

YOUNG MINDS

The voice for young people's **mental health and wellbeing**

Same Old... **the experiences of young offenders** **with mental health needs**

Research by Sarah Campbell Senior Lecturer, and Stephen Abbott, Research Fellow at The School of Health Sciences, City University London

In partnership with the Transition to Adulthood Alliance

Funded by The Barrow Cadbury Trust

I am pleased to welcome this report and its addition to the evidence that spotlights the lack of appropriate help for vulnerable young people in the 16-25 age group. The particular vulnerability of the 16-18 age group comes through very strongly. They experience so many different transitions at the same time, it's not surprising that their situation worsens. I have personally worked with this age group for over twenty years and am saddened that we seem to do no better now than then.

This is a personal report, written from the perspective of young people involved in the youth offending system, their support workers and health clinicians. Although this may be a small number of individuals, the stories they describe will be familiar to all of us with experience of working with these young people. This report succeeds where others have not, by providing the detail of the individual stories and experiences, the frustrations with the system that seems to work against rather than for them, and the consequences for young people and their lives.

We must remember there is a huge cost to us and society too. We continue to create situations where services are forced to respond to crises rather than prevent them developing, where we pay for imprisonment or inpatient care rather than help when times were tough. As Albert Einstein said; "insanity is doing the same thing over and over again and expecting different results".

It's time we changed how we do things for young adults.



Sarah Brennan
Chief Executive
YOUNGMINDS

**As Albert Einstein said;
"insanity is doing the same
thing over and over again and
expecting different results".**

YoungMinds would like to thank all those who contributed to this research and report.

In particular, the funders, Barrow Cadbury Trust, and also:

The Transition to Adulthood Alliance

Sarah Campbell, Professor Alan Simpson, Sally Hardy and Dr Julie Rowe at City University London

Sarah Anderson, Revolving Doors

Marcus Roberts, Drugscope

Jenny Talbot, Prison Reform Trust

Anna Saunders, Centre for Mental Health

All the T2A, CAMHS and AMHS staff and commissioners.

Lastly our sincere thanks to all the young people who gave their time to tell us about their experiences.

We will ensure your voices are heard.



Executive Summary & Recommendations

YoungMinds is delighted to publish the findings of the research into the provision of mental health services for young people and the relationship to offending behaviour in order to contribute to this vital debate.

However, we are not delighted about the findings of this research which are, as the name of our report suggests, that very little has changed in the last 20 years.

Despite the numerous reports, enquiries, policy documents, expert reference groups, working parties, consultations, white papers, Bills, Acts of Parliament and changes of government, we are still repeating the same old story – that the provision of mental health services for young people at risk of or engaged with offending behaviour is woefully inadequate.

This report sits aside from its many predecessors in that it cuts through all the policy and legislation and talks directly to those people who matter the most: the young people and the professionals that work alongside them.

They told us that:

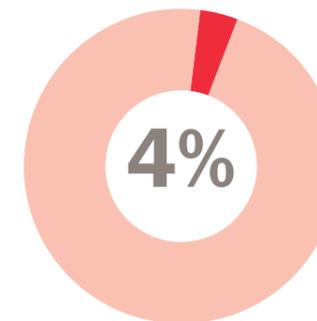
- **Waiting lists are too long resulting in young people self-medicating with drugs and alcohol while they wait to access services thus exacerbating their mental ill health and offending behaviour.**
- **Rigid criteria for mental health services means young people have to be enduring a severe and debilitating mental illness before they can access any type of help or support.**
- **There is still a gap in service provision between young people's and adult mental health services meaning many young people are slipping through the net and lacking support at a vulnerable time in their development.**
- **If a young person manages to receive support, it is largely centred around medication. Following prescription, young people are left lacking medication reviews, support or intervention.**
- **In the rare occasions where intervention extends beyond medication, professionals have little time for young people and a high turnover of staff means a lack of staff continuity making it difficult for the young person to establish rapport or trust.**

In other words, they told us the Same Old...

Alarmingly, the professionals we interviewed described a discriminatory service provision in some areas where professionals saw the crime first and the young person and their mental health needs second. At the same time, professionals working with young people felt their problems could often be predicted meaning young people could undoubtedly benefited from early identification services, had they been offered.

This report highlights five critical issues:

1. The need for consistency of relationships with young people. It takes time for trust, mutual respect and empathy to develop and is the core requirement for positive developmental work to take place.
2. All staff delivering services to this client group need greater knowledge and skills regarding the identification and awareness of mental health issues.
3. Lack of any coordination or collaboration between services. Young people reported how changing personnel and agencies, short term treatments, unclear expectations and different job roles undermined their progress. Improving the coordination, access to and transitions between services would have a significant impact on young people's experiences and care pathways.
4. Who holds the ring? Young people reported a chaotic mix of health care pathway management with the young person's mental health being the cost. Assertive health care pathway management is crucial for these young people whose life circumstances are changing rapidly. If one individual or agency took the lead they could actively monitor the clients' care pathway, hold other services to account, ensure medical case reviews happen regularly, medication is actively monitored and the young person actively engaged – as well as improve coordination.
5. Easy access to accurate information for young people, families, advocates and services is essential. Confusion and uncertainty leading to a lack of confidence caused by 'not knowing' was consistently reported. Information about all services, referral processes and confidentiality must be available which explains simply what can be expected and when.



only 4% of young people reported a good transition from CAMHS to AMHS



of imprisoned young offenders have a mental health disorder

We are calling on politicians, local government, commissioners, CAMHS and AMHS, magistrates, GPs and the children's workforce to grasp the nettle, take on board our recommendations and work with young people to ensure they get the mental health support and intervention they need. Young people deserve better and society deserves better. We should not be writing these young people off at the age of 20 with a bleak outlook of becoming engulfed in a life of crime which will dictate their futures because they did not receive the help, support and intervention they needed during adolescence.

We all have a duty to work with young people to ensure they have a brighter future where they are contributing to society rather than rebelling against it and to ensure that we are not sat here in 20 years time reading about the Same Old...

Key recommendations are:

1. Implement existing strategy

As the title of our report suggests, a lot of the issues we have raised have been highlighted in previous research. Implementing existing policy, namely the Mental Health Strategy Implementation Plan and the Caldicott 2 Review (2013), would go a long way to mitigating some of the problems we have outlined. We urge the Youth Justice Board and Ministry of Justice to ensure existing policy is implemented as a matter of urgency.

2. Training

All professionals and specifically education professionals working with children and young people at risk of offending should receive training to gain baseline knowledge and skills regarding the identification and awareness of mental health issues to ensure children are not written off as 'trouble children'. Both police and magistrates need training in mental health to deal with the young person appropriately and ensure appropriate sentencing. All professionals in the criminal justice system must understand any mental illness issues and not just see the crime.

3. Senior Clinicians Role

Make the best use of expensive senior clinicians time and expertise by enabling them to provide supervision and consultation for a large number of the youth and young adult workforce providing treatment for young people; thereby also providing 'on the job' training in a practical way.

4. Lead professional

Responsibility to actively monitor a young person's case needs to lie with a lead professional: an individual or agency that ensures that medical case reviews take place regularly, medication is actively monitored and the young person is actively engaged

in their mental and physical health care. GPs are well placed to fulfil this role as they are the only person who sees whole families and whose services span all ages. They also have clinical accountability.

5. Joint Commissioning

Health and Wellbeing Boards should ensure joint commissioning across offender mental health and local CAMHS to ensure 'joined up services'. Clinical Commissioning Groups (CCGs) should appoint a mental health lead at senior level.

6. Targeted Commissioning for at risk 16-19 year olds

Consideration should be given as to how services can be targeted at the 16-19 year olds most at risk given the apparent inability of CAMH or AMH services to respond appropriately. Contracting with local community services demonstrated success, as did engagement with the client group such as those supported by Youth Access and Transition to Adulthood (T2A), and co-location with other services.

7. Easy access to services and information

A single point of access to services should be extended to include young people involved with the criminal justice system. CAMHS websites should develop better information, targeting this group to provide a shared point of information for young people, social workers, health professionals, criminal justice professionals, parents and police.

8. Raise awareness

Local government should appoint an elected member to be a 'mental health champion' and this role should include raising awareness of mental health problems. YoungMinds is one of six national mental health organisations supporting member champions in local government. To take up the mental health challenge visit the website www.mentalhealthchallenge.org.uk

1. Introduction	8
.....	
2. Vulnerabilities of young people in the criminal justice system	9
.....	
3. Methodology and ethics	14
.....	
4. Research Findings:	
a) Part 1 – Problems with existing provision	16
b) Part 2 – How ideal services might look, according to young people and professionals	24
c) Part 3 – Implications for the criminal justice system	28
.....	
5. Recommendations for Achieving Excellence – What key agencies need to do	34
.....	
6. Examples of Best Practice	45
.....	
7. Appendices	
1) Acts of Parliament/Bills processing through Parliament	46
2) References	48
.....	

1. Introduction

The need for the Same Old... research came about because of a shared concern by YoungMinds and the T2A Alliance about the relationship between mental health services and youth offending. Our concern was that a lack of provision of mental health services exacerbates offending behaviour in young people who are in touch with the criminal justice system, and leads to further marginalisation from society and greater hopelessness.

The resulting report is a partnership between the T2A Alliance and YoungMinds funded by the Barrow Cadbury Trust. The research was undertaken by City University London during 2012-13.

This research project explored whether provision or non-provision of mental health services to young people (aged 16 to 25 years) had any impact on their offending behaviour.

It is well known that many young people who are involved in the criminal justice system have mental health problems, some have a diagnosis, others don't, some have accessed CAMHS services, many haven't but need support, some are referred to adult services but many are not accepted. The way mental health services are commissioned and configured makes it very difficult for young people who are offending to get the support they need. For example, young people who are diagnosed with disorders like ADHD, mild learning difficulties, autism spectrum disorders and personality disorder, even if seen by CAMHS services, will not be taken on by adult services. Sadly the prison system has a high proportion of young people with these disorders.

Many young people in the criminal justice system have a host of other vulnerabilities including being the victims of sexual and physical abuse, neglect, school exclusion, drug and alcohol addiction, unemployment and homelessness. The relationship between these vulnerabilities and mental health problems are well known and therefore poor provision of mental health support just adds to all these issues.

2. Vulnerabilities of young people in the criminal justice system

Number of young people in contact with the justice system

Young adults make up less than 10% of the British population, but account for:

- **more than 33% commencing a community sentence**
- **33% of the probation service's caseload**
- **almost 33% of those sentenced to prison every year (Transition to Adulthood Alliance, 2012).**

Complex Lives of Young People in Contact with the Justice System

We know that children and young people who come into contact with the justice system often have very chaotic lives, and experience a whole range of negative life experiences such as seeing their parents divorce, living in poverty and in a deprived environment, where violence and gangs are everyday experiences or where their parents have mental health problems.

There are a number of risk factors that increase the chances of children and young people getting involved in crime, and many of these are similar to risk factors for mental health problems (Centre for Social Justice, 2012). A recent evaluation of the Youth Justice Liaison and Diversion pilot scheme (Haines, A. et al. 2012), found that 80% of young people had between one and five vulnerabilities, which range from mental health issues, behavioural issues, and social problems.

These risk factors can be split into three groups and some of these are listed overleaf. The more risk factors a person experiences the greater the risk of that young person getting involved in anti-social or criminal behaviour. It is not always easy to address the risk factors. For instance, there is no easy fix for poverty or poor housing. However, there are also protective factors (shown overleaf), which can mitigate the risks, and help reduce the chances of a young person getting involved in crime. For instance, evidence-based parenting programmes improve outcomes for children who display behavioural problems (Brown, E.R. et al., 2012).

The ages between 16 and 18 years are the period where the majority of offending takes place, it is also one of the most vulnerable periods in young people's lives in relation to their futures.

80%

of young people had between one and five vulnerabilities, which range from mental health issues, behavioural issues, and social problems

Risk Factors

ENVIRONMENTAL

- Lack of commitment to school (including truancy)
- Aggressive behaviour (including bullying)
- Low achievement beginning in primary school
- Attending a school with a high delinquency rate/school disorganisation
- Associating with delinquent & drug misusing friends
- Living in a deprived neighbourhood/community disorganisation & neglect
- Growing up in a low socio-economic household
- Poor housing
- High population turnover & lack of neighbourhood attachment

FAMILY

- Criminal or anti-social parents/history of criminal activity
- Large family size
- Poor parental supervision & discipline
- Child abuse & neglect
- Parental conflict & family disruption
- Parental attitudes condoning anti-social & criminal behaviour

PERSONAL

- Personality & temperament
- Low intelligence
- Lack of empathy
- Alienation & lack of social commitment
- Impulsiveness & hyperactivity
- Attitudes that condone drugs misuse
- Early involvement in crime & drug misuse

Protective Factors

HEALTHY STANDARDS

- Promotion of healthy standards within school
- Prevailing attitudes across a community (ie school disapproval of drug misuse)
- Positive behaviour & views of parents, teachers & community leaders (who lead by example & have high expectations of young people's behaviour)
- Opportunities for involvement, social & reasoning skills, recognition & due praise

SOCIAL BONDING

- Stable, warm, affectionate relationship with one or both parents
- Link with teachers other adults & peers who hold positive attitudes & 'model positive social behaviour'

INDIVIDUAL

- Positive, outgoing disposition
- High intelligence
- Resilient temperament
- Female gender
- Sense of self efficacy

At Risk Groups

Some groups of young people are over represented in the justice system.

