Mapping Mental Health Interventions in the Juvenile Secure Estate

Report for the Department of Health

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EXECUTIVE SUMMARY

1. THE STUDY

This report describes a brief study commissioned by Prison Health (a partnership between the Prison Service and the Department of Health) to map the interventions provided to meet the mental health needs of juveniles in Young Offender Institutions (YOIs). The study was carried out during the final quarter of 2004 and included 17 sites – 13 for boys and 4 for girls.

2. METHODOLOGY

A specially-designed questionnaire was sent to the sites in October 2004, with visits and follow-up work during November and December. The findings were analysed in January 2005 and a draft report circulated to the sites for comment. The report was finalised in September 2005. The main contact in the sites was the Head of Healthcare, who was asked to co-ordinate responses from relevant colleagues, including Learning and Skills, Psychology, Residence, Throughcare, and outside agencies.

Sites were asked about four aspects of their work: the mental health problems experienced by juveniles in their site; current interventions to address problems; initiatives regarding mental health promotion; and staff views about achievements and aspirations for mental health provision.

A brief review of the published literature was conducted, to identify what is known about the mental health needs of young people in custody and about the effectiveness of interventions for meeting those needs.

3. FINDINGS

(a) Needs

Most children were deemed by staff to have some form of mental health problem, ranging from mild to severe. The full range of mental health problems was reported, with the most prevalent being anxiety, self-harm, depression, bereavement and other types of loss, conduct disorder, post-traumatic stress disorder, and needs arising from bullying and substance misuse. All but two YOIs had experience of children with psychotic disorders. Widespread and considerable concern was expressed about the number of children with learning disability and the problems they experienced. All sites referred to the damaging and distressing previous life experiences of many of the young people, experiences which had both contributed to their committing offences and underlay their mental health problems. All referred, also, to mental health needs that had arisen as a direct consequence of being in prison.

Although all sites screen for mental health problems at the time a child is admitted, this was rarely carried out in such a way as to identify the full range of needs. The good practice to which sites aspired was to have a staged assessment of mental health needs by involving a mental health trained professional, with a clear protocol for ensuring a timely and appropriate response.

It was widely reported that, in general, knowledge and understanding of mental needs – and how to respond to them - was poor among staff who have the most
contact with children in prison. As a result, emerging needs tend not to be recognised, or children are referred on, for someone else to deal with.

(b) Interventions available

Interventions available have been clustered into six groups:
1. Psychological treatments and psychotherapies
2. Medication and complementary therapies
3. Skills training
4. Systematic, multi-level and psychosocial interventions
5. Provision for vulnerable young people
6. Mental health promotion (and substance misuse).

All sites provide medication, and all describe mental health promotion activities provided by a range of different departments and people. They all provide, too, some specific interventions, namely cognitive behaviour therapy, bereavement counselling, and a sympathetic ear. In relation to offending behaviour programmes, all provide anger management courses.

About half the sites have added newer approaches to their repertoire. These include art, music and drama therapy, relaxation, acupuncture, and occupational therapy activities.

Smaller groups of sites (a third or fewer) described the particular responses being developed for vulnerable children. Some relate to specific needs: dialectical behaviour therapy for those at risk of self-harm, speech and language therapy for those with communication problems, mental health groups to help cope with a particular diagnosis, and small units for those unable to cope on the wings. Some responses take a holistic approach to linking needs and problems, as in the new JETS pilot programmes to improve children’s thinking skills and apply lessons to daily experience. Still others focus on developing skills for life beyond custody – examples of these initiatives are opportunities to learn cooking, parenting and other life skills.

Key gaps in interventions identified include those for children who have committed sex offences, for those with learning difficulties or severe mental illness that preclude them from joining in other activities, and those that involve joint work with children and their parents.

(c) The extent to which interventions are provided in line with good practice

It was not possible in this limited study to assess independently how interventions were targeted and how they were being delivered, when compared with the research evidence for effective practice. This evidence is, in any case, limited, especially as it applies to children in custody.

Effectiveness has often been shown to depend on the rigorous delivery of evaluated interventions; on engagement of the child and – often – of the family too; on sufficient intensity and length of intervention; and, crucially, on the skills and flexible knowledgeable response of the professional to the child. These, we were not able to measure. However, we did learn from staff in Mental Health In-Reach Teams (MHIRTs) about the difficulties of trying to deliver a ‘pure’ intervention in a YOI, because of problems over monitoring the child’s behaviour between sessions and
because children were often there for a short time only. There were widespread comments, too, about interventions that were on hold because staff shortages made it impossible to free up the staff needed. Another frequent comment was about the near impossibility of involving children’s families.

There is clear evidence of sites delivering some approaches or programmes that are indicated in the literature as being effective or promising. Thus, all sites gave a detailed explanation of the range of people and activities that come under the heading of mental health promotion, though only half the sites said explicitly that there was a commitment to providing a therapeutic or health-promoting environment. These included the 8 sites that were running small units or ongoing programmes for children who could not manage on the wings. Similarly, all sites have an anti-bullying strategy in place though only a third highlighted their scheme as an example of an achievement they were proud of. In relation to direct work, it is heartening that all sites referred to cognitive behavioural therapy or programmes that were in place, given the empirical support for this approach for both anti-social behaviour and mild to moderate emotional symptoms. A marked gap was an alternative approach for the significant number of young people unable to benefit from this type of work, because of intrinsic learning disabilities or learning difficulties arising from missed schooling.

