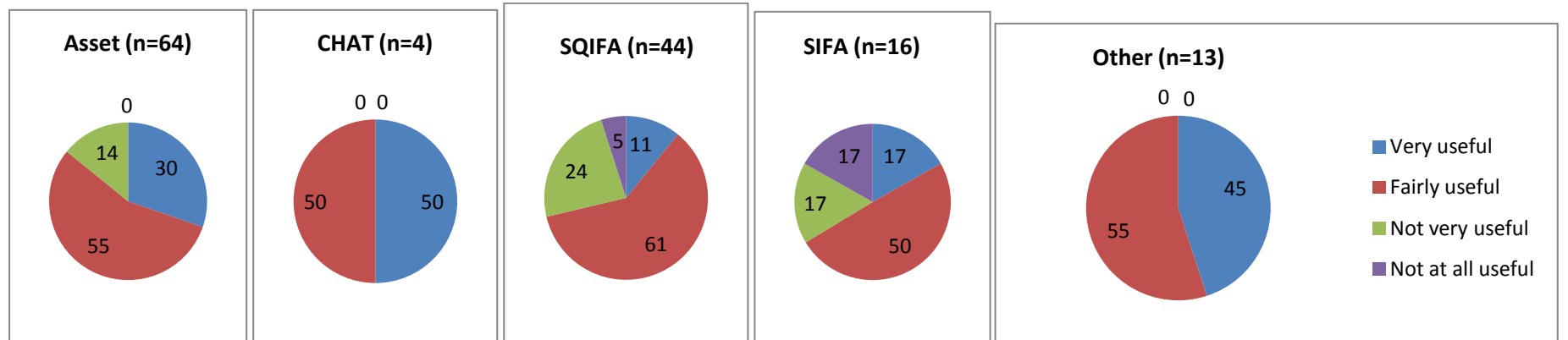


Figure Two: Usefulness of Assessment Tools as rated by Respondents (% of (n) respondents who said they used them)



Notwithstanding this important point, it seems that developments at a national level may lead to a change in screening and assessment practices across all YOSs in the near future. As is the case with ASSET which is gradually being replaced by the more open ended ASSET Plus, the strategy at national level appears to be for SQUIFA and SIFA to be phased out and replaced by the CHAT health assessment tool (Chitsabesan et al. 2014). Where a CAMHS worker is assigned to a YOT, this should mean that he/she will routinely run the CHAT as part of formal working processes. The key difference with current practice is that the intention is for a CHAT assessment to be run with every young person being managed within the YOT and not only, as at present, with those initially identified by ASSET as requiring this more detailed assessment. The other important point to note is that whereas SQUIFA was in principle designed to be used by non-clinical staff, the CHAT has been developed on the assumption that all such assessments will be undertaken by a qualified CAMHS professional.

In cases where a CAMHS worker is not available to conduct the CHAT assessment, perhaps the best available validated measure is the Massachusetts Youth Screening Instrument – Second Version (MAYSI [II], Grisso & Barnum, 2003). This scale is designed specifically for use with young people who have offended. It is not routinely used in England and Wales but is well validated (see for example, Grisso et al. 2012). Both the CHAT and MAYSI have been evaluated as part of a recent systematic review of mental health screening tools for use with young people who have offended (Richardson et al. 2015) and whilst there was sufficiently robust information available on the MAYSI (II) for it to be deemed as reliable as mainstream clinical screening measures (including, importantly, its elements on trauma), there was insufficient information on CHAT for its efficacy to be assessed because it is still being rolled out. One key advantage of MAYSI (II) moreover, is that it can be implemented, at least initially, without the presence of a clinician. In the USA, it has also been used as a screening measure when the young person fills it out in private, though there are obvious limitations with both literacy and insight that could pertain.

### **Existing Service Provision**

In the survey, respondents were asked to list specialist services providing support to young people with EMH needs linked to trauma under four headings: Youth Offending Team/Service, Health, Third Sector/Charity and Other. The follow up telephone interviews with both YOS professionals and key informants, online searches and projects cited in reports provided details, in a few cases, of further organisations including some apparently unknown to YOS staff. The combined results are summarised in Table Three where they are listed by Consortia and by YOS. This is not a fully comprehensive map of services, in part because despite the team's best efforts, it was not possible to speak to or obtain information from every YOS in the consortia but also because the number of organisations which provide relevant services in London is vast and changing all the time. The team are however pretty confident that the most significant providers of mental health and related services to children and young people in the areas in question have been identified.

Child and Mental Health Services were identified by all ten YOSs as the main provider of support. Whilst some respondents identified CAMHS under the heading YOS and others did so under Health, it would appear that in each of the YOSs with the possible exception of Hackney, there is a Child and Adolescent Mental Health Worker (CAMHS) worker seconded to the YOS or else a named service such as the 'Adolescents Resource Therapy Service' in Lewisham and the 'Targeted Youth Support' (TYS) Counselling Service in Islington. The local situation appears then to follow good practice

guidelines (Khan & Wilson, 2010; Newman et al, 2013) which state that all YOSs should have a dedicated mental health professional on site. The main services/activities being provided by the YOS based CAMHS staff are: assessment, screening, counselling and therapy as well as ongoing training/consultation for other YOS staff. In addition, they will refer young people on to other clinical specialists as appropriate, normally those based in mainstream CAMHS locally, but also third sector providers. In both consortia, a variety of third sector/charitable and other services were identified. These provide more specialist kinds of support, including work with those subject to child sexual exploitation, work on healthy relationships and on domestic violence, mentoring, work on substance misuse linked to trauma, family support, bereavement counselling, residential placements and psychological and psychiatric treatments provided by non-statutory organisations. The range of third sector organisations identified was reasonably broad though the focus of each organisation may not have been clear to individual survey respondents as they may not actually be routinely referring young people on to the interventions identified yet are aware that they exist.

Telephone interviewees with YOS Professionals largely confirmed the broad picture described in the table above whilst also indicating variations at a local level. In cases when young people are identified via ASSET or SQUIFA or via team meetings as potentially needing intervention around EMH needs, a further more detailed assessment is conducted, normally by a clinician attached to the YOS. This may trigger the offer of some further support – counselling or therapy – with the local CAMHS worker or, where necessary and appropriate, with local mainstream CAMHS services or third sector services such as the Brandon Centre (<http://www.brandon-centre.org.uk/>) which offers a range of therapeutic interventions including multi-systemic therapy (discussed further below). There are also links with local GPs and, where available, with psychologists working within Pupil Referral Units allowing for information sharing and joint working, as appropriate to individual need and circumstance. Gang prevention projects, mentoring schemes, local youth work centres, services for asylum seekers and refugees, domestic violence projects/services and victim support services were variously mentioned as offering forms of support relevant to young people’s emotional and mental health needs, albeit in less direct ways than clinical-type interventions.