Between **23-32%** of young people in custody have a generalised learning disability compared to just **2-4%** in the general population (Hughes, et al., 2012)

Between **65-76%** of young offenders had a traumatic brain injury compared to between **5-24%** in the general population (Hughes, et al., 2012)

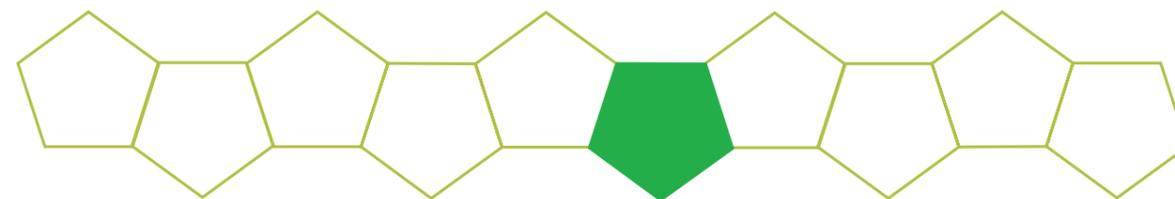
Up to half of the young people held in Young Offender Institutions are, or have previously been in care (Blades, R. et al., 2011)

In a survey of offenders, **41%** reported witnessing violence in their home as a child and **29%** reported emotional, sexual or physical abuse as a child (Williams, et al., 2012)

1% of young men entering custody had the literacy skills of a seven year old, and **46%** were rated as underachieving at school (Summerfield, 2011)

Nearly **90%** of young people in Young Offender Institutions had been excluded from school (Berelowitz, 2011) and **40%** of young people had been homeless in the six months before entering custody (Berelowitz, 2011)

Young people in the justice system who have mental health problems



1 in 10 of 5-16 year olds (Green, 2005), will experience a mental health problem at some point in their lives (HM Government, 2011)

45% of children who have mild or moderate conduct problems go on to commit half of all crime at an annual cost of some £37 billion (Sainsbury Centre for Mental Health, 2009)

43% of young people in prison have ADHD (Young, et al., 2011)

Some mental health problems are particularly prevalent in young offenders. Early intervention prevents mental health problems becoming more severe and helps reduce the risk of these young people becoming involved in crime or antisocial behaviour

A study from the Office for National Statistics (ONS) found that **95%** of young people in Young Offender Institutions, aged 16-20 years, had a mental disorder and many of them have more than one disorder (Lader, et al., 1997)

Most adults with anti-social personality disorder had a conduct disorder as a child (NICE, 2012)

90% of the most persistent adolescent offenders showed marked anti-social behaviour in early childhood (NICE, 2012)

3: Methodology and Ethics

Design

A cross-sectional qualitative study design was undertaken to explore the experiences and views of key stakeholders taken from across three different study sites.

Stakeholder groups were identified as:

- **Young people who had contact with criminal justice services and who may not have had access to mental health services (achieved via personal interviews)**
- **Staff providing services and support to these young people (achieved via focus groups)**
- **Commissioners of such services (achieved via email interviews).**

Ethics

Ethical considerations surrounding this research study undertaken at City University London are stringent and in line with City University London's ethical code of conduct. This is particularly important due to the significant vulnerability of some of the participants.

Ethical approval was successfully applied for through the formal processes involved at the Senate Ethics Committee, City University London and the National Offenders Management Service (NOMS) at the Ministry of Justice following the Integrated Research Application System (IRAS) procedure. Further approval and full consent was sought from all participating organisations and agencies. Copies of all information sheets and consent forms are listed in the appendices in the full report.

Interviews

Young people using T2A services were invited to participate in face-to-face semi-structured interviews, which explored the young people's experiences of offending, criminal justice services, mental health and other support services. Interviews were audio-recorded with consent.

Semi-structured individual interviews were chosen for data gathering to allow and encourage young people to talk in detail about their experiences and views.

Young people were recruited by research staff at the London, West Mercia and Birmingham T2A study sites. T2A staff chose suitable clients and approached them to find out if they would be willing to take part. An information sheet was provided for them to give to clients. When clients were willing to take part, T2A staff then arranged interviews on behalf of the researcher. Before the interview began, the researcher checked that the young person understood what was involved, particularly the fact that participation was voluntary and answered any questions. Consent forms were then signed by both parties.

- In London, five interviews were held in three sites between September and November 2012.
- In Birmingham, one interview was conducted at the end of November 2012.
- Nine interviews were achieved at two sites in West Mercia at the beginning of August 2012.

Ten young men and five young women were interviewed, ages ranging from 16 to 25. Ten were White British, one was 'White other', two were Black Caribbean, one Black African, and one of mixed race. Numbers of offences ranged between none and forty-two (those with no offences had nevertheless had contact with police because of their association with young criminals). Eleven were single, four in an established relationship. Eight lived with a family member, four in their own accommodation, and three in a hostel. Eleven reported drug and alcohol problems, and twelve reported mental health problems (most frequently depression was the diagnosis cited, although one reported bipolar disorder and borderline personality disorder, and one reported schizophrenia).

Focus Groups

T2A staff and local mental health service providers were invited to take part in a focus group. Each focus group was facilitated by two researchers and contained between three and twelve members of staff, who were asked to discuss the support provided and required for these young people.

T2A and local mental health staff were recruited by the City University London researcher who provided written information about the study and obtained consent to participate.

Two types of focus group were held: one for T2A staff and one for health professionals.

- In London 12 participants were recruited into the T2A focus group and 3 participants were recruited for the health professional's focus group.
- In Birmingham 3 participants were recruited into the T2A focus group and 7 participants were recruited into the health professional's focus group.
- In West Mercia 7 participants were recruited into the T2A focus group and 7 participants were recruited into the health professional's focus group.

Commissioner Interviews

We were unable to recruit local commissioners but were able to recruit senior health professionals in national commissioning and policy roles within mental health service provision. This was achieved via email responses to posed interview questions. Commissioners were recruited by the City University London researcher who provided written information about the study and obtained consent to participate.

We received two email responses to posed interview questions from 2 commissioners.

Participation

In total for this study, 41 adults and 15 young people were interviewed totalling 56 participants in all.



4: Research Findings

PART 1: Problems with existing provision

Rigid criteria

In the main, Child and Adolescent Mental Health Services (CAMHS) were criticised by practitioners for the lack of provision for young people who are not suffering from severe and enduring mental illness as their referral criteria are too rigid. This was said to be reflected systematically in CAMHS provision of early intervention as if a family did not attend the initial assessment appointments they were discharged. It was identified frequently that specific outreach or community CAMH services only exist if locally supported, prioritised and commissioned and that service funding grants come with specific conditions that can be exclusive of many young people's mental health needs.

The rigid and high threshold for referral to CAMHS was felt by professionals to be a factor contributing to more severe mental health problems.

There is a problem with referral mechanisms, as young people only get assessed if they meet the criteria. Often young people only meet criteria when they are older and the problem is more severe and the transition from one service to another happens when the young person is at their weakest point. (Professional)

In general, referral criteria was seen to block service provision access.

Eligibility criteria, because they don't have a mental health problem that is long-term and is severe enough for mental health services, they only have their GP... it's very difficult to get someone into longer-term counselling. Particularly if they're under 17 and not eligible for psychological services. (Professional)

Participants also raised concerns about referral criteria with "some disputes about what falls within mental health and what doesn't" meaning young people were left without support especially when they left school.

Waiting Lists

Many of the young people interviewed for this study were not engaged with mental health services and the professionals who were working with them reported problems accessing services for young people. A long waiting list for CAMHS was frequently stated as a contributory factor to increasing offending behaviour. Many examples were given to support the difficulty of getting adequate service provision due to the long waiting lists and how this encouraged young people to look for alternatives. An important reason for service discontinuity, was waiting lists for mental health services once referrals had been made, although this was sometimes facilitated by T2A staff.

There is a long waiting list for CAMHS which means things like offending can get worse because no one is giving them the right attention. (Professional)

Participants expressed concern around CAMHS resourcing and the pressure on streamlining and local determining of service provision to accommodate managing CAMHS waiting lists which can carry penalties. These factors were felt to be detrimental to a comprehensive CAMH service provision.

The long waiting lists exacerbated a difficult transitional stage between child and adult mental health services.

Transition between services

Participants expressed general concern that there is a gap in mental health service provision for young people aged between 16 and 18 years as they are at a transitional stage between child and adult services. It was felt that they do not receive a mental health service although need is identified.

Mental health is a real big one as well, especially between the ages of 16 and 18 because..., from 16 they're no longer under Child and Adolescent Mental Health Services. And then from 18 they then go on to Adult

Services, so that gap between 16 and 18 is a crucial nightmare to be honest because they just get lost in the system. And waiting lists to try and access these services are horrendous. Particularly if there's substance misuse, a dual diagnosis. (T2A Staff)

Health professionals expressed how different boroughs or trusts had different priorities and that provision of services could be a 'post-code lottery' with some areas "rationing services and support".

I think it's quite sad that we only have one CAMHS worker across the whole of the (borough) working with the Youth Offending Team (YOT) and you go to boroughs next door who have a psychologist service and a forensic service for young people, of a smaller population. Like a post-code lottery. (Professional)

It was expressed that young people are vulnerable not only because of their health but also that their transitional age made accountability, parental involvement and guardianship confusing, and their rights to welfare and services and criminal law was unclear to them.

...also legally young people are very confused at 16 to 18 as to what they can and can't do, because you can do some things but it's illegal to do other things. And the decision-making is very confused with parental responsibility in the eyes of children and young people. (Professional)

Disengagement was discussed as a consequence of poor service transition.

There are some services, for example, targeted youth support that will continue to 19, but a lot of the time you find disengagement happens when there's a transition between agencies, when they leave children's services and linking into adults. I think that's a particular issue for CAMHS because, ... it's often perceived as a child and family [service]. (Professional)

Serious concerns with dual diagnosis were reported within CAMH service provision.

I think what we're looking at is the discrepancy between service criteria and the challenges that that presents for this age group in terms of their maturity, and their needs including mental health, and I think one of the particular challenges is where there is dual diagnosis of mental health and substance misuse and the challenges that that presents for service provision in the absence of transitional service in mental health. (Professional)

The issues regarding referral and diagnostic classification were relevant within adult services too and the consequences and relation to offending were far reaching.

If we're dealing with the 16 to 24 group, they hit 18 and medication stops. Adult services won't acknowledge or treat Attention Deficit Hyperactivity Disorder (ADHD) in adults. There is no specific service for young people when they become that age. ADHD causes impulsivity, so the young people are not necessarily aware that they're going to offend, that they would suddenly do it, because the disability is inattention, distractibility and hyperactivity, and so they can easily manipulate, be manipulated. If they have Asperger's syndrome or autism as well as ADHD, which is a common co-morbidity, they can be naïve, trusting and extremely vulnerable. ... it's often common for a perpetrator with ADHD and autism to also be a victim. (Professional)



There is a long waiting list for CAMHS which means things like offending can get worse because no one is giving them the right attention.

Professional



Referrals

Most of the young people interviewed mentioned the help they received from T2A and other services, in the form of referrals or introductions to other services. Most also valued support in accessing services including mental health, GP, college, benefits, housing and solicitors that they found difficult to access alone. Again and again, young people mentioned times when workers had helped them to complete application forms or to make phone calls, had accompanied them to appointments and had acted as an advocate. Some young people lacked the confidence to do such things on their own, often with disastrous consequences, so the help of staff was critical.



The medication they put me on, it was making me that drained and I was dribbling all the time, I couldn't even care for my son. That's why I had to send my son to his dad's ... it's affected my life even more losing him, really.

YP8



As discussed in an earlier theme around rigid criteria and high thresholds, it was often hard for young people to be referred for services and if they were, the referral pathway was often blocked. If they received a referral and saw a professional, the most common experience young people had of mental health services related to the prescribing and taking of medication.

Medication

Some young people recognised the contribution that this could make to their stability and enhanced life skills, and some praised those people or structures that had supported them to take their medications prescribed.

My case worker here always calls me to make

sure I've taken my medication so I don't lose it. (YP10)

It was getting on the medication in jail, being stable, having a safe environment to be in where I knew everything that was going on. It got me that sense of security and safety that I can start getting better. (YP2)

However, mental health services were not reported as being involved directly in providing such support.

Some young people interviewed showed an awareness of debates about the appropriateness of prescribing medication to younger people. One had wanted medication but was denied it. Two others felt that their medication needed review, but found it difficult to get one.

Well, they put me on diazepam, which is from the benzodiazepines, and I've been on that now for over a year. And you're not supposed to be on it that long because it's a very addictive drug ... [My GP] can't lower my dosage and he can't do anything about that because it's the mental health services and the consultant decides what I take ... But he's very upset with the mental health services, he's sent them a couple of emails now saying, she shouldn't be on this anymore, because, in the long run, it's really going to mess her up. But they haven't emailed him back or got in contact. (YP10)

I'm trying to say, look, my medication needs to be looked at all the time, you can't just give it me and then leave me for two years. It needs to be moderated, we need to look at it, make sure that it's still working. Because this was the problem that I had with the medication before, which is why I stopped taking it, because it wasn't working ... Then I obviously plummeted down into a bout of depression. (YP2)

While for some young people the medication helped, for others the consequences of side effects had been far-reaching.