There are some overall messages from the relatively few reports about the effectiveness of Offending Behaviour Programmes (OBPs), or of cognitive skills’ work designed to lead on to OBPs. The findings indicate that:

- the focus of research has been, almost exclusively, on adult offenders rather than children,
- the likelihood of negative peer influences, of young people’s dislike of group programmes, and of the low baseline in terms of their literacy and cognitive skills, may render group programmes unsuitable for juveniles, and
- the climate in which interventions is delivered is important. Both children and staff need to feel confident about what is on offer.

Some assessment of good practice could be made according to whether the YOI had a strong presence of mental health expertise with an appropriate range of skills, including clear leadership from a senior clinician. We found this to be the case in a quarter of the sites. On the other hand, all sites indicated that staff – generally in Healthcare but also amongst chaplains and personal officers – were “looking out” for children, in the sense of offering a sympathetic ear and the chance to escape the pressure of life on the wings. These are helpful responses that do not need to be justified by research evidence of effectiveness.

**(d) Factors undermining good practice**

Detailed discussion with staff identified the factors that make it difficult to institute and/or maintain good practice in meeting the mental health needs of children in the prison setting. Staff were acutely aware of these problems. They felt overstretched, but were striving to change what they could. Several commented on marked improvements in recent years, albeit from a very low start point.

The factors undermining good practice include:

- A lack of recognition of mental health needs within the prison.
- Inadequate assessment.
• A poor understanding of mental health issues and their importance for child welfare and positive outcomes.

• A physical and cultural prison environment that is not conducive to the promotion of children’s mental health: the prison ethos is about punishment and security rather than positive change to promote a child’s welfare.

• Lack of recognition that children’s mental health is everyone’s business. This is difficult to achieve because of the barriers to communication and joint working among staff from different disciplines and agencies (health, mental health, prison, social care, education), both within the YOI and between the prison and outside agencies.

• Lack of clarity about what constitute significant mental health needs, and too much reliance on referrals to outside sources of expertise because of a lack of confidence among staff and a shortage of mental health expertise within the YOI.

• Lack of confidence, even among healthcare staff, in mental health work.

• Lack of specialist mental health clinicians with dedicated time and interest to offer consultation, supervision, co-working, training to staff in the YOI, and to help take a lead on a mental health-promoting strategy for the institution.

• Long waiting times, with an uncertain response from the appropriate specialist services – CAMHS locally and NSCAG (the National Secure Commissioning Advisory Group) nationally - when children become acutely or seriously ill.

• Insufficient attention to the development of a whole-institution strategy for the promotion of children’s mental health, taking account of a tiered approach to provision and of the need to appraise critically the extent of good and less good practice in what is currently provided, to inform implementation of the strategy.

• Limited access to the range of interventions indicated by the variety and complexity of children’s needs.

• Major difficulties in carrying out consistent work with families.

• Limited resources for work with the child’s home services, which is acknowledged as being especially important in ensuring continuation of support and treatment after discharge.

4. FRAMEWORK FOR EFFECTIVE MENTAL HEALTH CARE

The Framework set out on pages 11-22, after our recommendations, has been developed as a basis upon which the above factors may be addressed. The Framework draws upon examples of good and innovative practice from the published literature and found in the study, and described in the text of the report.
It is also in line with the standard on child and adolescent mental health that forms part of the Children’s National Service Framework:

“All children and young people, from birth to their eighteenth birthday, who have mental health problems and disorders have access to timely, integrated, high quality, multi-disciplinary mental health services to ensure effective assessment, treatment and support, for them and their families.” (DH 2004a)
RECOMMENDATIONS

1. That individual YOIs are supported by the Department of Health (DH) and the Youth Justice Board (YJB) to develop a mental health-promoting environment in the interest of positive change and improved life chances for children in prison.

2. This support should include:
   a. knowledge dissemination and workshop events for those working in and with YOIs and other secure care institutions, to improve mental health awareness and to create a strong learning network to help develop greater capability in promoting children’s mental health, and
   b. exploring ways in which, jointly, funding for the necessary developments can be secured, working with mental health and youth justice commissioners at a regional level as well as using other appropriate forums.

3. Individual YOIs will not be able to develop more effective mental health promotion or the management of children with serious mental health problems unless a local specialist mental health clinician takes a special interest and has adequate dedicated time to help plan and monitor a strategic approach, in collaboration with the Governor and the Head of Healthcare. The strategy should recognise the importance of collaborative working and planning with local agencies such as the PCT and the Children’s Services Authority (the latter, introduced under the Children Act 2004, brings together local authority services such as children and family social services, education, leisure and play).

4. The strategy should inform the service specification for the YOI, agreed with the local PCT or PCT consortium, and with funding agreed and secured jointly with the YJB.

5. As a basis for defining a strategy, each YOI should undertake a detailed audit or critical appraisal of the resources and interventions for children’s mental health that are available both within and from outside the institution. Each YOI should then assess what additional resources and work is deemed necessary to implement a service in line with the Framework given below, and over what timescale.

6. The DH and the YJB could ask to see these plans with a view to supporting regular reviews of progress and creating opportunities for networking and learning between the different units holding juveniles – YOIs, Secure Training Centres (STCs) and Local Authority Secure Children’s Homes (LASCHs).

7. It should be recognised, nationally and locally, that an on-going programme of training for staff within the YOIs is fundamentally important in achieving the promotion of the mental health of children in the juvenile secure estate.
PROPOSED FRAMEWORK FOR PROVIDING EFFECTIVE
MENTAL HEALTH CARE FOR CHILDREN IN YOIs

The Framework is based on and incorporates what is known of good practice.