### **Unmet Need and Gaps in Provision**

The survey of YOS professionals provided two indicators of unmet need. Referring back to Tables 1 and 2 above, respondents indicated that just under half of those clients who have been identified as having emotional and health needs linked to trauma were currently receiving support. On the basis that each YOS has an overall caseload of between 140 and 170 young people (to be confirmed), this would suggest that approximately 60 to 80 could benefit from some support and that around 30 to 40 are being provided with this at any one time. Of course it will be the case that some clients new to the YOS will receive such support in due course whilst others have received and completed an intervention. Nonetheless it also seems plausible at least that a proportion of these children and young people have needs which are currently not being met. This situation appears to pertain across both the consortia as a whole and the different YOSs within them.

Table Three: Named organisations providing services by YOS

North	YOS	Health	Third Sector	Other
Enfield	Therapeutic Social Worker attached to YOS (3 days per week)	CAMHS – CBT, MST, Counselling SAFE	Empower – Child Sexual Exploitation Support 'Lyrc' - mentoring 'YEP' - mentoring	
Hackney	Hackney YOS Family Intervention Service (Source: OCC, 2011)	CAMHS – clinical support, CBT	'Off Centre' – CBT/Talking Therapy Hackney MIND	
Islington	Targeted youth support counsellor	CAMHS worker who directly supports YOS – 'Assesses and treat YP with significant emotional and mental health needs'	Support for young women with sexual exploitation issues (organisation not named)	TYS- Counselling Service (unclear whether YOT based) AMASS – 'support re past experiences/safeguarding'
Newham	CAMHS worker allocated to YOT Work around peer/gang association	CAMHS – 'Trauma'; 'Therapy' 'CFCS' - Therapy Children's Services - Qualified nurse designated to support Looked After Children	Fight for Peace and West Ham Boys Boxing club – raise self esteem 'Tender' – Group work on healthy relationships & domestic violence Families First – early intervention support for families	'CFCS' Substance misuse specialist – dealing with substance misuse linked to trauma Aanchal Woman's Aid – support domestic violence victims/survivors
Redbridge	CAMHS Worker			'Residential placement and victim support' – psychological assessments and counselling 'Tier 3' CAMHS – 'receiving EMDR treatment'
Waltham Forest	CAMHS Clinical Nurse attached to YOS	GP – medication and counselling	'722 Substance Misuse' – anger management 'Kyloe House' – psychological treatment and counselling Safer London Foundation (Including 'Empower' (CSE) & 'Safe & Secure' (Gangs Prevention))	KNI Foundation – bereavement counselling  Brandon Centre - MST
<b>South</b>				
Greenwich	Clinical Health Team – assessments & 121 work using a range, approaches - Family therapist, Forensic Psychologist and an assistant, a specialist SMU worker with skills to do dual diagnosis CAMHS - Tier 2 interventions and access to Tier 3	'Oxleas' - Assessment, medication and therapies to yp with acute needs	Act For Change - Voluntary Counselling/Therapeutic Intervention Service Several local groups - counselling and interventions including therapies	Social Care - Commission a range of service to support families and children  Multi systemic therapy
Croydon				
Lambeth	CAMHS Worker based at YOT - work therapeutically with young people identified as having mental health needs.	CAMHS – 'one to one therapy'	The Well Centre (Redthread)	

Lewisham	'Lewisham Adolescents Resource Therapy Service' (ARTS) – 1 to 1 counselling; 'work on PTSD' 'YOS' – anger management	CAMHS – trauma therapy	Building Bridges - Community support for Families with MH needs	Carers Lewisham - Counselling for Lewisham Residents
Southwark	YOS based CAMHS Worker – counselling and support  Functional Family Therapy – 'therapy'	CAMHS – Assessment and Screening	Reachout   outReach – RO OЯ. (MAC UK 'Integrate' project  Faces in Focus – counselling  Kids Company – wide range of support including for mental health needs	
Wandsworth	'YOT Psychology Service' – training for staff; one to one counselling; consultation service CAMHS – work on ADHD, depression	CAMHS – screening, support, review of medication		

A second indicator comes from the responses to a later question which asked whether over the last three years, there had been cases when there was not a suitable service available to refer a young person with EMH needs linked to trauma. It is worth noting that the question carries with it an assumption that respondents are equally knowledgeable about EMH needs and that what represents a suitable service is also open to interpretation. For example, some may consider anger management classes (which were mentioned) as relevant, others may not, others may see them as relevant but not specific enough to mention in this context. With this caveat noted, twenty six percent of respondents reported having had such cases; again the distribution of responses by YOS suggested that this occurs across the consortia. The most commonly given reasons were: 1) that a sufficiently specialist service was not available (for example for “young people from war zones who have been exposed to extreme violence”), or that there was a shortage of ‘CAMHS-type’ resources more generally; 2) that clients had not engaged with the service, sometimes due to resistance to the mental health label; and 3) the age of clients meaning they fell between children and adult mental health services. Further reasons were the unavailability of mental health services to children in prison; the service not being child-friendly, a service not being available in an appropriate language and the client’s underlying disorder having been masked by substance misuse.

In order to better understand why young people may not be receiving support, survey respondents were asked what they felt were the main barriers to effective working with young people identified as having EMH needs linked to trauma. These responses divided into two broad themes. The first focused on the difficulty of engaging young people for reasons to do with the young people themselves: an unwillingness to acknowledge or disclose their vulnerability, a sense of stigma towards mental health services and a mistrust of professionals, especially those working in the criminal justice system. The second set of responses identified more ‘supply side barriers’ to effective working: a general need for more time, resources and information; a lack of knowledge, awareness and expertise amongst professionals; an absence of specialist services to address specific needs linked to different forms of trauma and poor information sharing.

Some responses captured both of these themes. One respondent emphasised that a number of inter-related factors will influence the effectiveness of any work – “the young person feeling able to disclose, support of the family or carer, support of other services such as CYPS, the quality of the relationship between the young person and YOS officer, compliance with their Court Order i.e if they are attending consistently.” Another drew attention to a scenario where young people may choose not to engage as a result of bad past experiences or may be denied the opportunity to engage at the right moment:

“Young people do not trust professionals due to various reasons, e.g. YOS links to the police, and young people have also disclosed that they do not believe that anyone can help them - sometimes it has been based on their personal experience with services when "wounds" have been opened, however young people have not been provided with coping mechanisms between sessions and they have resorted to substance misuse. A service is often not available, when young people need it and/or are most receptive and willing to engage.”