The medication they put me on, it was making me that drained and I was dribbling all the time, I couldn't even care for my son. That's why I had to send my son to his dad's ... it's affected my life even more losing him, really. (YP8)

Pressures on existing services

T2A workers described how professional mental health services are unable to give individual care and the quality of contact as a major concern.

I find as well that even with time constraints, if you go to other organisations, not even just organisations, but statutory bodies and even YOTs that we work with, they've got such an immense workload that they cannot give considerable due time to each case. So for example if someone's on a YOT order and they have to see the YOT worker once a week they will do a workshop where they get 10 or 12 people and they'll talk about knife crime. So they're not talking about their individual problems, it's as a group. (T2A Staff)

Participants felt that professional and practitioner resources are very limited.

Some organisations there's a quota that they can take on, even with us, we can't take on too many heavy caseloads because its intensive work that you're doing with each client and there isn't enough budget to get another paid member of staff. (T2A Staff)

The pressure school systems are under and the quality of the training teaching staff receive was felt inadequate for identifying mental health problems and learning difficulties and was a concern.

If you look at the pupil referral units, the numbers have grown immensely because at the end of the day if the child is not conforming and doing what you want to do you want them out, they're holding back the rest. Because there's pressures on the teachers who have targets, it's like a vicious circle here. How do they expect a teacher who's just come out of university a couple of years ago, who doesn't know anything about the ghetto- because that's what it's all about, being in the ghetto – to talk to these kids? How are these teachers meant to control them? (T2A Staff)

Time limited relationships

In general young people did not report lasting relationships with mental health workers. Rather more of them did so with probation officers or voluntary sector workers. Though some had had the same GP for a long time, they did not report sustained support beyond the prescribing of medication. Few had had much contact with mental health services, though one (YP10) reported a long though discontinuous history of contact. This included a helpful relationship at the age of 11 with a psychiatrist, and a wait for seven months when the latter retired for a replacement, whom YP10 did not find helpful and did not continue to see. She had also been an in-patient.

It's interesting, I'll give you that. I was on section and volunteered, I went in at first voluntary because I knew I was losing it. It was interesting in there because it's not that – it makes you more crazy. Watching the crazy people when you don't feel that crazy ... I don't think it's a place that helps anyone. Everyone that I know that I was in hospital with is still in a bad way now. (YP10)

A major emphasis was lack of staffing continuity. YP1, for example, reported having had six different probation officers in three months. Discontinuity disrupted relationships with staff and made the building of rapport difficult. Several suggested that changes in staff tended to de-motivate them.

My problem is opening up to people I don't know. I like to work with the same person all the time because once I've met that person, you know me, I know you, there's no need for 23 introductions and then each time I work with them I get to know them a bit better, so by the end we've got a good rapport. But I don't want to have to keep being thrown to and from this person, that person. (YP2)

When professionals [in this case, school staff] did not listen, the results could be damaging.

They never sat down and said to me, what is the problem? They never took up the issue of my dad dying and of giving me that sympathy, or not even just the sympathy, they never gave me the time to even grieve. They just wanted me to do exams and exams, exams and they never took it into consideration that I was grieving for my father. (YP12)

Voluntary sector workers confidence around competencies

T2A staff often felt competent at identifying critical issues for their clients but expressed concern about passing these issues on to other services due to the reception they received.

I think we're all more competent at realising there's something that needs more investigation. What we're not so confident in is actually then phoning the services and saying, 'Hi, I'm so and so from T2A, and we've identified X'. Because again it's the reception that you get from the person on the end of the phone, well what do you know about it? Not, who are you? (T2A Staff)

Many T2A workers felt comfortable identifying mental illness most of the time and they had learnt this from experience. Their role demands a lot of contact with young people and they felt this was useful in terms of identifying problems or mental illness.

And you see them (young people) for a prolonged period of time whereas again other services might have 10, 15, 20 minute appointments, when you're spending 1 hour, 2 hours, 3 hours at a time a couple of times a week with somebody you can notice those changes. (T2A Staff)

Some participants expressed concerns about recognising a learning difficulty. However participants felt that illiteracy in this client group is extremely high and should be distinguished from a learning disability, although it increased vulnerability.

Sometimes a young person is classified as having a learning disability when really they've just never really learnt how to write properly.... But that isn't a learning difficulty ... That's a big problem I'm telling you because I've seen it and it's hurtful to see somebody 20 something years old and they can't read, they can't write. In prison you see a lot of people, they drive a big BMW car, got a lot of clothes, got everything, but when you see them in jail, they can't read or write and they just sink. ...they've got to ask a man, 'I've got a letter from my girlfriend, read it for me'. (T2A Staff)

Complexity of need

Drug and alcohol abuse was discussed as a very common experience for most young people. Many young people used illegal drugs such as cannabis or skunk to self-medicate to try to manage their own mental health problems in the absence of alternatives.

Yeah, I've got a young lad at the moment. I chased up a mental health appointment for him on Friday and I was told that there is an 18 months wait.... and you can see why young people tend to self-medicate with either cannabis or alcohol purely because they can't wait that long to get the help. (T2A Staff)

Worries were also highlighted around young people copying their parents' substance misuse and participants were particularly concerned about the dangerous quality and the cheap availability of substances.

These young kids are smoking skunk and don't realise the effects of it and then they're drinking alcohol on top of it. It's easier to buy a bottle of cider than it is to go to the cinema. They're just committing crime, they don't even realise that they're committing crime until the next morning until they're in the police station and their parents are being called. And a lot of the time it's because their parents are actually smoking weed and that's why they're getting into it as well. (T2A Staff)

Professionals felt that often a young person's problems could be predicted. Homelessness, substance misuse and child abuse were frequently cited together as identifiable factors contributing to the young person's offending behaviour and this was considered a growing trend.

There was also considerable concern that many young people the participants worked with struggled with housing issues. The majority of these young people are 'care leavers' with identified mental health problems as well as young offenders. T2A staff reported having very few supported accommodation options and the lack of suitable accommodation and the risks of young people taking what is on offer seems a current national picture.

Participants expressed concern that the legal status of 'Intentionally Homeless' reduces options and precipitates further offending behaviour, criminalising young people. These young people often come from high risk and abusive backgrounds which are traumatic and precipitated them being 'in need' and 'in care'.

And a lot of the behaviours particularly around offending, also around things like becoming 'Intentionally Homeless' through housing law, start closing doors for your future at that age. And for people, for example, leaving care, fine, I'm homeless on my 18th birthday, that's good, isn't it, because I've blown, got an arson offence, I smoke weed all the time, and I've been kicked out of three hostels, therefore I'm 'Intentionally Homeless'. May as well say, "OK, youth offending institute's over there, your honour, just walk to the gate and admit yourself", because unfortunately that's where a lot of them (care leavers) are going. (Professional)



These young kids are smoking skunk and don't realise the effects of it and then they're drinking alcohol on top of it. It's easier to buy a bottle of cider than it is to go to the cinema. They're just committing crime, they don't even realise that they're committing crime until the next morning until they're in the police station and their parents are being called. And a lot of the time it's because their parents are actually smoking weed and that's why they're getting into it as well.

T2A Staff



Stigma

Issues surrounding stigma arose constantly within different contexts. The local community was frequently described as a hostile place for children and young people to grow up in. The absence of community support was commented upon and a lack of activities such as youth clubs was mentioned by professionals.

Children aren't accepted in the community and that comes back to the stigmatisation and the labelling. Because communities see a group of youngsters playing in the street and even if they're building a go kart out of planks of wood that they've found they'll get done for criminal damage because they've nicked the planks of wood. (T2A Staff)

In schools, young people with mental health problems or learning difficulties were labelled as 'trouble children' and did not receive the support they needed. The T2A workers felt there was a lack of identification of mental health problems and learning difficulties in school environments. This was further remarked upon as being an early factor in the development of delinquent behaviour because of the lack of attention to identified difficulties.

We have these children who are dyslexic and it's not recognised ... they're left to the back of the class ... eventually they're going to think, you know something, no one even gives a shit, so you know something, I'm not going to give a shit. ADHD is being recognised, there was a time when it wasn't being recognised. But even now I don't think it's up to scratch where it should be. ... But to even get them a statement is a mission. It's a mission and a lot of parents will give up. Because most of them that you see with a statement are trouble. They're put down as being trouble children... and because they're trouble kids they're put to the back of the class and you do what the hell you want to do, you're already labelled as, you're never going to achieve anything. (T2A Staff)

Young people did not want to engage with CAMHS because of the stigma around having a mental health problem and accessing services.

I think young people don't access mental health services simply because of the name ... Once I

get a young person sat down I can explain my role in such a way that they want to engage, ... Half my job is just getting them to sit in a chair for a moment of time and give them the opportunity to choose. (Professional)

Participants stated that they experienced CAMHS as having preformed ideas regarding young people who had offended. Both of these aspects created difficulty in providing services and making services accessible to meet the need.

Speaking with some of my colleagues within CAMHS to kind of dispel the whole criminal aspect of young people and that actually they're not as dangerous as they sound,... the kind of myths that these types of young people are very hard to engage with, and they're never going to turn up and they're not going to respect you and they're going to trash the place, you still have these attitudes in this day and age. I would like to say that actually if a young person is involved with the Youth Offending Team then actually no one really wants to touch them. (Professional)

Social factors

Health professionals and T2A staff in both sets of focus groups recognised that many of the problems for the young people they were working with had started from a very young age. Social, economic and psychological factors played a big part alongside the environment the child was raised in. The economic climate also impacted upon young people, with professionals identifying that young people they worked with had limited opportunity.

I think financial difficulties play a part. I've had clients in the past that have felt they had to offend because their parents couldn't afford to buy them things, because they can't get jobs or because they've only just got to stay in the country. And the kids have felt that due to financial difficulty that they need to commit crime. (T2A Staff)

Peer pressure was identified as a massive social issue for young people and that combined with financial worries led to offending behaviour.

Everyone wants what they can't have. If you've got curly hair you want straight hair, if you're

black some people want to be white, if your friend's slim you want to be slim. Peer pressure is a big, big problem for children, so to go to school ... and wear the wrong shoes... And when they can't get some, well some of them will go out and nick it. (T2A Staff)

There was general consensus amongst health professionals in their group that social pressures had changed.

Understanding something of what it must be like now to be an adolescent, 16 to 25 say, in 2012. I think the pressures have accumulated massively ...the whole idea of how they place themselves within a peer group, has just become so complex. Some of that is all to do with the modern technology that they have to face, you know, we all used to perhaps have a bit of bragging and a bit of bullying in our lives, now it's sort of viral, it's sort of networked and it's Tweeted. (Professional)

Participants discussed the impact of absent parents or parents who are overstretched and trying to make ends meet as factors contributing to young people's situations. Young people had a lack of rules and boundaries and little attention from their busy or absent parents. Participants also felt that there is an increase in vulnerable families that need support.

...there is a lack of early intervention when problems have escalated and there is lack of services to support vulnerable families. There has been an increase in vulnerable families. (Professional)

There was also considerable concern that many young people struggled with housing issues. The majority of these young people are care leavers with identified mental health problems as well as young offenders.

We've got very few supported accommodation options in. We've had young people refused access to one young persons' supported accommodation/hostel because they're too low risk to go into the adult hostel at 18 but they're too high risk to go into the young persons' hostel at 18, so where do they go then? I don't know, but we can't help them. (T2A Staff)

A real lack of alternative safe and supported accommodation for troubled young people can increase the risk of further mental health problems and offending in young people.

So one of the people I was working with had no accommodation, he was a young lad leaving care, I think he was 19, he had an order to go back to prison and he just said, 'I'm going to kill myself or I'm going to commit an offence'. He felt they were his options. He went out and burgled a family member's home, and he was then sentenced back to custody and he was remanded. He did get released from custody and got a community order, but then was re-arrested the next day for being under the influence of alcohol and assaulting a police officer. And unfortunately a really traumatic incident happened to him in custody the previous time round, which he disclosed to his solicitor who disclosed it to the judge, who on that basis said that he wasn't going to send this young person back to custody because it wasn't a safe place for him. And he self-harmed very badly. (T2A Staff)



Children aren't accepted in the community and that comes back to the stigmatisation and the labelling. Because communities see a group of youngsters playing in the street and even if they're building a go kart out of planks of wood that they've found they'll get done for criminal damage because they've nicked the planks of wood.

T2A Staff



PART 2:

Creating the ideal services; according to young people and professionals

Trust and rapport with practitioners

T2A participants repeatedly acknowledged the reasons why trust takes time to develop with young people and that short-term interventions are unable to develop this vital aspect of recovery.

It's actually about relating,... So most of these kids have had trust issues from the beginning, for a long time, they don't trust people in authority... for them to speak to somebody and open up it's not going to happen overnight. ...It's going to take a long time to build that rapport, so to build quality support, a real support and the support you're talking about, not just a minor intervention, but a major transformational change, you have to be able to go into somebody's life and go back and understand why they are the way they are and then rebuild a life. (T2A Staff)

Young people were clear, and often emphatic, that having a good relationship with service staff was crucial to the successful offer and acceptance of support.

This young man gave an example of someone who had understood how to build rapport.

