Reaching out, reaching in: 
Promoting mental health and emotional well-being in secure settings

Lorraine Khan

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Executive summary

Young people sentenced to custody have very high levels of mental health problems. They are also more likely to have learning disabilities and speech, language and communication needs, as well as a range of other complex and multiple vulnerabilities that compromise their future life chances and their health and well-being.

This study was commissioned by the Department of Health to review current levels and standards of mental health provision in the young people’s secure estate in England. Specifically, the study aimed to:

• consider how provision in the young people’s secure estate compared with mental health services for children and young people in the community
• consider the extent to which mental health services in secure settings meet the mental health and emotional well-being needs of young people
• disseminate examples of promising practice

A particular focus was the impact of the additional funding provided by the Department of Health from 2007/08 for the provision of child and adolescent mental health services in young offender institutions (YOIs).

This research suggests that the Department of Health funding had resulted in significant improvements in mental health provision and awareness in YOIs. However, it had the unintended effect of throwing into greater relief disparities in the mental health care provision across the whole young people’s secure estate; these commissioning differences result from different commissioning arrangements. A number of areas were identified where further development is needed.

Overall, this research suggests that there is an urgent need for all secure units to develop an integrated, whole system and comprehensive approach to supporting the mental health and well-being of the very vulnerable children and young people in their custody and care and, no less important, to ensure that any improvements and progress made while in custody are supported and maintained following release.

We end the report with the warning that funding to sustain those improvements made in the mental health care of young people in YOIs is not currently guaranteed, and the progress identified in this report could be reversed if sustainability is not addressed.
Recommendations

Research shows that placing children and young people who offend in custodial units is one of the most expensive, least effective methods of reducing crime. Furthermore, we know that children and young people with the poorest mental health and greatest health inequalities currently tend to cluster in these custodial settings. Practitioners indicate that many have drifted into custody with insufficient attention in the community to long standing mental health needs. Over reliance on custody to address the mental health and health needs of vulnerable young people in the youth justice system should be avoided; international legislation also states that custody should be used as a measure of last resort for children. This is particularly important for those with health and mental health problems since the literature suggests that gains made in these settings are rarely sustained after release often due to poor transitional care. Commissioners need to invest in the full range of proven community interventions that have been shown to be both more effective and most cost-efficient in reducing the re-offending both of those with and without diagnosable mental health difficulties. Particular attention should be given to improving access to evidence-based family interventions for those with conduct and behavioural problems which start at an early age; these young people are most at risk of poor outcomes as adults.

The recommendations of this report include the following:

Identification of health needs

We know that children and young people in the youth justice system are, with homeless, substance misusing and looked after children and young people, the most likely to have significant health needs and also the least likely to access primary healthcare. We would argue strongly for improved accessibility to mainstream primary care services for vulnerable children and young people as early as possible to prevent escalating difficulties and costly poor outcomes later on. However, for those who enter custody, their period in custody offers NHS commissioners a unique opportunity to target a high risk population for health promotion interventions and to engage with a (literally) captive audience to build on and sustain health gains post-release.

A comprehensive health checklist (including mental health and emotional well-being) should be developed for use across all agencies and in all settings to help identify issues that young people may be reluctant to disclose. This checklist will need to be integrated into existing mainstream and youth justice screening and assessment arrangements. This health checklist should be updated at each stage of the youth justice pathway and should include the Health Action Planning process for those with learning disabilities.

A standardised health information summary tool (HIST), as currently used at Hindley YOI, would ensure vital health information is passed on through all points of transition and into the community post-release.
Resettlement

Given what we know about the very high levels of complex needs among young people in secure settings, there is an urgent requirement to see young people in custody as children in need and for Children’s Trusts to prioritise them, as they do other children in need. The case is particularly strong for those identified with early behavioural problems and ADHD (both of which are known to have strong associations with offending behaviour, substance misuse and later mental health problems), those who have suffered previous maltreatment, young females (who have high levels of mental health and other needs), young people from BME communities (who remain over-represented in custody settings), and those with mild to moderate learning disabilities and communication difficulties, who currently fail to access community services.

Young people who go into custody should have a lead professional identified before entry who follows them through the system. This throughcare and resettlement work needs to be seen as the highest priority, and not an ‘add on’ to other community work. Children’s Trusts should be made more accountable for the resettlement of the young people who return to their local areas, rather than this being seen as the sole responsibility of local YOTs.

Family support is a major protective factor for young people seeking to make progress and achieve their potential. Lack of family intervention work with young people in secure settings and their families represents a significant missed opportunity. There is a need to consider how we can improve partnership between secure units and families and promote contact, cohesion and linkage with community support and networks. Links could usefully be made with Family Intervention Projects and memoranda of understanding developed to provide young people and families with support before the young person is released.

Given these young people’s very high levels of vulnerability, resettlement packages should include the most intensive, evidence-based support. There should be more focus on parenting support to prepare families for their child’s release and intensive, holistic, wraparound support, to prevent deterioration in well-being and behaviour on release.

The Care Programme Approach (CPA), a system of case management for those with mental health difficulties to promote continuity of care and resettlement, is poorly understood and currently underused to promote care and speedy access to services on release. Use of CPA, along with persistent problems in accessing services, should be monitored by local safeguarding boards and by commissioners.

There is a need for comprehensive, user friendly and regularly updated directories listing local voluntary and statutory children’s services to inform staff, families and young people about support services available when young people are released to their home area. This information should build on the CAMHS mapping data and should include a brief description of the service, type of support offered, criteria for acceptance and contact details.
Regional strategy

There are signs that the new Government will encourage increasingly localised commissioning. The findings from this research indicate, however, that it will still be important to ensure that local commissioners coordinate and plan some activities together in their regional areas, particularly to address the needs of those in custody. Regional coordination and commissioning will continue to be important (both for those with direct commissioning responsibility for secure settings and those without). This coordination will help develop a consistent approach to and pathway through the youth justice system for children with health, mental health and emotional well-being needs in custodial catchment areas. Such planning should promote consistency of mental health and well-being services and care throughout all secure sites, YOTs and other services supporting vulnerable young people regionally. It will also provide greater continuity in and out of the secure setting to help young people resettle. Finally, regional planning allows a more cost effective way, across a cluster of local areas, of providing access to highly specialist consultation on forensic mental health and sexually harmful behaviours to support the management of the small number of high risk young people.

Workforce development

The Children’s Workforce Development Council has identified a common core of competencies and knowledge that all those working with children and young people (including volunteers) should have. These competencies should inform the training of secure care staff in all settings and should underpin interactions and work with young people and their families. Together with the Skills for Health (2007) competencies for Tier 3 CAMHS work, these competencies should provide a benchmark for inspectorates assessing the quality of comprehensive CAMHS support in secure settings.

At present, throughout the entire young person’s secure estate, training is provided in very different ways depending on the type of unit (e.g. private versus prison-service run, YOI, Secure Children’s Home and Secure Training Centres). All frontline workers in secure settings need ongoing common and consistent training in child and adolescent development and forensic mental health as well as in the impact on behaviour of childhood maltreatment and trauma, neglect, mental health problems, learning disability, speech language and communication problems, physical health inequalities, and social deprivation.

Regional specialists and CAMHS in-reach teams should provide ongoing ‘booster’ training for all disciplines working in the young people’s secure estate, as well as consultation, supervision and informal training in the day to day management of young people with complex needs and behaviours.
Health commissioners should conduct an audit of child and adolescent mental health competencies and skills in primary healthcare and devise a workforce development strategy to improve workers’ expertise.

**Primary care**

The GP Quality Outcome Framework should be adapted to support work with children in secure settings, together with the necessary technology. GP practices should be established in each youth custodial setting so that practice-based commissioning can develop, mirroring developments in the community. GPs who work in secure settings for children and young people should have enhanced training in child and adolescent development and in the particular health and health promotion needs of young people in these settings.

**Comprehensive CAMHS**

Particularly in larger secure units, ongoing attention should be given to developing multidisciplinary collaboration and a comprehensive CAMHS approach to meeting mental health and emotional well-being needs and supporting the management of young people with other complex needs. Greater use should be made of multidisciplinary meetings (established in some YOIs) to improve the coordinated planning and review of the mental health and well-being and safeguarding of young people. In smaller SCHs, where specialist staff are often working outside the unit, more use should be made of conference calls to co-ordinate care, share information and improve management and resettlement planning.

**Safeguarding**

Units should adopt a proactive approach to reviewing safeguarding. There should be a log, reviewed annually, for recording practices that could compromise the well-being of young people while in secure settings and following release. The log would include incidents within and outside the immediate authority of secure units (e.g. last minute, unsuitable accommodation on release, inadequate interventions or care arrangements at the point of resettlement for those at risk of sexually harmful behaviours or with emerging personality disorders). These concerns should be referred either to the safeguarding board overseeing the unit or to the board with responsibility for the young person’s home area.

**Outcome monitoring**

There is currently no standardised method for assessing mental health and emotional well-being outcomes from the different secure units. The Children Society’s (The Children’s Society, 2010) emotional well-being scale should be included in Her Majesty’s Inspector of Prisons inspections of individual units to enable comparison of well being and outcomes.
Young people’s participation

Young people should be involved in designing and shaping services and how they are delivered. There is a need to consult with young people on how to improve processes for accessing support for mental health and emotional well-being in secure settings, taking into account the particular challenges posed by loss of liberty, locked doors and institutional procedures.

For those with diagnosed mental health difficulties, there should be some investigation as to how the recovery approach can be integrated in practice throughout the youth justice system and the young people’s secure estate.

More use should be made of peer mentoring. Young people should receive training to use peer mentoring skills in secure settings and, following release, in the community.

Young people should be involved in inspecting and auditing provision in secure settings, as happens in some settings for looked after children.

Young people’s awareness of mental health

The Social, Emotional Aspects of Learning programme (SEAL) should be incorporated into educational provision in the young people’s secure estate to promote awareness of mental health and emotional well-being and to support resilience and encourage young people to seek help.
Introduction

In 2007 the Department of Health and the Youth Justice Board commissioned the Centre to review mental health service provision in the young people’s secure estate in England. The aims of the review were:

- to consider how provision compared with mental health services for children and young people in the community
- to consider the extent to which mental health services in secure settings meet the mental health and emotional well-being needs of young people
- to disseminate examples of promising practice.

A further aim was to identify models of audit used in these settings to review quality and outcomes of interventions.
The Study

Methodology

Visits were made to healthcare and mental health teams covering:
- 13 (of the 18 within the secure estate) young offender institutions (YOIs)
- 5 (out of 15) secure children’s homes (SCHs)
- 2 (out of four) secure training centres (STCs).

The units ranged in size from 15 places (the smallest, female-only YOIs) up to 400. Two of the YOIs were female only; the remainder was for males. The SCHs and STCs were mixed gender. Most visits took place between September 2007 and October 2008. Some follow-up visits were made in 2010 to include new developments such as the Willow Unit for complex needs at Hindley YOI and the Keppel Unit in Wetherby YOI. It should be noted that changes have been made to the organisation of the young people’s secure estate since completion of the fieldwork, and a number of YOIs and SCHs are no longer being used for young people under 18 years old in the youth justice system.

Semi-structured interviews were conducted with a total of 70 members of staff (see table 1). Researchers also sat in on multidisciplinary meetings and observed interactions between mental health teams and their colleagues and between staff and young people.

Table 1: Interviewees by profession/role

- Governors and unit directors at SCHs 6
- Healthcare, in-patient and mental health service managers 12
- Modern matrons 2
- Healthcare nurses 5
- Specialist mental health nursing staff 8
- Psychiatrists 7
- Psychologists 4
- Assistant psychologist 1
- Occupational therapists 1
- Drama therapists 3
- Social worker 1
- Youth Offending Team health practitioners and case workers 4
- Adult mental health provider in custody 1
- Secure care staff in YOIs and SCHs 9
- Commissioners 2
- Substance misuse staff 1
- GP 1
• Admin worker 1
• Speech and language therapist 1

A small number of young people and family members with experience of mental health difficulties and the youth justice system were consulted throughout the review and invited to discuss the findings and contribute service user experiences and perspectives.
The context

The youth justice system

The age of criminal responsibility in England is 10 years. Children aged 12 to 17 can be sentenced to custody under a Detention and Training Order for periods of four months up to a maximum of two years. The first half of the sentence is spent in custody and the second half in the community, under the supervision of a Youth Offending Team (YOT). A young person aged 10 to 17 convicted of a serious offence (one that carries a sentence of 14 or more years in custody for adults) can also receive a custodial sentence under sections 90 and 91 of the Powers of Criminal Courts (Sentencing) Act 2000.

There are three types of unit for children and young people sentenced to custodial sentences.

Young offender institutions (YOIs) are secure units run either by the Prison Service or by the private sector. They take young people aged 15 to 21 years. Young offenders under 18 years old are housed apart from young adults (aged over 18) and their places are commissioned by the Youth Justice Board. YOIs for males are much larger than other types of secure settings for young people (up to 400 places each), and are generally considered to be inappropriate for vulnerable young people, such as those with mental health needs. Girls and young women are placed in smaller units of up to 15 places. In 2007/2008 the National Health Service assumed responsibility for mental health services in YOIs.

Secure training centres (STCs) are run by private operators under contracts that set out detailed operational requirements. They negotiate with local contractors to buy in specialist services to fulfil these contractual obligations. There are four STCs in England, with a maximum operational capacity of just under 90 beds each. They take young offenders from the age of 12 to 17. They hold fewer young people than YOIs and have a higher staff to young offender ratio. Secure training centres provide mental health services as part of their contracted agreement with YJB. They commission these services in different ways depending on what expertise is available to support commissioning and what specialist resources are available to draw on in local areas.

Secure children’s homes (SCHs) are smaller units run by local authority social services departments and overseen at the time of writing by the Department of Health and the then Department for Children, Schools and Families, or Department of Education.

Secure children’s homes provide young people with specialist support tailored to their individual physical, emotional and behavioural needs. They charge the Youth Justice Board a unit price per bed, taking into account all resources and services contracted in to meet the young people’s needs. They purchase mental health services (often from the local area) and add costs to the unit
‘bed price’ which they agree with the YJB. They have a high ratio of staff to young people and generally range in capacity from 6 to 40 beds.

Secure children’s homes are generally used to accommodate young offenders, aged 12 to 14, girls up to the age of 16, and boys aged 15–16 years who are assessed as vulnerable.

Policy and guidance

Key research and policy guidance were reviewed for the study to identify current policy and best practice in service provision for the mental health and emotional well-being of children and young people both within and outside secure settings.

The literature review included:

- a review of mental health prevalence data for young people
- a review of what is known about other multiple and complex needs among children and young people who offend
- key publications on health, mental health and well-being in secure settings
- key policy guidance governing practice in custodial settings and the mental health and emotional well-being of children and young people both within and outside secure settings
- a review of international literature on the effectiveness of secure settings and other interventions for young people who offend and who have poor mental health.

Mental health and well-being

Healthy Children, Safer Communities (Department of Health, 2009a) defines mental health as:

“... a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. This focus on well-being, in addition to health, is particularly important during childhood and adolescence because of the complex interplay of risk and protective factors and their impact on the long-term development of children and young people. Well-being also encompasses recognition of the importance on children being secure in personal identity and culture. It takes account, too, of the duty on agencies to co-operate to improve children’s well-being (section 10 of the Children Act 2004) and to improve the health and well-being of children and young people (PSA 12).” (Department of Health, 2009a)

This is the definition adopted in this study. The study also recognises that mental health problems in children do not manifest as clearly as they do in adults, are often much less easy to identify, and can manifest in other ways, such as in behavioural problems.
Mental health needs among young people in custody

Mental health needs are three times more common among young people aged up to 18 years in the youth justice system than among their peers who do not offend (Hagell, 2002). Studies of young people in custody indicate higher than average levels of depression (18%), anxiety disorders (10%) and psychotic-like symptoms (5%) (Chitsabesan et al, 2006). Half of the young people in custody surveyed in one study met the criteria for conduct disorder (Fazell, 2008). In another almost nine out of 10 young people aged 16–20 years in custody met the criteria for personality disorder (Lader, Singleton & Meltzer, 2000). The same study found that eight out of 10 of the young people had more than one mental health problem that met the criteria for a formal diagnosis.

Young women in custody have the highest rates of mental health problems: particularly depression, post-traumatic stress disorder and self-harm (Chitsabesan et al, 2006). One study found over a third of 17 year old girls in YOIs had self harmed in the previous month (Douglas & Plugge, 2006).

Learning disabilities and speech, language and communication needs

One in five young people in custody have some form of learning disability and nearly three quarters of young people in these settings have been assessed as having some form of speech, language or communication need (Bryan, Freer & Furlong, 2007). These issues can interfere with the young person’s ability to understand basic communications and instructions as well as affect their engagement with therapeutic and offending behaviour work.

Black and minority ethnic (BME) young people

Young people from some black and minority ethnic (BME) communities (specifically black/black British young people and those of mixed heritage) are considerably over-represented in the young people’s secure estate and tend to receive longer sentences (House of Commons Home Affairs Committee, 2007).