In similar vein, a third respondent highlighted the general difficulty of meeting the emotional and health needs of young people as victims in the YOS context, when by definition they are there primarily because of their offender status:

“In youth Justice the focus is often on punishment and YP behaviours may be linked to E&MH needs yet is punished. Little room for understanding and explaining behaviours as a symptom. For example a yp with PTSD who's behaviour is a response to trauma (eg aggression towards a worker he perceives as threatening) will receive a warning or be breached for unacceptable behaviour when what is really needed is treatment and understanding.”

In general comments about services for young people with EMH needs linked to trauma, concerns about young people’s engagement were reiterated. One respondent observed that “Young people are often reluctant to talk about gang related trauma (witnessing acts of violence, inflicting harm on others or experiencing violence) due to practitioners' duty to report crime” whilst another stated that “there appears to be a strong stigma attached to the mental health services and young people are not willing to engage in the intervention because they do not think that they are ‘mad’”. Otherwise, respondents referred to a range of potential improvements: closer working between YOS and mental health services, more culturally diverse service responses, specialist support for particular groups such as young people who have been involved in warfare, better screening and assessment tools, more information about what services are available, the involvement of schools and more training.

On the specific issue of training needs, around 60 percent of respondents said they had received training in the assessment of emotional and health needs, mostly within the last five years. In general, whether or not people had received training varied as much within as across all ten YOSs. Views were also evenly spread as to the effectiveness of training with the most common response being to neither agree nor disagree as to whether it had given them confidence to conduct assessments well and similar numbers agreeing or disagreeing. Nevertheless, as Table Six shows, there appears to be a correlation between whether or not respondents had received training and how confident they felt in making accurate assessments. Of the 14 respondents who said they not confident that assessments were correct or accurate, ten reported that they had not received training (see Table Four below).

Table Four: Number of Respondents who have received training by level of confidence in accuracy of assessments

	Received training	
	Yes	No
Very Confident	5	1
Fairly Confident	31	21
Not very Confident	3	10

Fisher’s exact test of probability indicates that the differences reported here are statistically significant ( $p < 0.05$ ) such that more training does indeed lead to greater confidence in making assessments. Almost all respondents commented on what would be useful to them in assessing young people with EMH needs linked to trauma. Leaving aside the small number who said any kind of training would be helpful, the most common needs identified, in order of frequency, were for:

- training in the assessment of trauma – “Training which helps to identify indicators of trauma, helps when interviewing young people to be able to ask the right questions, helps to analyse and assess the information which may indicate that a young person has trauma, informs us of what trauma is, how it manifests in young people and it’s link to development and risks of offending or vulnerability”
- training about trauma and mental health in general – “What trauma is, the consequences of it, how it plays out, and tools for how to work with these.”
- training on interventions: “Training on how to work with young people who have /mental health emotional trauma needs”
- training on different forms of trauma: “Training on how to work with young people who have /mental health emotional trauma needs”

A need for training along these lines is identified by the OCC (2011) report into services for young offenders with mental health problems, where they write that:

“Professionals from all disciplines working with children whether detained or in the community, should have a shared understanding, delivered through joint training, of key factors affecting child and adolescent health and well-being including child and adolescent development, attachment theory, resilience factors and children’s rights so that they are competent to work with children in all settings. This would encourage and promote shared working between community-based mainstream services and those provided to children in custody and improve information sharing on admission, whilst in detention and when planning good transitions on exit “ (OCC, 2011: 15).

As well as training, key informants emphasised the importance of ongoing clinical supervision of professionals working with young people assessed as having EMH needs linked to trauma, not least because these may change and/or become more manifest over time.

The question of unmet need and gaps in provision was also explored in telephone interviews. Amongst YOS professionals, the difficulty of engaging young people in mental health interventions was raised continuously. In many cases the suggestion is that young people are identified as having EMH needs, that it is possible and fairly routine for a more clinical assessment of these needs be undertaken, that counselling and other forms of therapeutic support are offered on a voluntary basis but that these are frequently declined, especially where they are located within mental health settings. One suggestion for addressing this issue was for an intervention that could serve as a bridge between the YOS and clinical services. A mentoring, advocacy and/or brokering role is envisaged here, provided at one arms length from the YOS but with links to clinical support services so that these remain available to young people should they come to feel more receptive to them. The need for a similar kind of service or role was seen as particularly important to young people leaving custody where there may be EMH needs linked to the transition to the community, to immediate practical needs for income, housing etc. and to longer term resettlement. Again the idea is for the young person to have a nominated worker whose role is to offer long term, consistent support, beyond the lifetime of an order if necessary and who can connect a young person with services as needs change and develop over time. As discussed in the review of best practice and innovation below, such ideas echo findings from research into effective resettlement strategies.



Some interviewees observed that gaps in provision predate young people's involvement in the YOS. For example one professional said that "it is as if they need to commit an offence before these services are made available to them" and a number expressed the view that preventative services in schools, children and family services and health services were as valuable as they were over-stretched. Conversely, there was also widespread concern about the temporary nature of the support that can be offered within the time a young person is with the YOS and as to what happens when they move on, especially where there are concerns that underlying emotional and mental health needs that appear are unresolved. Linked to this, frequent reference was made to the relative scarcity of mental health support for young people aged 17-21 and so between child and adolescent and adult services and to the need for further research into the needs of, and gaps in provision for, those young people making this transition..

Although respondents and interviewees did identify gaps in clinical services, both in terms of quantity and quality, the stronger sense was that it was not so much that mental health support was unavailable as that it was not always available in the right place, at the right time and in a form acceptable and practicable to the young person, especially when individuals feel that the problems they have are less significant than those they face, which may in itself be a coping mechanism. Problems of acceptability and accessibility would seem to be more pressing than those of the effectiveness of interventions per se. Professionals could cite examples of successful clinical interventions, be it counselling or therapy and recognised there were some excellent resources, but the number of young people who had benefited significantly from them was seen as small in relation to the level of need that exists.

## **Best Practice and Innovation**

The review of literature encompassed evaluative evidence on a number of approaches/practices linked to victimisation and/or trauma that are deployed by youth justice and other services in England and Wales and beyond. The key points from this review are set out below. Specific forms of intervention of most relevance to the potential development of new services are considered alongside key elements of best practice in such work.