[My alcohol worker] actually asked me how my week had been, how my daughter was getting on, before we even started the session ... And then she'd start the session, once she'd got me in a good space of mind, which was quite good... As soon as someone tries poking and talking about something I don't want to talk about, I get agitated, my barriers go up, I get defensive, and I close myself off. (YP6)

If the person that's involved doesn't feel any trust or that they can relate to that worker you can give them all the support in the world, it is not going to mean anything. (T2A Staff)

Meaningful and regular engagement

Young people described the short appointments as insufficient to tackle their multiple problems and asked how they could talk about changing their lives around in a 15 minute appointment? They also gave accounts of discontinuous or intermittent services if they managed to receive a service.

The psychiatrist put me on the medication, and then he said, I'll see you three months, four months and that will be it. Left me. There was no therapy then, there was no CPN (Community Psychiatric Nurse), there was no social worker, there was nothing. I was left on my own with all these tablets. And he was giving me a month's worth of tablets. I did OD, I think, twice on them, and they still gave me them. And then I just stopped taking them... (YP8)

[On another occasion] the community crisis team were working with me at home and stuff, monitoring me. But that only lasts four weeks, so they only work with you for a short period of time. And that was perfect then with them there. Everything was fine, I was on my medication, it was good, but only for that four weeks, and then they go. And then there was nothing else put in place after. I was left to my own devices, and someone that ill shouldn't really be left on their own, you know? (YP8)

Providing the right sort of substantive care that is effective was discussed in relation to short-term interventions.

An example I can give, this time last year we had a group of six young boys who offended over the summer, ...robbing people in parks and stuff... we did some quite intense thinking around their offending behaviour, we put aspects of mental health in there, ...So there'll be three of us with these young boys and we would talk to them about what's going on and what's happening, why they think they're offending? ...for the period of time that they had that, they weren't out robbing. It was only once a week, it wasn't kind of an intensive five day programme or anything like that and the rate that they were offending definitely came down ...

they weren't so much on the police's radar, but as soon as that stopped ... it (offending behaviour) gradually started creeping in. Then one got sent down, got remanded, one had a court appearance, their offending started to repeat. It would be great for some of these projects if they were, certain, really long and sustaining in terms of maybe six months to a year ... rather than six to eight weeks worth and involve their families, because very often if you're able to engage the family, some of the behaviours which may be reinforced by the family slow down or stop. So if we kept it to the same time, same day, every week, they knew that was coming up whereas you know if it's not then it kind of loses its momentum and pace. (Professional)

Consistency and motivation

It was recognised that when young people get let down this can have a negative impact on their motivation and aspiration. Participants discussed the impact of this service and worker withdrawal on the young person.

I remember more than one young person asking me, so how long are you going to be here for? young people do want to access support, but like we've been saying, I think trust is a massive, massive thing and if they open up and trust someone and then all of a sudden they're pulled, ... it's just that actually young people become mistrusting of those sorts of services, because they don't feel that they're going to be there long enough for them to actually do a piece of work or support them in the way that they actually need. That's quite difficult. (Professional)

Young people said that they felt GPs in particular had no time for them with one describing an appointment as his GP "clock-watching".

A strong direct link was repeatedly made between access to ongoing support and re-offending rates.

Authenticity

Improved service reliability and consistency are seen as crucial factors in service provision. This featured more regularly than distinct specialist services. An authentic, sincere approach is also needed because as a professional pointed out "young people are so skilled at picking up what's authentic and what's not".

..whatever we offer it's got to be consistent, reliable and appropriate. And in that I think it should be completely long-term, that allows sustainability... (Professional)

It was felt by all the participants that any provision is not going to work unless the care provider is genuine and can be relied upon.



I remember more than one young person asking me, so how long are you going to be here for? but young people do want to access support, but like we've been saying, I think trust is a massive, massive thing and if they open up and trust someone and then all of a sudden they're pulled, ... it's just that actually young people become mistrusting of those sorts of services, because they don't feel that they're going to be there long enough for them to actually do a piece of work or support them in the way that they actually need. That's quite difficult.

Professional



Quality relationships

T2A staff felt very strongly that the quality of the relationship between the workers and the young person was paramount.

Stability, that's all, and boundaries set. And I think the help and support that they could do with is having somebody they can trust in, somebody they can communicate with, and somebody that believes in them, that they can achieve. A lot of them, think that they're just no good. (T2A Staff)

Young people were clear, and often emphatic, that having a good relationship with service staff was crucial to the successful offer and acceptance of support.

I'm one of those people if I don't click with someone, then I'm like a closed book, I won't talk, I'll just sit there in silence. But then the thing is I'll get in trouble for that. So it's better for me – well, it would be better for everyone – if they can find down to earth people instead of people that are in your face all the time. I know you're in the wrong, that's why you're on the order, but it makes it a lot more comfortable for the person to try and talk about their problems if they can seem to get on with the person... I need to build a rapport with someone before I can be open with them. (YP6).

Availability

It was felt by all that any provision is not going to work unless the care provider is genuine and can be relied upon.

Being available is definitely 100% a massive thing. (T2A Staff)

Young people noted the importance of relationships and said they wanted workers who had time for them, who were accessible, who listened and who didn't speak down to them. They often spoke of the importance of having someone to talk to and people providing constructive advice.

She nags at me, she's bossy, yeah!... My mum shouts at me, she just shouts, screams. [T2A staff] just tells you in a nice way, she explains it to you. My mum just skips the explaining and starts with the screaming. (YP11)

Young people recognised that voluntary sector workers had more flexibility in the service they offered.

What's she [T2A staff] got that's extra? Time. No-one ever had time for me before that. And the time she gives me is quality time because in our time we do a lot of things, like we all go out for lunch, and just talk about normal day-to-day, basic things, like, what have you been doing today? How was today? (YP12)

Non-judgemental

Many of the young people valued the opportunity to discuss their problems with service staff.

[T2A staff], he was the first person I properly opened up to about my past, about the way that I felt and stuff like that, about the things that I've done in the past, and a lot of things that I didn't get caught for, the way it made me feel and stuff. It helped a lot to come out with these things, to tell him these things, to get it off my chest. And he always reassures me that at the end. I was always worried about people judging me, whereas he never did, never did judge me about the things that I used to do. What he used to do is just say, how much better it is that I've come away from that now and sorted it out. Now that was a massive help. (YP3)

Young people valued having a rapport with their worker and this was generally associated with a degree of informality. Service staff whose manner was non-authoritarian were more able to establish rapport and young people appreciated being treated "like you're an equal".

Quite a few people I know, in the end we stop going for help because there's no point sitting there in front of someone who's just going to judge us all the time. (YP10)

Informal/non-clinical

Rapport was generally associated with a degree of informality.

Working with [T2A staff] and having conversations, because it's not really in a formal setting she just, we just have normal conversations and it just, she just works it in with the normal conversation and it works that way. Probation could take a leaf out of T2A's book. ... The reason why people are re-offending is because a lot of them have the wrong attitude, so you need to change their attitude. But you can't do that by sending them to speak to somebody that they don't like, can you? You need somebody there that you can go in, talk to, have a laugh with, a bit of a giggle in a less formal setting. (YP2)

Participants cited Jobcentre staff using inaccessible language for young people, especially those with learning difficulties and literacy problems. Participants made a direct link between these attitudes in service provision and the emotional wellbeing, self-esteem and offending behaviour of young people.

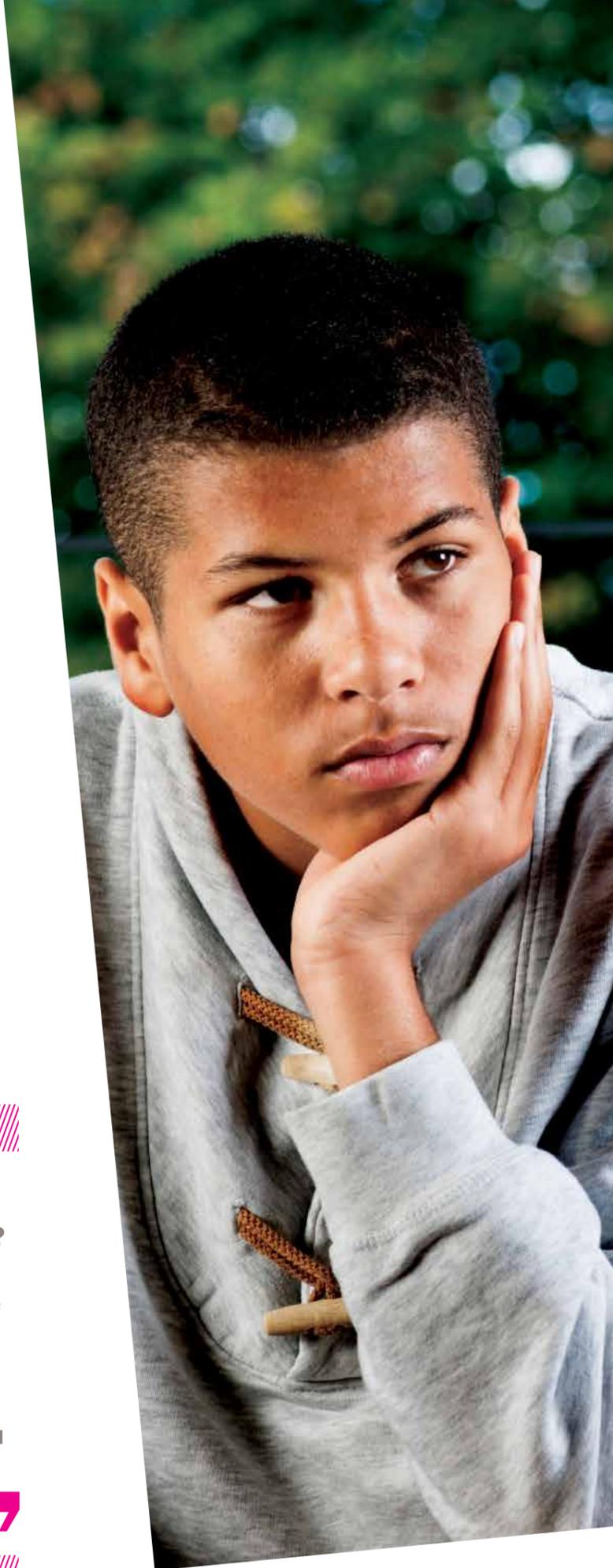
Some young people highlighted staff going the extra mile for them. This young woman went on to talk about how her T2A worker demonstrated concern.

She just bonds, you know like someone that cares, like she cares and I know she cares because she just checks up on me ... 'Are you all right? Are you staying out of trouble?' (YP12)



What's she [T2A staff] got that's extra? Time. No-one ever had time for me before that. And the time she gives me is quality time because in our time we do a lot of things, like we all go out for lunch, and just talk about normal day-to-day, basic things, like, what have you been doing today? How was today?

YP12



PART 3: Criminal Justice Implications

Re-offending exacerbated by a lack of care

Participants in the focus groups expressed how the lack of co-ordination of care was striking despite different care co-ordinators being involved. There did not seem any evidence of adequate individual care planning in several examples presented, where it appeared the young person was suffering from enduring and serious mental health problems.

I'm working with one person, diagnosed with personality disorder and bipolar, she was on a load of medication which I don't understand, which medication is for what and what the dosages are. But to get the mental health team involved with her was so hard and it was her probation officer who kept on, they wouldn't return calls. She's had four care co-ordinators, she's been left, and when she was in crisis when we needed the mental health team they shut her case because one of her things was she'd shut down and she would shut off all agencies, wouldn't speak to anyone. There were a few serious incidents with her where she needed the support of the mental health team. (T2A Staff)

The health professionals identified undiagnosed serious mental health problems and learning difficulties as a factor of their clients developing offending behaviours.

... One reason could be that they have an undiagnosed autism spectrum condition or that they have ADHD and it is not understood... They're not given any support or advice for their condition and because of their vulnerability they go into crime. (Professional)

A strong direct link was repeatedly made between access to ongoing support and re-offending rates.

I think in terms of the repetition of crimes, young people who don't feel supported or are not supported, generally re-offend. I think that's the reality whether or not they're on a court order or not. (Professional)

Offending behaviour can be a barrier to services

A young person's criminal behaviour was seen as a barrier to healthcare services due to the practitioners seeing only the criminal behaviour and not offering a comprehensive CAMHS assessment despite a risk assessment being completed. Mental health care was not perceived as a human right.

It can be quite difficult just to get a general mental health service for some young people. Straightaway many people will ask 'what's the crime that they've done?' For me actually a young person coming into the system should have every right to the same service as anybody else, whatever crime they have committed. (Professional)

General concern was expressed surrounding referral pathways and that the young person's right to healthcare became a secondary factor when in prison or a Young Offender Institution.

Now the only time it (referral) gets activated or realised is when funding comes into play, because obviously if they're 'Out of Borough' and you want to do an assessment, the locality service will say actually, hey we've got your young person, we want to do an assessment, that will cost you a few hundred pounds and then people kind of fluster and then the next issue is, well what's the crime? Who's going to do it? I haven't got the time and you know, so on and so forth...and it doesn't happen. (Professional)

Integrated working

There was general support amongst participants for more integrated working particularly because service uptake and communication improved.