We know that adults from a number of BME communities are more likely to enter mental health services via criminal justice referral routes (House of Commons Home Affairs Committee, 2007), and also to be treated under more restrictive sections of the Mental Health Act (Clinks, 2008).

The reasons for this are not, as yet, fully understood but are likely to include socio-economic factors, exacerbated by racism and discrimination (Youth Justice Board, 2004). For example, many risk factors for offending and for mental health problems overlap. These include low family income and poor housing (Diamond, Floyd & Misch, 2004). Academic low attainment and low self-esteem are also factors in mental ill health, and young black men are three times more likely to be excluded from school than white British students and five times less likely to be seen as gifted
(Department for Education and Skills, 2006). There is also evidence that young people from some BME communities are less likely to access primary care for help when they first experience mental health problems, leading to the need for crisis intervention if their problems escalate (Street et al, 2005).

Black young people in custody have been found to have higher rates of post-traumatic stress disorder (Healthcare Commission, 2007). This may be partly explained by the numbers of young asylum seekers and refugees in custodial settings, who have been identified with higher rates of trauma (Chitsabesan et al, 2006).

Asylum seekers, refugees and their families are known to be at high risk of mental health problems (Ehntholt & Yule, 2006). Services and support for these groups need to be flexible and responsive to the different cultural understandings of and ways of managing mental health issues (Montgomery & Foldspang, 2005). There is an absence of research into effective interventions to support young people and their families who have experienced multiple traumas.

Other complex needs affecting mental health and emotional well-being

Young people in the youth justice system have a range of other significant complex needs and vulnerabilities:

- two in five young females and one in four young males in custody report violence in the home (Social Exclusion Unit, 2002)
- three quarters of children and young people in custody have lived with someone other than a parent (Healthcare Commission, 2007)
- 40% of children and young people in the youth justice system were homeless in the six months before they entered custody (Prison Reform Trust, 2009a)
- 84% of 12–18 year olds in custody have problematic drug use and a further 64% have concurrent mental health difficulties (Galahad SMS Ltd, 2009)
- 86% of young men and 79% of young women in the youth justice system aged 15–18 years have been excluded from school (Parke, 2009)
- one in three girls and one in 20 boys in custody have disclosed sexual abuse (Social Exclusion Unit, 2002)
- one in ten young women in custody have been paid for sex (Douglas & Plugge, 2006).

Effectiveness of custody as a response to crime

There has been a consistent fall in the number of young people sentenced to custody in the UK since 2008. However, the UK still has one of the highest youth custody populations in Western Europe. Reconviction rates for young people following release from custody also remain high. The reconviction rate for young men aged 15–17 who have served a previous sentence is 92% (Home Office, 2005).
Research in the United States suggests that custody can only ever exert a very modest effect on crime rates when the prison population is at a small but optimum point. As the prison population rises these benefits are quickly lost. Community based programmes (such as Family Functional therapy and multi dimensional fostering treatment) perform much better than custody. A number of evidence based community sentences have resulted in lower re-offending rates when compared with matched samples of young people receiving more usual interventions - including custodial sentences (Aos, Miller & Drake, Medhurst & Cunliffe, 2007; Marsh, 2009). These interventions are also much more cost-effective than custody (Marsh, Fox & Hedderman, 2009; Aos, Miller & Drake, 2006) reducing economic wastage and the burden on the public purse.

Few studies have compared outcomes from different sizes, types and regimes of secure unit. One UK study compared a more intensive cognitive behavioural YOI regime (which also placed a high emphasis on finding jobs for young people at the point of release) with a ‘boot camp’ approach regime (Farrington et al, 2002). Those in the intensive cognitive behavioural regime showed some improvements in re-offending rates but only in the year immediately after release. The young people attending the more punitive ‘boot camps’ had higher rates of reoffending. The cognitive behavioural and boot camp regimes did not achieve any measurable change in the young people’s attitudes to offending, and none of the regimes were experienced as less stressful.

The conclusions of this study back up earlier studies highlighting the general ineffectiveness of boot camp regimes (MacKenzie et al, 2001) in reducing re-offending rates. Although some health benefits were noted from the boot camp regime (such as improved self-reported physical and mental health), evidence-based community interventions are generally regarded as achieving better outcomes than custodial interventions (Aos, Miller & Drake, 2006).

There is little evidence to date on differences in outcomes from smaller custodial units, although there is some emerging evidence from Spain (Fundacion Diagrama, 2007) and from Missouri in the US (Youth Transition Funders Group, 2005) that smaller, intensive therapeutic units result in lower reconviction rates.

Some custodial-based programmes do achieve positive outcomes for young offenders. Effective programmes tend to start in custody and continue ‘over the wall’ at the point of release. For example, the US Family Integrated Transitions (FIT) approach (Washington State Institute of Public Policy, 2004) is showing very promising results with young people who have co-existing mental health and substance misuse difficulties. The FIT programme is an intensive family and community based treatment combining multi-systemic therapeutic approaches and dialectical behavioural therapy. The programme (including family therapy work) begins during the young person’s final two months in custody and seeks to foster behavioural change in the home environment, building on the strengths and resources of the family, peers, school and local community.
Family integrated Transitions (FIT)

In the US, young people with a substance misuse difficulties and a co-existing mental health problem can be placed on the FIT programme.

The goals of the FIT programme include lowering the risk of recidivism, connecting the family with appropriate community supports, achieving abstinence from alcohol and other drugs, improving the mental health of the young person, and increasing pro-social behaviour.

The FIT programme includes:
- dialectical behavioural therapy
- functional family therapy
- motivational enhancement therapy.

Towards the end of the young person’s sentence, work begins in the unit with the whole family together. This work continues intensively with young people and families on their release.

Custody, mental health and emotional well-being

There are few robust and comprehensive studies specifically exploring the impact of child custody on emotional well-being and mental health. The evidence that does exist is mixed, but predominantly negative. For example, we know that custodial units are a high risk setting for some young people; young males in custodial settings are 18 times more likely to take their own life (Fazell, 2008). There is also evidence that around a third of young people feel unsafe in custody (Her Majesty’s Inspectorate of Prisons, 2007). Custody has also been shown to have a negative effect on some aspects of young men’s mental health: Kroll and colleagues (2002) found that some mental health disorders had worsened or even started in secure settings, while depression and anxiety levels remained high and in some cases accelerated or started after admission. Women who have experienced abuse are more likely feel traumatised by routine prison procedures such as body searches (Moloney, van den Bergh & Moller, 2009).

Other studies have found improvements in some young people’s functioning while in custody. Alongside the deterioration in neurotic disorders, Kroll and colleagues (2002) found a decrease in conduct disorder, although this was primarily attributed to better supervision and the restrictive environment. The study queried the sustainability of such changes after release from custody.

Other studies have highlighted the opportunity presented by custody to address entrenched health problems in at-risk children and young people and to work on factors affecting health in the longer term:
“A period in detention is currently a missed opportunity to detect, diagnose, and treat health problems in a population which is often hard to engage in the NHS.” (Gould & Payne, 2004)

Young people who end up in custody are increasingly recognised as at high risk of poor health. In Australia, Coffey and colleagues found that young people who had served a custodial sentence had a significantly higher mortality rate than the general population (Coffey et al, 2003) and were more likely to die from drug-related causes and by suicide. These findings underline the importance of prioritising the well-being of those from the most disadvantaged communities and with the poorest access to healthcare, and also the need for continuity of care and assertive health tracking on release to build on health and lifestyle improvements.

In one study, comparing young people in the community (and in YOT contact) with those in custody, an improvement was noted in the number of needs addressed in those who ended up in secure settings; however, these improvements were not sustained once the young person returned back to their home areas (Chitsabesan et al, 2006). Indeed, most research looking at the impact of custody on emotional well being, social exclusion and life chances indicates that, on balance, periods in custody result in dislocated relationships with families, restricted life opportunities, reduced employment chances and a downward cycle of economic dependence and social exclusion (Willmott & van Olphen, 2005).

- Socially excluded young people experience high levels of psychiatric disorder, childhood abuse and substance dependence
- Mortality rates among young male offenders are nine times higher than those for young men in the general population. Mortality rates among female offenders are 40 times higher than among young women in the general population
- Drug use, suicide and non-intentional injury are the leading causes of death among young offenders
- Mortality in young offenders is higher than in equivalent age groups who have schizophrenia or eating disorders
- Young offenders account for a quarter of drug related deaths in young men aged 15–19 years.

(Coffey et al, 2003)

**International legislation and child custody**

The United Nations Committee on the Rights of the Child (UN Convention on the Rights of the Child, 2007) takes the view that custody generally has a negative impact on children and young people’s development and should be used sparingly:
“The use of deprivation of liberty has (very) negative consequences for the child’s harmonious development and seriously hampers his/her reintegration in society. In this regard, article 37(b) of the CRC explicitly provides that deprivation of liberty, including arrest, detention and imprisonment, should be used only as a measure of last resort and for the shortest appropriate period of time, so that the child’s right to development is fully respected and ensured.” (UN Convention on the Rights of the Child, 2007)

In 2008 the Commissioner for Human Rights of the Council of Europe acknowledged some improvement in custody rates, but raised continuing concerns. In his memorandum following two visits to the UK, the Commissioner called for:

“…the immediate discontinuation of all methods of restraint that aim to inflict deliberate pain on children (among which are physical restraints, forcible strip-searching and solitary confinement). The UK Government must as a matter of urgency ensure that corporal punishment is explicitly prohibited in all custodial settings and is reminded in this respect of its obligations to protect children from all forms of harm and ill-treatment, under Article 19 of the Convention on the Rights of the Child and Article 3 of the ECHR.” (Hammarberg, 2008)

A subsequent independent review (Smallbridge & Williamson, 2008) reinforced the importance of the use of control and restraint procedures as a measure of last resort. Serious case reviews of children who have died in custody indicate that use of these measures is not restricted to exceptional circumstances, as other studies (Mooney, Statham & Storey, 2007) and Home Office YOI Inspectorate reports confirm.

**Child and family well-being**

The last decade has seen a growing body of policy governing the health and social care of vulnerable children and young people and their families. These changes began with the last government’s Every Child Matters policy (HM Government, 2003) and its aim to reduce the differences in outcomes between children who do well and those who do not. Every Child Matters identified five outcomes as essential to well-being in childhood and later life:

- being healthy
- staying safe
- enjoying and achieving
- making a positive contribution
- achieving economic well-being.

Subsequent policy was built on Every Child Matters, reinforcing and echoing key policy themes, including:

- narrowing the gap between the most vulnerable and least vulnerable children (e.g. the CAMHS review (Department for Children, Schools and Families & Department of Health,
improving access to services for all children but especially for those who are most vulnerable, at risk of poor outcomes or perceived by services as hard to reach (CAMHS review, Think Family strategy, Youth Crime Action Plan (Ministry of Justice, 2008), Healthy Children, Safer Communities). These recognise that every child should have access to universal services; those with high risk factors for poor outcomes may also need targeted support, and those with the most complex needs may need specialist input

- acknowledging the views and preferences of families and children on how help is provided and achieving improved outcomes (Every Child Matters, CAMHS review)
- intervening as early as possible to improve outcomes (Healthy Children, Safer Communities, New Horizons and Youth Crime Action Plan)
- investing in families to improve outcomes for children (Healthy Children, Safer Communities, Think Family, New Horizons and Youth Crime Action Plan)
- safeguarding all children and young people (all policies).

Equivalence of access

At the time of writing, the Government’s policy for prison health was built on the principle of ‘equivalence of care’ (HM Prison Service & NHS Executive, 1999). People in custody should receive the same range, quality and standard of health services as the rest of the population, including primary care and referral to specialist outpatient services.

The World Health Organisation, in guidance on promoting the health of young people in custody, also strongly supports the outcome of equivalence recommending that:

“Young people in custody have the right of access to good quality health services (including comprehensive healthcare, preventative services and health promotion) that are broadly equivalent to those offered in the outside community.” (World Health Organisation, 2003)

Improving health outcomes for children was one of the core aims of the previous government’s Every Child Matters policy and strategy and embodied some of the core principles of international legislation relating to the rights of the child. On this basis, health improvement and equivalence became the business of every worker. Equivalence in broader terms:

- recognised that children’s needs should take centre stage and that these needs are better served through strategically coordinated services focused on children’s and families’ well-being, as described in Every Child Matters
- promotes the idea of Comprehensive CAMHS or the ‘plethora of services that have an impact on children’s mental health and psychological well-being because all these services must recognise and optimise the overall contribution they make’ (Department for Children, Schools and Families & Department of Health, 2009).
“Everybody has a responsibility to make sure that children and young people have good mental health and psychological well-being as they grow up. Anyone working directly with children and families needs to ask themselves regularly, ‘What can I do to improve the mental health and well-being of this child?’.”
(Department for Children, Schools and Families & Department of Health, 2009)

**Equivalence of outcomes**

Equivalence of outcomes is also an important consideration. A core principle underpinning recent child and adult policy developments was a commitment to reduce the gap between those achieving the best and the worst outcomes in society.

At an event on Fatherhood, the Deputy Prime Minister, in one of his first speeches after the election in 2010, continued to articulate a commitment to improve the life chances of the most vulnerable children ensuring that all children had the ‘best chance to flourish’. He saw the current Government’s role as empowering parents to support improved outcomes for their children (Clegg, 2010).

Young people who offend have well documented multiple risk factors for poor outcomes and broader health inequalities. Some of the long-term health outcomes documented in later life include an increased risk of major health problems, sexually transmitted disease, injury, tobacco or substance dependence, poorer self-assessed health, mental health problems and disorders such as depression, co-morbid problems, and early pregnancy in females (Macdonald, 2006). Young people with mental health problems also have the highest morbidity and mortality rates of any group of patients (Royal College of Paediatrics and Child Health, 2003).

It has been argued that, rather than thinking about equivalence of services in secure settings with what is provided outside, we should instead be thinking about what needs to happen to promote equivalence of outcomes for those in these settings. A focus on equivalence of outcomes thus requires not the same pattern and level of services but enhanced service provision in order to raise outcomes for those in secure settings to a level with those of children and young people in the wider community (Lines, 2006). Both understandings of equivalence need to be taken into account when planning healthcare provision in secure settings.

What is available in custody has also needed to reflect wider developments in the community to promote the population’s mental health and emotional well-being, including:

- the Every Child Matters agenda for a whole system approach to promoting and supporting the mental health and emotional well-being of young people and for improved
participation of young people in the shaping of service development (National Children’s Bureau, 2008)

- the strength-based approach, with interventions aimed at building resilience and enhancing protective factors for mental health and well-being (World Health Organisation, 2004)

- commissioning best practice principles – in particular, commissioning based on accurate and up-to-date needs assessments (Department of Health, 2007a)

- the Think Family (Social Exclusion Unit, 2007) evidence base and agenda for whole family approaches to address vulnerability, improve psychosocial outcomes and reduce offending behaviour

- the New Horizons public health agenda with its emphasis on early intervention and prevention (Department of Health, 2009b).

### Endeavour day centre

Wetherby YOI has converted an old workshop into a day centre for inmates wanting support with mental health and emotional issues. In this hub, young men receive therapeutic and speech and language interventions, group work focused on mental health awareness and relationships, support with daily living skills (cooking, laundry), diversionary activities to help manage stress, drama therapy and one-to-one education. The day centre is also used as a staged ‘step down’ for young men in the Keppel specialist unit for those with challenging behaviour.

### Mental health services in secure settings

In 2001, Changing the Outlook (Department of Health, 2001) made the case for modernising the provision of mental health support for people in custody settings and heralded the introduction of mental health in-reach teams in the prison service and YOIs, in recognition of the high rates of mental illness in these settings. However, no specific guidance was published on how the teams should operate, resulting in a great deal of variation in models of provision.

In 2007/08, additional money was made available to YOIs by the Department of Health to adapt the in-reach model to the needs of children and young people in their custody. A total of £1.5 million additional funding was given to PCTs in 2007/08 and renewed annually to support the implementation of tier 3 CAMHS in the young people’s secure estate. This funding was part of £4 million allocated for the further development of mental health services, beyond in-reach, in local Prison Service establishments and establishments holding young people under 18 years old.

SCHs and STCs did not receive the extra funding and continued to fund mental health input as before, through their respective contractual arrangements with the Youth Justice Board.
The Department of Health also produced guidance to support commissioners in providing specialist CAMHS within YOIs (Department of Health, 2007a). This guidance stated that:

- children and young people in custody are a particularly vulnerable group with well evidenced complex needs and health inequalities
- children and young people need support that focuses on their broader holistic needs
- children and young people should have access to services in custody that are equivalent to those available in the outside world.
- the support provided should be appropriate for children and young people
- services in custody should take into account the duty to safeguard and promote the welfare, health and emotional well-being of these young people
- children and young people should be consulted on the shape of services
- services should cater for the diverse needs of the young people in the units
- children and young people should experience continuity of care, from the community into custody and back into the community, as well as across transitions relating to age
- what is provided is based on best evidence and on what children say they want
- secure units should involve and encourage contact with families
- practical opportunities should be provided for changing lifestyles and mindsets and developing pro-social relationships. These opportunities should provide a ‘springboard’ back into the community.