A. THE FRAMEWORK - GUIDING PRINCIPLES

• The young people under 18 in YOIs are children. They are vulnerable because of their age, and -- for some -- because of their delayed development.

• The Prison Service is acting in a parental role, similar to that of a local authority in relation to looked-after children. Guidance developed for work with vulnerable children and their families is likely to be most helpful in directing the development of interventions.

• The response to the mental health needs of children in prison is the most important aspect in meeting their overall health needs.

• What is offered for mental health needs in the YOIs is but one part of a child’s care pathway before, during and after custody.

• Many children will have missed out on help with their mental health needs before being in custody. Admission to secure care provides an opportunity to begin to remedy some of those gaps. The work should build on the promising initiatives that already exist.

• Responses to other needs (social relationships, self-care, education, skills training) are also important in achieving good mental health outcomes, and should involve a range of on-site and community resources.

• Each YOI should have a designated person to take responsibility for the promotion of children’s mental health. This should probably be the Head of Healthcare -- someone with authority to manage the work with both internal departments and external agencies, and someone who can maintain a focus on the full range of severity and type of mental health need and on a response that integrates the children’s mental health and other needs.

• It is important to reduce the barriers to good communication between staff from different disciplines within the YOI and between all those who will be involved in continuity of care for the children.

• More widespread knowledge and understanding is needed about the full range of services and approaches that are available to meet children’s mental health needs. This is needed both within each establishment and across the sector as a whole.
B. THE FRAMEWORK - MENTAL HEALTH PROMOTION

(a) The prison environment

Work is needed to improve the prison environment in which children are placed. Their life chances are unlikely to change without this. Attention needs to be paid to the physical and emotional ethos of establishments, the knowledge and experience in child development that staff bring to their work, and the extent to which children are encouraged to make choices and assume responsibilities. The focus should be on enabling positive change, not on punishment per se.

**Good practice**

At Thorn Cross – the only open YOI - there is a minimum of door locking and escorted movement. The atmosphere is more akin to a children’s home, with unit doors open, informal mingling of boys and staff, and easy movement between different units on the site.

(b) Minimising the negative impact of prison regimes

Healthcare staff, working jointly with other prison staff, have an important part to play in minimising the negative impact for children of traditional prison regimes. This is about enabling the children to engage in positive relationships and meaningful activities and – where appropriate - to participate in therapy. Involving prison officers in intervention programmes (as well as other activities) offers a double advantage: their knowledge of individual children can be harnessed when planning the intervention, and they can continue to observe and talk to the children before, during and after sessions.

**Good practice**

At Feltham, the mental health nurses try and arrange weekend activities for the boys in the inpatient unit because the prison regime takes over from the healthcare regime at the weekend, meaning boys spend more time locked up, doing kit changes and having their cell inspected.

At Hindley, a new suite includes a well-equipped kitchen where boys can learn basic cooking and a popular “cosy” room with low lighting and soft furnishings conducive to relaxed conversations.

At Wetherby, a therapy room has been refurbished with rugs, beanbags, wall hangings and soft lighting.

At Thorn Cross, the chaplain organises community mentors who do evening visits to boys without family contact or join them on outings to the local town. The boys also offer informal support to one another, often going to Healthcare or other appointments in twos, or sitting with a friend in their cell, to chat and calm down.

(c) A relationship of trust

The promotion of a relationship of trust between children and those adults with whom they spend most of their time is essential in custody, if children's mental health is to be promoted, their needs identified, and they are to engage positively with interventions to deal with problems. Children also need to feel safe and cared for before they can move on to deal with their offending behaviour. They need to be able to express themselves, and staff need to really understand their interests and concerns. It is people rather than programmes that are likely to have most impact on improving the life chances of this group of children.
Good practice
At Parc, an integrated multi-disciplinary team runs the juvenile wing and the relaxed atmosphere fostered by the team has resulted in a willingness among the children to talk to a range of staff about their problems, including disclosing past abuse.

At Eastwood Park, the Mental Health In Reach Team have good rapport with the girls. As the Team are not involved in the incentives scheme, the girls can say and do anything without it counting against them. The girls know that the Team will stick by them, even when they shout and scream. The Team say they will come back later, and do so, and the girls are pleased to see them. The Team take the view that the girls have had few adults in their life whom they can trust and are testing them out.

(d) Advocacy

An advocacy service, provided by visitors with appropriate experience, must be available to all children in custody and easy for them to access, to help ensure that children can communicate their needs and opinions effectively to staff and others. The issues regarding advocacy services for young people in custody and with mental health needs have been reviewed (Kurtz 2004), and a number of organisations – including the National Youth Advocacy Service and Voice for the Child in Care – have developed remarkable expertise in the field.

Good practice
At New Hall, there are “juvenile listeners” – two young adults whose role is to be available for any young person who wishes to speak to them. They are trained and managed by the Samaritans, who also do a walkabout session once a week and attend suicide prevention meetings.

(e) Informal responses to need

While planned interventions are important, informal responses by staff should be the norm. This is especially relevant for the high proportion of children with needs around smoking, drinking and using illegal drugs. It should be the business of all staff to talk to children about these issues rather than respond simply by making a referral to a specialist service.

Good practice
At Lancaster Farms, the chaplain does a lot of work with young people with complex needs, including yoga and relaxation, and social and life skills work.

At Hindley, the mental health staff do not close cases after an assessment or course of work, but encourage the boys to come back if they need to at any time in the future. As in some other sites, the healthcare unit is seen as a place to chill out for a while, away from the pressure of life on the wings.