If a young person is inside very often the communication between the prison or the Young Offender Institution and either CAMHS or the Youth Offending Team, is not very good. And one of the good things about having a CAMHS worker within the YOT, is those lines become a lot straighter and a lot easier. (Professional)

A clear link was made by participants that most young people who are in custody in the criminal justice system were having contact with CAMHS prior to being imprisoned.

Quite often, to be honest, if a young person goes inside, very often they're discharged from a CAMHS service, with the expectation that the locality or the prison will contain and do some of those services. (Professional)

Court orders

There was a consensus that young people's mental health needs are best met when dictated by the court through their order and not left to the service providers.

The best way for a young person to get mental health services is if the court orders it. If the court orders it, then it's going to happen by someone independent who, although it's an incentive for them because they're paid out of the normality of the CAMHS system, the young person will get a good assessment with recommendations. Now, for me that works quite well because a young person is going to get pretty much what they need, or the court is going to hear what they need and maybe put it as part of their licence or part of their order, so that's one way. (Professional)

A number of young people talked about the role of the criminal justice system in their personal development. Some mentioned court orders or referrals by probation and Youth Offending Teams to mental health services, alcohol services or T2A.

I committed this offence, which obviously ended me back up on probation. But in a way I am grateful because I've got to work with T2A and without T2A I wouldn't have got myself sorted. So, although I'm very sorry for the crime that I committed, there are good things that have come out of it. (YP2)

Early intervention

Professionals felt early intervention was an essential ingredient to improve current service provision. Schools were identified as a place that might encourage early intervention.

There needs to be a bit more interaction between the teachers and the families. Most schools have one family day maybe every year or so, they should be on a regular basis, if you bring the parents in, you find out what's going on within the family home. (T2A Staff)

One young woman, who regarded her probation officer as a key support for a period of five years, was unclear of the process whereby she had been put in touch with her, though she realised that the referral had been preventative in nature.

I think it was because I was gang-related, and police kept coming to my mum's house and raiding my mum's house. They obviously noticed that I was young and I was a female and they must have picked it up. Somebody referred me to her and she came out to see me, and she was like my support worker from then on, like even until now. I think it was the police. They could see that I was slipping into the system slowly. (YP12)

“

I committed this offence, which obviously ended me back up on probation. But in a way I am grateful because I've got to work with T2A and without T2A I wouldn't have got myself sorted. So, although I'm very sorry for the crime that I committed, there are good things that have come out of it.

YP2

”

Reliance on the voluntary sector

Many of the health participants expressed a reliance on voluntary agencies to carry out vital work that they are not able to do due to stigma, competing demands and professional confines.

Because, you know, if we can't refer onto a mentoring service or a boxing club which does mentoring service or various different aspects, then actually we don't have the ability to sustain everything, so it is about using the services we have. (Professional)

Concern was expressed about these agencies being able to sustain this work.

I link with a (voluntary) service that does incredibly good and very sensitive work around street workers and particularly around early prostitution. This service really will be there and help, and it's living, honestly, from hand to mouth.... think of the good it could have been achieving had it been reliably certain of its funding? And I don't understand how we can be reliable if we're not based ourselves on something reliable. (Professional)

Comment was made regarding the stress this put the voluntary agency staff under and how these resources, which statutory service often depend on for referral, are reduced and put under strain due to their need to write continuous applications for funding.

Sometimes you get projects where the actual staff have to apply for their own funding. It's very difficult because there are some really good workers who are really able to do the work and get young people engaged, but you know, if you're worrying from day to day whether you're going to be able to survive yourself then the impact of that mental health issue on the worker is enough, let alone trying to work with a young person. (Professional)

There was a definite link reported between the poor sustaining of service provision and a negative impact on young people's offending behaviour.

Support is short-lived because of funding. Some support has been cut so there is nowhere to refer young people. This has an impact on offending behaviour. For instance there may be mentors to help young people get out of gangs.

When the service is no longer available, the young people have few choices and get back in with their old friends who encourage them back into the gang. (Professional)



I think it's relationships and resilience which is a big thing for me. So it's not what necessarily happens to young people, it's how they're taught to cope and their resilience to whatever it is that happens to them.

T2A Staff



Education, training and skills

Young people had received a range of help with life skills, either in prison, from the probation service, from T2A and other voluntary sector organisations, or from specialist services they were referred to. Topics included thinking skills, anger management, controlled drinking, reasons for drugs misuse, reason for offending and consequences of offending for victims.

Some young people spoke of how such courses had helped them to think about themselves differently and consequently behave more constructively. Most often, just feeling able to spend time thinking about and discussing past behaviour seems to have helped them to see the disadvantages of old behaviour patterns and motivated them to change.

I found it a bit hard at first because part of it was delving into my past, why I offended, why I did these things. But I'd got to the stage where I could explain the reasons why I got into cars and drove, it was a release for me, it was a coping mechanism for me to calm down. I learnt a lot from that course, which I do believe would help a lot of people. (YP6)

In addition, some spoke of how they had been helped to reflect on their own behaviour in ways that motivated them to attempt to change.

[Victim Support offered] just loads of victim stuff and that, how victims feel and it's like you learn how they feel and if they did it to you, how would you feel. I even wrote a letter to one of them, saying how sorry I was and explained what I was going through. (YP8)

Another spoke of how her probation officer had helped her manage her anger better.

I thought the whole world was against me, like I didn't care at all. And she showed me that the world isn't against me, I'm against the world. She showed me that I could deal with my anger by just coming out of the room wherever I am or just going outside, breathing in and out. Learning not to swear as much, being able to have that balance, she showed me that balance. (YP12)

Most of those interviewed mentioned the help they received, from T2A and other services, in the form of referrals or introductions to other services. Though this was generally much appreciated, this was not invariably the case. One reported many instances of not taking up opportunities because he didn't believe they could help.

I just didn't think it would help, to be honest. Well, I just think, if I need to stop drinking and change my life I've got to do it myself at the end of the day. (YP15)

Prison also provided opportunities for some, for example, learning to read, obtaining qualifications, courses on drug use and thinking skills, all mentioned by YP1, who added that he was sure that he would not have accepted any of this help had he been offered it earlier in life outside prison. Another described how prison had encouraged him to take a constructive approach to life.

That's when I started to apply for extra courses in my own time and stuff to try and keep the time busy, keep busy. That's why my time flew, because from seven in the morning till eight at night I was out of my cell busy doing something. (YP2)

Naturally, not all responses to prison were so constructive. YP9 spoke of thinking: "Well, it can't get any worse, know what I mean, so why should I bother carrying on?"

Prison, probation, Youth Offending Teams and T2A were all mentioned as having provided or facilitated access to training and education (literacy, gym instruction, painting and decorating). Undergoing these had increased confidence and self-esteem as well as improving chances for employment.

It just got worse and worse and the route that I was heading was jail or I would be dead. Then I got onto a course, an apprenticeship, which the probation officer helped me get on, which was in customer service and hospitality. I completed the course and then I got my certificate, it was the first time I'd ever been rewarded and I graduated from something positive. I then realised that I wasn't just another statistic, I was somebody. (YP12)



I can't find a job, it's really hard, and it's really hard for ex-offenders, because as soon as they've seen your criminal record on your CRB check and stuff, people just don't want to employ you.

YP6



Two mentioned that T2A was helping them to get Construction Skills Certification Scheme cards to enable them to work in the building industry. Though many wanted work, there was recognition that opportunities were few.

Like now I don't think I'd ever get a job and things. Who's going to employ someone who's bipolar with a borderline personality disorder? To me I feel for the rest of my life I will be stuck at my home, and never getting anything more out of life. And that's a pretty sad thought, isn't it, at 25? That your life is finished really. You've got no opportunities and nothing to look forward to. (YP8)

I can't find a job, it's really hard, and it's really hard for ex-offenders, because as soon as they've seen your criminal record on your CRB check and stuff, people just don't want to employ you. (YP6)

This young man had thought about how work opportunities could be increased.

The government keep banging on about all the prisons being full and that. But if they'd do something about it, give them [prisoners] help. Why don't they buy derelict farms and get loads of ex-prisoners to build them into new, nice new places? Just simple things, which would put jobs out there for ex-prisoners, give them a chance. If they fail then that's their problem, but as long as there's the chance there for them to prove themselves. (YP6)

Gang Culture

Participants from the city focus groups expressed their understanding of how the involvement in organised crime and gangs offered disenfranchised young people a credible option for their sense of isolation.

There's been a lot of research on gang culture, ... particularly, young men who become involved with gangs and have a diagnosis of ADHD or various other disorders including autistic spectrum disorders and various other personal issues. Individually they may be as scared of the world as their peer group, but together in a group of other young people become, find a social group identity. They find a place within that gang, whereas they may feel alienated from their local community because they may be regarded as anti-social simply by the way they look. So issues around feeling rejected and wanting to feel part of something bigger, and sometimes this can lead to a culture of anti-social behaviour because the group norm is to do that. (Professional)

There's a lot of kids that get into gangs because they want to look good in their area. Because if you're in a rich area to look good, you have to go to school, you know, you have to go to college, you have to go to uni, you have to have a car to look good. In a poor area you have to carry a gun and a knife to be able to look good. And if you don't and you don't look good, then you're the one that's going to be on the receiving end of it. (YP10)

In terms of gangs, some professionals expressed the view that they felt inadequately trained to work with girls who are experiencing sexual exploitation and with the boys who are or have been involved in exploiting them. Trying to help the young person to identify their resilience was considered an important factor.

I think it's relationships and resilience which is a big thing for me. So it's not what necessarily happens to young people, it's how they're taught to cope and their resilience to whatever it is that happens to them. (T2A Staff)

T2A staff were also concerned with the exposure and dependency of young people to certain groups involved in organised crime and that this would exacerbate their offending behaviour further. Peer pressure was identified as a social issue that seemed important to determine difficulties young people had.

Peer pressure, the area that they grow up in, they live in. Sometimes the surroundings and the people around it will pressure them into going into things that they probably wouldn't normally go into if they were living somewhere else. (T2A Staff)

Hooking children into gangs from a young age with a promise to be 'looked after and protected' and given a bigger, better status was also discussed.

The gangs, the kids can be like recruited from a young age, so if they're young this is where the problems start, they could just be in the hood and someone could just come along and go, 'Hey, can you just take that there for me?' And he knows he's one of the big boys and he might just say, you know what, it's nothing, I'll do it for you. And he knows from then on he's got his little clout, he's got his little power, and then as he's growing up it's like, don't worry, little man, we've got you. (T2A Staff)

The participants added that for this group of young people to leave a gang could well trigger a hostile response from fellow gang members, but in addition it was stated that leaving the gang could potentially exacerbate mental health issues.

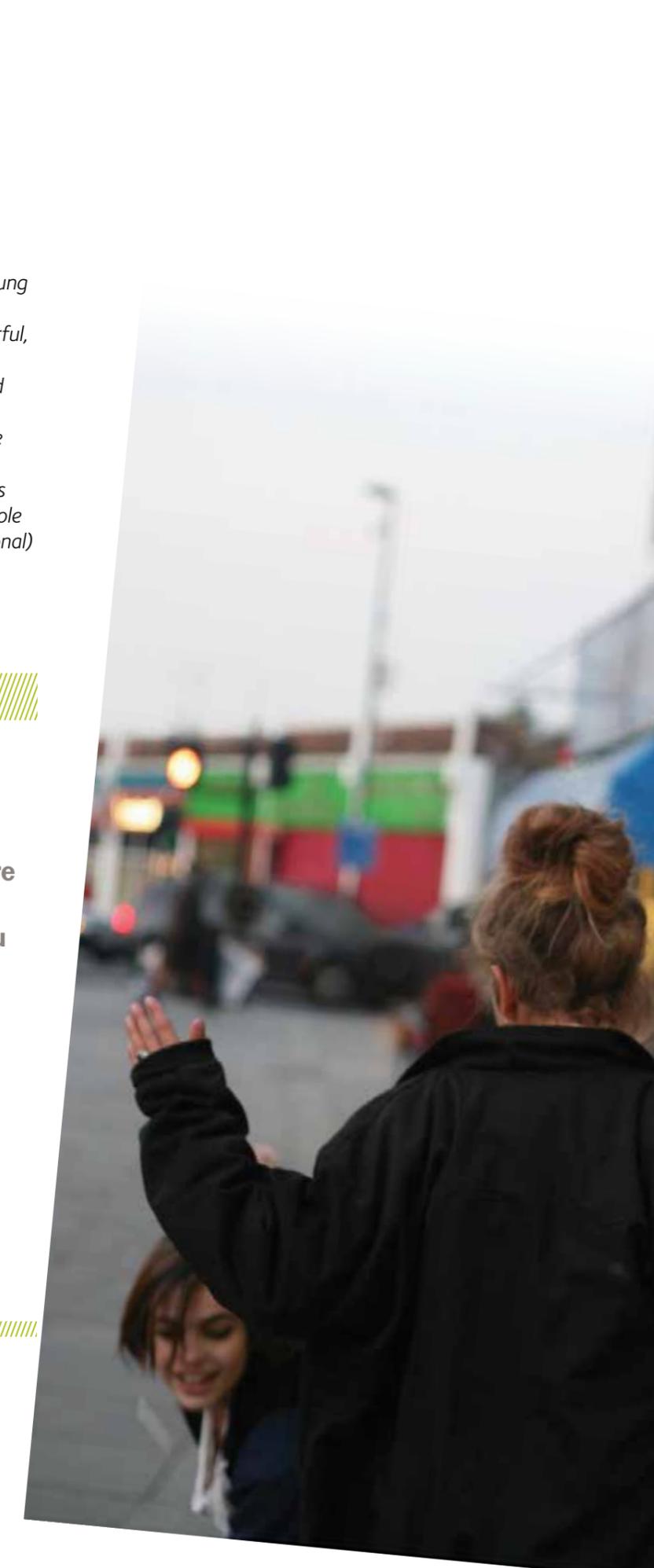
And it can be a very difficult place for that young person to leave. So in terms of mental health, feeling part of something, feeling more powerful, being a part of a whole, of a group - that can actually bolster a person's self-confidence and self-esteem and make them feel considerably more at ease within their world, and therefore the thought of leaving that culture and that group can actually trigger anxiety and feelings of rejection and separation and loss and a whole range of other psychological issues. (Professional)

Does this indicate that the gang culture in our cities may be acting as an alternative or substitute to community mental health care?