The guidance emphasised the pivotal role of PCT and children’s services commissioners in the implementation of a comprehensive CAMHS approach in line with the National Service Framework for Children, Young People and Maternity Services (Department of Health, 2004) and Every Child Matters (HM Government, 2003). A comprehensive CAMHS approach saw children and young people’s mental health and emotional well-being as the responsibility of all workers in the secure estate, not just the responsibility of specialist mental health/health services.

In addition, to improve access to medium secure care for young people with severe and complex mental health difficulties, funding was made available to provide additional beds in these units.
Findings from our study

Baseline provision in YOIs before national funding

Before the introduction of national funding, availability of mental health services for children and young people across the whole secure estate was described as inconsistent and, in the words of one CAMHS manager in a YOI interviewed for this study, “very ad hoc”. Some units reported having previously purchased hours from local psychiatrists and psychologists to address higher tier mental health needs. For example, one YOI had introduced a small team of primary mental health nurses to provide an outreach service to young people on the wings in 2006. These nurses proactively identified mental health difficulties, supported lower threshold difficulties and referred cases on for further assessment. They were also responsible for promoting and supporting emotional well-being in units. However, funding for this initiative had been subsequently withdrawn as new priorities emerged.

There was a general pattern of funding for such initiatives being withdrawn as personnel or commissioning priorities changed. Mental health service development across the entire young people’s secure estate was generally seen as being unsupported by PCT commissioners, who were described as on the whole “indifferent” to the needs of children and young people in custody. Other difficulties described by YOI staff before the availability of national funding included:

- inconsistent identification of mental health difficulties in children in custody
- poor access to specialist assessment even where concerns were identified by frontline staff
- poor linkage and communication between health care services in secure settings and the community at entry into secure settings and at release, and between units when young people were transferred
- health workers not routinely involved in review meetings to discuss the young person’s progress or release plans
- limited support for frontline staff trying to manage young people with complex vulnerabilities in secure settings
- young people with severe behavioural difficulties (and suspected personality disorders) being held in isolation for long periods due to the challenges they presented to staff.

The impact of additional funding for CAMHS work in YOIs

Many of those interviewed in YOIs felt that the introduction of the new in-reach teams had resulted in significant changes both in the awareness of mental health issues and in the delivery of treatment in these settings. One forensic child and adolescent consultant psychiatrist described witnessing “dramatic improvements” in the way mental health was managed in the unit. Staff felt that moderate to severe mental health difficulties were much more likely to be picked up and acted on following the introduction of the mental health in-reach teams. These teams said they were able to identify young people needing very specialist assessments within days of their
arrival and were able to initiate assessments for transfer to medium secure psychiatric units much more quickly than previously. It should be noted, however, that this transfer was very rarely possible within the 14 days recommended for adults in the Bradley review (Department of Health, 2009c).

“At any one time we’re monitoring a quarter of the prison.” (CAMHS manager, YOI)

However, there was a general feeling that, even with the additional funding, YOIs were only scratching the surface of the true extent of mental health and multiple needs. Estimates of the percentage of the YOI population reached by in-reach teams ranged from 10% to 25% at any one time. Those issues least likely to be picked up were the more hidden needs such as speech, language and communication difficulties, learning disabilities and early signs of mental health problems, and issues that could easily be misinterpreted as bad behaviour rather than related to mental health (for example, emerging personality disorders and conduct disorders/problems).

“It’s difficult with adolescents because you’re getting an emerging situation rather than a definitive one and you don’t really want to say that there’s schizophrenia or there’s a personality disorder.” (CAMHS manager, YOI)

Interviewees also pointed out that the funding was not part of the core budget for PCTs and there was, therefore, no guarantee of longer term sustainability, particularly given the current difficult financial climate.

The range of functions provided by these teams was broad, and included:

- training for YOI and specialist staff
- liaison with prison management to advise on clinical governance issues and to resolve conflicts between containment and clinical management
- consultation and joint working with staff to advise on the management of complex behaviours and young people at risk of self-harm or suicide
- assessment of mental health difficulties, learning disabilities and speech, language and communication needs
- referral of young people with severe mental health difficulties for assessment for medium secure psychiatric units
- liaison with community health, children’s services and mental health services to develop resettlement packages in the catchment area
- liaison and joint working with the healthcare and in-patient teams
• liaison and joint work with special educational needs coordinators (SENCOs) and substance misuse workers
• development of behaviour management plans to manage complex behaviours and needs while young people are awaiting transfer to medium secure units and to manage young people with challenging behaviour
• reviewing young people held on the care and control unit
• delivering interventions directly (teams varied in the range of interventions they provided but these generally covered CAMHS tiers 2 to 4)
• liaison with and provision of advice to the courts and youth offending teams (YOTs)
• attending and contributing to sentence planning meetings and reviews
• accompanying transfers to medium secure units to complete handover
• care coordination and CPA within the secure unit as well as attendance at CPA meetings in the community.

Range of interventions being delivered

CAMHS in-reach teams and practitioners described using a ‘toolbox’ of approaches, although again what was available varied, depending on the mix of staff employed and the knowledge base of those designing services.

Interventions included:
• pharmacological management of mental health disorders
• solution focused therapy
• motivational interviewing and brief intervention approaches
• dialectical behaviour therapy
• cognitive behaviour therapy
• behavioural management approaches
• occupational therapy including social and life skill coaching
• music therapy
• drama therapy
• arousal control techniques
• coaching to improve communication skills (for staff managing young people and for young people with speech, language and communication needs)
• Snoezelen rooms
• post-traumatic stress disorder and survivor counselling
• bereavement counselling.

Supervision and consultation

Frontline secure care staff talked of the benefits of being able to consult with mental health teams promptly when they had concerns about young people on their units. In-reach workers had also
tried to increase mental health awareness among a range of other stakeholders in the YOIs (for example, governors, healthcare staff, education, segregation staff, etc.). Most in-reach teams delivered training on a regular basis to other secure care staff to improve identification, referral, management and support of young people with mental health needs.

**Joint working**

There was evidence of in-reach teams working well with frontline secure care staff to manage very complex and challenging behaviours. For example, in Hindley YOI Willow Unit secure care staff and mental health teams were jointly managing young people with the most complex mental health and behavioural problems. Staff described how they tried to work with and manage the attachment difficulties that they identified as underpinning the extreme behavioural problems of these young men. They had been trained by the mental health team to respond in ways that both supported young people’s recovery and encouraged positive and more consistent attachments with adults.

In Vinney Green SCH, preventative de-escalation training is provided for staff:

- to make frontline staff more aware of the common triggers for young people’s frustration
- to promote skills in reducing the risks of setting off such triggers
- to make staff (and colleagues) more aware of their own and team members’ triggers so that they knew when to step away and let colleagues take over.

In one of the YOIs for young women, daily monitoring of all young people and consultation with staff was reported to have changed staff attitudes to the use of the care and separation unit; staff now saw it as a failure if young people remained for over a month in the unit. Previously stays of over a month were said to be common and in a few high profile cases young women with extreme mental health and behavioural difficulties were kept in these settings for most of their time in the unit.

Many mental health teams encouraged a shared approach to managing young people’s mental health and well-being, rather than all mental health concerns being referred to them. One worker in a YOI described the CAMHS team as an ‘outreach team’ in that one of its main functions was empowering and advising frontline workers to support the management of young people in their units. Joint working was observed on a number of occasions during visits; where such joint working was least evident, in-reach teams tended to be struggling to do anything more than crisis intervention.
Managing challenging behaviour in Hindley YOI

Hindley YOI has dispensed with both the healthcare in-patient unit (leaving just an outpatient resource) and its segregation unit, establishing in its place the Willow Unit. This new unit is designed as an intensive support setting for young people who:

- persistently refuse to engage with the residential regime
- have committed extreme acts of violence in custody.

A new regime has been established and staff are trained and supervised by mental health teams in understanding and working with attachment disorders and adolescent development.

Every young person has an individual management plan with short term behavioural goals that are set and reviewed at weekly meetings attended by the young person and secure care staff, mental health staff and education, case workers (when possible) and a governor. The young men also receive therapeutic interventions from mental health specialists as well as support from secure care staff. There is a system in place for the staged reintegration of the young people from the unit back to the main YOI.

Many of the young people in the unit have long histories of serious behavioural problems, often resulting in disciplinary moves between prisons. Many have experienced severe disruptions in early life, including histories of multiple placement breakdowns in foster care, early offending and previous secure placements, all resulting in serious problems with emotional regulation arising from disrupted attachments and traumatic life events.

Case example
One young man with a history of prolific and serious violent and gang-related offending was transferred to the intensive support area of the Willow Unit after a series of assaults on staff in a number of units. He had a long history of refusing to engage with the secure regimes. Initially he refused to engage with the regime at the Willow Unit or comply with staff requests. However, the secure care officers and the therapists continued to try to engage him, with eventual success. He became more compliant, started to communicate with officers and became more trusting and respectful. His violent behaviour towards staff also stopped. He began attending education and other activities, and started making good progress. Some social/family issues were also identified and he was given therapeutic support (although promoting family contact was difficult as his family did not live nearby). Subsequently he was transferred to a prison closer to his family where he engaged well with the regime, established reasonable relationships with officers and had no further discipline problems.
Liaison with primary care

Most of the specialist CAMHS in-reach teams in YOIs said they wanted to improve liaison between primary care and specialist mental health teams and the quality of primary mental health care in secure settings. Some teams said that they were no longer thinking in terms of primary and specialist care but preferred to see both as elements of an integrated mental health team.

We found collaborative working was better developed where:

- in-reach teams were co-located with healthcare teams
- there was good liaison and joint working with the healthcare manager
- there was a joint healthcare/in-reach allocation and case management meeting
- primary care link workers had been introduced to provide support, supervision and consultation for healthcare staff.

By the end of fieldwork for this study, there were signs that YOI in-reach teams and commissioners were trying hard to overcome the gap between primary and mental healthcare by recruiting primary mental health link workers into healthcare teams as a ‘go-between’. These posts were funded through mental health in-reach money. In one instance, the introduction of this role had resulted in a turnaround in relationships between healthcare and CAMHS teams during the lifespan of this study.

Care and control

CAMHS in-reach teams had made efforts to understand the culture of YOIs, integrate themselves with the regimes, cope with the challenges posed by a setting driven by different values and gain acceptance from a range of staff and stakeholders. Many mental health practitioners talked about the tension between their values and those of the secure care setting and of their need to be both “terrier-like” and constantly creative to ensure that clinical standards of care were met. One consultant psychologist said that liaison to resolve these tensions between care and control occupied “about a third” of his time and energy.

“The Governor had the prison to protect, I had my patient to protect.” (CAMHS manager, YOI)

“I don’t know how to put it...If I’m struggling a bit and I want to chat to them they don’t chat to you about stuff like that. They just chat about criminals and stuff.”
(Male aged 16 of his YOT worker)

This theme was echoed by other clinical managers interviewed in YOIs. Staff talked of the importance of having clear governance and good quality clinical management and supervision. One team without a clinical manager described struggling to influence the YOI regime and feeling
overwhelmed. They felt they “coasted”, doing what they could to meet need but without really having an impact on practices in the units, which undermined both their work and the young people’s well-being. Such tensions tended to come up more frequently in interviews with staff in ‘split sites’ that housed both young adults aged 18+ and young people under 18 years. These often seemed more ‘adult’ in their orientation and more dominated by a culture of order and control.

Wetherby YOI has introduced a primary care liaison role into their CAMHS team, to provide training, consultation and monthly supervision for healthcare nurses. This system of linkage has built up knowledge and skills in mental health and emotional well-being, is developing practice and facilitates provision of lower level mental health support.

**Communication and learning needs**

CAMHS in-reach staff were observed engaging well with young people during visits and often used creative approaches to adapt interventions and working practices to the learning and communication and other complex needs of this young population. In one YOI inpatient setting (which contained some young people with the most complex difficulties, whose management posed considerable challenges), the CAMHS team supported healthcare workers. Many of these young men had emerging personality disorders and developmental or learning disabilities that made them impulsive and impeded their ability to think ahead and understand the consequences of their actions. They struggled to cope with the standard regime, which used a system of rewards for good behaviour. The CAMHS manager worked with staff and the young person to design and implement behaviour management plans that included shorter term reward systems with more clearly explained standards of expected behaviour. These plans were reviewed with staff and progress was discussed with the young person during the day, when the plans were amended if necessary and then reviewed again each evening. Many of these young men were awaiting transfer to medium secure psychiatric units. YOI staff welcomed this joint working approach, and the consultation between mental health and frontline healthcare and secure care teams.

“We’re not commissioned to look after learning disability but then no one is. We pick it up in here because it is personality driven. I was a learning disability nurse and an RMN second and so was my deputy...I think that every in-reach team should have a learning disability nurse in it, if you look at the figures of the proportion of units that have people with learning disability teams in.” (CAMHS practitioner, YOI)
Another YOI had introduced drama therapists to deliver interventions in a way that staff felt would be better suited to the communication and learning needs of the young people in their care. In another YOT an occupational therapist had been contracted in specifically to support young people with learning disabilities and speech, language and communication needs. At the time of the study fieldwork, there was a high awareness of the extent of speech, language and communication needs and learning disabilities but responses tended to be ad hoc rather than strategically commissioned. However, during the course of the study, three YOIs took on speech therapists to work with young people and staff to improve the quality of interactions between them (although funding for these posts was often only short-term).

Teams often ended up supporting young people with learning disabilities because they happened, by chance, to have a member of staff who had previous experience in this field. Some teams said that they had not been commissioned to provide learning disability services, although most had taken on this work. By the end of the study period there were some signs that commissioners and providers were beginning actively to recruit staff with these skills, although once again funding was often not guaranteed.
Meeting mental health needs across the young people’s secure estate

Despite the very definite achievements of these CAMHS in-reach teams in YOIs, a number of challenges continued to undermine the provision of effective support for the emotional well-being and mental health needs of the young people. These included:

- barriers to information sharing as young people move in and out of secure settings
- the short time that workers have to engage with young people and support their progress
- difficulties on release, when there can be a rapid reverse in any progress made in secure settings if young people receive no follow-up support.

These and other challenges are described in this section.

**Inconsistency of service provision**

An unintended side effect of the discrete funding stream for YOIs to develop specialist mental health services has been an increased inconsistency in mental health resources across the whole young people’s secure estate. Although some inconsistency is to be expected (particularly as SCHs hold younger children and in smaller numbers and staff have access to different packages of training), we found this variation was not just related to size. The variations in mental health provision are more the result of ad hoc purchasing decisions, lack of any overarching clinical governance framework, inconsistent commissioning expertise in settings with no in-house mental health teams and variable responses from local commissioners to providing services in STCs and SCHs.

The availability of funding for mental health services in YOIs had encouraged commissioners to think through what such provision in these settings might look like. However, the same attention was not given to the development and sustainability of mental health services in SCHs and STCs, where commissioning was still dependent on individually negotiated contracts and relied either on commissioners’ knowledge and interest in vulnerable young people or on the skills of the directors of SCHs. Some of these said that they felt out of their depth because they had no specific expertise in the health and mental health commissioning process and systems. Many interviewees (practitioners in SCHs and managers) talked about the lack of awareness of clinical governance in these settings to support developments and service provision. Furthermore, SCHs and STCs often held young people from outside their PCT boundaries, leading to disagreements about who held commissioning responsibility for health and mental health needs identified by the staff.

Thus, although SCHs and STCs were aware of the need to improve the quality of mental health and emotional well-being services for children and young people in their care (in part due to what they
saw happening in the YOIs), their ability to negotiate these changes was limited by the same factors that previously hampered higher quality provision.

Some regions had attempted to address this variability by establishing a regional service to cover all the secure units in their area, usually drawing on community forensic CAMHS. For example, one forensic community CAMHS team provided specialist sessional work for young people in a YOI, an STC and an SCH.

In another region, commissioners were attempting to negotiate a service that would provide mental health resources, expertise and governance mechanisms for a YOI, a small unit for females under the age of 18 and two SCHs. However, there appeared to be some resistance to this development and the goal of ‘whole region commissioning’ had only been partially achieved by mid 2009, after many years of negotiations.

In the Thames Valley and Sheffield areas, community forensic services provided a service both for secure settings and for young people in local youth justice teams in the local community. These services:

- provided hands-on consultancy to health practitioners in one local YOT
- contributed to court reports and on occasions provided proactive advice to courts
- provided specialist CAMHS in-reach services and consultation to secure settings (to a YOI and to a local SCH). In one case the psychiatrist leading the community forensic mental health service chaired the weekly healthcare case review meeting in the YOI
- delivered training for sentencers, generic CAMHS and YOT teams about the mental health needs of young people in the youth justice system.

Variation in provision between units

We found significant variation in levels of mental health provision between similar types of units, and even between YOIs who had received the additional specialist funding to support mental health service development. These included variations in the ratio of mental health staff to young people and in the models and compositions of mental health teams.