(f) Access to services

Positive ways of encouraging children to make use of on-site services should be explored and developed. Participation in education and other activities will often provide the opportunity for the development of relationships from which the mental health of children can be promoted. Besides advocacy, mentioned above, there are other creative ways of engaging children in education, training and activities. Various sources of helpful approaches to draw on are now available, covering mental health community responses (Kurtz & James 2005a, b), participation (Street & Herts 2005),
and good practice in services for the mental health of black and minority ethnic young people (Kurtz et al 2005).

**Good practice**
At Brinsford, the Mental Health In Reach Team noted a reduction in referrals following an increase in activities for the boys, including extra education facilities and access to television in bedrooms.

At Thorn Cross, prison officers know which children have been referred for counselling or other support, follow them up if they have not attended, and are good at encouraging the boys to give it a try.

(g) **Shifting the culture – the challenge ahead**

It will be difficult to implement those parts of the Framework that are about mental health promotion because it is harder to shift the culture of an institution than to identify gaps in staffing and services. The shift will be made easier if YOIs have in place, and value highly, robust strategies for celebrating diversity and reducing bullying.

**Good practice**
At Ashfield, a dedicated anti-bullying co-ordinator investigates all incidents of bullying by talking to the young people and all relevant staff. There is a timed intervention, including work that is specific to the nature of the bullying incidents. The message across the unit is that it is not cool to bully and that it will be taken seriously. The strategy is evaluated through exit interviews with the boys and comments from parents.

At Bullwood Hall, the Safeguarding Group has a good reputation for dealing with bullying. The monthly meetings are well run and informative. They always act on concerns raised by staff. The meetings include the child protection liaison social worker who is based on site and helps the Mental Health In-Reach Team follow up girls with emotional problems.

(h) **Training**

If there is to be a helpful shift in culture, all staff working in YOIs – managers as well as front-line staff – will need opportunities to reflect on and improve their skills and confidence in working in an enabling manner with children who may be seriously disturbed and disturbing, and to recognise and understand mental health needs and appropriate responses. Training of this nature is not a one-off activity. To ensure change occurs across the whole institution, an ongoing programme should be established, with more experienced staff working alongside others. It will also be helpful, linked to more formal inspections of YOIs, to conduct a regular, whole-organisation consultation about effective practice in working with children.

**Good practice**
At Parc, the prison officers who work with juveniles have made a positive choice to work with this age group and have attended specialist training to do so. There is a waiting list of officers who are trained and wanting to transfer to the juvenile wing. The training is commissioned from an outside agency that trains foster carers, and there is an expectation that staff will bring this approach to their work.

At Bullwood Hall, the Mental Health In Reach Team provide half-day taster sessions for prison officers, about different mental health problems. They also attend prison training sessions, in part so they can explain why and how children with mental health needs present differently to adults with similar problems.
C. THE FRAMEWORK - IDENTIFYING NEEDS

(a) A good start
All else depends on identifying needs expertly and comprehensively. Much useful information may be available – with the child’s consent - from the child’s family and a variety of previous service providers. This should be sought proactively and noted, so that it can inform work with the child.

(b) Initial screening and ongoing identification of needs
Sound arrangements should be in place for the initial screening of children’s mental health needs. This should be carried out by a team of prison officers and nurses with an interest in, and understanding of, mental health issues. This team should include members of staff who are appropriately trained to administer and interpret mental health screening and who will have regular contact with the child throughout their stay. The initial screening should be regarded as a “getting to know you” exercise, in the full knowledge that a great deal more is likely to be learned about the child’s needs over time and as a result of the development of a trusting relationship between the child and these staff members.

Good practice
At Stoke Heath, there is a good relationship between Education and Healthcare. As a result, if Education become aware of a boy with learning disability that has not been identified previously, they invite Healthcare to do an assessment.

(c) A relevant tool
The screening tools used should be ones developed for children, not adults, and they should be relevant for the range of needs that may arise. Each YOI should develop use of screening tools in collaboration with the mental health specialist clinicians who take lead responsibility for mental health issues in that YOI. It would be useful to test more widely the advantages offered by the YJB’s mental health tools (SQUIFA – Screening Questionnaire for Adolescents, and SIFA – Screening Interview for Adolescents. See Appendix 2).

Good practice
At Lancaster Farms, members of the Mental Health In Reach Team have designed a mental health awareness training course. It includes the SQUIFA and SIFA tools and has been delivered (in 2004) to 30 staff.

(d) Staged screening
Each YOI should have a clear protocol for those circumstances when more detailed identification of mental health needs is indicated. The content of the protocol should include what triggers a more detailed assessment; who carries out this assessment, and by what method; how the findings are made known, and to whom; and the actions that will result.
D. THE FRAMEWORK - RESPONDING TO NEEDS

(a) Approaches to underpin responses at all levels

• A multi-disciplinary response

Children’s mental health is everyone’s business. Children will be helped best if there are considered and consistent responses from all staff – including prison officers, teachers and primary care nurses, as well as mental health and other specialists. There is no single “right” way of delivering mental health promotion and early intervention responses but a key issue, whatever the local arrangements, is to ensure that all staff bring this approach to their work.

**Good practice**

The two sites with a Speech and Language Therapist – Werrington and Brinsford – are very positive about their work. The SLTs help identify previously undiagnosed issues such as hearing impairment and mild learning disability. They also work with children frustrated by communication difficulties, to help them deal with anger in a non-violent way. Staff can access, and make referrals to, the SLT at any time.

At Stoke Heath, every boy has a multi-disciplinary conference, albeit they are held more frequently for those who are self-harming.