There's a lot of kids that get into gangs because they want to look good in their area. Because if you're in a rich area to look good, you have to go to school, you know, you have to go to college, you have to go to uni, you have to have a car to look good. In a poor area you have to carry a gun and a knife to be able to look good. And if you don't and you don't look good, then you're the one that's going to be on the receiving end of it.

YP10



5: Recommendations for Achieving Excellence – What key agencies need to do.

Introduction

This research exemplifies very clearly how systems that are trying to offer effective help can in fact exacerbate already problematic circumstances. Too often the result for young people is increased cynicism, further loss of self-esteem, motivation, confidence and basic skills. For the state it can mean spiralling costs of welfare dependence, health problems, policing and custodial sentences as well as the loss of an active, working citizen.

The Government's cross-departmental strategy "No Health Without Mental Health Implementation Framework" (HM Government, 2011) states:

“Effective mental health interventions can improve the health of some of the most excluded people in our communities and address some of the factors that contribute to offending behaviour. Improved awareness, support and evidence-based training for criminal justice professionals can also improve the experience of people with mental health problems accessing the criminal justice system as either a victim or a witness.

Following Lord Bradley's (2009) report, the strategy emphasises the importance of ensuring offenders (including young offenders) have the same access to mental health services as the rest of the population throughout their journey through the justice system, and that mental health problems, substance misuse and learning disabilities are picked up as early as possible.”

From the interviews in the research some key themes emerged which provide the basis for the recommendations and practical steps that follow:

Critical Issues:

1. The need for consistency of relationships with young people. It takes time for trust, mutual respect and empathy to develop and is the core requirement for positive developmental work to take place.
2. All staff delivering services to this client group need greater knowledge and skills regarding the identification and awareness of mental health issues.
3. Lack of any coordination or collaboration between services. Young people reported how changing personnel and agencies, short term treatments, unclear expectations and different job roles undermined their progress. Improving the coordination, access to and transitions between services would have a significant impact on young people's experiences and care pathways.
4. Who holds the ring? Young people reported a chaotic mix of health care pathway management with the young person's mental health being the cost. Assertive health care pathway management is crucial for these young people whose life circumstances are changing rapidly. If one individual or agency took the lead they could actively monitor the clients' care pathway, hold other services to account, ensure medical case reviews happen regularly, medication is actively monitored and the young person actively engaged – as well as improve coordination.
5. Easy access to accurate information for young people, families, advocates and services is essential. Confusion and uncertainty leading to a lack of confidence caused by 'not knowing' was consistently reported. Information about all services, referral processes and confidentiality must be available which explains simply what can be expected and when.

Key recommendations:-

1. Implement existing strategy

As the title of our report suggests, a lot of the issues we have raised have been highlighted in previous research. Implementing existing policy, namely the Mental Health Strategy Implementation Plan and the Caldicott 2 Review (2013), would go a long way to mitigating some of the problems we have outlined. We urge the Youth Justice Board and Ministry of Justice to ensure existing policy is implemented as a matter of urgency.

2. Training

All professionals and specifically education professionals working with children and young people at risk of offending should receive training to gain baseline knowledge and skills regarding the identification and awareness of mental health issues to ensure children are not written off as 'trouble children'. Both police and magistrates need training in mental health to deal with the young person appropriately and ensure appropriate sentencing. All professionals in the criminal justice system must understand any mental illness issues and not just see the crime.

3. Senior Clinicians Role

Make the best use of expensive senior clinicians time and expertise by enabling them to provide supervision and consultation for a large number of the youth and young adult workforce providing treatment for young people; thereby also providing 'on the job' training in a practical way.

4. Lead professional

Responsibility to actively monitor a young person's case needs to lie with a lead professional: an individual or agency that ensures that medical case reviews take place regularly, medication is actively monitored and the young person is actively engaged in their mental and physical health care.

5. GPs are well placed to fulfil this role as they are the only person who sees whole families and whose services span all ages. They also have clinical accountability.

6. Joint Commissioning

Health and Wellbeing Boards should ensure joint commissioning across offender mental health and local CAMHS to ensure 'joined up services'. Clinical Commissioning Groups (CCGs) should appoint a mental health lead at senior level.

7. Targeted Commissioning for at risk 16-19 year olds

Consideration should be given as to how services can be targeted at the 16-19 year olds most at risk given the apparent inability of CAMH or AMH services to respond appropriately. Contracting with local community services demonstrated success, as did engagement with the client group such as those supported by Youth Access and Transition to Adulthood (T2A), and co-location with other services.

8. Easy access to services and information

A single point of access to services should be extended to include young people involved with the criminal justice system. CAMHS websites should develop better information, targeting this group to provide a shared point of information for young people, social workers, health professionals, criminal justice professionals, parents and police.

9. Raise awareness

Local government should appoint an elected member to be a 'mental health champion' and this role should include raising awareness of mental health problems. YoungMinds is one of six national mental health organisations supporting member champions in local government. To take up the mental health challenge visit the website www.mentalhealthchallenge.org.uk

Achieving Sustainable Improvement: Implementation of Existing Policy

To achieve sustainable improvements for young people who are in the youth justice system and experience mental health problems there are a number of practical steps that individuals and agencies can take. It requires change and collaboration from all affected agencies in order to embed new practices.

There are a number of existing government policies and strategies that impact on many of the key issues above. Some, such as the cross-government Mental Health Strategy Implementation Framework were developed with YoungMinds and we believe, would, if enacted, greatly contribute to addressing the issues and needs of this report.

Sometimes small changes can have a big impact on the whole system. Therefore the practical steps are aimed at being as specific as is possible.

For clarity and where appropriate, the recommended actions from relevant government policy will be repeated here for the sake of comprehensiveness.

The need for consistency of relationships with young people. It takes time for trust, mutual respect and empathy to develop and is the core requirement for positive developmental work to take place.

Current Government Policies impacting on the report findings:

- **No Health Without Mental Health (HM Government, 2011)**
- **No Health Without Mental Health Implementation Framework (Department of Health, 2012)**
- **NICE guidance**
- **National Youth Agency Commission into the role of youth work in formal education**
- **Health and Social Care Act 2012**
- **The Inclusion Health programme**
- **Dame Fiona Caldicott Information Governance Review (Caldicott 2 Review, 2013)**
- **Preventing Suicide in England; a cross-government outcomes strategy (HM Government, 2012a)**
- **Ministerial Working Group on Homelessness**
- **The Children and Young People's Health Outcomes Strategy**
- **Support and Aspiration: A new approach to Special Educational Needs and Disability**
- **The National Diversion Programme**
- **Comprehensive Health Assessment Tool (CHAT)**
- **Dangerous and Severe Personality Disorder (DSPD) services review**



Detailed Recommendations: What organisations can do locally to implement change for improvement

Government – cross cutting actions

Existing policy in the Caldicott Review (2013) should be implemented:-

- The Caldicott 2 Review recognised the importance of managed information sharing for patients. Point 7 of the 'Professional standards and good practice' states: **The duty to share information can be as important as the duty to protect patient confidentiality.** Health and social care professionals should have the confidence to share information in the best interests of their patients within the framework set out by these principles. They should be supported by the policies of their employers, regulators and professional bodies.
- Recommendation 2 (sections 3.3 and 3.4) states: **For the purposes of direct care, relevant personal confidential data should be shared among the registered and regulated health and social care professionals who have a legitimate relationship with the individual.** Health and social care providers should audit their services against NICE Clinical Guideline 138, specifically against those quality statements concerned with sharing information for direct care.
- Recommendation 14 (section 9.2) states: Regulatory, professional and educational bodies should ensure that: (a) **information governance and especially best practice on appropriate sharing is a core competency of undergraduate training.** And (b) **information governance, appropriate sharing sound record keeping and the important of data quality are part of continuous professional development and are assessed as part of any professional revalidation process.**

We recommend:

- **Ensure cross-government strategies and policies are understood by each department and their strategies reflect an implementation plan to achieve government's desired outcomes e.g. Preventing Suicide Strategy requires a 'tailored approach' for identified people in contact with the criminal**

justice system as they are a key high risk group who are a priority for prevention (HM Government, 2012a). Continuing to improve the mental health outcomes for people in contact with the criminal justice system will contribute to suicide prevention.

- **Raise the profile and awareness of key government recommendations and policies which impact on the lives of young people in the criminal justice system with mental health problems.**

Local Government:

Existing policy in the Mental Health Strategy that needs to be implemented:

- **Appoint an elected member as 'mental health champion.'** This role might include raising awareness of mental health issues, including the impact of stigma and discrimination, across the full range of the authority's work and with other elected members, including lead members for children. It can also link to the work of the Overview and Scrutiny Committee (OSC) and health and wellbeing board.
- **Assess how its strategies, commissioning decisions and directly provided services support and improve mental health and wellbeing.** Almost all areas of a local authority's responsibility have the potential to contribute to good mental health and wellbeing, or to lead to poor mental health. Decisions about employment, housing, planning, transport, leisure and green spaces and other community services all directly affect mental health.
- **Involve the local community, including those with mental health problems, their families and carers, in the co-production of service pathways and in service design.** This includes providing clear and accessible communication regarding how people's views and priorities have been taken into account.
- **Consider using 'wholeplace' or community budgets** to improve the quality and efficiency of support offered to people with multiple needs including a mental health problem.

- **Use the Local Government Association's Knowledge Hub** allowing members and staff to share innovative approaches and good practice.
- **Sign up to the Time to Change campaign** to raise the profile of mental health across the authority and address stigma among staff. Authorities can also develop local initiatives to make tackling stigma 'business as usual'.

Health and Wellbeing Boards:

Existing policy in the Mental Health Strategy (HM Government, 2011) needs to be implemented:-

- **Ensure local mental health needs are properly assessed, and ensure they are given appropriate weight in comparison with physical health needs.** A robust Joint Strategic Needs Assessment (JSNA) process will ensure mental health needs, for people of all ages and including vulnerable, excluded and seldom heard groups, are properly assessed – building on existing information and data. This will include links between mental and physical health and implications for families and carers.
- **From the Report of the Children and Young People's Health outcomes Forum (2012)** chapter 4: the Forum welcome the new duty on the Secretary of State for Health and CCGs which should increase action to address health inequalities. Whilst there are many groups facing disadvantage, the Forum has focused in particular on the very poor health outcomes of the 65,000 children and young people who are looked after by the State, as many of these poor outcomes are avoidable. To address this disadvantage we recommend: directors of Public Health, through their health and wellbeing board, should ensure that they include comprehensive data for all children and young people within their Joint Strategic Needs Assessment – including those requiring tailored provision, such as those who are looked after, those with disabilities and long-term conditions and those in contact with the criminal justice system.
- **Bring together local partnerships to improve mental health and enhance life chances:** Encourage joint commissioning between health and health-related services (such

as with criminal justice agencies on the overlap between mental health issues, drug and alcohol misuse, and offending). Pooled and community budgets offer a means for achieving this.

- **Involve people in all aspects of development of JSNAs and Joint Health and Wellbeing Strategy (JHWS).** This includes pro-active and meaningful involvement of the most vulnerable and excluded groups, who often have the highest levels of mental health need, as well as people who use mental health services, their families and carers. They can also enrich the picture by involving local independent, voluntary, community and user and carer-led organisations, which have significant knowledge of local mental health needs and assets. For more specialist needs, they can also seek input from national organisations and forums.
- **Consider the mental health impact of services and initiatives beyond health and social care.** Gaining input from organisations outside the health and care system is particularly important in relation to mental health. This approach supports the government's approach to tackling multiple disadvantage outlined in Social Justice: transforming lives (HM Government, 2012b), published in March 2012, and is in line with evidence about the wider determinants of mental health problems.

Ensure local mental health needs are properly assessed, and ensure they are given appropriate weight in comparison with physical health needs.

General Practitioners

We recommend:

- There needs to be clarity and consistency in the management of the care pathway which clarifies who the lead clinician is. All young people who are in receipt of medication for mental health problems, should be called for review regularly e.g. every three months, especially on starting a new course of medication.
- Lead Professional: Young people at risk of offending behaviour should have more regular contact with their GP. When appointments are missed, the GP takes responsibility for making contact with the young person and inviting them for a review. If several appointments are missed or additional concerns arise, CAMHS will be alerted and treat the referral as high priority.
- Following good practice guidelines, as laid out in shared decision making recommendations in Children and Young People's IAPT service, on initial prescribing of medication, clinicians will explain the reasons for choosing a specific medication, its purpose, strengths and weaknesses in addressing their mental health concerns along with possible side effects. Ideally the clinician and young person will agree the best treatment pathway and management of taking the medication and coping with side effects together.