These differences could not be explained by the number of young people in the unit, the function of the unit, the catchment area, or whether it was a split site (with young people aged up to 18 years and 18+) or not. For example, one split site YOI had a comprehensive multidisciplinary team including sessional psychiatric and psychologist time, child and adolescent mental health nurses, an occupational therapist, a social worker and a learning disability nurse focusing primarily on secondary care. Another similar split site had one CPN fulfilling a secondary care role. Yet another had two in-house CPNs who were backed up by sessional input from a local forensic mental health community service. It was difficult for teams and for commissioners to compare effectiveness as systems for monitoring outcomes and effectiveness were not standardised or well developed.
Similar variations were found in the provision of mental health support in secure children’s homes and secure training centres. One SCH had a consultant psychologist and an assistant psychologist in-house. Another had established an arrangement with a community based mental health team to have a base in the unit. Another had brought in a drama therapist and had subsequently negotiated CAMHS time from the PCT. One STC reported a constant struggle with PCT commissioners to negotiate sustainable mental health expertise, while another had employed an in-house psychologist and bought in psychiatric sessional time from a local early intervention in psychosis team. Another brought in services from a local community forensic team. Inspectorate reports indicated that the quality of provision across the STC estate varied considerably from area to area.

“You can’t influence unless you’re inside.” (CAMHS manager, YOI)

Staff in all settings reported gaps in service provision that were not being addressed through any systematic commissioning process. For example, workers in secure settings frequently said they identified young people with learning disability and speech, language and communication problems. However, either teams had no skills in these fields, or they happened by chance to have a member of staff who had previous experience of this work. A number of units had tried to adapt the services they provided to meet the learning disability needs of young people in secure settings. For example:

- Wetherby YOI had employed two drama therapists. Staff believed that drama therapy was more effective for young people with limited cognitive abilities (there is currently no research evidence to support this)
- Castington YOI had negotiated regular sessional input from Northumberland child and adolescent community learning disabilities team (CALDT) for a clinical psychologist, a senior community nurse and a community nurse to work with young people with learning disability and speech, language and communication needs
- Wetherby and Hindley YOIs had employed in-house speech and language therapists
- Stoke Heath YOI had contracted sessions from an occupational therapist to focus specifically on the needs of young people with learning disability, autistic spectrum disorder and ADHD.

Needs assessments

“A joint strategic needs assessment, carried out by PCTs and local authorities, provides a rich picture of the current and future needs of their populations. This results in comprehensive and better managed care.” (Department of Health, 2007b)
Staff and commissioners reported that needs assessments of populations in secure settings had been completed during the study period. In two units, an analysis of needs had resulted in changes in the way the service was provided. In one YOI, in the south west, services were completely re-commissioned as part of a tendering process for all CAMHS and children’s health services. This was said to have resulted in clearer targets for activity and outcomes. In another YOI, the commissioner decided to re-commission health, mental health and pharmacological services in response to evidence from practitioners and needs assessments that they were not young person-focused or fit for purpose.

However, some staff criticised the needs assessment process. There were concerns that needs assessment tools in common use were not always appropriate for this population. Staff wanted greater clarity as to the content of a comprehensive assessment for children with complex needs.

**Primary care and health promotion**

A significant gap in provision identified by interviewees was good quality, primary mental health care – specifically, health promotion and identification of young people needing further assessment and intervention for health needs.

Most mental health workers in secure units agreed that they were better at reacting to clear cut needs and had limited capacity for early identification and preventive work (i.e. looking out for early signs of mental illness) or identifying and addressing risk factors for poor mental health. We were also told about young people who continued to ‘slip between service cracks’ because of disagreements between mental health teams and community YOTs about whether a young person’s behaviour was rooted in mental health difficulties or a response to other factors.

The previous government’s New Horizons strategy for mental health (Department of Health, 2009b) highlights the clinical and economic case for targeted, systematic preventative activity to improve mental health and well-being through:

- early identification
- targeting at risk groups
- intervening early to improve resilience, enhance protective factors and promote good mental health in the population as a whole.

It also reinforced the links between improvements in mental health and general health and well-being.

Primary healthcare workers have an important potential role in meeting mental health needs in custody settings. We know that young people in the youth justice system tend to seek help from health services only in times of crisis, and that this is most likely to occur through their contact with other agencies (Macdonald, 2006). We also know that young people presenting in primary
care settings often fail to report or hold back from talking about the health issues that are really worrying them (such as mental health problems and substance use) (Klein, 2002). They are also more likely to seek help from their GP for physical health problems than for health risk behaviours or mental health problems (Marcell & Halpern-Felsher, 2005). This same study also found that young people tend to lack knowledge of available health services. It recommended training for GPs to help them engage better with young people and capitalise on opportunities for health promotion with this age group.

We also know that what young people want from health services are friendly staff of both sexes with personal experience of the issues with which the young person is struggling; professional expertise; confidentiality; flexible hours; and (for some) drop-in facilities rather than formal appointment systems (Hewitt, Roose & John, 2004).

Some mental health practitioners in the secure settings visited in the course of this study recognised that young people are less likely to approach mental health staff because of the stigma commonly attached to mental ill health. However, some primary care nurses talked generally of feeling unconfident about how they might help support young people with mental health difficulties in their secure units. They also talked of feeling, at times, overwhelmed by the extent and range of other health needs and the deadlines for assessments and other routine procedures that governed their work. There was a particular problem in relation to the competencies of primary care and general healthcare staff in terms of:

- promoting mental health
- identifying risk factors and early flags for poor mental health
- identifying moderate mental health problems
- supporting lower threshold mental health difficulties through IAPT approaches.

These findings echo those of other studies showing that GPs tend to have poor knowledge of the health, developmental and service issues needed to provide a high quality, effective and acceptable service to young people, and in particular the specific health issues affecting vulnerable and disadvantaged populations such as young people in secure settings (Macdonald, 2006).

“GPs should receive specific training for delivering primary mental healthcare in prisons, and should take responsibility for the clinical management of primary mental healthcare.” (Her Majesty’s Inspectorate of Prisons, 2007)

GP services in secure settings have traditionally been commissioned in different ways to those in the community, and service development has not been supported by the same quality outcomes framework and related incentives for development. Mental health practitioners in our study reported varying levels of knowledge among GPs about child and adolescent mental health issues,
risk factors for poor mental health outcomes, speech, language and communication needs, early signs of mental distress, and the management of common mental health problems.

Given the low rates of unprompted disclosure by young people in interactions with primary care staff, Klein (2002) recommends use of a comprehensive health checklist to ensure the best possible chance of identifying problems that the young person is worried about but nervous of disclosing. Other ways to encourage young people to disclose health concerns include privacy and confidentiality (Klein, 2002) and workers who are “competent, warm, compassionate, unpretentious [and] non-judgmental” (Ginsburg et al, 1995).

“In terms of accessing social support...studies have found adolescents to be highly selective about who they ask for support. Indeed, support from professionals is rarely sought even when adolescents are extremely distressed. Adolescents most commonly turn to peers or family.” (Whitaker et al, 1990)

Although GPs and primary healthcare workers routinely screen for mental health difficulties at the point of entry into the secure unit, the scope of screening tools is variable and often limited. Many of the units we visited used the Grubin screening tool (Gavin, Parson & Grubin, 2003), which focuses on immediate risks or signs of severe mental health problems. Screening tools and staff competencies were not geared towards spotting complex risk factors for poor mental health outcomes such as school academic failure, learning disabilities, communication needs, experiences of multiple losses, experiences of trauma and so forth. Screening tools also rely on self-disclosure and inspectorate reports suggest this is disadvantageous for some BME groups and for young men, who do not want to be seen as vulnerable. There was a risk of lower level needs and risk factors being missed.

Medway STC was collaborating with Kids’ Company in London to develop a training package for secure care staff to increase awareness of how young people’s brains, well-being and behaviour are compromised and affected by trauma, unskilled parenting and multiple disadvantages.

Primary care staff was not always trained in early identification of psychosis and depression (Garber, 2009), even though prevalence data suggest that young people in custody are likely to be a key high-risk group. A more holistic health triage tool designed to address substance use, mental health, health, speech, language and communication needs and learning disability, as well as risk/protective factors, was being piloted during the course of this study but was found to have limited sensitivity to mental health issues. This lack of skills and competence at the primary care
stage is significant as the initial health check and screening presents an important first opportunity for staff to identify non-urgent concerns and any needs for further assessment and follow up.

Some units were continuing to use the newer holistic health triage tool at the point of entry into the unit and one STC had adapted it to meet their particular needs. A number of workers talked about the importance of not conducting the assessments in one session as children and young people could find it overwhelming. However, unit targets and sentence planning deadlines could make it difficult to collect the information within a more child-friendly timescale.

One region (Hindley YOI) was piloting a locally developed Health Information Sharing Tool (HIST) to collect information about young people’s health needs. The record is started by the health practitioners in the YOT, follows the young person into the secure setting, where it is added to by secure care staff, and is passed back to the YOT health practitioner and GP when the young person is released.

**Health education**
Healthcare workers in secure settings sometimes contributed, along with other multidisciplinary staff, to Personal Social Health and Economic education (PSHE) sessions for young people on health, mental health and substance misuse. A recent review has recommended (Galahad SMS Ltd, 2009) that PSHE content be reviewed throughout the young people’s secure estate to iron out the wide variations in what is provided and to produce a curriculum that is better designed to target and engage higher risk young people. This review found the quality of PSHE in relation to substance misuse in particular compared unfavourably with some of the more dynamic and interactive work observed in many schools in the community.

**Improving access to psychological therapies**
A recent HM Inspector of Prisons review (2007) noted that provision for common mental health and emotional problems in prisons had not benefited from initiatives such as the Improving Access to Psychological Therapies (IAPT) programme to boost access to talking treatments in primary care settings (Department of Health, 2008a).

The IAPT programme introduces a ‘stepped care’ approach. This means mild to moderate mental health problems such as depression are self-managed with support from GPs and primary health care staff. If the person does not respond or their difficulties become more severe they were referred on to specialist mental health services such as tier 3 CAMHS. We found that GPs and primary nursing staff were mostly not delivering any psychological interventions in the YOIs, STCs or SCHs we visited. Only four units had primary healthcare nurses or graduate workers who were delivering primary mental health interventions as part of an integrated healthcare and specialist mental healthcare team.
“The first time I tried cocaine I was at my brother’s wake. I just got given it in the pub and it sort of made me happy...After, if anyone mentioned my brother’s death, I would just snap, but if I was on the drugs and someone mentioned my brother I could talk about him; but the next morning if anyone mentioned him, again I would go back to the usual. I can talk about him more easily now because of the counselling. That’s just helped me to talk about him more and I can remember him now without having to have drugs.” (Male aged 17, YOI)

Comprehensive CAMHS

The National Service Framework for Children, Young People and Maternity Services (Department of Health, 2004) highlighted the importance of developing comprehensive CAMHS across the NHS. Children and young people’s mental health is seen as being not just the responsibility of clinical mental health practitioners but ‘everyone’s business’, and thus reliant on collaboration and partnership working across all agencies, settings and services in contact with children and young people. There was an expectation that comprehensive CAMHS would be established in all areas by 2006 (Department of Health, 2002).

Converting the four-tiered CAMHS framework to secure settings

**Tier 1:** Services provided by practitioners working in universal services (such as GPs, healthcare nurses, secure care staff, teachers, chaplaincy, physical education staff, etc.), who are not necessarily mental health specialists. They listen and support, provide positive attachments and pro-social modelling, build resilience, promote mental health, aid early detection of problems and refer to more specialist services. Clinical staff offer general advice and evidence based brief interventions and treatment for less severe problems.

**Tier 2:** Services provided by specialists working in primary care settings (such as primary mental health workers, chaplaincy staff trained in bereavement counseling and counsellors). They offer consultation to families and other practitioners, ‘wing based’ outreach to identify severe/complex needs, and assessments and training to practitioners at Tier 1 to support service delivery.

**Tier 3:** CAMHS in-reach services, usually working as part of a multidisciplinary team, offering more specialist evidence based interventions for those with more severe, complex and persistent needs and disorders.

**Tier 4:** Services for children and young people with the most serious problems. Staff working in inpatient units to facilitate the assessment, management and transfer of young people to medium psychiatric secure settings. Forensic support for young people with complex needs and consultation for staff.
Recent policy and guidance has also emphasised:

- the importance of not just reacting to mental ill health in young people but preventing it through building resilience (particularly in those with high risk factors for poor outcomes) (Department of Health, 2009b; Youth Justice Board, 2004)
- early identification and intervention (Edwards & McGorry, 2002)
- recognising the interplay between poor educational performance, conduct problems, poor mental health and poor physical health outcomes (Department of Health, 2009a, 2009b).

The 4 tier CAMHS model provides the framework for commissioning, structuring and delivering comprehensive CAMHS. The key elements include:

- effective commissioning of services to meet all levels of need and the allocation of resources based on local multi-agency needs assessments
- making mental health and emotional well-being everyone’s business through multi-agency ownership, strategic planning, joint commissioning, joint care planning, joint training and the establishment of consultation processes where additional expertise is needed to support complex needs
- developing a range of services to meet the specific and diverse needs of all young people, particularly in relation to engagement and access to services
- 24 hour access to meet urgent needs
- a balance of services to meet all levels of need, staffed by a knowledgeable, trained and supported workforce who are confident in delivering lower level support and interventions but know when to refer on for specialist help
- a full range of specialist treatments
- managers with both clinical knowledge and executive authority (dual management)
- smooth transitions
- provision of services with clear clinical governance.

Equivalence of service provision should mean that the comprehensive CAMHS approach is replicated in the secure estate for children and young people (see box for an illustration of how this might translate in a secure setting).

To establish effective, comprehensive CAMHS, universal services (i.e. those in day-to-day contact with young people) need to have a good understanding of:

- the core components of young people’s emotional well-being, mental health and resilience
- what behaviours might be indicative of early signs of poor mental health and the importance of early intervention
- the tell tale ‘flags’ for learning disabilities and for other hidden disabilities that may be hampering their progress
• who to refer on to and the role they can play in the day-to-day support of these young people.

We found in our study that the concept of comprehensive CAMHS was generally at an early stage of development in secure settings and the models of service provision did not always reflect developments in best practice in the community, which have been firmly focused on improving young people’s access to services and encouraging their participation in shaping and designing services and support.

Although some frontline secure care staff understood their responsibility to support young people’s mental health and emotional well-being (as well as to ensure their safe containment), we noted considerable variation in the active encouragement of secure care staff to balance containment, control and maintaining good order with caring functions such as listening, engaging, providing support, and acting as pro-social models.

In smaller SChs, frontline staff had generally developed closer, more informal and supportive relationships with the children and young people. They ate their meals and chatted informally with the children and young people and saw it as their role to listen and proactively engage with them, as well as maintain a secure regime. For this reason, and because they were small units, key workers could often develop a more in-depth knowledge of the young people in their care.

One manager in an SCh said that the changes and training brought in after the Warner report recommendations (Warner Committee, 1992) had changed local authority practice in the recruitment and training of staff so that the culture of such units, on the whole, was more child and young person focused, rather than being purely about containment and control.

However, these units in many cases struggled to commission effective care for children and young people with more complex mental health/learning disability or speech and communication needs. They also struggled to obtain specialist advice and input to help them manage these needs.

Practice in STCs, which were larger, could vary. Because of their size, there were more pressures to function as institutions rather than group homes. However, staff in some STCs still ate with young people and frontline key workers demonstrated a good knowledge of the young people in their charge.

In YOIs, staff could be managing up to 400 plus young people. They were often better able to access tier-3 and sometimes tier-4 CAMHS, thanks to the availability of additional funding. However, due to the size of the units and the number of children held in custody, relationships with staff could be more distant and less therapeutic. The Youth Justice Board has developed the Juvenile Staff Awareness Programme (JASP) for all secure care officers working for the prison service with children and young people (Youth Justice Board, online) to ensure that secure care officers in YOIs have more child-centred training, but this training was felt by mental health teams...
to be generally inadequate. In particular it was felt not to address key issues of child and adolescent development, attachment and experiences of maltreatment and their link to behavioural and emotional problems, the extent of the mental health, learning and communication challenges faced by children and young people in the youth justice system, and how secure care staff might contribute to young people’s emotional well-being in a manner consistent with a comprehensive CAMHS approach. During the latter stages of this audit, amendments had been made to JASP training to include speech, language and communication needs, as well as links between behavioural problems and mental health difficulties.

“This YOI deals with 120 sentencing courts. The catchment area of this prison goes from all the way down in Cornwall up to Birmingham, across to South Wales, to Carmarthen, to Reading to Southampton and Portsmouth. YOIs have a lot bigger catchment area than the adult secure estate.” (CAMHS manager, YOI)

Many in-reach teams and mental health workers said that they delivered regular awareness raising training to generic staff on mental health and emotional well-being, both formally and informally. In Wetherby YOI, they felt this systematic training had created much more of a comprehensive CAMHS approach to managing young people’s mental health, making it ‘everybody’s business’.