• Work with the child’s family

The evidence shows that mental health interventions are most effective if work is carried out with the individual child and his or her family. This approach presents almost insuperable difficulties for staff working with children in prison but its importance cannot be overstated. Increasing the number of Family Liaison Officers (FLOs), ensuring that they can allocate sufficient time to this important role rather than being deflected to other prison duties, and strengthening their skills in mental health work, are all likely to have a positive impact.

Although the local YOT team, working with the YOT team near the child’s home, should and do play this important family liaison role, they are often constrained in their attempts to try and engage families in promoting their child’s positive mental health. YOTs were reported generally as being overstretched. Being based on site, and so in daily contact with the children, is an obvious bonus that FLOs bring to this vital support for families.

**Good practice**

Some sites have found ways of trying to overcome the difficulties inherent in working with the families of children who are in custody.

At Ashfield, the Family Liaison Officer arranged for a mother to travel and stay overnight so that she could take part in discussion about her son’s mental health disorder, and a new member of the Mental Health In-Reach Team has a particular brief for outreach work with families and the community. At Parc, they link the new training kitchen with family work: families come in for meals that the boys have cooked. Werrington have found that taking a family round the whole site can help them and their son feel more able to cope with being separated from one another.

At Warren Hill, the CAMHS nurse contacts parents as a matter of course if a boy is referred to her from Healthcare. She does this as a courtesy to parents, because they are of prime importance in helping her understand their son, and because their feelings of guilt or depression may deter them from contacting her.
(b) Tier 1

The mental health needs of children in YOIs will be addressed best using a tiered approach, as in CAMH services for the general population. All front-line staff have a role to play as part of this first Tier. Achieving this will require a change in culture in many, perhaps most, sites, so that everyone feels confident in looking out for, recognising, and responding to the signs that a child needs a quick and caring response to what is troubling them. A good way of doing this is informally, whilst children are engaged in activities such as meals and recreation, sport, IT, classroom learning or basic skills’ training. Prison officers are key providers of this Tier 1 approach.

(c) Tier 2

As in community settings, the role of this team is to have close links with the work that occurs at both Tier 1 and Tier 3. The tasks will include:

- Conducting the initial mental health assessment when the child arrives on site
- Acting as the first port of call for advice and consultancy, and providing mental health training, for prison officers, teachers and other front-line staff (including visiting primary care professionals such as GPs and dentists), to help them provide the Tier 1 service described above
- Some direct work, and co-work with Tier 1 staff, with children with less severe mental health needs such as anxiety, and those related to alcohol and the worry of being separated from their family, and
- Acting as an Early Response Team, making timely and appropriate referrals to Tier 3 when there is a need for more specialist mental health input.

The Tier 2 team should include at least one full-time mental health specialist, which might be a Primary Mental Health Worker - PMHW (NHS HAS1995) - or psychologist. They will provide supervision for the rest of the team. They will also act as the mental health component of the Healthcare Manager’s team, being involved closely in setting the mental health strategy and in monitoring the delivery of mental health care for the YOI. Other members of the team might be nurses who have an interest in mental health and have developed their skills in the consultation, co-working and training aspects of the job.

The chief aim of having a pervasive expert mental health presence within the YOI is to encourage ready and informal access by children and all staff to those with mental health expertise, to increase awareness of mental health issues, and to reduce - as far as possible - the need for formal referral for more specialist help.

**Good practice**

At Castington, staff in the Mental Health In-Reach Team have developed strong informal links with other disciplines, helping staff to improve their ability to identify and describe children’s mental health problems and to understand the responses that can be provided by all staff members, both general and specialist.

At Huntercombe, the psychologist and psychiatrist spend time on the wings, chatting to staff and boys, to raise awareness of their existence and to be seen as staff members who are available to offer help rather than “distant” specialists.

At Werrington, there are group sessions each morning for boys who find it hard to mix and make friends. The work has been developed from school-based programmes and is underpinned by attachment theory. Psychologists and education staff provide a range of group and individual sessions to help boys learn and practise new skills.
At Warren Hill, the psychologist and chaplain run one session a week to give boys who don’t mix well the chance to be away from the wings and to get some individual work on coping skills and prison life.

As well as fostering good links within the YOI, the Tier 2 team should be connected to local community resources. Supervision and consultation should be provided to the PMHW by a local CAMHS Tier 3 team.

**Good practice**
At Werrington, the psychology service has supervision from the forensic and clinical psychologist who leads a local specialist CAMHS team that works with young offenders in the community. The service, called Engage (2006), does direct individual and group work with children and families, offers training and consultancy to Tier 1 professionals, and is undertaking research into the mental health needs of young offenders in the community.

(d) **Tier 3**

- **Managing more significant mental health needs**
  Each YOI needs dedicated time from child and adolescent mental health specialists, including both a psychologist and a psychiatrist. Their role, as in any Tier 3 team, is to:
  - offer assessment and treatment for the children who require their specialist input
  - support and supervise the PMHW
  - co-ordinate, as appropriate, multidisciplinary team input, and
  - make referrals, when necessary, to Tier 4 and specialist forensic services, including the national NSCAG service.

- **Connected to the local CAMHS**
  The CAMHS specialists should be embedded within the CAMHS structure local to the YOI. This will help ensure that services are available from the YOI’s community base and that work involves the local YOT, both of which will enhance the chances of the smooth organisation of the child’s care pathway when they move on or return to their local community.

**Good practice**
At Huntercombe, the Mental Health In-Reach Team is based in the local CAMHS, covering work in the YOI and with offenders in the community as well as doing ordinary CAMHS work. The work is jointly funded by the NHS and the Youth Offending Team, with a Service Level Agreement with the prison to specify the range of interventions to be provided.