Clinical Commissioning Groups (CCGs)

Existing policy in the Mental Health Strategy that needs to be implemented:

- **CCGs can appoint a mental health lead at senior level**, to oversee their mental health commissioning work and ensure links to other services. This could include developing mental health elements of Joint Strategic Needs Assessments (JSNAs), ensuring integration of primary and secondary care mental health services, developing CQUIN7 measures for mental health, developing expertise in the mental health aspects of QIPP8, and keeping up with the latest developments in evidence-based mental health practice. CCGs may also wish to establish a sub-committee which includes mental health professionals.

- **Ensure they consider the mental health needs of their whole population, including seldom-heard groups.**

This includes:

- People not registered with a GP, those in the criminal justice system, and those less likely to access mainstream services.
- Commissioning for effective transitions – between Child and Adolescent Mental Health Services (CAMHS) and adult services, and between working age adult services and services for older people.
- Considering the role of mental health promotion and mental illness prevention, alongside commissioning services for people with mental health problems.

- **Use specialist support and guidance for mental health commissioning.**

This includes the published NICE Quality Standards on **service user experience in adult mental health** (NICE, 2011), other NICE Quality Standards, and guidance produced by the Joint Commissioning Panel for Mental Health. It also includes drawing on a range of specialist expertise, including mental health networks where they are established.

- **Commission to intervene early.**

Evidence-based and cost-effective early interventions include early treatment of childhood conduct disorder and early intervention in psychosis teams. CCGs may wish to commission some of these jointly.

- **Develop robust systems and structures for the local community, service users and carers to influence and lead commissioning decisions.** This could be achieved by strengthening relationships and joint working with local groups and service users to: assess the quality, performance and outcomes of services and the effectiveness of care pathways; and to co-design new service models. To embed involvement work, CCGs can demonstrate to the local community what actions they have taken to implement the strategy and this framework.

- **Commission talking therapies which offer the full range of NICE approved therapies.**

Offering a choice of providers through Any Qualified Provider (AQP). This will ensure equal accessibility for all groups, particularly older people and Black and Minority Ethnic (BME) communities.

- **Commission for recovery** Recovery-oriented services aim to support people to build lives for themselves outside of mental health services with an emphasis on hope, control and opportunity. The **Implementing Recovery through Organisational Change programme** provides tools to assess how well they are doing and take steps to become more recovery-oriented. The Individual Placement and Support approach to employment is effective for working age users of mental health services.

- **Utilise specific mechanisms to support choice in mental health** including choice of provider, where possible, and choice of treatments, interventions and therapies. These include Advance Directives, Independent Mental Health Advocacy and Independent Mental Capacity Advocacy – plus the rollout of personal health budgets.

We recommend:

- **Make best use of expensive senior clinicians time and expertise by enabling them to hold overall case supervision and provide consultation and advice for a large number of young people who receive treatment and care from across the youth and young adult workforce. This would provide 'on the job' skills and knowledge training in time efficient and practical ways.**
- **Young people at risk who are in the criminal justice system and have mental health problems need access to longer term treatment if they are to have sustained, improved mental health.**
- **Commissioners should review CAMH and AMH services referral and acceptance protocols for the 16-19 year age group needing mental health services, recognising that the current transition arrangements are often detrimental to their mental health. There is a clear case for the continuity of care for a small number of complex cases involving**

the criminal justice system should those young people have started their treatment pathway under CAMHS.

- **Consideration should be given as to how services can be targeted at the 16-19 year olds who are at most risk, and given the difficulty of CAMH or AMH services responding appropriately. Contracting with local community mental health agencies (e.g. Youth Access member agencies offering counselling along with a range of other co-located services) could be a more constructive route for commissioned services for this group.**
- **Commissioners should ensure that services are in place in every local area to treat and support adults with ADHD to prevent them being left with no support at 18 years of age and thereby being at increased risk of offending behaviour.**

CAMHS and AMHS

- **Should work actively together to create effective pathways of care for vulnerable young people aged 16+ and ensure their mental health care needs are met regardless of which service holds the casework responsibility.**
- **Should actively work together to implement the government's Mental Health Strategy implementation plan and Caldicott 2 Review (2013) regarding sharing patient information effectively.**
- **Ensure NICE guidelines and quality standard on ADHD (NICE, 2008 & 2013), Transitions and suicide prevention are enshrined in the organisations strategies and implementation practice.**
- **Ensure NICE guidance on conduct disorders (2013) is implemented.**
- **Ensure NICE guidelines on provision of training for foster carers and guardians for children at risk of or in contact with the criminal justice system are implemented.**
- **Ensure NICE guidelines on provision of group social and cognitive problem-solving programmes are offered to children 9-14 years who are at risk of or are in contact with the criminal justice system.**

Local Criminal Justice Organisations:

Existing policy in the Mental Health Strategy (HM Government, 2011) needs to be implemented:

- **Contribute fully to JSNAs and JHWSs.**

It is good practice for criminal justice organisations to be involved. This can also set out how local work to improve health and wellbeing outcomes can contribute to local efforts to reduce crime and re-offending. This could be through joint working with or even being invited onto the health and wellbeing board; or through joint working with existing criminal justice partnerships.

- **Develop staff awareness of mental health issues**

ensuring that staff have attended appropriate, evidence-based awareness training and have access to relevant guidance and information; and can build mental health awareness into more general learning and development programmes as appropriate.

- **Support victims and witnesses with mental health problems**

to ensure they feel able to report crimes and go through investigation and court processes.

- **Consistently apply safer custody policies and procedures for identifying and caring for prisoners at risk of suicide and self-harm.**

Be conscious of the evidence which shows that people in contact with the criminal justice system are at high risk of suicide, and that the raised risk occurs at all stages within the system, not just among those in custody.

- **The Crown Prosecution Service can ensure they are aware of the options available to enable treatment for offenders with mental health problems to be provided as part of an out of court disposal.**

This includes through a conditional caution with a condition to attend an appointment with mental health services.

- **Courts can ensure they are aware of options available to them, including to divert offenders with mental health problems from custody or the criminal justice system, where appropriate, so that treatment is provided in the best place.**

These include the use of the mental health treatment requirement as part of a community sentence, and secure mental health services where an individual requires assessment or treatment under the Mental Health Act.

- **Probation services can work with Youth Offending Teams, mental health services, and liaison and diversion services to develop effective diversion routes.**

Strong partnerships between probation and these services are crucial for timely identification of needs and effective joint working for the duration of a sentence, for the use of the mental health treatment requirement, and as a means of diverting offenders from the criminal justice system or from custody where appropriate.

- **Prisons can ensure that offenders with mental health problems are identified as soon as possible, and given appropriate support.**

This includes suitable access to health services and rehabilitation services offered within the prison, or externally where necessary, both for prisoners with common mental health problems and those with more specialist needs, including personality disorders.

- **Prisons can ensure relationships and joint working exist with the relevant health services, local authorities and community organisations to support prisoners on release.**

Support should be offered 'through the gate' to provide as much continuity as possible.

- **Police forces can play an important role in identifying offenders with mental health issues. They can ensure their officers are aware of the support available to them to help identify potential mental health problems and deal with known issues.**

This includes appropriate use of their powers under Sections 135 and 136 of the Mental Health Act, of local policies on health-based places of safety, and of liaison and diversion services. Association of Chief Police Officers (ACPO) has produced guidance and training resources to assist police forces in responding to mental health needs in a range of situations.

- **Youth Offending Teams should observe the statutory requirement to employ a health worker and, in line with guidance, consider whether the post should be filled by a mental health professional,**

based on an assessment of the health needs of the young offender cohort. They can also refer young people to evidence based alternatives to custody programmes, such as Multisystemic Therapy and Intensive Fostering, where these are available.

Develop staff awareness of mental health issues ensuring that staff have attended appropriate, evidence-based awareness training and have access to relevant guidance and information.



6. Best practice examples

Generic Children's Workforce (including youth workers)

We recommend:

- Training, both in service and as part of the professional qualifications, is required for all the children and young people's workforce which enables an increased understanding of how to support the development of good mental health, how to identify mental health problems and the importance of early intervention.
- Advocacy by generic staff and volunteers on behalf of children and young people's mental health needs is required in order to ensure services respond and deliver support appropriately.
- All services working with children and young people need good relationships and support from the local CAMHS and possibly AMHS teams with access to specialist advice and referral routes to access appropriate care and support.

Magistrates:

We recommend:

- Ensure all magistrates working in the youth courts are trained in the issues relating to mental health and offending as well as in the services and help available.
- Pre-sentencing reports must be complete, comprehensive, up to date and include information about the young person's emotional wellbeing and mental health needs.

Community Groups:

Existing policy in the Mental Health Strategy needs to be implemented:-

- **Inform JSNAs and JHWSs** so they proactively provide input to local needs assessments and commissioning processes.
- **Raise awareness of services and support.** They are ideally placed to raise awareness locally of the services and support available, as well as of people's rights and entitlements.

This includes both voluntary sector support and government programmes such as Work Choice and Access to Work. They can also ensure local commissioners and providers are aware of the contribution of voluntary, community, user and carer-led support available to people with mental health problems in their area.

- **Support communities in holding public bodies to account.** This could include:
 - Supporting people affected by mental health problems to engage with MPs, Councillors and Overview and Scrutiny Committees (OSCs).
 - Support local youth representatives to take up places for lay members on Boards or governing bodies of relevant organisations, including Foundation Trusts and clinical commissioning groups.
 - Offering mental health awareness support, including user-led training, for local public services which have a role in improving mental health outcomes.
- **Raise awareness of mental health amongst relevant organisations.** This could include public services, businesses and other private sector organisations. It could also include other community groups, including those with a focus on physical health, particularly long-term conditions. In rural areas, this could also include parish councils, who work with many local voluntary organisations and are close to their communities.

Schools and Pupil Referral Units (PRUs):

We recommend:

- All schools and PRUs to train their staff in mental health awareness.
- All schools and PRUs to ensure the Personal, Social and Health Education (PSHE) curriculum includes how to look after your mental wellbeing.

MAC-UK

<http://www.mac-uk.org/>

MAC-UK aims to radically transform the way in which services are delivered to excluded young people. Their model of working is called Integrate and it takes mental health professionals out of the clinic and onto the streets to work with excluded young people where they are, when they need it.

AMBIT

<http://www.annafreud.org/pages/ambit.html>

The AMBIT (Adolescent *Mentalisation*-based Integrative Treatment) model was developed by the Anna Freud Centre and involves training frontline workers to deliver help for young people in crisis, who are defined as hard to reach. The frontline workers are training in a number of treatment methods and are supported by psychiatrists and psychologists.

The Zone

<http://www.thezoneplymouth.co.uk/>

This Youth Information, Advice and Counselling Service in Plymouth provides a range of community based services such as counselling, sexual health, and drugs advice, but also provide a service for young people with emerging personality disorders, an early intervention in psychosis service, and a service to help young people reduce their criminal behaviour.

Brandon Centre and Multi-systemic

therapy (MST)

<http://www.brandon-centre.org.uk/multisystemic/what-is-multisystemic-therapy/>

This is an evidence-based, intensive, community based therapy that addresses the range of difficulties that lead to anti-social behaviours and emotional problems.

Right Here Newham – boxing project

<http://www.right-here.org.uk/projects/newham/>

Right Here Newham commissioned a boxing project, where young people can access one to one mental health support whilst attending a boxing club. The aim is to help engage 16-18 year olds, who would not access traditional mental health services.

Kings Youth Violence Project

<http://www.redthread.org.uk/?projects=kings-college-adolescent-emergency-room-ear>

The youth worker organisation Redthread have been embedding workers within the trauma centre at King's College Hospital. The team work closely with accident and emergency staff to try and disrupt the cycle of violence that bring hundreds of young people to the hospital each year.

1. Acts of Parliament/Bills processing through Parliament Timeline

The timeline sets out some of the key government bills going through parliament, acts of parliament and initiatives connected to mental health, the justice system, and early intervention over the last 20 years in chronological order.