**Wetherby YOI: training strategy for mental health**

The team in Wetherby considers training and supervision to be a positive tool to empower all staff to deal with young people safely and confidently; it also contributes to keeping the staff safe and healthy.

*Formal training*

NHS Leeds community healthcare (CAMHS) deliver a rolling training package to promote mental health for children in a secure setting, which is a 2 day course over the 3 school terms. The training is split into modules so that staff in the YOI can catch up if they miss any module.

The content includes a focus on:

- risk and resilience in young people
- differentiating between typical and atypical developmental tasks of adolescence
- attachment and the containment of behaviour arising from attachment difficulties
- communication and active listening
- intervention and staff resilience
- what CAMHS do
• working together and examples of real practice.

Training is delivered to all staff, and feedback from staff has been positive with many feeling that it should be part of their initial training whilst at college.

Supervision

The CAMHS team also offers one to one supervision on a monthly basis to the healthcare team to support primary mental health skills. This supervision aims to offer an opportunity and a safe space for reflective practice.

Supervision is organized around shifts on a monthly basis to frontline staff on the Keppel Unit. This unit caters for young people with high levels of behavioural and emotional difficulties. This development is a new experience for frontline staff and in order to maximize engagement, has been offered flexibly. Some workers prefer scheduled and systematic one-to-one supervision; others use the mental health lead on a consultation basis and more informally to deal with difficult situations as they occur. The expertise of the mental health practitioner on this unit is also used following major or challenging incidents.

A review is currently taking place of the training strategy with the hope that the approach can be adopted more widely in the unit, particularly in the care and separation unit.

The aim of the supervision is to offer support to the staff and provide ongoing professional development and education through reflective practice.

It should be noted that variations in culture and practice were not just the product of size or type of unit but appeared also to be affected by culture, leadership and training. For example, split site YOIs (where staff could be more influenced by young adult and adult prison service cultures) were generally noted to be less child-centred. Differences were observed between two female units of very similar size. One had a regimented and structured approach to managing the young women; the other was much more relaxed and therapeutic. Staff in this latter unit focused on engagement, pro-social modeling, and listening and talking to the young women as well as controlling their behaviour.

“Women had the highest levels of emotional and psychological distress, often related to past abuse and exacerbated by distance from home and children. Primary mental healthcare, relationship support, and survival counselling are particularly important to meet their needs.” (Her Majesty’s Inspector of Prisons, 2007)
Integrated and collaborative working

A varied picture emerged of the extent to which mental health work in the secure estate was integrated and joined up across different disciplines. On the one hand, there were more systems in place pulling together the information each discipline collected on young people’s progress and coordinating activity through sentence planning systems. However, there was still evidence of the collection of duplicate information through assessments and of inconsistent attendance at key meetings in larger units by some disciplines (mental health and healthcare workers in a number of units reported that they rarely attended review meetings).

“Because we’re based in healthcare, there’s informal discussion over a cup of tea. Nothing waits here. I know before I’ve got my coat off if someone needs seeing.” (CAMHS manager)

Coordination was easier in smaller SCHs where young people were well known and there were often weekly meetings for all staff to discuss residents. However, even in smaller SCHs children were still reported to have had to undergo assessments by several different specialists, rather than having their needs assessed and their care coordinated by a lead professional, as recommended in Every Child Matters (Children’s Workforce Development Council, 2009). As a result young people sometimes had to repeat their stories again and again. Also, specialists visited the SCHs at different times, making it difficult to get all those concerned together to contribute to systematic review processes.

In larger YOIs there was often a range of professionals coming in to discuss young people’s needs linked to their mental health and emotional well-being. For example, social workers, substance misuse workers, mental health workers, Connexions workers, SENCOs, psychologists, YOT workers and the multi-faith team/chaplaincy could all be contributing to supporting young people’s emotional well-being.

Many mental health teams/workers talked of struggling to work with substance misuse teams/workers, in spite of the well documented associations between mental health and substance use (Galahad SMS Ltd, 2009). Other mental health teams highlighted poor links with education services, who would hold important information about a young person’s learning and developmental difficulties. Sometimes this fragmentation was the result of workers being recruited through specific pots of money from different sources and working to different priorities and targets. Other factors included traditional ways of working, physical distance and separation by numerous locked doors, departmental rivalries and competition for rooms and time with the young person. One YOI mental health in-reach team was based in a building outside the custodial unit, making it difficult to communicate with the substance misuse and other staff inside the walls. In another STC, a substance misuse manager who had once shared a corridor with social workers,
psychologists and health workers found it much harder to maintain collaborative working after being moved to a different location.

On the whole, therefore, this study found that support for young people’s mental health and emotional well-being still tended to be addressed in a separate silo, using separate assessment processes and fragmented interventions, with no recognition that substance misuse or mental health or educational difficulties were likely to be inter-related and required a coordinated, integrated approach with other teams within the unit.

“I had a bereavement. My brother had passed away so I couldn’t actually concentrate in school but coming into prison has given me a chance to do my GCSEs again.” (Male aged 17, YOI)

In the community, as part of Every Child Matters and comprehensive CAMHS developments, there is a move to place the child’s and family’s needs centre stage. Systems are developing to support complex needs that aim to minimise the number of professionals and assessments involved in each child and family’s care (e.g. the team around the child, the lead professional, the integrated team approach). For example, in Telford and Wrekin multidisciplinary co-located teams have been established in the community to deal swiftly with all referrals for support for children and families in difficulty or for those identified at high risk of poor outcomes.

Likewise, the Anna Freud Centre, recognising that young people with complex needs can have several professionals and services involved in their lives, is piloting and evaluating an integrated treatment approach in which frontline workers deliver wraparound interventions, backed by expert outreach consultation from psychiatrists and psychologists, who also offer emergency mobile phone consultation and advice.

By the end of this study, there was some evidence that regular supervision by CAMHS teams was improving interactions between frontline and non-specialist staff and young people and changing the culture and ownership of responsibility for young people’s well-being within some YOIs.
Promoting integrated working in a large YOI

Ashfield YOI has attempted to cultivate a comprehensive CAMHS approach and manage fragmentation between services more effectively in relation to mental health and emotional well-being by creating a ‘virtual’ multidisciplinary team focusing on mental health and emotional well-being. A weekly intake and case management meeting provides a single point of referral and is chaired by the CAMHS manager. This is attended by:

- primary healthcare workers
- secure care staff representatives
- substance misuse link workers
- mental health specialists
- a psychology link worker
- SENCO workers
- learning support worker
- the chaplaincy representative (who provides bereavement support).

All referrals to the virtual CAMHS team are considered and decisions are made as to who is best placed to complete an initial screening and work with the young person. Each case currently open is also briefly reviewed each week.

This approach seems to have a number of benefits. There is less scope for duplication of work; it allows for a broader focus on the young person’s well-being through bringing together work on learning difficulties and substance misuse with mental health work; the person already engaged with the young person can take forward work focused on their well-being (the ‘lead professional’ approach), supported if necessary by specialist workers or mental health or substance misuse workers. It also raises awareness among all stakeholders and disciplines of the specific part they play in supporting the young person’s mental health and allows link staff to cascade knowledge and influence their team cultures.

Although this meeting does not include some workers who might have a contribution to make to supporting mental health in the unit (such as YOT workers, social workers and physical education staff), it has helped to break down barriers between departments in relation to mental health issues and has resulted in a high degree of integration with primary healthcare in comparison with most other units.
The Keppel Unit

The Keppel Unit in Wetherby YOI is a 48-bed national resource for young men with high levels of vulnerability who pose significant challenges in the secure system as a result of their behaviour.

Frontline staff had volunteered to work on the unit and had received enhanced training. They received regular supervision from the mental health nurse on the unit to support them in their therapeutic and behaviour management work with the young men.

Staff working on this smaller unit talked positively about the regime and about their central role in modelling pro-social attachments and behaviours. As well as receiving therapeutic interventions, the young men learn social skills with unit staff leading cooking sessions. Relationships between the young men and staff seemed relaxed.

Prioritising safeguarding

There are still a number of systems and practices in the young people’s secure estate that require ongoing review in relation to the safeguarding of children and young people (see, for example, Smallbridge & Williamson, 2008). Concerns have also been raised about the withdrawal of social work posts in YOIs – a role that is widely seen to have a primary focus on safeguarding issues in these settings (Puffet, 2010). Other common practices such as the placement of children and young people in units far from their families, the release of children and young people to bed and breakfast accommodation, the rapid movement or ‘churn’ of young people around the custodial system and the numbers of young people in the system with unidentified learning disabilities and speech, language and communication needs all raise questions about the level and quality of safeguarding. In the case of young people with learning disabilities, secure settings that do not have adequate systems for identifying and making special provision for them may be risking non-compliance with disability discrimination legislation.

Safer Regimes meeting – Hindley YOI

Hindley YOI holds a weekly multidisciplinary ‘safer regimes’ meeting to talk through any young person about whom staff have concerns. These concerns may be about mental health and emotional well-being, behavioural difficulties, complex needs or vulnerability. The aim of the meeting is to pull together a clear picture of how the young person is progressing, what approaches are supporting steps forward and to develop and review an action plan to which all staff then commit. All disciplines contribute actively to this forum. During the study visits, frontline secure care units’ representatives showed good knowledge of the young people they discussed.
Different perspectives could often emerge about the same young person, which allowed joint learning and understanding of what works. The meeting is chaired by a governor grade member of staff.

Young people’s voices and access to services

Young people in secure settings face particular challenges in disclosing mental health difficulties and maintaining their well-being. This is for a number of reasons:

- they have been separated from many of those who would form part of their natural support system and are surrounded by strangers
- custody involves a loss of freedom and this limits the young person’s ability to access support systems because of locked doors, institutional communication systems, etc
- those with whom young people have day-to-day contact are also those responsible for their custodial containment - it is unclear to what extent this interferes with trust and disclosure.

The CAMHS Review (Department for Children, Schools and Families & Department of Health, 2009) highlighted the importance of improving access to services so that parents and young people could get support in a timely fashion, and also so that support could be offered at an early stage before difficulties escalate into destructive or self-destructive behaviours. Guidance also stresses the importance of ensuring that the help is provided in a child and young person-friendly manner, takes into account any learning disabilities and recognises the young person’s circumstances, “particularly if they may affect access” (Department of Health, 2004).

As highlighted earlier, there was evidence that CAMHS in-reach teams and mental health staff (where these workers were available in secure units) had tried hard, often without guidance, to provide the kind of service needed to support young people’s mental health and other complex needs. Nevertheless, we found limited evidence that young people’s views had been considered. What was provided tended on the whole to be service led rather than needs led.

Notable improvements were reported by mental health teams in terms of the speed with which young people could access help with mental health difficulties and the nature of the support that was offered. However, most mental health teams (particularly in larger settings) still felt they were reacting to mental illness rather than the whole unit adopting a proactive and systematic approach to supporting emotional well-being and detecting problems and risk factors early on.

In terms of thinking through access to mental health services in secure settings, it is particularly important to recognise the unique circumstances in which these young people are placed, and to consider the implications of their loss of liberty. We know from the CAMHS Review that young
people generally rely on a number of informal support networks (such as friends, families and teachers) in their day to day life to support their emotional well-being and mental health (Department for Children, Schools and Families & Department of Health, 2009). Talking to professionals is not their preferred way of coping with emotional difficulties. In custody settings, where they do not have ready access to these preferred informal support systems, they are forced either to keep problems to themselves, to talk to other young people who they may not know or trust, or to talk to professionals.

The mental health practitioners we interviewed were generally well aware of the barriers young people face in secure units when they need some support. These workers felt that it was not easy for a young person who had concerns about their emotional well-being or about their mental health to link up with the help they might need. Barriers to accessing help included:

- mistrust on the part young people of those in authority
- stigma and fear of being seen to have a mental health difficulty and of being labeled (this was thought to be a particular issue with young people from some BME groups)
- fear of being seen as ‘vulnerable’
- physical barriers to accessing services such as locked cells, doors and corridors
- frustration with and a lack of faith in the ‘application’ system (the main way in which young people in secure units request help), which was described as slow and not confidential - some staff felt that the system presented a particular challenge when so many of the young people in these units have learning and communication difficulties.

“Young people don’t want to be seen as being mentally ill, they’re wary of contact with mental health teams. I would like to see health support workers out on the wings supporting young people who are reluctant for contact with our team.” (CAMHS mental health nurse, YOI)

A further barrier to accessing mental health care was young people’s perceptions of mental health. Young people generally tend to see mental health as irrelevant to their day to day lives. They associate mental health with mental illness and are keen to distance themselves from the stigma of the label. They see it as affecting “other people”, and do not consider it to be relevant to their daily life. They would rarely think that they need specialist services.

From this point of view, young people in secure units would not necessarily think of contacting mental health teams unless workers themselves make active efforts to engage with them and explain or demonstrate how they can help. These perceptions of mental health services, along with their loss of natural support networks and the loss of freedom to choose how they accessed services, posed the greatest barrier to accessing help in custody.
There was also limited evidence of units engaging young people in thinking through how to access help and support (although by the end of the study one unit had started to consult with young people about what help they might need and in what form).

“I’d say the NHS would be the easiest person to talk to though it wouldn’t be a doctor. Though it depends on if you get on with the guards. I get on with the guards so I know I can go up to certain ones and say ‘Look, can we have a chat about this, that or the other?’.” (Male aged 17, YOI)

This contrasts with developments in the community where improving access to health and to comprehensive CAMHS has been a priority. For example, one-stop-shop health centres have been developed next to schools to make it easier for young people to seek help and receive early support; extended schools have been introduced partly with a brief to promote resilience, provide positive activities and link children and young people with support services; detached outreach youth worker services have been established to work with hard to reach and vulnerable groups and provide support and linkage into mainstream services.

Consultation with staff, young people and parents during this study confirmed and added to the findings of previous reports such as the CAMHS review about what young people need to support their mental health and emotional well-being. Young people and young adults with experience of the youth justice system value:

- choice about whom they engage with
- to talk to and be listened to by someone they know, who uses language they understand
- patient, persistent workers whose judgment they can trust
- a non-patronising, non-judgmental or lecturing approach
- a choice of solutions that best suit their needs
- workers who do what they promise and do it quickly
- workers who are open and honest with them
- expertise ‘by experience’ – workers who have been through similar difficulties and can inspire confidence that change is possible
- feeling safe with workers
- workers who meet them in settings where they feel comfortable
- help that also addresses their other priorities (getting a job, practical problems, concerns about relationships, etc.), not just help with problems that have been defined by an adult or an ‘expert’.

These preferences accord with the key principles of the recovery approach for mental health (Anthony, 1993), which reinforces the importance of people with mental health needs working with staff to decide what their goals are and how to achieve them. Recovery approaches
recognise that, for some young people, improvements in emotional and mental well-being (and the recovery of hope for the future) will come about through other activities, not just mental health service interventions (Sainsbury Centre, 2008).

The Recovery Approach

“Professionals do not hold the key to recovery; those experiencing mental health difficulties do. Recovery comes about as a result of joint problem solving and partnership between those recovering and professionals. It is important for mental health providers to recognize that what promotes recovery is not simply the array of mental health services. Also essential to recovery are non-mental health activities and organizations, e.g. sports, clubs…education, and churches. There are many paths to recovery, including choosing not to be involved in the mental health system.” (Anthony, 1993)

Continuity of care, resettlement and sharing of information

Mental health teams in secure settings described continuity of care as one of the greatest challenges they faced in their day to day work.

Mobility and churn

Young people are often placed in secure settings some considerable distance away from their homes, and mental health workers in secure settings can be working with young people from a number of different geographical areas. By the end of the study period, this situation had worsened with the closure of smaller YOI units so that young people are now held in fewer, larger units, often further from their homes. In Ashfield YOI, for example, over 40% of young people were over 100 miles from home. The situation for girls was reported to be even worse.

Secure care and mental health staff frequently reported the particular difficulties of trying to arrange support when they were unsure about the resources available in the young person’s home area, which could also change rapidly. Although local areas carry out regular audits of what is available, this information is mainly for strategic use. There was often no clear and up-to-date local directory listing the full range of services with the capacity to support young people’s mental health and emotional well-being (and those providing support to parents and carers) following release.

One manager, who was responsible for locality service mapping, acknowledged that, for just a little extra investment, information could be collected in a format that would be useful for practitioners (services offered, eligibility and exclusion criteria, key contacts, etc.).
There has been particular expansion in community-based parenting programmes but, according to interviewees, they were generally poorly integrated with specialist CAMHS and secure care services, and were not usually included in any resettlement activity.

**Access to specialist CAMHS**

Many CAMHS in-reach teams and practitioners reported difficulties in accessing community specialist CAMHS, due to long waiting lists or because young people were considered too old or not sufficiently ill to meet the threshold for treatment. Secure unit staff told us there were still gaps in services for 16 to 18 year olds with mental health needs in a number of areas. In addition, YOI mental health in-reach teams varied in their awareness of the potential role of the YOT health practitioner in brokering access to services and providing some continuity at the point of release from custody.