- **The YOI mental health team**
  A dedicated team for the mental health of children in the YOI should comprise the most senior specialists, as described above, the PMHW (also described above), nurses with specialist training, and other staff such as psychotherapists, art and drama therapists, and occupational therapists (OTs) who may have dedicated sessions with the YOI or be brought in from the local CAMHS services as and when required. The team may be called a Mental Health In-Reach Team (MHIRT), although it will generally include a number of staff who work full time within the YOI.

  One of the CAMH specialists should take responsibility for developing and overseeing a mental health strategy for the YOI, in collaboration with the
Head of Healthcare, the Governor and others. The strategy should describe the monitoring and audit arrangements for the YOI, as well as drawing on the growing evidence about children’s mental health needs and effective interventions.

**Good practice**
At Wetherby, the establishment of a therapeutic services team has extended the use of CBT work with juveniles, as well as bringing psychotherapy, drama therapy and other OT work on site.

- **Accepting referrals and providing interventions**
The team should meet regularly and, since the PMHW will be part of the team, it should be possible for referrals to be made quickly, without the need for a formal or lengthy procedure. Time is of the essence in responding to children with serious mental health problems in the prison setting, hence the need for the PMHW to be able fast track children to Tier 3, as needed.

There are particular considerations in assessing and managing children with mental health problems and disorders within the YOI setting, and for these there is no single satisfactory solution. A flexible approach is needed in order to respond to the full range of mental health needs in this high-risk group of vulnerable children. There are two sides to this. One is about the flexibility to use Tier 3 services to provide the full range of interventions that might be needed. The other is about how and where the interventions should be delivered. While local professionals coming on site will provide much of the therapeutic work, there should also be scope for developing ways of providing interventions off site, in community settings. In either location, there will be a need for a suitable environment in which to do the work.

**Good practice**
At Castington, Huntercombe, New Hall and Werrington, there are regular multi-disciplinary meetings of the Mental Health In-Reach Team and other staff, to discuss referrals or issues and to decide who is best placed to respond to the children’s problems. As in some other sites, staff have developed standardised referral forms and protocols.

At Bullwood Hall, the referral form is kept as simple as possible (referrer, reason for referral, known risks, who else is involved). Plus the girl's signature, because girls were being referred without their knowledge and, understandably, were very angry about this.

At Thorn Cross, if a second opinion were needed about a boy's mental health problem, the Head of Healthcare would make an outpatient referral to the local community mental health service.

- **Regional pathway links**
To provide continuity of care for children who need protracted intervention or who stay in custody for a short time only, it is suggested that a team of Care Pathway Managers should be appointed, one for each region in England (as is the case for adult secure services). The team should work together, and individually with local services, to smooth the way for children being linked into the next stage of assessment or treatment as they move on or out of custody. They will need to work closely with YOIs, STCs and the National CAMHS Support Service (NCSS), as well as with commissioners. The establishment of such a team will acknowledge the lack of resources in both local CAMH and YOT services to do enough of this vital linking work for
children in custody. It should also ensure that feedback about outcomes for children are received, collated and reviewed.

**Good practice**

At Eastwood Park, the Mental Health In Reach Team place importance on having good links with community services. At the time of making an assessment they seek information from the YOT, the GP and the girl’s social worker. They also focus attention on contacting home services so that girls know how to access help once they leave custody, as for many the prison environment is not conducive to intensive work on past issues.

At Bullwood Hall, the Mental Health In Reach Team copy the care plan, review notes and running records to IMR, if they have the young person’s consent. This is to ensure that, if girls are moved suddenly, the next site will know what has been done and whom to contact, thus avoiding the problems the Team faces when girls are transferred to them from other sites.

In Warren Hill, the CAMH nurse and chaplain are planning to run a loss and bereavement group on the specific issues affecting boys about to leave custody – including the loss of childhood as they become adults, and the loss of a peer group and lifestyle when they have to make changes and move on in life.

**Good practice**

At Castington, the unit copes with a young person with mental illness if they are able to do so through a combination of medication and therapy. If not, they have a fast-track arrangement (via their visiting consultant psychiatrist) to the local mainstream mental health hospital and usually secure a bed there within a few weeks.

Bullwood Hall, Feltham, Hindley, New Hall and Warren Hill have introduced or are drawing on the Care Programme Approach, to help ensure continuity of care when children are discharged from inpatient care or transferred to adult services. This is in line with the good practice marker in the CAMHS Standard of the Children’s NSF (DH 2004a).

**Inpatient admission**

Referral for admission to an inpatient bed must come from the lead child and adolescent psychiatrist. Clear guidance is now available about the criteria and process for admission to a medium/high secure inpatient ‘bed’ in the national NSCAG service (NSCAG/DH 2005). Pending the availability of enough resources in this service, healthcare staff in YOIs need up-to-date information about alternative facilities in the private sector.
• **Support for children staying on site**
  Consultation, co-working, supervision and training for each YOI mental health team from one of the NSCAG services is greatly to be encouraged and has been established in one or two instances. This is likely to enable more children with acute mental illness and/or severe and complex needs to remain on site within the YOI and obviate a long-distance move. There is ongoing consideration by the Department of Health, NSCAG and the YJB about ways of developing and resourcing this facility further.

  **Good practice**
  At Feltham, the consultant psychologist runs a short session with inpatient staff after each weekly ward review. It includes the young person’s nurse, prison officer and junior doctor. It provides the opportunity to think about problems and practice, to boost staff confidence in what they are doing, and to help foster a therapeutic environment.