### **Diversionary Initiatives**

Schemes which aim to divert young people assessed as having EMH needs away from the youth justice system at the point of entry and/or as an alternative to more traditional community based offender programmes have been trialled in the US with some success. Jeong et al. (2013: 7) for example evaluated the Social Needs Development Programme (SNDP) in Texas, " a statewide program that involves personnel from juvenile justice and mental health agencies, (and) seeks to provide mental health services and specialized program for the purpose of rehabilitating juvenile offenders and diverting them from being processed into the juvenile justice system (Texas Juvenile Probation Commission, 2010). Based on the wraparound philosophy and team-based treatment, a majority of program services are provided to meet the needs of youthful offenders and their family." The authors summarise the way the scheme works as follows:

"This collaborative, community-based approach across social services systems introduces surveillance and rehabilitation into the coordination of care. Probation officers, upon receiving referrals through the courts, have the ability to hold the youthful offender accountable for his behavior while on probation, including program participation. In addition

to monitoring compliance with the conditions of supervision, the probation officer works in conjunction with the therapist, client, and family to determine the client's criminogenic needs and develop an appropriate case/treatment plan. The therapist provides rehabilitative services to the client and family that address the identified needs of those parties. (Jeong et al., 2013: 7)

The initial evaluation concludes that "participation in the SNDP was strongly associated with reduced recidivism compared with nonparticipation in the SNDP among mentally ill youthful offenders" (ibid.: 17) and so echo the positive findings from earlier research into the initiative (Cuellar et al., 2006).

In England, a similar if more modest approach is the Youth Justice Liaison and Diversion Scheme, summarised by the team who evaluated the project in this way:

"The Youth Justice Liaison and Diversion (YJLD) pilot scheme was developed in 2008 to enhance health provision within the youth justice system and facilitate help for children and young people with mental health and developmental problems, speech and communication difficulties, learning disabilities and other similar vulnerabilities at the earliest opportunity after they enter the youth justice system" (Haines et al., 2012: 7)

The pilot involved six trial projects, each of which operated in slightly different ways. One of these was the Lewisham Adolescent Resource and Therapy Service (ARTS), a multi-disciplinary CAMHS based on the same site as the YOS with one full time mental health practitioner dedicated to the YJLD team. The evaluators note that the YJLD was linked to Triage in order to "strengthen responses for those with mental health and learning disability issues as part of the triage process. Having Triage along YJLD means (theoretically) that all young people who are screened by Triage workers and referred to the appropriate service (including YJLD) are not being charged by the police, thus being diverted away from the youth justice system" (Haines et al., 2012: 43).

The researchers found no significant reduction on reoffending across the pilot project as a whole. They did record a delay in the onset of repeat offending and a small improvement in mental health outcomes for those referred to the YJLD project but the results were not consistent across all sites and they qualify their cautiously optimistic assessment due to the relatively the small sample of young people involved.

The researchers make a number of conclusions and recommendations of relevance to this study:

- "YOT and CAMHS specialist services working and pooling resources together appears to be a more effective approach in addressing the specific needs of vulnerable children and young people";
- "Fuller training (is needed) of YOT staff in child and adolescent mental health and developmental problems, learning disabilities, speech and communication difficulties, including broadening their general knowledge of the field and including practice in the use of assessments"
- "Further comprehensive assessment and support should be offered to all young people who show signs of problems relating to mental health, development, learning disabilities, speech and communication difficulties and similar vulnerabilities"

- “There were significant improvements in reported depression and self-harm ... suggesting that these particular problems are particularly amenable to effective therapeutic interventions “
- “YJLD workers should aim to optimise outreach approaches, delivering appointments/interventions at home, in schools and in the community, as opposed to YOT and CAMHS offices. This, coupled with support into services (post referral) and family work is likely to improve engagement and retention (where appropriate)” (ibid.: 190-91)

### *Children first*

During piloting of the enhanced ASSET currently being rolled out across England and Wales, comparisons between Youth Offender Services indicated wide variation in how the scaled approach was interpreted and implemented an associated with this, a marked lack of consistency in recidivism outcomes (Haines and Case, 2012). Haines and Case argue that that this is due to a problem with the ways in which risk are conceptualised and a lack of guiding philosophy. They contrast this with the "Children First model" which has been implemented in Wales, via the 'Swansea Bureau':

“The delivery of youth justice at the local level eschews the offence and offender focus inherent to the Scaled Approach. Instead, it seeks to animate practice along a continuum of universal and rights-based preventative interventions (see Haines and Case, 2011) to promoting positive behaviour (see Haines and Case, 2005), through diversionary approaches to anti-social behaviour and minor offending (see Hoffman and MacDonald, 2011), to tiered targeted interventions focused on achieving positive outcomes for young people” (Haines & Case, 2012: 215).

This approach is similar to the YJLD model above but has been claimed to be more successful in reducing both the number of young people given a criminal record and levels of reoffending. One difference with the bureau model is that support services outside of the YOS can be offered on a voluntary basis and beyond the lifetime of something like a final warning programme. Whilst the model does not target young people with EMH needs specifically, the argument is that an approach which makes possible access to support services and avoids criminalisation is a better means to address such needs as and when they arise.

### **YOS / CAMHS based Approaches/Practices**

#### *Cognitive Behavioural Therapy*

Following the wider policy shift of increasing use of cognitive behavioural therapy (CBT), this and other talking therapies are available from YOS and CAMHS based clinicians in the LRC areas. If young people are well-engaged, then CBT is consistently associated with positive outcomes including: improved institutional behaviour, better problem solving skills and lower recidivism rates, or longer time to re-arrest (survival analyses). However, CBT is most effective when differences in age/development are taken into account and when additional support, or appropriate modifications are available. For young people who have been traumatised, CBT would not be recommended as an initial intervention. This also relates to behavioural change interventions that may be run within a YOT, but where the young person's mental-well-being is such that they are not able, or ready to engage (Ford & Hawke, 2012; Jewell et al., 2013; Mitchell & Palmer, 2004 and Robertson et al., 2001). Young people's communication skills also need to be taken into account. “Most, if not all, interventions are verbally mediated to some extent...To complete these tasks verbal comprehension

and expression skills are required that can be beyond the skill level of many youth. These interventions require modification to succeed with the youth with weak verbal skills” (Archwamety & Katsiyannis, 2000 p68).

### *Mediation and Restorative Conferences:*

Restorative practices are part of formal youth justice orders and can help with conformity to the EU Victims Directive (2012/29/EU). Victim offender mediation and family group conferencing are generally shown to be effective at reducing recidivism over 12-24 months with meta-analysis demonstrating reductions of 26% (Bradshaw & Roseborough, 2005). They also consistently report high degrees of satisfaction for victims, higher rates of programme completion and attitude change with young people who have offended.

In the YOS context, however, where young people are being asked to participate in restorative practices in their role as offender, it is more difficult to see RJ as addressing their needs as victims, albeit that RJ processes encourage both parties to reflect on the wider personal and social context in which the offending has occurred. Research also suggests that both victim-survivors and offenders can find the process to be a time of heightened vulnerability and greater need, even when ultimately very positive. As with behavioural interventions then, it is important that assessment of young people’s readiness and preparedness to engage with restorative processes takes into account underlying emotional and health needs alongside other factors.