2013

- Age of Criminal Responsibility Bill
- Anti-social behaviour, Crime and Policing Bill
- Care Bill
- Child Maltreatment Bill
- Children and Families Bill
- Crime and Courts Act 2013
- Education (Information Sharing) Bill
- Offender Rehabilitation Bill
- Sentencing Escalator Bill
- Young Offenders (Parental Responsibility) Bill

2012

- Draft Anti-Social Behaviour Bill (Home Office, 2012)
- Children And Young People Health Outcomes Forum (2012)
- No Health without Mental Health: Implementation Framework (DH, 2012)
- Preventing Suicide in England (HM Government, 2012a)
- Social Justice: Transforming Lives – strategy to help families with multiple disadvantages (HM Government, 2012b)
- Swift and Sure Justice (Secretary of State for Justice, 2012)
- Legal Aid, Sentencing and Punishment of Offenders Act 2012

2011

- Troubled Families Programme
- Parenting Classes Trials
- NHS becomes responsible for commissioning young people’s health services in Secure Children’s Homes and Secure Training Centres
- No Health Without Mental Health—the coalition government’s mental health strategy
- The National Liaison and Diversion Programme

2010

- Breaking the Cycle – effective punishment, rehabilitation and sentencing of offenders (Lord Chancellor and Secretary of State for Justice, 2010)

2009

- Healthy Children, Safer Communities – strategy to tackle youth crime/anti-social behaviour (Department of Health, 2009)
- Youth Justice Liaison and diversion schemes – six pilots set up
- Healthy Child Programme – early intervention public health programme
- Multi-systemic Therapy pilots
- Lord Bradley’s review of people with mental health problems or learning difficulties in the criminal justice system (Bradley, 2009)

2008

- Criminal Justice and Immigration Act 2008
- Children and Young People in Mind – National CAMHS Review final report (National CAMHS Review Expert Group, 2008)

2007

- Family Nurse Partnerships – first 10 sites start testing
- Mental Health Act 2007

2006

- Family Intervention Projects established, part of Respect Action Plan
- 2005
- Intensive Fostering pilots

2004

- National Service Framework for Children, Young People and Maternity Services (Department of Health, 2004a; Department of Health, 2004b)

2003

- Criminal Justice Act 2003
- Anti-social Behaviour Act 2003
- National CAMHS Support Service launched

2002

- Youth Inclusion and Support Panels pilots launched

2001

- Introduction of the Intensive Supervision and Surveillance Programme

2000

- Youth Inclusion Programme
- Youth Offending Teams
- NHS Plan (Secretary of State for Health, 2000)

1999

- National Service Framework for Mental Health (Department of Health, 1999)
- Audit Commission’s report Children in Mind (Audit Commission, 1999)

1998

- Crime and Disorder Act 1998

1997

- No More Excuses White Paper, new approach to tackling youth crime (HM Government, 1997)

1995

- Together We Stand – National Review of CAMHS (NHS Health Advisory Service, 1995)

1994

- Working Group on High Security and Related Psychiatric Provision report (Reed, 1994)

1992

- Review of the Health and Social Services for Mentally Disordered Offenders and Others Requiring Similar Services (Secretary of State for Health and The Home Department, 1992)
- Health of the Nation – national health strategy (Secretary of State for Health, 1992)

2. References

Age of Criminal Responsibility Bill 2013-14. <http://services.parliament.uk/bills/2013-14/ageofcriminalresponsibility.html>

Anti-Social Behaviour Act 2003. <http://www.legislation.gov.uk/ukpga/2003/38/contents>

Anti-Social Behaviour, Crime and Policing Bill 2013-14. <http://services.parliament.uk/bills/2013-14/antisocialbehaviourcrimeandpolicingbill.html>

Audit Commission (1999) *Children in mind*. London: Audit Commission.

Berelowitz, S. (2011) *I think I must have been born bad*. London: Office of the Children's Commissioner. http://www.childrenscommissioner.gov.uk/content/publications/content_503

Blades, R. et al. (2011) *Care - a stepping stone to custody? The views of children in care on the links between care, offending and custody*. London: Prison Reform Trust. <http://www.prisonreformtrust.org.uk/Publications/vw/1/ItemID/147>

Bradley, K, Rt. Hon Lord (2009) *The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system*. London: Department of Health. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098694

Brown, E.R. et al. (2012) *A chance to change: delivering effective parenting programmes to transform lives*. London: Centre for Mental Health. http://www.centreformentalhealth.org.uk/pdfs/chance_to_change.pdf

Caldicott, F. (2013) *Information: to share or not to share? The Information Governance Review*. London: Department of Health. http://webarchive.nationalarchives.gov.uk/20130805112409/https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/192572/2900774_InfoGovernance_accv2.pdf

Care Bill 2013-14. <http://services.parliament.uk/bills/2013-14/care.html>

Centre for Social Justice (2012) *Rules of Engagement: Changing the heart of youth Justice*. London: Centre for Social Justice. <http://www.centreforsocialjustice.org.uk/publications/rules-of-engagement>

Child Maltreatment Bill 2013-14. <http://services.parliament.uk/bills/2013-14/childmaltreatment.html>

Children and Families Bill 2012-13 and 2013-14. <http://services.parliament.uk/bills/2012-13/childrenandfamilies.html>

Children and Young People's Health Outcomes Forum (2012) *Report of the Children and Young People's Health Outcomes Forum*. London: Department of Health. <https://www.gov.uk/government/publications/independent-experts-set-out-recommendations-to-improve-children-and-young-people-s-health-results>

Crime and Courts Act 2013 <http://services.parliament.uk/bills/2012-13/crimeandcourts.html>

Crime and Disorder Act 1998. <http://www.legislation.gov.uk/ukpga/1998/37/contents>

Criminal Justice Act 2003. London: HMSO. <http://www.legislation.gov.uk/ukpga/2003/44/contents>

Criminal Justice and Immigration Act 2008. London: HMSO. <http://www.legislation.gov.uk/ukpga/2008/4/contents>

Department of Health, et al. (2012) *No Health Without Mental Health: Implementation Framework*. London: Department of Health. <http://www.dh.gov.uk/health/files/2012/07/No-Health-Without-Mental-Health-Implementation-Framework-Report-accessible-version.pdf>

Department of Health, et al. (2009) *Healthy children, safer communities: a strategy to promote the health and well-being of children and young people in contact with the youth justice system*. London: Department of Health. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_109771

Department of Health (2004a) *Promoting Health and Well-being Identifying Needs and Intervening Early: Standard 1 of the National Service Framework for Children Young People and Maternity Services*. London: Department of Health. http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_4865614

Department of Health (2004b) *Promoting the mental health and psychological well-being of children and young people: report on the implementation of: Standard 9 of the National Service Framework for Children, Young People and Maternity Services*. London: Department of Health. http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_4870561

Department of Health (1999) *National service framework for mental health: modern standards and service models*. London: Department of Health. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009598

Education (Information Sharing) Bill 2013-14. <http://services.parliament.uk/bills/2013-14/educationinformationsharing.html>

Green, H., et al. (2005). *Mental health of children and young people in Great Britain 2004*. London: Palgrave. See http://www.statistics.gov.uk/downloads/theme_health/GB2004.pdf

Haines, A. et al. (2012) *Evaluation of the Youth Justice Liaison and Diversion (YJLD) pilot scheme: final report*. Liverpool: University of Liverpool. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_133007.pdf

HM Government (2012a) *Preventing suicide in England: A cross-government outcomes strategy to save lives*. London: Department of Health. <https://www.gov.uk/government/publications/suicide-prevention-strategy-launched>

HM Government (2012b) *Social justice: transforming lives*. London: The Stationery Office. <https://www.gov.uk/government/publications/social-justice-transforming-lives>

HM Government (2011) *No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages*. London: Department of Health. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123766

HM Government (1997) *No more excuses: a new approach to youth crime in England and Wales*, cm 3809. London: The Stationery Office.

Home Office (2012) *Draft Anti-Social Behaviour Bill*. London: Home Office. <http://www.homeoffice.gov.uk/publications/about-us/consultations/community-remedy-consultation/draft-antisocial-behaviour-bill?view=Binary>

Hughes, N. et al. (2012) *Nobody made the connection: The prevalence of neurodisability in young people who offend*. London: Office of the Children's Commissioner. http://www.childrenscommissioner.gov.uk/content/publications/content_633

Lader, D. et al. (1997) *Psychiatric morbidity among young offenders in England and Wales*. London: Office for National Statistics.

Legal Aid, *Sentencing and Punishment of Offenders Act 2012*. London: HMSO. <http://www.legislation.gov.uk/ukpga/2012/10/contents>

Lord Chancellor and Secretary of State for Justice (2010) *Breaking the Cycle: Effective Punishment, Rehabilitation and Sentencing of Offenders* (CM 7972). London: Ministry of Justice. <http://www.justice.gov.uk/consultations/consultation-040311>

Mental Health Act 2007. London: HMSO. <http://www.legislation.gov.uk/ukpga/2007/12/contents>

National CAMHS Review Expert Group (2008) *Children and young people in mind: the final report of the National CAMHS review*. London: Department for Children, Schools and Families & Department of Health. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_090399

NHS Health Advisory Service (1995) *Together we stand. NHS Health Advisory Service*. London: HMSO

NICE (2012) *Conduct disorders in children and young people: draft guidance*. London: NICE. <http://www.nice.org.uk/guidance/index.jsp?action=download&o=60587>

NICE (2011) *Service user experience in adult mental health*. London: NICE. <http://guidance.nice.org.uk/CG136>

NICE (2008) *Attention deficit hyperactivity disorder: Diagnosis and management of ADHD in children, young people and adults*. London: NICE. <http://guidance.nice.org.uk/CG72>

Offender Rehabilitation Bill 2013-14. <http://services.parliament.uk/bills/2013-14/offenderrehabilitation.html>

Reed, J. (1994) *Report of the working group on high security and related psychiatric provision*. London: Department of Health.

Sainsbury Centre for Mental Health (2009) *The chance of a lifetime: preventing early conduct problems and reducing crime*. London: Sainsbury Centre for Mental Health. http://www.centreformentalhealth.org.uk/pdfs/chance_of_a_lifetime.pdf

Secretary of State for Health (2000) *NHS Plan (CM 4818-I)*. London: Department of Health. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_118522.pdf

Secretary of State for Health (1992) *The health of the nation (CM 1986)*. London: HMSO.

Secretary of State for Health and the Home Department (1992) *Review of health and social services for mentally disordered offenders and others requiring similar services*. (CM 2088) <http://www.official-documents.gov.uk/document/cm20/2088/2088.pdf>

Secretary of State for Justice (2012) *Swift and sure justice: the Government's plans for reform of the criminal justice system*. London: Ministry of Justice. <https://www.gov.uk/government/publications/swift-and-sure-justice>

Sentencing Escalator Bill 2013-14. <http://services.parliament.uk/bills/2013-14/sentencingescalator.html>

Summerfield, A. (2011) *Children and young people in custody 2010-11: an analysis of the experiences of 15-18-year-olds in prison*. London: HM Inspectorate of Prisons. <http://www.justice.gov.uk/downloads/publications/inspectorate-reports/hmipris/thematic-reports-and-research-publications/children-young-people-2010-11.pdf>

Transition to Adulthood Alliance (2012) *Pathways from crime*. London: Transition to Adulthood Alliance.

Williams, K. et al. (2012) *Prisoners' childhood and family backgrounds: results from the Surveying Prisoner Crime Reduction (SPCR) longitudinal cohort study of prisoners*. London: Ministry of Justice. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/217401/prisoners-childhood-family-backgrounds.pdf

Young, Susan. et al. (2011) The identification and management of ADHD offenders within the criminal justice system: a consensus statement from the UK Adult ADHD Network and criminal justice agencies. *BMC Psychiatry*, 11 (32). <http://www.biomedcentral.com/1471-244X/11/32>

Young Offenders (Parental Responsibility) Bill 2013-14. <http://services.parliament.uk/bills/2013-14/youngoffendersparentalresponsibility.html>

Further Reading

Allen, G (2011) *Early Intervention: the next steps*. London: Cabinet Office.

Balbernie, R. (2002) *An infant in context: Multiple risks and a relationship*. *Infant Mental Health Journal*, 23:3, pp. 329-431.

Bradley S, Kramer T, Garralda E, Bower P, MacDonald W, Sibbald B, Harrington R, (2003) *Child and adolescent mental health interface work with primary services: a survey of NHS provider trusts*. *Child and Adolescent Mental Health* 8: 4, pp.170-176.

Cowie, H. (2012) *From birth to sixteen: children's health, social, emotional and linguistic development*. London: Routledge,

DOH, DfES: (2006). *Transition: getting it right for young people*. London, Department for Education and Skills, Department of Health.

Finch, H. & Lewis, J. (2003) Focus groups. In: Ritchie J, Lewis J, eds. *Qualitative Research Practice: A Guide for Social Research Students and Researchers*. Thousand Oaks, CA: Sage: p172-98.

Leininger, M. M. (Ed). (1985). *Qualitative research methods in nursing*. Orlando, FL: Grune & Stratton.

Meltzer, H. (2003) *The Mental Health of Looked After Children*. London: Office of National Statistics.

Penner, Erika K. Roesch, Ronald Viljoen, Jodi L.: *Young Offenders in Custody: An International Comparison of Mental Health Services*. *The International Journal of Forensic Mental Health*, Jul 01, 2011; Vol. 10, No. 3, p. 215-232

Punch, K.F. (2006). *Developing effective research proposals*. Second Ed. London, Sage Publications.

Reder P, McClure M, Jolley A: (2000) Interface between child and adult mental health. In *Family matters: interface between child and adult mental health*, edited by: Reder P, McClure M, Jolley A. London, Routledge :3-20.

Singh SP, Evans N, Sireling L, et al (2005): Mind the gap: the interface between CAMHS and adult services. *Psychiatric Bulletin*, 29, pp. 292-294.

Schoenwald, S. Halliday-boykins, C. Henggler, S. (2003) Client Predictions of Adherence to MST in Community Service Settings. *Family Process*, 42.

YOUNGMINDS
The voice for young people's mental health and wellbeing

TA
TRANSITION TO
ADULTHOOD

BARROW  CADBURY
TRUST



**CITY UNIVERSITY
LONDON**