**The challenge of thresholds and service acceptance criteria**

Practitioners in the secure estate say that most CAMHS services still exclude those over 16 year olds or not in full time education. This is in spite of government guidance advising that services should provide timely mental health services up to 18 years (DH, 2004). There are also particular problems with specific mental health problems, as described by this CAMHS manager below:

“Young people coming out of YOIs rarely meet these criteria. They have often not been involved in services for several years beforehand. They stop their contact with CAMHS at about the same time they are excluded from school, so we have to set them up with services. And then there’s the young person aged 16 with ADHD. CAMHS don’t accept them because of their age; adult services don’t accept them because they don’t cater for ADHD. There are some good CAMHS that go up to 18, and some good adult services that will accept ADHD, but it is patchy.

“The other issue is when in custody we have been doing…primary care plus, that is providing intense support for young people with high levels of anxiety. These young people don’t meet the criteria for most community CAMHS services who only engage with a ‘serious’ diagnosed mental illness. Yet, we know that if they had the continued support and intervention we give in here, some young people who struggle to cope may well stay out of custody.” (CAMHS manager, YOI)

One team described having much more success in linking young people up with early intervention in psychosis teams (where these were available and where the young person was eligible). These teams provide a good model of support – they are young person friendly and focused, and they cross age transitions that can disrupt continuity of care for many young people. Multi-agency support for young people with emerging personality disorders was said to be difficult to arrange, as was wraparound community support for those with mild to moderate learning disabilities and other developmental disorders such as ADHD.
One mother consulted as part of this project described a lack of intensive support when young people feel at their most vulnerable. Her daughter had a significant history of emotional difficulties dating back to the age of 13 years of age. However, no clear diagnosis emerged until she approached the age of 18 years (when she was eventually diagnosed with emerging personality disorder following an attempted suicide in custody). Before this suicide attempt she had a history of making some progress whilst in custody but of struggling to cope on release and subsequently breaching her parole. She had waited for over seven weeks for mental health support when most recently released. Her mother described arguments taking place between professionals about whether her daughter had mental health needs or was just ‘badly behaved’. These arguments hindered her access to the intensity of support she needed. She eventually began drinking (which put her in breach of her licence for the second time) and was recalled to custody. Both the young woman, her mother, and her YOT worker in custody, talked of their ongoing frustration at their inability to arrange the right level of support required to avoid her cycling in and out of custody.

Information sharing
Most teams/workers in YOIs and other secure settings reported difficulties in obtaining accurate and systematic information about young people’s mental health and broader health issues from the community. Inconsistent and incompatible data systems were seen as the main obstacle. However, there were also complaints that information from YOTs did not reach YOIs, and vice versa, at the resettlement stage. In both instances, both parties were adamant that they systematically shared this information with each other. Some practitioners suggested that health passports, carried by the young person, should be created for young people with complex needs in the youth justice system. It is hoped that the introduction of a new database called SystmOne\(^1\) in YOIs over the next 18 months may at least improve health information sharing in these units. Further investigation and action to tackle persistent problems with health information exchange is required, particularly for STCs and SCHs.

From our observations in youth courts, it was also clear that information was shared inconsistently between secure settings and the court or the YOT report writer, particularly when young people were in contact with CAMHS in-reach services and were currently being assessed. There was debate in some CAMHS in-reach teams as to the ethical appropriateness of this, although one in-reach service provided via a regional forensic mental health team regarded training for and liaison with the courts as a key function. A pilot system in the south west of England in which adult criminal justice liaison and diversion teams and in-reach teams linked up to inform court reports had overcome these barriers and reservations. Generally, information relating to health is not being included systematically in youth pre-sentence reports (Healthcare Commission & Her Majesty’s Inspectorate of Probation, 2009).

\(^1\) http://www.tpp-uk.com/
The Care Programme Approach (CPA)
The Care Programme Approach was not used consistently by specialist mental health practitioners to support the co-ordination of services at the point of release and resettlement. Some teams and practitioners appeared not to have thought of using this approach for cases that might meet the criteria for CPA; some thought that the approach did not apply to young people under 18; others disputed whether this approach should be used with young people under 18, because of the ethical implications of labeling at such a young age. Confusion and debate still persisted, in spite of updated guidance on CPA (Department of Health, 2008b). There was also some confusion as to how this approach dovetailed with the Common Assessment Framework, youth justice case management and the lead professional approach. The CAF was not generally being used by CAMHS teams/practitioners in the sites we visited.

Accommodation, education and employment
Some 40% of young people in secure settings are known to have been homeless before coming into custody (Youth Justice Board, 2007). Mental health teams were concerned that post-release accommodation was often still being arranged too late in the day, frustrating plans to organise resettlement services. There were still instances of young people being released into bed and breakfast accommodation, and into environments that did not support their emotional well-being and which were unsafe.

Education (Youth Justice Board, 2004) and employment are also key supports for good mental health (Social Exclusion Unit, 2004). Educational attainment is key to building resilience against future offending and is protective of long-term mental health and well-being. Staff reported significant difficulties linking young people back into mainstream education, even if they had made some educational progress while in the secure setting. If young people had been statemented (due to learning disabilities/difficulties) in school prior to entering custody, these could not be maintained, and educational support had to be renegotiated at the point of release. The new Apprenticeship, Skills, Children and Learning Act 2009 will hopefully address many of these longstanding challenges through placing responsibility of education in secure settings with the host Local Authority.

A further barrier to promoting children and young people’s well-being and safeguarding in secure settings was seen to be the reduction of the number of social worker posts in YOIs. In 2003, a review of safeguarding and child protection in YOIs (following the Munby judgement in 2003, in relation to the application of the Children Act 1989 to children in custody) resulted in the deployment of 25 social workers in YOIs. Findings from an evaluation of the introduction of these workers in YOIs (Fielder et al, 2008) suggested that they had enhanced the focus on safeguarding in these units, increased the degree to which children’s needs were being met, and improved Looked After Children’s access to resettlement entitlements; an estimated half of all children in custody are looked after by their local authority (House of Commons Children, Schools and Families Committee, 2009).
However, the initiative has not been sustained nationwide after central Government funding ceased in 2009, passing responsibility over to local authorities. A lack of agreement on the part of local authorities as to how these posts would be funded resulted in fewer than half of the posts being filled as of December 2009 (Hansard, 2009).

**Management of transitions and resettlement**

We identified several examples of good practice and innovating partnerships for managing transitions and resettlement.

One YOI that covered a very broad catchment area had allocated four mental health workers to the team with specific responsibility for resettlement. The manager said that this system had resulted in a notable improvement in their ability to set up aftercare appointments. The resettlement workers:

- started planning for resettlement, wherever possible, on the day the young person came into the unit
- used the Care Programme Approach as a lever for facilitating continuity of care for young people with mental health problems
- mapped all services supporting young people with mental health difficulties and learning disabilities in the YOI catchment areas
- attended initial meetings in the community for cases open to specialist CAMHS, to improve handover and communication
- accompanied young people to all medium secure psychiatric units when they were transferred to help them settle and to improve exchange of information.

Challenges still persisted, however, because of the rate of churn through the system, when young people were moved suddenly or were transferred in from outside the usual catchment area.

Regional models were also described, such as that provided by the Thames Valley child and adolescent forensic mental health service (see box).

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**The Thames Valley child and adolescent forensic mental health service**

This team covers Oxfordshire, Berkshire, Milton Keynes and Buckinghamshire providing specialist (Tier 4 equivalent) CAMHS expertise at a variety of levels and to a variety of institutions and networks working with young people in the youth justice system.

The regional service takes referrals from local CAMHS teams and YOTs across the Thames Valley Area and provides consultation and advice where a specialist forensic mental health opinion can aid the local management of these young people.
The team also provides training, liaison and advice to courts and the wider legal system.

The team provides training, formal case consultations for frontline workers, specialist assessments and advice about risk management with the twin aims of preventing children from ending up in custody unnecessarily and facilitating liaison between custody settings, the criminal justice system, NHS inpatient facilities and community CAMHS teams.

The Thames Valley team also provides multidisciplinary mental health in-reach to the young offenders institute at Huntercombe, where it conducts clinical and risk assessments, interventions and health promotion activities and facilitates resettlement through its knowledge of regional community resources.

In some instances, teams had developed models whereby they had ‘one foot in and one foot out’ of the secure units. In Swanwick Lodge secure children’s home, support for mental health and emotional well-being was provided by workers contracted in from a local adolescent team. The same team continued contact and supported resettlement if young people were released back into their area. In another YOI, a mental health nurse worked part-time in the YOI and the rest of her time as a health practitioner in the community. This nurse described how she had been much more successful in encouraging young people to use local services as they were familiar with her from their time inside, and that they were more likely to keep appointments and had begun to trust her advice. Another YOI (with a predominantly local population) had a clinical manager who was also a deputy director for local community mental health services. He felt that this ‘foot in, foot out’ approach helped the unit bring in additional services (such as early intervention in psychosis, drama therapy and occupational therapy), as well as enabling him to monitor the capacity and preparedness of community teams to support the resettlement of young people in the area. In Feltham YOI, a consultant psychiatrist in the CAMHS in-reach team had one foot in the local medium psychiatric secure unit and one foot in the YOI. This unit reported the fewest problems with transferring young people speedily to medium secure care where this was needed.

However, the ‘one foot in and one foot out’ approach had its limitations if young people were from outside the immediate catchment area, which was common.

During the fieldwork phase of this audit, the Youth Justice Board had introduced 59 wraparound resettlement pilots for young people with significant substance misuse and other vulnerabilities including mental health needs. These Resettlement and Aftercare Pilots (RAP) were popular with young people, because of their focus on needs-led, practical problem solving and lifestyle change. In 2009, the scheme was re-branded with an enhanced requirement for partnership working with other community support services; the target group for the scheme was also extended to all young people leaving custody. However, we found inconsistent knowledge of this (the RAP or the new...
Integrated Resettlement Scheme) among some mental health teams, and variable joint working between substance misuse and mental health teams generally in secure settings.

In two regions, the Youth Justice Board was piloting resettlement consortia that sought to secure the active commitment of all stakeholders and agencies concerned across a region. Although at an early stage, some headway had been reported by the Youth Justice Board in securing commitment from local employers, housing providers and local authorities to supporting resettlement. There were plans to link in health providers in the region.

**Health action planning**

In spite of the emerging evidence that learning and developmental disabilities and speech, language and communication problems may be over represented among children and young people in the youth justice system (Bryan, Freer & Furlong, 2007), we found evidence that Health Action Planning (Department of Health, 2009d) was not being used to facilitate links between secure and community healthcare services for young people with identified learning disabilities.

**Youth justice liaison and diversion work**

Criminal justice liaison and diversion teams and YOT health practitioners have an important part to play in the management of young people in secure settings. Young people in the youth justice system have a range of complex problems but rarely meet the criteria for specialist support. Specialist services are also not well designed to engage and meet the needs of this group of young people. For this reason young people can remain unidentified and unsupported until their behaviour escalates and they come to the attention of the police. Findings from a recent study of health provision in YOTs (Centre for Mental Health, 2010) indicate that very few have invested resources in systems to identify mental health problems at the point of arrest. There is also evidence that many young people with mental health difficulties are not identified through standard YOT screening (Harrington & Bailey, 2005), and that court reports contain insufficient information on mental health and physical health vulnerabilities (Healthcare Commission & Her Majesty’s Inspectorate of Probation, 2009).

Most mental health screening tends to take place when a court report is prepared, even when difficulties have been identified at the point of arrest. This can lead to long delays, as psychiatric reports are then ordered very late in the sentencing process.

Furthermore, the timescale from arrest to sentence can in more complex cases span some three to four months and a young person who has had no previous contact with the YOT can be left without any support over this period while they await sentencing. Statistics made available to this study by the National Commissioning Group indicate that most young people with severe mental health or learning disabilities are not identified until they enter secure custodial settings and are seen by the CAMHS in-reach team. At this late stage referrals are then made to secure units.
Criminal justice liaison and diversion schemes exist to ensure offenders with mental health needs are identified, assessed and referred to appropriate treatment at point of arrest or early in the court process. They also offer advice and consultancy to police, sentencers, the Crown Prosecution Service and solicitors, to ensure mental health needs are speedily identified and more effectively addressed.

Lord Bradley’s review of people with mental health problems and learning disabilities in the criminal justice system (Department of Health, 2009c) highlighted the role of such teams in improving coordination between mental health and criminal justice teams, facilitating the sharing of information within the criminal justice system and linking and supporting people back into their communities at the point of release.

Very few of these schemes exist for those under 18 years old, although six Department of Health pilots are currently being set up and evaluated to assess impact.

**Gaps in service provision**

*Work with families*

The most successful interventions for young people with mental health difficulties in the youth justice system involve evidence based parenting programmes and family work. These programmes are most effective when they are targeted at an early age (under the age of 12 years) at children and young people who are showing signs of conduct disorders and behavioural problems (Fergusson, Horwood & Ridder, 2005).

There is also evidence that some parenting interventions (Multisystemic therapy, Functional Family Therapy, Family Integrated Transitions see Aos, 2006) work with older age groups, but these are rarely made available to support resettlement in the UK.

There are a number of barriers to implementing family work in custody:

- young people are separated from their families
- families often have to travel some considerable distance to see their children
- there are few rooms in secure settings that are suitable for family work
- young people in custody are often in conflict with families or come from chaotic family backgrounds: 40% of young people were living with someone other than a parent before they entered custody (Youth Justice Board, 2007).

However, trials of family work are producing promising results both in terms of impact on reoffending and cost effectiveness for young people in secure units in the US (Washington State Institute of Public Policy, 2004).
Family work in secure settings in England and Wales tends to be restricted to parents attending reviews, awards ceremonies or ‘fun days’ organised by family liaison officers. Family liaison officers are frequently secure care officers, who reported to this study that the work could be de-prioritised in favour of core duties.

Some SCHs were able to offer enhanced and prolonged family visits, and had developed the organisation of the unit to prioritise contact. Family work was also sometimes taken forward by resettlement workers in the form of conciliation and practical support in preparation for release.

In multi-dimensional fostering treatment, intensive work takes place both with the young person in foster care and with the biological family at the same time in order to improve parenting skills and support the family for the young person’s return. This would seem to present an appropriate model for family work when young people enter and leave secure settings, but at present no such preparatory work is offered.

Parenting support has been expanding in the community under the former government’s Think Family (Department for Schools, Children and Families, 2009) agenda, but there has been no equivalent expansion and focus in secure settings or as part of release planning. One CAMHS in-reach team had trained up a worker in family therapy and had plans to convert a room into a therapeutic family room. However, the CAMHS manager reported barriers to the development of this work in most units, including lack of appropriate accommodation in secure units, the distance of the unit from most young people’s families and the short length of time that most young people spend in secure settings.

Moreover, it was difficult for in-reach teams to keep up with the rapid expansion of family and parenting work in the community and to factor it into release plans. At the time of site visits, therapeutic family work was rarely talked about as a resettlement option.

**Young people at risk of sexually harmful behaviours**

Practitioners in CAMHS and forensic CAMHS teams described work with young people at risk of sexually harmful behaviour in the young people’s secure estate as “under developed”. One consultant psychiatrist felt that this work did not come within the remit of CAMHS in-reach teams, but was concerned that there was no multidisciplinary strategy or accountability for how the work could be taken forward. The Lucy Faithfull Foundation was mentioned most frequently in relation to this work in secure settings. One team in an STC also talked of having adapted the Assessment Intervention, Moving on (AIM) (Audit Commission, 2001) approach for use in a secure setting.

Concerns raised about this area of work included:

- lack of clear guidance driving and coordinating multidisciplinary activity
- lack of multidisciplinary management and resettlement
- poor evidence of effective programmes for this age group and for those who also have high levels of learning disability and communication needs
- no adaptation of the multi-agency (AIM) model for use in the young people’s secure estate.

Also, unlike adults, young people under 18 years old, who are sentenced for sexually harmful behavior, tend to be held on normal location in secure units and so live with the ever-present anxiety about disclosure of their offence. One practitioner pointed out the risk that everyone would know the nature of that young person’s offence if workers from a specialist organisation such as the Lucy Faithfull Foundation visited them on the unit.

Practitioners talked of having waited for some time for clearer guidance to support work with this group of young people.

**BME young people and mental health**
There was limited evidence of services proactively addressing risk factors specific to young people from BME communities, or of thought being given to the need to offer services in a different way in order to engage BME young people and at an earlier stage. CAMHS in-reach teams in secure settings were generally not aware of the existence of BME community mental health development workers in their locality. Some teams were aware that the chaplaincy and spiritual leaders could offer some BME groups (as well as other groups) more effective mental health support than mental health teams. One practitioner in a secure unit reported that young BME people were under-represented in custodial mental health caseloads, in contrast to their over-representation in adult mental health services (Malek, 2004). Workers felt that some BME young people were reluctant to engage with mental health teams due to the associated stigma.

There is anecdotal evidence that peer mentoring and voluntary sector support are more effective than statutory services in engaging some BME groups (Department of Health, 2009e). Inspection reports indicate that adults with mental health and emotional difficulties in custody rate the support of frontline staff and of other prisoners highly. The voluntary sector was often involved in advocacy work on behalf of young people in secure settings. In one unit, efforts had been made by the voluntary sector to involve young people in secure settings in the recruitment of new workers. However, we generally found limited awareness among mental health workers of the potential role of the voluntary sector in meeting the needs of groups who are wary of engaging with mental health teams.