### *Enhanced Resettlement/Transition Programmes*

Research shows that young people leaving custody often need enhanced support to manage their resettlement, to cope with the “weirdness” (Hazel et al., 2014) of the transition and to prepare young people for the kinds of challenges they will actually face “on the out”, including challenges to their resilience and psychological well-being (Moore et al., 2013). Enhanced transition programmes have been shown to be effective in reducing recidivism and outcomes can also be improved for young people with concomitant mental health challenges when dedicated, tailored support is provided through transition and afterwards for 18 to 24 months, tapering off gently towards the end of that time (Unruh et al., 2009). Such sustained level of support may be beyond the level of service provision available here but it is what has been shown to be effective. Enhanced programmes require management board representation and well-structured partnerships between referral services, stakeholders and other agencies, such as housing, training organisations and CAMHS. Skilled, possibly paid mentors and well trained transition co-ordinators or intermediaries can help to facilitate access to different services with and on behalf of young people themselves. Hazel et al. (2012) recommend that YOTs should consider appointing co-ordinators in a partnership role and that they should not engage in case work.

### *Mentoring*

There is evidence to suggest that mentoring type schemes have been used effectively in supporting young victims through the criminal justice process in countries such as Canada, the US and Scandinavia where ‘buddies’ form the core of child centred justice approaches and are reported to have worked well with young children and adolescents (Cronch, Viljoen and Hansen, 2005; Miller and Rubin, 2009; Davidson et al., 2012). In England and Wales, Victim Support offer one to one advice and support to young victims though such services were rarely mentioned by survey respondents in our research who more frequently observed that young people tend to resist the

victim label. This said, the role of the mentor in supporting young offenders with EMH and other needs, is clearly much the same as that of a victim's buddy, inasmuch as independent, consistent advice, guidance and support are shared aims. As noted above, some professionals interviewed suggested that mentors could help to address the frequent issue of non-engagement, by offering informal support at one remove from the YOS context, and acting as a bridge between the YOS and services such as CAMHS.

### *Enhanced Case Management Practice*

Focused on young people serving community orders, the YJB in Wales is piloting the development of an Enhanced Case Management Practice Project based on the Trauma Recovery Model (TRM) (see <http://www.traumarecoverymodel.com>). This has yet to be evaluated in community settings but is strongly grounded in best practice principles from clinical psychology and rigorous previous evaluations of interventions provided to young people who have offended. The aims of the approach are:

“Firstly, to provide youth offending team practitioners and managers with increased knowledge and understanding in relation to how early attachment, trauma and adverse life events can impact on a young person's ability to engage effectively in youth justice interventions; Secondly, to provide a psychology-led approach to multi-agency case formulation, and intervention planning“ (Welsh Government, 2015)

In this approach, the idea is to bring mental health support to young people within the YOS context through enhancing the skills and practice of staff with whom they already have regular contact. The TRM emphasises that forms of therapeutic intervention should be layered according to the developmental and mental health needs of young people. The focus in training therefore is on equipping professionals to know how to assess these needs and what kind of support or therapy is appropriate at different stages of development.

The TRM was initially developed in a secure children's home setting and is currently being piloted and independently evaluated. It is worth noting that the model begins with the setting of routine (meals/bedtimes) and boundary setting which would appear to be more challenging in a community based environment and that it remains essentially experimental at this time. The model does appear to address issues raised by professionals and in the literature. For example, it acknowledges the widely cited problem of non-engagement with mental health interventions, explains this as reflecting a young person's psychological readiness to engage, posits that that first securing a trusting relationship with them is an essential first step and aims to equip professionals with a range of strategies for building the necessary rapport, trust and confidence. The model also chimes with the finding from the survey that professionals would see a need for training around identifying trauma and responding to trauma based needs. The model does not seek to replace clinical interventions by qualified mental health staff but to render YOS staff better able to make timely and appropriate referrals. In many ways then, the TRM represents a well thought through theory of change which has EMH needs linked to trauma as a central point of focus, but it does remain largely theoretical at this stage.

### **Parenting and Family Interventions**

Well managed and sustained family involvement has been found to improve outcomes both for community and secure interventions, with young people who have diverse offending histories and it

may be noted that interventions such as Family Intervention Projects (FIPs) and related strategies central to the government's Troubled Families Initiative (TFI) are often likely to be working with children at risk of offending and victimisation. The Department for Communities and Local Government (2012) report on the evidence and good practice for work with troubled families can be distilled into five effective family factors:

1. A dedicated worker, dedicated to a family
2. Practical 'hands on' support
3. A persistent, assertive and challenging approach
4. Considering the family as a whole – gathering the intelligence
5. Common purpose and agreed action

The FIP approach is holistic and as with the Swansea Bureau, EMH needs linked to trauma, abuse and violence are likely to be addressed in the context of other possible needs around building family relationships, education etc. which may contribute to psychological wellbeing. Haines et al. (2012), in their evaluation of the YJLD note that diversion schemes that are family focused and holistic tend to be the more successful for the same reasons.

In the survey returns concerning existing provision for this study, family focused interventions were mentioned less often than one to one interventions such as CBT (though see below). There was no mention for example of the family intervention service ran by Hackney YOS even though this is highlighted as an example of good practice in the OCC (2011) report into the emotional and mental health of young people in the youth justice system. Moreover, as each Local Authority has a Troubled Families Co-ordinator, one might have expected, perhaps, more reference to them.

### ***Functional Family Therapy***

Functional Family Therapy (FFT) has been consistently shown to be of value within North American settings e.g. (Aos et al., 2006, 2013; White et al., 2013). Twenty years ago, Gordon et al., wrote: "Six times as many adjudicated criminal offenses were committed by over four times as many offenders in the comparison group that received only traditional probation. The majority in both groups avoided records of adult criminal behavior, as is the case nationwide. However, a significant proportion of the comparison group (41%) continued their juvenile records" (1995, p68). FFT has been implemented in England and Wales and was identified as available in (at least) one of the YOS in the LRC.

### ***Multi-systemic Therapy***

Multi-systemic Therapy (MST), is increasingly prevalent both within youth offender services and clinical practice. It was mentioned as a "gold standard" by at least one interviewee in this project. Most evaluations of it show clear improvements on family relationships and re-arrest or recidivism decreases, that are sustained over time (Allen, 2011; Henggeler and Sheidow, 2012; and Woolfenden et al., 2002 ) and can thus show positive net social benefits, although costs findings are mixed (Olsson, 2010; cf Schaeffer & Borduin, 2005). Findings in relation to substance misuse are also more equivocal and there is some limited evidence that there may be less noticeable differences when the "treatment as usual" comparison groups are better quality, e.g. run by thoroughly trained staff and, or, where other, effective approaches are also utilised with families (Littell et al. 2005, Olsson, *ibid*).