• **Monitoring need and provision**
  A system has been set up by NSCAG to monitor referrals made by YOIs for admission to the Secure Forensic Mental Health Service for Young People (SFMHS for YP), including the reasons why a referral is rejected and the timescales involved. This will help give a clearer picture of how the national provision needs to develop.
E. THE FRAMEWORK - COMMISSIONING

- If the Framework for providing a comprehensive service for the mental health of children in custodial settings is to have every chance of leading to positive outcomes, it must be specified and supported jointly by the Department of Health, the Youth Justice Board and local commissioners. Elements of the care of these children are also the responsibility of local authorities (LAs) or children’s services authorities (CSAs - introduced by the Children Act 2004). There are a number of difficulties in setting out what must be a joint commissioning framework, including the rather obvious one that – because of the geographical distribution of sites - individual children are usually placed in a YOI that is located outside the boundary of the LA/CSA and PCT responsible for specifying and funding their care.

- The services within whose administrative boundaries individual YOIs are located must be given additional resources in order to provide effectively for the population of children within the YOI. A robust mechanism for securing the funding for the necessary mental health and other resources (such as education) must be established. This mechanism has been established, through NSCAG, for the most highly specialist and expensive component of the service, the Secure Forensic Mental Health Service for Young People.

- A consortium or regional approach to specifying and developing the level and type of resources needed in each YOI, depending upon the established local service situation, is likely to be fruitful, and it should take account of the nature and extent of local services already in place. But the approach needs to include both the Prison Health department of the DH and the Youth Justice Board, given their national oversight of provision in YOIs. It is hoped that this Framework will form a useful basis for developing a more detailed and effective mental health service specification in each YOI.
1 INTRODUCTION

1.1 PURPOSE OF THE STUDY

This report sets out the findings of a mapping exercise to describe how one section of the secure estate identifies and responds to the mental health needs of juveniles (children under the age of 18 years). The study covers the 17 Young Offender Institutions (YOIs) that accommodated juveniles at the end of 2004. Thirteen sites were for boys, and most of these also house young offenders (those over 18). The other four sites were for girls and were units in female adult prisons. Early in 2005 girls were moved to completely separate establishments. The study YOIs are listed at Appendix 1.

The study was commissioned by Caroline Twitchett, Project Manager for Juvenile Health at Prison Health, a partnership between the Prison Service and the Department of Health, based at the DH. The purpose of the study was to map current provision for mental health in the juvenile secure estate and to report on the evidence base for any interventions, programmes, services and approaches provided for young people under 18 and their families. It is intended that the information provided by the YOIs will help in developing support for staff, both to improve the mental health of this very vulnerable group of children and to meet the targets of current legislation and guidance (Children Act 2004; DH 2001, 2004a, 2004b; Home Office 2003; YJB 2004a).

1.2 CONTEXT OF THE STUDY

1.2.1 The legal framework whereby children are placed in custody

The age of criminal responsibility in England is 10 years. Children aged 12 to 17 can be sentenced to custody under a Detention and Training Order. The length of the sentence can be between four months and two years. The first half of the sentence is spent in custody and the second half is spent in the community, under the supervision of the Youth Offending Team (section 73, Crime and Disorder Act 1998). A child aged 10-17, if convicted of a serious offence (one for which an adult could be sentenced to 14 or more years in custody) can also receive a custodial sentence (sections 90 and 91, Powers of Criminal Courts (Sentencing) Act 2000).

Once a child is given a custodial sentence, the YJB decides where the child should be placed, having regard to their age and vulnerability:

- YOIs can accommodate children aged between 15 and 17. The YJB website notes that, as these institutions hold large numbers of young people, they are less able to address their individual needs and so are considered inappropriate accommodation for vulnerable young offenders (www.youth-justice-board.gov.uk).

- Another possible placement is in a Secure Training Centre (STC). An STC can hold young offenders from the age of 12 to 17 and there are four such centres in England. They hold fewer young people than YOIs and they have a higher staff to young offender ratio.

- Finally, children sentenced to custody can be placed in a Local Authority Secure Children’s Home (LASCH). These also cater for young people who
are looked after and need a secure placement, even if they have not committed an offence. Such homes also have a high ratio of staff to young people and are small in size. They are generally used to accommodate young offenders aged 12 to 14, girls up to 16, and 15 and 16 year old boys who are assessed as vulnerable.

Case law (the Munby judgement) has established that the Children Act 1989 applies to children (anyone under the age of 18) who are in a YOI. This means that the duties imposed on local authorities to safeguard and promote the welfare of children in need, and to make enquiries in cases where it is suspected that a child is suffering or is likely to suffer significant harm, apply to these children. The Children Act 2004 specifically requires the Governor of a prison or STC to ensure that they discharge their functions, having regard to the need to safeguard and promote the welfare of children (section 11).

1.2.2 Key facts about juvenile offenders

The following key facts are taken from Annex D – Juveniles of the government’s report about reducing offending by ex-prisoners (SEU 2002).

Background
• There are just under 3,000 juveniles held in secure accommodation.
• 86 per cent are kept in YOIs – the others are in Secure Training Centres (STCs) or Local Authority Secure Children’s Homes (LASCHs).
• Daily costs (in 2002) were £104 for YOIs, £370 for STCs, and £402 for LASCHs.
• 84 per cent of 14-17 year-olds discharged from prison in 1997 were reconvicted within two years.
• The main types of offence for which juveniles are sentenced are theft and handling, burglary, violence against the person, and robbery.