**Mental health needs of young women**
In almost every comparative study, young women fare less well than adult female or young male prisoners on a range of health indicators (Douglas & Plugge, 2006). Young female offenders’ health and mental health are compromised by a range of inter-related risk factors such as substance misuse, poor sexual health, mental health problems and violence/sexual violence.

Young women in secure settings have well-evidenced, complex mental health and other needs:
• 71% of young women have some form of psychiatric disturbance (Douglas & Plugge, 2006) 
• more than one in three young women in custody have a history of self harm (Douglas & Plugge, 2006) 
• young women in custody have higher rates of anxiety disorders (67% compared with 47% of young men (Lader, Singleton & Meltzer, 2000)) 
• young women have higher rates of PTSD (Chitsabesan et al, 2006) 
• one in three girls in secure settings (compared with one in 20 boys) have experienced sexual abuse (Social Exclusion Unit, 2002) 
• one in ten young women in custody report that they have been paid for sex (Prison Reform Trust, 2009a). 
• ‘Relationship building’ (Batchelor & Burman, 2004) has been identified as particularly important for young women.

Young women under 18 years of age are now accommodated in smaller units of 15 beds. Three of these units were visited during this study and the cultures of all were very different, as were the resources they had available and the way that mental health care was organised.

In one unit, mental health services were provided by a prison in-reach team and a dedicated healthcare worker. This team did not have a predominantly child and adolescent approach or culture and it was easy, therefore, for adult-orientated mental health approaches to dominate. For example, there was no clear policy driver for work focused on emotional well-being and preventative work and limited understanding of the comprehensive CAMHS approach.

Healthcare staff in this unit described a number of other challenges. The in-reach team felt that health and health improvements were very much seen as an ‘add-on’ to containment and core educational and offending behaviour work, rather than being an intrinsic part of service provision. Educational targets were prioritised to such an extent that health and substance misuse workers could not access the young people they needed to see.

In another unit, lower level day to day support and pro social modelling was better developed through the work of in-house YOT workers, but the unit had been without access to specialist mental health support for nearly two years.

In the third unit, mental health services were provided by a locality CAMHS in-reach team based in a local YOI for young males under 18 years old, and a part-time worker had been allocated to the unit. This CAMHS practitioner worked very closely with secure care officers to support frontline staff and the staff appeared confident about supporting the day- to-day emotional well-being of the young women in their charge. Officers had access to 24/7 consultation and support from mental health specialists in the event of crises, and work being carried out by other workers (such as substance misuse teams and healthcare) was coordinated through weekly meetings.
One particular problem reported by practitioners was a lack of medium secure psychiatric beds for young women with severe learning disabilities as the staff was not trained to meet these higher level needs.

**Remands and short sentences**

Because of their mobility, the uncertainty about their length of stay and the speed, on occasions, of their passage in and out of the young people’s secure estate, remands presented difficulties for all workers. Very few teams mentioned any particular strategy for managing remands, although one team did use remand status and sentence length to prioritise cases for assessment and referral.

Up until very recently, three quarters of under-18 year olds locked up on remand by magistrates or district judges were either acquitted or given a community sentence (Prison Reform Trust, 2009b). Many of these had unidentified mental health needs. In the past year, practitioners noted a dip in remands.

A few examples were reported to this study of young people with suspected ADHD missing the opportunity for fuller assessment both at the pre-court stage and in custody, due to lack of time. ADHD assessments are typically very lengthy and require involvement in the assessment process on the part of schools and families.

**Access to medium secure units**

We found a reluctance to diagnose young people under the age of 18 with a personality disorder. This applied in particular to young women, but also some young men, who were displaying highly unusual and seemingly disturbed behaviour over long periods of time. Staff and specialist mental health staff on secure units struggled to manage these young people unsupported. When they were assessed for medium secure care, they were turned down, even after multiple requests for re-assessment. Eventually, at the age of 18, even though their behaviour had not changed over a two year period, they would be deemed eligible for acceptance into medium secure units. This pattern was described on more than one occasion and in different sites.

Young people placed in medium secure units then had fewer opportunities for step down care, due to a lack of low secure and PICU type units.

**Age transitions**

Young women and staff on the small secure units for females in some instances reported access to high levels of multidisciplinary support. However, this changed dramatically at age 18, when the young women were moved into larger units for 80 young adult women, with much fewer secure care staff offering day to day support and where they had to wait to access other specialist support services.
Officers on one wing for young adult women described how many of these younger women struggled to adapt to regimes and, commonly, resorted to self-harm as they ‘withdrew’ from the higher levels of support in the small secure units.
Conclusion

The introduction of specific funding to support CAMHS in-reach services in young offenders institutions has resulted in notable improvements in YOIs. We found evidence that young people with evident mental health difficulties are identified, assessed and supported much more quickly, whether directly within the secure settings or through liaison with multidisciplinary community-based services. Workers have made significant and energetic progress, despite a lack of guidance on appropriate services and systems for children and young people.

However, looking across the entire young people’s secure estate, we found that the additional funding for YOIs had served to highlight and exacerbate existing inequalities and inconsistencies in provision. We found a number of persistent challenges to the achievements of mental health teams and practitioners, including cultural barriers to developing an integrated, ‘whole unit approach’ in which the mental health and emotional well-being of young people who offend (and who have well documented vulnerabilities) are prioritised and considered ‘everybody’s business’.

“It is important to recognise that supporting children and young people with mental health problems is not just the responsibility of specialist CAMHS. In many cases, the intervention that makes a difference will come from another service. For example, a child presenting with behavioural problems may make better progress if his/her literacy problems are also addressed, in which case an input is required from education... partnership working is an essential requirement of high quality service.” (Department of Health, 2004)

We found evidence of practices in secure regimes that compromise rather than support the emotional well-being of young people in custody; a predominantly reactive approach to mental health problems rather than an early intervention and proactive approach to supporting mental health and well-being; variations in commissioning expertise and interest throughout the entire young people’s secure estate and across primary and secondary care; fragmentation in the provision of comprehensive CAMHS services; problems with access to sufficiently intensive support services at the point of resettlement; problems more generally with continuity of care, and underdeveloped work with particular groups of young people who offend.

Faced with these difficulties, CAMHS teams and mental health workers in secure settings have had to adopt creative solutions to meet the needs of young people on their caseloads. Some of these solutions are described in this report.

Detailed recommendations are set out below for the further improvement of services and systems to support the mental health and well-being of children and young people in secure settings.
This report ends on a note of caution. Funding to sustain these improvements in the mental health care of young people in secure units is not currently guaranteed, and the progress identified in this report could be reversed if sustainability is not addressed. Funds for the provision of mental health services within the young people’s secure estate needs to be made part of PCT core budgets, to ensure continuing development and improvement of what remains a vulnerable but essential service.
Recommendations

Research and international legislation shows that placing vulnerable young people who offend in custodial units is the highest cost, least effective way of reducing offending behaviour and should only be used as a last resort. Research also highlights that gains in health and mental health while in these settings are rarely sustained after release, due to poor transitional care. Commissioners need to invest in the full range of evidence-based community interventions that have been shown to be both more effective and most cost-efficient in reducing re-offending. Particular attention should be given to improving access to proven effective family interventions for those with emerging conduct and behavioural problems, who are most at risk of poor outcomes.

Identification of health needs
We know that children and young people in the youth justice system are, with homeless and looked after children and young people, the most likely to have significant health needs and also the least likely to access primary healthcare (Macdonald, 2006). Their period in custody offers NHS commissioners a unique opportunity to target this high risk population for health promotion interventions and engage with a (literally) captive audience to build on and sustain health gains post-release.

A comprehensive health checklist (including mental health and emotional well-being) should be developed for use across all agencies and in all settings to help identify issues that young people may be reluctant to disclose. This health checklist should be updated at each stage of the youth justice system pathway and should include the Health Action Planning process for those with learning disabilities.

A standardised health information summary tool (HIST), as currently used at Hindley YOI, would ensure vital health information is passed on through all points of transition and into the community, post-release.

The following detailed recommendations are made to address the shortcomings in mental health services, systems and provision identified in this study.

Inconsistency in provision
All commissioners in a region (both those with direct commissioning responsibility for secure settings in their area and those who commonly commission services in these units) should jointly develop a comprehensive governance framework and specialist CAMHS service covering all secure settings within the region.

Local commissioners should conduct a thorough health and mental health needs assessment of all the vulnerable young people in secure settings as a starting point to inform service development.
There is also benefit in commissioners working regionally to:

- develop a formula for the equitable distribution of funding for mental health service provision in secure care settings
- consider how a consistent service might be provided and funded through this formula across the whole region. This could include the development of protocols governing the provision of all components of a regional specialist mental health service: prison in-reach services, consultation for YOTs and other teams supporting vulnerable young people, court report writing, the provision of very specialist interventions, training and support of comprehensive CAMHS, etc.

Regional virtual specialist consultative teams should be developed to meet the needs of all young people with complex behaviours and needs, including those in secure settings. These teams would bring together staff with a range of very specialist skills, including forensic mental health expertise, that are expensive to commission in single localities due to the very small numbers of young people involved.

Forensic mental health skills and functions would form an important part of these regional teams’ skills set and role but they would in addition address the broader, complex needs of young people who are at high risk of poor outcomes (one of which may be offending).

These teams would have a specific brief to support those providing services for young people at high risk of a range of inter-related poor outcomes (young people in secure units, families of young people in secure care, looked after children in local authority care, young substance misusers, those at risk of exclusion from school and those identified through anti-social behaviour processes). They would supervise and act as ‘outreach consultants’ to frontline primary and secondary care staff and community based CAMHS workers, delivering services directly or jointly to young people with the most complex needs. Ideally these teams would need to have a solid foot in custodial settings, in order to understand the culture and to ensure that they are well placed to influence the regime, and outside of the settings so that they remain up to date with community developments and are able to think outside the ‘institutional’ box. These virtual forensic mental health teams would need to retain close links and networks with CAMHS in their region as well as with YOT health practitioners.

Staff in these regional virtual teams would have the following skills and functions:

- forensic mental health assessment and behaviour management skills
- knowledge of the criminal justice system and of the court setting; court report writing skills
- knowledge of multi-systemic therapeutic skills and evidence-based parenting approaches and links with community services
- specialist substance misuse assessment, clinical management and dual diagnosis skills and community links
• sex offender assessment and management skills
• Multi-dimensional fostering treatment (MDFT) and intensive fostering
• PTSD assessment and clinical management
• expertise in supporting those working with young people with early signs of personality disorder
• expertise in supporting colleagues working with anger management difficulties and sexual abuse/trauma
• evidence-based management of ADHD, speech, language and communication needs and meeting the needs of young people with learning disabilities.

A portfolio of outcome measurements is currently being piloted in community mental health settings to evaluate effectiveness of mental health interventions. A similar work programme is needed to develop a standardised approach to outcome measurement in secure settings.

Needs assessments
A standardised outcomes monitoring framework for mental health and well-being should be developed to evaluate the impact of secure care on young people and to assess the effectiveness of the services provided by mental health teams.

Needs assessment tools currently being used in secure units and in YOTs should be reviewed to ensure that they are picking up all the needs of all vulnerable young people in order to inform commissioning plans (see also primary care and health promotion below).

A regularly updated summary of the evidence base on effective interventions with children and young people with offending behaviour and mental health needs would help ensure greater consistency of mental health provision. This would include NICE guidance, evidence-based offending behaviour work, and promising practice with young offenders (and those at risk of offending) with personality disorders and conduct problems, and those with mental health, learning disabilities and/or other complex needs such as substance misuse. Given the average length of stay in secure settings, there is a particular need to identify effective short-term interventions so young people can derive the most benefit from their time in secure settings. This summary would include a detailed update of the Youth Justice Board’s professional certificate (Youth Justice Board, 2004) for YOT case workers and practitioners.

Primary care and health promotion
There is immense scope for PCT and children’s services commissioners to target young people in secure care to address the healthcare and health promotion needs of this high-risk population. Commissioners should consider how this opportunity for engagement can be used to improve health, build on health gains, and sustain these improvements post-release.
Healthcare teams in custody settings and YOTs should be supported, as a matter of urgency, to develop further specialist competencies and skills to address the well-documented health needs of young people in the youth justice system.

Health promotion and interventions to support health behaviour change should form a central part of primary and secondary care services in secure care settings. Primary care provision within secure settings should encompass:

- routine screening for health and mental health issues
- drug and alcohol screening and smoking relapse prevention work
- sexual and reproductive health
- oral and optical health
- nutritional and lifestyle advice
- immunisation checks and updates
- health and mental health promotion and motivational interviewing approaches to support health behaviour changes, and to promote continuing contact with primary care services on release
- screening for early identification of mental health problems
- referral to specialists for follow-up
- psychological therapies and basic counselling
- community liaison to facilitate resettlement/continuity of support and care to build on health gains
- screening for learning disability, speech, language and communication needs, and ADHD, in liaison with education services and CAMHS in-reach
- production of health action plans for young people with learning disabilities in preparation for release.

Health commissioners should audit child and adolescent mental health competencies and skills in the primary healthcare workforce, including GPs, and develop a workforce strategy to enhance expertise. Motivational interviewing techniques, which show promising evidence of effectiveness in promoting health behaviour changes in adolescents (Erickson, Gerstle & Feldstein, 2005; Brown et al, 2003), should be included in core training for all primary and secondary healthcare staff.

### Range of chronic health issues identified among a predominantly BME young sample screened at Hackney YOT through the Teenage Health Demonstration pilots.

The majority of young people in Hackney YOT were from BME populations. 36% of young people in contact with the YOT were identified with chronic health problems including:
- Eczema
- Asthma
- Perthes disease
- Epilepsy
- Mental health issues
- ADHD (Attention Deficit Hyperactivity Disorder)
- Injury from Road Traffic Accident
- Psoriasis
- Kidney conditions
- Eye condition
- Enuresis
- Sickle Cell Anaemia

(Bekaert, S, 2008)

The GP Quality Outcome Framework (QOF) should be adapted for work with children and young people in secure settings. This will require improvements in compatibility between custodial and community health information technology. A case can be made for every custodial setting having its own GP practice so that practice based commissioning can be developed, as now happens in the community where GPs can commission specialist services for their practice population’s particular needs (Sainsbury Centre, 2007). Additionally, GPs who work in secure settings should have enhanced training in child and adolescent development and in the health needs of young people in these settings. They should also develop competencies in dealing with complex health and mental health issues.

**Workforce education and training**

The Children’s Workforce Development Council (2010) has recently refreshed the Common Core of Skills and Knowledge for all staff working with children and young people (including volunteers). These competencies should be part of the training for secure care staff in all settings and should underpin interactions and work with young people and their families. They should also provide a benchmark for inspections of comprehensive CAMHS support in secure settings, together with the Skills for Health competencies for Tier 3 CAMHS work (Skills for Health, 2007).

The Healthier Inside self assessment toolkit (National Children’s Bureau, 2008) provides a useful tool for non-clinical staff to support young people’s emotional well-being. This was designed with input from a wide range of agencies and government departments to promote a ‘whole system approach’ to supporting young people in secure settings. It sets out 27 health and well-being entitlements for children and young people in secure settings, bringing together key national policies, targets and standards. By reviewing services against these entitlements, staff can be confident they are delivering a comprehensive package of care to support the health and well-
being of young people in custody. The toolkit is linked with a website\(^2\) and network. A further publication on bereavement has also been produced.

All frontline workers in secure settings should have common training in child and adolescent development, forensic mental health, the impact of trauma, neglect, mental health problems, learning disability, speech, language and communication problems and health inequalities, and the effects of social deprivation on behaviour.

All frontline workers should also receive basic training in what approaches support young people to achieve their potential and change. There is a need to review recent changes made to JASP training to assess the impact of changes in secure units and also to standardise training across all settings. Regional specialist and CAMHS in-reach teams should provide ongoing ‘booster’ training for all disciplines, as well as consultation, supervision and more informal training through day to day advice in managing young people with complex needs and behaviours.

Frontline staff should also receive regular supervision to enhance awareness and skills, and shift the culture (particularly in some larger units) towards a focus on promoting children and young people’s well-being.

**Integrated and collaborative working**

Each unit should develop a comprehensive CAMHS strategy outlining the contributions of all staff to supporting and improving the mental health and well-being of children and young people.

There is still scope for greater integration between the various health disciplines in secure units.

There may be benefit in creating virtual multidisciplinary ‘access and support’ teams within units that can draw on the support of specialists for children with complex needs. These teams would need to meet on a regular basis; ideally they would share office space (it is recognised that this could be a challenge in some settings where office space is scarce). This would enable frontline workers to provide lower level support and lower threshold interventions, promote emotional well-being and mental health on the unit, track the case management of young people with complex needs, and call on specialist assessment and advice speedily where necessary.