The Brandon Centre in North London, which has pioneered the use of MST in England, is contracted to provide MST and other therapeutic interventions with a number of boroughs in the LRC area but was only mentioned once or twice by survey respondents and follow up interviews with professionals.

### **Youth Work/Street Based Initiatives**

The question of how to better engage young people in mental health services has led to projects which use a youth outreach approach. Music and Change (MAC UK) is a North London based third sector youth work project which targets young people involved in group and gang violence and uses “a youth-led approach to make mental health accessible to excluded young people within their own community” by “putting mental health workers at the heart of activities led by the young people themselves” (<http://www.mac-uk.org/about-us/>). The organisation’s website describes one of its projects as follows:

“The Integrate Model works intensively for 2 to 4 years with up to 50 young people per year. These young people are among the 5% that commit 50% of youth crime and have a history of non-engagement with existing services. By giving them the opportunity to create and own a project they find interesting, whether that might be setting up a boxing club or DJ-ing, young people successfully engage.

The MAC-UK team works collaboratively with the young people on their chosen project, helping them to develop leadership and employment skills and build trusting relationships with MAC-UK staff. Young people peel off into ‘streetherapy©’ at their own pace and wherever and whenever they feel comfortable. This can be anywhere, for example on a bus, in a stairwell, or whilst waiting at court. Streetherapy takes what we know works from the mental health field, and delivers it in a highly adaptive and flexible way” (<http://www.mac-uk.org/integrate/the-integrate-model/>)

Based in South London, another third sector organisation, RedThread, has operated in partnership with hospitals to provide access to youth-work and other services to young people admitted with injuries sustained in street based conflicts. Their website summarises the rationale for this level of intervention and the type of work involved:

“Research has clearly shown that the increasing numbers of young people who are accessing accident and emergency units rather than primary care facilities would both prefer and benefit from the provision of dedicated youth-friendly care within these units. In this context, RedThread and King’s Accident and Emergency Department jointly founded the Youth Violence Prevention Project in 2006. This is a pioneering service for adolescents that aims principally to decrease the impact and likelihood of destructive patterns of behaviour that are harmful to young people’s health and wellbeing, particularly cycles of violence related to gang activity. For young people who are involved or who are likely to become involved in gangs, RedThread provides holistic support in order to reduce the traumatic effects of violent incidents and try to encourage individuals to break away from gang culture. Operating from a small room adjacent to the accident and emergency ward, RedThread’s strategies include:

-offering a youth-friendly, discrete space in the King’s trauma centre that makes adolescents feel more comfortable and confident to access healthcare advice

- giving young people the opportunity to discuss any issues and concerns that they may have with an experienced youth worker
- providing clear information and advice about health issues that are particularly relevant to young people
- signposting young people to secondary care, organisations and practitioners who may be able to support them, such as counsellors and drug and alcohol services
- promoting events that adopt a positive approach towards helping and empowering young people” ([http://www.redthread.org.uk /](http://www.redthread.org.uk/))

In partnership with health services, RedThread has also established a community based health centre ('The Well Centre') in Lambeth and school and GP based drop in clinics in Southwark which aim to make advice, counselling and referral services more directly available to young people in general.

Both MAC UK and RedThread were cited as promising and innovative forms of intervention in the government's report on the Ending Gangs and Youth Violence programme and RedThread has been the subject of positive independent evaluative research (Ilan-Clark et al., 2013) which has highlighted the benefit of intervening with young people at the moment when they may well be experiencing (physical and mental) trauma and more open to accepting help. Relatedly, the fact that interventions are dealt with in the community and underpinned by a 'youth-friendly' philosophy is said to make mental health services more acceptable and accessible.

Although MAC UK has projects running in both LRC consortia, it was not identified as a service provider by survey respondents. The longer established Kids Company was mentioned though only once or twice. Kids Company describes its work in London, Bristol and Liverpool in the following way:

“We work across four street level centres, two therapy houses dealing with extreme trauma, five alternative education centres, and in over 40 schools. Our therapeutic work helps children and young people to manage the devastating effects of trauma and abuse and is complemented by practical support providing bare essentials such as food, clothing and bedding, together with longer term support for education, training and employment” .

By intention, these third sector organisations target a much wider population than the young people managed by Youth Offending Services and in quite different settings, unrestrained by the requirement to monitor young people's behaviour and potentially report them for breach of orders. In a number of ways then, they inhabit a different kind of space to that of YOS workers, who readily acknowledged the disadvantages of developing relationships and providing voluntary therapeutic support in the YOS context. Interestingly however, there is a similarity with the Trauma Recovery Model in the emphasis on relationship building and in the intention to bring mental health services to the young person (within the YOS in one case, the community in the other) rather than referring them out to another service based elsewhere.



## Further Elements of Best Practice

### *Positive Relationships*

Repeated themes are evidenced in evaluative research into youth justice interventions which take into account the perspectives of young people. These include the importance to young people of feeling respected, being treated with fairness and recognition and that their views are being considered. Good rapport between practitioners, young people and their families can underpin positive engagement. Strong but appropriately bounded relationships are not sufficient to predict positive outcome solely, as the interventions need to be considered in terms of content, perceived utility and appropriateness. Nevertheless, the literature more broadly suggests that staff relationships with young people are part of a multi-faceted picture of effective intervention (Lowenkamp et al., 2010). England (2009) argues that:

“Logistical factors such as education support and accommodation assistance are acknowledged components of successful intervention, as are formalised programmes of offending behaviour intervention. However, the working alliance between both a professional and a young offender underpins successful intervention” (England 2009: 228-229)

Both the difficulties with and the importance of developing effective relationships were widely recognised by professionals who participated in this research and many cited this as integral to their own practice. Whilst different methods for achieving this goal vary, all the models considered above stress in one way or another the importance of relationships that are consistent, respectful, trusting and focused on mutually agreed goals.

### *Coordination and Information Sharing*

Although multi-agency working is commended for community based approaches, if it is not implemented with good systems of oversight and practice, findings indicate that standard probation casework is more effective. One way designed to build formal partnerships is to take a multi-systemic intervention (MSI) approach which can have very positive outcomes whether directed at first time entrants (Myers, et al. 2000) or those at risk of violent reoffending (Scott et al., 2002). More generally, evaluations of the Swansea Bureau (Case & Haines, 2012) and the YJLD projects (Haines et al., 2012) and research into enhanced resettlement schemes (Hazel et al., 2012) highlight the importance and benefits of representing all stakeholders on management boards, clear lines of referral accountability, inter-professional collaboration and mutually agreed aims and objectives.

Effective information sharing between professionals is another staple ingredient of effective interventions with young offenders. Whilst the research undertaken for this study demonstrated the difficulty of mapping existing services, not least because it relied principally on the knowledge of a relatively small sample of YOS professionals spread across large parts of London, it also suggested that such knowledge is partial and contingent on length of experience and on one’s specific role. There is a case for developing a more systematic and widely accessible database of relevant services, as some professionals themselves identified.

## Conclusions and Recommendations

1. The evidence from the survey and interviews conducted for this study are consistent with existing research. They indicate that as many as fifty percent of the young people being managed in the community by Youth Offending Services will have had traumatic experiences and/or been the victim of or witnessed crime, abuse and/or violence. Additionally, a significant proportion of this group, representing 40 percent of young people on a typical YOS caseload, will have emotional and mental health needs that are linked to these experiences.

2. This research suggests that around half the young people on YOS caseloads assessed as having EMH needs linked to prior victimisation are currently receiving some form of support for these needs. However, as would be expected from existing studies, provision is variable and stretched to beyond existing capacity at times. Most YOSs in the LRC areas have dedicated CAMHS workers on site and there is evidence of good partnership arrangements with mainstream CAMHS services. However, the findings also indicate some anxiety about the impact of budgetary freezes and cuts at central and local government levels as well as a strong sense that demand outstrips supply and that suitable interventions are not always available where and when needed. **Our first recommendation then, is to accept the premise of this research and seek to increase service provision for EMH needs of young people who have offended.**

3. Diverse causes and manifestations of trauma were identified by research participants, consistent with the literature. Bereavement, bullying, street-based and domestic violence, sexual abuse and the experience of war were all cited as underlying factors. Anxiety, depression, anger, emotional instability, troubled relationships and substance misuse were identified as possible consequences and indicators of EMH needs linked to trauma. The proportion of young people with clinical disorders such as PTSD, compared to those with less severe EMH needs is estimated to be relatively small but on the other hand the range of needs linked to having been a victim of crime, abuse and violence is broad and complex.

There is accordingly a need for diverse provision to meet the different needs of young men and women and those of young people in specific circumstances such as young asylum seekers. Ways to encourage engagement will vary depending on the nature of the offence against the young person and the context in which it occurs. There will be predictable differences in outcomes for young girls who are not likely to thrive if placed in programmes, designed for and mainly delivered to boys. The over-representation of young black men in criminal justice and mental health institutions needs to be taken into account in developing services. Inappropriate responses can increase young people's vulnerability to re-victimisation and may also increase their likelihood of non-attendance and breach.

Whilst referrals to CAMHS professionals and services were identified by survey respondents as the most common, almost default, response to EMH needs linked to trauma, voluntary, third sector provision such as gang prevention projects, mentoring schemes and services for victims-survivors of domestic and sexual violence were also viewed as relevant and necessary and examples, though by no means a comprehensive list of such organisations, were mentioned in addition to statutory services. **Our second recommendation is that service provision needs to be tailored to individual needs. This may mean that difficult decisions will need to be taken within each LRC and YOS management boards as to how to prioritise and share services. It is also important for details of**

**organisations providing specialist services to young people from particular backgrounds or with specific needs to be disseminated amongst staff in the consortia areas.**

4. Although research participants were generally confident that existing assessment and screening instruments and procedures were useful in identifying EMH needs at a basic level, it was also acknowledged that the most commonly used tools such as ASSET and SQUIFA were of limited use in assessing the level and nature of such needs. This is especially so if, as was implicit from the survey, staff have limited knowledge and understanding of the signs and effects of trauma and there appears to be a relatively strong appetite for more training on these issues. In a context where ASSET Plus is, and the Comprehensive Health Assessment Tool (CHAT) appears set to be, rolled out across YOSs as standard screening measures, it is recommended that any new services or interventions are dovetailed with the introduction of these instruments. This said, it is important to also stress a point made by both research participants, key informants and in the literature on mental health services that a full clinical assessment of EMH needs is an essential pre-requisite of effective therapeutic and other interventions, not least to assess young people's readiness for different levels of intervention and especially so in cases (for example involving serious sexual offences) of acute and specific need. **We recommend that all YOSs review screening for EMH as part of the roll out of ASSET Plus and the CHAT. The intention is that all young people will be screened and that the CHAT will be implemented by clinically trained staff. However, it is clear that disclosure and need may both change and only be revealed over time so all case workers should be provided with at least basic training in recognising the signs of EMH distress or vulnerability. This could be done with reference to materials from *Young Minds* and may also be informed by the recently commissioned review of mental health screening measures (Richardson et al., 2015).**

5. A recurrent theme throughout this research concerns non-engagement with mental health services even where provision is offered. Professionals could cite examples of successful clinical interventions, be it counselling or therapy and recognised there were some excellent resources, but the number of young people who had benefited significantly from them was seen as small in relation to the level of need that exists and frequently this was attributed to the acceptability, credibility and accessibility of services from young people's perspectives. A variety of possible reasons for this emerged during the course of the research from young people not being developmentally and psychologically ready to engage with certain forms of treatment, to the social stigma attached to mental health services, to resistance based on poor past experiences of interventions, to support being unavailable at the right time or place. **We therefore recommend that screening and offers of intervention be assessed more than once for any one person, how many times this should be will vary depending on his or her length of sentence, degree of need and changing circumstances and could be assessed as part of integrated offender management systems.**

6. A related point is that where young people do have EMH needs linked to victimisation and associated trauma, these will often sit alongside a range of other behavioural, educational, familial, practical and social needs and problems. Moreover, this and other research studies indicate that a number of overlapping preconditions may need to have been met in order for therapeutic/clinical interventions to be effective: children and young people should feel safe and secure and able to trust professionals, substance misuse issues need to be addressed and practical accommodation and nutritional needs met. Given this, it is unsurprising that best practice models and approaches in work

with young offenders and their families are often those which provide holistic packages of support, involving the input of more than one agency, nor that research into the resettlement needs of young people leaving custody has pinpointed a need for mentors, coordinators or brokers who can work alongside a young person and guide them through the maze of potential services. **We commend multi-systemic interventions but recognise that they can be confusing for young people, we therefore also recommend that buddy systems, or other liaison co-ordinators be part of the additional provision (see also 11 below)**