In larger units, these teams could include:

- primary health workers
- specialist mental health link workers
- link substance misuse adviser
- SEAL/PHSE teachers
- secure care senior officers or wing representatives

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• chaplaincy representative
• health and fitness staff
• family liaison workers
• Connexions workers
• family liaison leads
• sentence planning leads
• advocacy and voluntary sector workers.

These staff would all be alert to young people’s emotional needs and would generally act as pro-social models (Cherry, 2005). They would support young people to access help while also delivering low threshold interventions such as listening to and supporting young people in distress on their units, adapting their own approaches to the needs of young people with speech, language and communication difficulties, and helping young people find ways to manage problems of daily life.

Primary mental health workers could deliver CBT interventions as part of Improving Access to Psychological Therapies (IAPT) pilot work; substance misuse professionals could also take forward work supporting mental health and emotional well-being as the lead professional, either jointly or in consultation with specialist mental health workers.

The access and support teams would be supported by a specialist multidisciplinary team for young people with complex needs, whose role might be to:

• chair the weekly intake and allocation meeting
• provide supervision for the delivery of lower level interventions or behaviour plans
• provide ongoing training and immediate consultation for frontline secure care staff to support management of young people with complex needs and behaviours
• work jointly with access and support teams, where this is required
• work directly with the most complex cases and facilitate resettlement plans
• work with all staff to pull together information and systematically plan the management of young people with the most problematic or worrying behaviour in the unit. Planning for young people with more complex behaviours could be coordinated through a similar mechanism to the Hindley weekly Safer Regimes meeting, with links to staff from the Access and Support team attending.

Depending on the size of the unit, these specialist multidisciplinary teams could include:

• substance misuse specialist manager and workers
• forensic mental health assessment, court report and risk management teams
• clinical psychologists
• consultant psychiatrists
• CAMHS manager and CAMHS tier 3 workers
The specialist workers in secure settings would ideally form part of broader regional specialist provision supporting all young people with complex needs and behaviours and providing consultation to staff in secure settings, health and case workers in YOTs, and staff in teams for looked after children and in generic CAMHS. The broader regional network would also include the following link workers and functions:

- multi-systemic therapy link workers
- intensive fostering link workers
- Think Family and Family Intervention Projects link workers
- youth liaison and diversion teams
- behaviour and education support teams
- specialists for young people with sexually harmful behaviours
- early intervention in psychosis link workers.

**Prioritising safeguarding**
Any comprehensive CAMHS in secure settings should place safeguarding at its heart. Where young people are deprived of their liberty as a punishment, safeguarding in secure settings should aim to:

- use approaches that minimise distress and the potentially negative impact of custody on children’s mental health and maximise any potential benefits
- mitigate the impact of custody and particularly separation from families as far as possible through promoting regular contact, helping to resolve tensions that might jeopardise release plans
- promote young people’s well-being on release and their safe resettlement back in the community.

Units should adopt a proactive approach by creating an annual log of practices that have the potential to compromise the well-being of young people placed in these settings. These may relate to activity in and outside secure units (e.g. last minute unsuitable accommodation on release, inadequate interventions or care arrangements at the point of resettlement for those at
risk of sexually harmful behaviours or with emerging personality disorders). These concerns could then be referred either to the safeguarding board overseeing the unit or to the board with responsibility for services in the young person’s home area.

**Young people’s voices and access to services**
There is a need to review, in consultation with young people, current arrangements for accessing support for emotional well-being in secure settings, taking into account the particular challenges posed by loss of liberty, locked doors and institutional processes.

This review should ideally include the following issues:

- changing the paper based ‘application system’ for young people to ask for help with emotional/mental health issues
- the introduction of the SEAL programme as part of educational provision in secure settings
- introducing models to improve access to services in settings with restricted freedom of movement (for example, adopting an assertive outreach model) - there is a particular need to consider how young people can ask for help and raise concerns and how concerns can be identified more effectively
- clarifying who young people would most trust in terms of disclosing concerns.

For those with diagnosed mental health difficulties there should be some investigation as to how the recovery approach can be integrated into the youth justice service and the young people’s secure estate.

The Social, Emotional Aspects of Learning programme (SEAL) could also be introduced into the educational provision within the young people’s secure estate, to promote awareness of mental health and emotional well-being among young people and support resilience and readiness to seek support.

There is also a need for mental health promotion in secure settings to de-stigmatise mental health difficulties so that young people feel able to seek help at an early stage.

**Continuity of care, resettlement and sharing of information**
Given what is known about the very high levels of complex needs among young people in secure settings, young people who go into custody should be regarded as children in need and afforded the same priority given to children in need by Children’s Trusts.

Young people should be allocated a lead professional, before entry into a secure setting, who follows them through the entire process. This throughcare and resettlement work needs to be given the highest priority rather than seen as an ‘add on’ to community based work.
Children’s Trusts should share responsibility for the resettlement of young people returning to their home areas, rather than this being seen as the responsibility of local YOTs on their own. Where lack of arrangements jeopardise the well-being of young people, these incidents should be reported to local safeguarding boards.

Secure settings should keep a log of all instances where resettlement practices compromise the safety of young people. These audits should be passed to the relevant safeguarding boards in the young person’s home area.

**Health action planning**

Young people with learning disabilities should be assessed and supported back into the community using Health Action Planning (Department of Health, 2009d). Care pathways for supporting children and young people with these needs should be developed as part of catchment area mapping.

**Intensive evidence based resettlement models for high risk groups**

There is a need to provide highly vulnerable young people and those with multiple complex needs with more intensive support at the point of release. A case could be made for investing in evidence based parenting interventions, multi-systemic approaches and intensive wraparound support for children and young people with particular needs: those with emerging behaviour difficulties and ADHD (both of which are strongly associated with offending behaviour and substance misuse in later life), those with emerging personality disorder (for whom there are few appropriate community services), dependent drug/alcohol users, those with multiple needs and those at risk of self harm.

Focused provision is also needed for children and young people in the youth justice system with mild to moderate learning disabilities or speech and communication impairment. They appear to have particularly poor access to much needed wraparound practical support on release back into the community.

**CPA guidance**

Further awareness-raising is needed of the CPA approach and how it applies to young people in the youth justice system. Guidance is needed on how to dovetail the CPA, youth justice and lead professional systems.

**Directory of local services**

There is a need for comprehensive directories of all voluntary and statutory services that support young people, building on the CAMHS mapping. This database (and at the very least CAMHS mapping) should be made available to CAMHS in-reach teams. The database should include a brief description of the service, type of support offered, contact details, eligibility and exclusion criteria and referral processes.
Education
Mental health teams both in custody and in the community need to be aware of importance of ensuring young people are able to re-engage in mainstream education following release: academic failure is a major risk factor for poor mental health.

Information sharing
There is a need to investigate and review problems with information exchange and transfer across the entire youth justice pathway and at all transition points in the young people’s secure estate.

Youth justice diversion and liaison
Commissioners should consider the scope for developing point of arrest criminal justice liaison and diversion teams in localities to support the early identification and support of vulnerable young people who offend.

Work with families
All children under the age of 12 going into custody should have access to evidence-based family interventions that start while they are in secure care and continue following release.

The former Think Family approach (Department for Schools, Children and Families, 2009) should be adapted to meet the needs of young people in secure settings to support family contact, cohesion and linkage with community support. Links could usefully be made with family intervention projects, and memoranda of understanding could be developed to link up young people and families before their release.

Consideration should be given to the feasibility of using the multi-systemic therapy programme as a resettlement package for some young people with highly complex needs.

Consideration should be given to piloting the US Family Integrated Transitions (FIT) model in the UK.

Young people at risk of sexually harmful behaviours
Work with young people under the age of 18 sentenced for sexually harmful behaviour requires further development.

BME young people
Secure units should consult with BME young people, families, faith advisers and community mental health development workers to develop effective, culturally appropriate and acceptable support for young people from BME communities in secure settings who have emotional well-being and mental health difficulties.

CAMHS in-reach and primary mental health care teams should collect and analyse data on access to mental health services in custody for young people from BME communities.
Pilot projects should be established to trial peer mentoring as an effective model for engaging with young people with mental health needs in the young people’s secure estate. The role of the voluntary sector should be enhanced in these settings and at the point of release.

Secure units need to review the extent to which their regimes promote recovery for young asylum seekers, refugees and other young people who have experienced extreme trauma. Units will need to adopt flexible and culturally competent approaches to reflect the different ways in which mental health is understood, perceived and managed within different cultures and ethnic groups.

**Mental health needs of young women**

Primary care and CAMHS in-reach teams working with young females in the young people’s secure estate would benefit from access to an up-to-date summary of effective mental health practice to shape provision.

Given the range and complexity of young women’s mental health and emotional problems, wraparound support at the point of release is important.

Greater consideration should be given to the use of family interventions, both in custody and at the point of release.

Young women in custody should be considered a priority group for youth justice diversion and liaison interventions, and for targeted mental health and offending behaviour support as an alternative to custodial sentences.

**Remands and short sentences**

YOTs and point of arrest triage/youth justice liaison and diversion schemes should prioritise young people on remand and those serving short sentences, and work with bail support workers, solicitors and courts to develop holistic packages of support and behaviour management. CAMHS in-reach teams should liaise proactively with the YOT health practitioner or with youth justice liaison and diversion schemes to ensure that mental health issues are supported and followed up for young people on remand. This follow up is especially important where a longer term assessment (such as a Conners assessment for ADHD (Conners et al, 1998)) is needed.

**Access to medium secure units**

A best practice guide and synthesis of current evidence is required to support the development of work with young people with emerging personality disorders or extreme behavioural difficulties.

A strategy should also be developed to support the effective multidisciplinary management and resettlement of those with conduct disorder and emerging personality disorder, building on NICE guidance and considering its implications for services.
Age transitions

A current study and consultation with young people is being completed through Barrow Cadbury funding, and in partnership with Revolving Doors, to investigate best practice models for supporting young people’s transitions in the youth justice system and in the young people’s secure estate. The findings of this study should be monitored and followed up.

Difficulties relating to the transition of young women from small secure units to larger units for women require further investigation.
Appendix

Topic guide for CAMHS in-reach in the young people’s secure estate

Team composition

- Number of WTEs in the team. Demographics?
- Professional background/skill bases of workers (include training, whether CAMHS or general MH background; previous work experience etc)
- What geographical area does the unit cover?
- Snapshot of where the populations come from, demographics (age and BME, female etc)
- Formula for deciding staff ratio and any needs assessment completed.
- How much time is devoted (in split sites) for younger age range? Funding allocated to younger age group and formula for allocating time.
- Funding stream via specialist commissioning or other methods? Find out more. Sustainability of the funding?
- How would they describe the function of each team member?
- How would they describe the role of CAMHS in-reach in the unit? What tier?

Range of functions fulfilled and services offered

For example:

- Assessment and screening (who does this and how do referrals get to the in-reach team?) Are they paper? Verbal? Formal?
- Where does screening activity take place?
- IAPT?
- Early Intervention into psychosis and depression?
- Does local team come in to do above work?
- PD work/DBT?
- Sex offender work?
- Self harm management, interventions and systems?
- CBT or Brief Interventions
- Counselling (sexual abuse counselling; bereavement counselling)
- Link to psychological services.
- DD work
- Groupwork/one to one?
- Family work
- Liaison with the community services and support given to the PCT?
- Map of services in custody and their role in relation to these (PMHC; Inpatient units; Day Centres; Comprehensive CAMHS)
- Procedure for managing self harm risks: e.g. self harm in the past recorded: what’s the procedure?
• Resettlement work? How is this done? Have they mapped services in their catchment area? Do they attend post release meetings?
• Do they use the CPA and if so in what circumstances?
• Any links with RAP schemes? DIPs?

Integration
• Formal links with other parties in the unit (see who they come up with and then prompt)
• Systems for linkage (joint reference meetings; DAAT; reps at what meetings; joint work; community and inside; linkage workers, safeguarding, etc.)
• Are there PMHTs in the unit? Integration with primary care mental health workers in healthcare. Systems and examples? Describe the differences between PC roles and inputs?
• Tools used for assessment and systems for integration across the tiers
• Links with learning disability assessment work: who does it and when? How does it integrate with what they do?
• Resources for autistic spectrum and screening for mental health issues among this group?
• OT/Speech, communication and therapy work
• Co-existing SM and MH
• Information sharing: how does it work? Shared notes? Computerised notes? Do they have access to the EMIS system in custody?
• Resettlement activity: how do they do this? S: 117 meetings?
• Transitional care offered?
• Links with families?
• Links with outside services (particularly YOT, Forensic services, Children’s services, parenting work, CAMHS, GPs)?

Specific populations
• BME specific issues and work. Do they link with community development workers/community agencies to understand the issues?
• How do they deal with the specific health needs of remands?
• How do they deal with those with different lengths of sentence?
• How do they ensure a fair deal for those who are far away from home?
• How do they deal with female needs and what are these needs?
• Do they monitor access and diagnosis patterns via ethnic tracking?
• Faith groups and their support role for mental health?

Resettlement
• How well does this work?
• Enablers and barriers

Miscellaneous
• Targets for transfer to outside healthcare units
• Biggest challenges/areas for development
• What has aided the work?
• Developmental plans/ do they have a development plan? Who puts it together and how is it decided?
• In what ways do they link with commissioners?
• Patient involvement/participation strategies
• Outcome monitoring systems and patient feedback/complaint systems
• Targets?
• Involvement in training for Secure Care officers and other comprehensive CAMHS staff (including support and consultancy with healthcare and outside services)
• Providing support to women
• Providing support to BME young people.
• Supervision (operational; clinical; do they provide it?)
• Examples of what has gone well
• Examples of cases which have gone well/caused them problems with mental health difficulties (transfers/funding/diagnosis/gaps in provision, etc.)
• Examples of community enablers and gaps
• How could they see their work being improved? What practice would they want to develop?
## Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ADHD</td>
<td>Attention Deficit Hyperactivity Disorder</td>
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<tr>
<td>AIM</td>
<td>Assessment, Intervention, Moving on programme</td>
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<tr>
<td>ASSET</td>
<td>A structured assessment tool used by YOTs</td>
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<tr>
<td>CAF</td>
<td>Common Assessment Framework</td>
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<tr>
<td>CAMHS</td>
<td>Child and Adolescent Mental Health Service</td>
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<tr>
<td>CBT</td>
<td>Cognitive Behaviour Therapy</td>
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<tr>
<td>CHI</td>
<td>Commission for Health Improvement</td>
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<tr>
<td>DCSF</td>
<td>Department for Children, Schools and Families</td>
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<tr>
<td>DH</td>
<td>Department of Health</td>
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<tr>
<td>FIP</td>
<td>Family Intervention Project</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
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<tr>
<td>LD</td>
<td>Learning disability</td>
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<tr>
<td>MAPPA</td>
<td>Multi-Agency Public Protection Arrangements are set out in guidance issued by the National Probation Service. The offenders subject to the arrangements fall into three categories:</td>
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<tr>
<td>MDTFC</td>
<td>Multidimensional Treatment Foster Care</td>
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<tr>
<td>MST</td>
<td>Multi-Systemic Therapy</td>
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<tr>
<td>PCT</td>
<td>Primary Care Trust</td>
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<tr>
<td>NCG</td>
<td>National Commissioning Group</td>
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<tr>
<td>NSPCC</td>
<td>National Society for the Prevention of Cruelty to Children</td>
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<tr>
<td>PTSD</td>
<td>Post-traumatic Stress Disorder</td>
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<tr>
<td>SCH</td>
<td>Secure Children’s Home</td>
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<tr>
<td>SDQ</td>
<td>Strengths and Difficulties Questionnaire</td>
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<tr>
<td>SHA</td>
<td>Strategic Health Authority</td>
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A statutory duty is placed on agencies to cooperate with MAPPAs.
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<tr>
<th>Abbreviation</th>
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<tbody>
<tr>
<td>SLCN</td>
<td>Speech Language and Communication</td>
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<tr>
<td>STC</td>
<td>Secure Training Centre</td>
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<tr>
<td>SQIFA</td>
<td>Screening Questionnaire Interview For Adolescents</td>
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<tr>
<td>SIFA</td>
<td>Mental Health Screening Interview for Adolescents</td>
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<tr>
<td>YIP</td>
<td>Youth Inclusion Programmes</td>
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<tr>
<td>YISP</td>
<td>Youth Inclusion and Support Panels</td>
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<tr>
<td>YJB</td>
<td>Youth Justice Board</td>
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<tr>
<td>YOI</td>
<td>Youth Offender Institution</td>
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<td>YOT</td>
<td>Youth Offending Team</td>
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<tr>
<td>YJS</td>
<td>Youth Justice System</td>
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<tr>
<td>YPSE</td>
<td>Young People’s Secure Estate</td>
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References


Centre for Mental Health (2010) You just get on and do it: healthcare provision in Youth Offending Teams. London: Centre for Mental Health


http://www.barnardos.org.uk/news_and_events/events/barnardos_lecture_series.htm


Khan, L and Wilson, J (2010). *You just get on and do it: Health Provision in YOTs.* London: Centre for Mental Health.