7. A review of best practice models and approaches revealed a variety of strategies designed to address the issues summarised above. There is no magic bullet and no particular form of intervention that emerges as obviously superior, either to plug the gaps and unmet demand identified in the primary research undertaken for this study or on the basis of existing research into EMH needs linked to victimisation and associated trauma and evaluative studies of current practice. However, certain options for intervening at different levels and in different ways, each with their own strengths and weaknesses, do suggest themselves. **We recommend that each approach suggested below be assessed further, particularly with a view to assessing whether they can be commissioned or embedded within the available timeline.**

8. The Enhanced Case Management Practice Project based on the Trauma Recovery Model (TRM) currently being trialled in and by Youth offending Teams/Services in Wales focuses on training and supporting YOS professionals to better recognise and respond to EMH needs linked to prior victimisation and associated trauma. Underpinned by psychological research and theory which suggests that responses to such needs must be tiered according to children and young people's level of cognitive, emotional and behavioural development, the model aims to equip front-line staff to achieve this goal. One reason why this approach seems appropriate is that professionals who participated in the current study signalled a need for more knowledge about trauma and were accordingly receptive overall to training geared to enhancing their own and colleagues' practice. Importantly, the model includes the provision of ongoing clinical supervision from appropriately trained professionals and aims to ensure that referrals to CAMHS and other services are better informed and so more likely to be effective. There are significant caveats however. First, is that the model remains essentially experimental at this stage; systematic evaluation of the model applied to community based work with young people who have offended has yet to be completed though is underway. The second caveat is that the model assumes a degree of stability within a YOS staff group which our research suggests has not been the case in at least some of the YOSs in the LRC area. Relatedly, there was some evidence of and/or concern about training fatigue amongst YOS professionals, suggesting that it may be best to target those staff for training in the model, who feel able, willing and in need of this kind of professional development. Finally, it is important to say that this approach does not obviate the need for high level interventions from a full range of properly qualified, clinical specialists. Enabling front-line staff to know when and who to refer young people to for higher level interventions requires, it goes without saying, such interventions to exist. The analysis of existing provision for this study suggests that, as per national guidelines and standards, service level agreements and joint working arrangements between YOS and CAMHS do provide access to appropriately qualified mental health professionals but that these essential resources are overstretched, with waiting lists that may exceed a YOS's time with a young person and are subject to ongoing budgetary constraints.

9. The widespread and substantial evidence that young people who have offended are disproportionately likely to have been victims of crime, abuse and/or violence and that this there is associated with their offending has informed the development of diversionary models such as the Swansea Bureau in Wales and the Social Needs Development Programme in Texas, USA, along with the belief that where entry into the youth justice system can be averted or even postponed, this makes reoffending less likely and the offer of professional support to meet EMH and related needs more acceptable to young people. Our findings suggest that at present, referral to CAMHS services in the LRC area operates more as an adjunct than an alternative to youth justice interventions. It may therefore be possible to formalise and/or extend arrangements for diverting more young people who are assessed as having EMH needs to a service that is removed, physically or procedurally, from YOSs. One reservation here is that it is possible that diversionary schemes and processes are already in place, (such as national schemes for first time offenders or as would appear to be the case in Lewisham, via ARTS,) for example, and that these slipped under the radar of this study because it focused on responses to young people already on the YOS caseload. This said, initiatives such as the Swansea bureau entail significantly more than referral to CAMHS, aiming rather to providing holistic responses that require input from a range of different agencies. Whilst this suggests that there is potential for a new kind of diversionary service, such a development would appear to be more radical and more resource intensive than permitted by the time-delimited limited funds available for service development..

10. A third option suggested by the review of best practice and innovation is to invest in voluntary sector providers such as MAC UK and RedThread which aim to improve access to mental health services for young people in community settings, using outreach and youth work approaches. The main attraction with this strategy is that it appears to address the problem of non-engagement with CAMHS. As has been noted, many of our research participants identified lack of engagement with mental health services as more of a problem than the availability of such services per se and it does seem plausible that young people are more receptive to support of this kind when it is offered within settings they have chosen, as opposed to those which they are compelled to attend. A significant caveat with this option is that there is little authoritative evidence (from evaluation studies for example) that the take-up of therapeutic support is higher amongst young people in these settings than amongst those on community orders and being managed by YOSs, nor could we find rigorous evidence of outcomes.

11. Deploying mentors, buddies, advocates, coordinators or brokers to work with and support young people was suggested both by research participants and by existing research into the resettlement of young people leaving custody. In part, the rationale here is similar to that for offering services outside of the YOS context, namely that young people are more likely to trust and accept advice and support from workers whose role is less to monitor and correct their behaviour than to address and help them cope with various problems they face. The related argument is that where there is a need for support from different services, including mental health services but also, potentially, education, and training, accommodation and care providers, there is a concomitant need for individuals who can broker these kinds of support on their behalf and/or in conjunction with them. The difficulty with this option is that the role envisaged would seem to involve a level of commitment and skill that is on a different level to that offered in existing mentoring schemes involving volunteers meeting with a young person on an occasional basis. Although we could not find an existing model of what one might term enhanced mentoring, nor therefore of empirical evidence that it is effective,

there is some evidence that transitions co-ordinators and resettlement brokers may be effective in sustaining engagement with education and training (e.g. Powell et al. 2012).

12. It may be possible to commission a floating service with additional psychiatric or other clinical expertise. This could be shared within and possibly between LRCs. It might provide face to face, telephone or possibly virtual consultations and these could be directly for young people, as part of their treatment plans, or, potentially more cost effective, would be for them to support YOS practitioners in interpreting initial screening and, or as additional clinical supervision for CAMHS workers or even for multi-disciplinary working. Indeed services may be for practitioners as well as for young people, not just in terms of clinical debriefing, but also to help them in knowing what is a concerning behaviour or not. For example, this report has not really mentioned suicide or self-harm but levels of distress are high and clearly feature as part of broader safe-guarding approaches.

13. In outlining the five options above, the focus is on interventions which seem to address the problems with and barriers to the take-up of mental health services amongst young people identified by YOS professionals in the survey and follow up interviews conducted for this research. It is important to note, however, that much of the research into best practice with young offenders more generally, concludes that holistic and family focused interventions which address the spectrum of needs presented by young people who offend are often the most effective in terms of reducing reoffending. A final option to consider then is the further development of family intervention projects within the YOS context. There are of course inevitable constraints in the commissioning of services and of research. Concentrated as it was on services targeting victimisation and trauma-induced emotional and mental health, the audit of existing provision conducted here did not provide a comprehensive scoping of these kinds of holistic family-focused projects - the Hackney Family Intervention Service, for example, was not identified by participants in our research but in a separate study. The broader landscape of research relating to youth offending is, therefore, important to consider when acting on the findings from this study.

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