Low educational attainment
• Of those of school age, nearly half had literacy and numeracy levels below those of the average 11 year old.
• Over a quarter had the equivalent levels to those of the average 7 year old or younger.
• Between a quarter and a third of juvenile prisoners had no education and training available to them before custody.

Disrupted family backgrounds
• Over half of those under 18 in custody were estimated to have a history of being in care or social services involvement.
• 2 out of 5 females and about 1 in 5 males reported having suffered violence at home.
• 1 in 3 females and 1 in 20 males reported sexual abuse when younger.

Coming from a black or minority ethnic background
• The estimate of black juveniles in custody is 10 per cent, against 2 per cent in the general population.

Behavioural and mental health problems
• 1 in 5 sentenced males and 2 in 3 of sentenced females have symptoms of anxiety, depression, and fatigue and/or concentration problems, compared with 1 in 10 of young people in the general population.
• 1 in 10 young men remanded in custody have considered suicide within the last week and 1 in 5 have attempted suicide some time in the past.

Drugs and alcohol
• Over half of young people in custody reported dependence on a drug in the year before being in prison.
• Of these, 1 in 4 sentenced females and 1 in 7 males were dependent on opiates such as heroin.
• Over half of female prisoners and two-thirds of males had a hazardous drinking habit before entering custody.

1.2.3 The mental health and associated needs of children in custody

There is a lack of specific information about the mental health and associated needs of juveniles (those aged 15-17), as distinct from the general age group held in YOIs (those aged up to 21). As a result, this section groups together available evidence on both the younger and older age group.

“Mental health problems, both in young offenders and older offenders, represent the single area of most concern in the available literature. The findings of an overall association between mental health problems and offending in young people are variable from different studies in different countries. However, most, especially those from the UK, conclude that the prevalence of mental health problems is increased among young offenders before, during and following incarceration. The most obvious and serious example of this is demonstrated by the high rates of suicide or attempted suicide amongst young offenders.” (Macfarlane, in HMIP 1997)

Young offenders suffer the whole range of mental health problems and disorders and, for young people in prisons, “research has shown that mental health and emotional difficulties are major problems; over 50 per cent of remanded young males and 30 per cent of sentenced young males have a diagnosable mental disorder” (HMIP 1997, p 50). What is known of the health needs of children in prison is summarised in a recent short article (Gould & Payne 2004). Although there are few direct studies, it is clear that levels of mental illness are much higher than in young people in the general population; high numbers of young people in prison self-harm and commit suicide.

A study carried out by the Office for National Statistics found a prevalence rate for schizophrenia of 6 per cent for young male offenders and 9 per cent for female young offenders. Ten per cent of young offenders have self-harmed and 11 per cent say they have contemplated suicide (Lader et al 1997). In addition, a high proportion (around 50 per cent) of children in prison have been looked after by a local authority, many have been excluded from school, few have any academic qualifications, and almost a fifth admit to having suffered abuse of a violent, sexual or emotional nature (Howard League, in Gould & Payne 2004; Fonagy 2003) – all known to be associated with a high risk of mental health problems and disorders (Fonagy et al 2002). Violent behaviour is found in about 25 per cent of young offenders.

A recent study offers comprehensive standardised assessment of the needs of young offenders in custody and in the community (Harrington & Bailey, 2005). Based on six geographically representative areas across England and Wales, each site included a YOT and a custodial establishment. The young offenders were assessed in 17 different areas of need, defined as a significant problem that can benefit from an intervention. The mean number of areas of need per individual was found to be 2.6
(standard deviation 2.57 and range 0 to 13). Some of the main findings are summarised as follows:

- “The Asset form was not always completed. Of the 600 Asset forms evaluated, only 15% of young offenders were identified as having mental health problems. This is much lower than the 31% identified as having a mental health need in this national study, using the S.NASA (Salford Needs Assessment Schedule for Adolescents – Kroll 1999), which is a fully validated mental health screening tool.

- Young offenders were found to have high levels of needs in a number of different areas, including mental health. About half had problems with relationships (peer and family), while one in three young people had significant problems with education or work.

- These young people were found to be a particularly vulnerable group. They had frequent histories of social care placements, family breakdown and school exclusions.

- Almost one in four young offenders were identified with learning difficulties (IQ<70), while a further third had borderline learning difficulties (IQ 70-80). However, this finding must be taken in the context that a number of these young people had missed education. Commonly used psychiatric measures including the WASI (Wechsler Abbreviated Scale of Intelligence) cannot easily differentiate those with intrinsic learning difficulties from those with low IQ scores secondary to lack of education.

- A third of young offenders had a mental health need. Almost one-fifth of young offenders had problems with depression. One in ten young people reported a history of self-harm within the last month. Similar rates were found for young people suffering with anxiety and post-traumatic stress symptoms (PTSD). Hyperactivity was reported in 7% of young people and psychotic-like symptoms were reported in 5% of the sample.

- While there was no significant difference in the total number of needs by gender or ethnicity, it is important to note that, overall, female offenders had more mental health needs than males, particularly in areas of depression, deliberate self-harm and post-traumatic stress. Also, young offenders from ethnic minorities were found to have higher rates of post-traumatic stress.

- Young offenders in the community were found to have significantly more needs than those in secure care. Specifically, the numbers of needs were higher in areas of education, risky behaviour (alcohol and drug misuse) and peer and family relationships. There was no significant difference between the two groups with respect to the number of mental health needs.

- Needs increased for young offenders discharged from secure facilities back into the community, suggesting that needs are only temporarily reduced whilst in custody.

- Many of these needs remained unmet, with few young people having any form of intervention for their needs. The most recommended intervention was the basic requisite for an assessment, particularly for mental health needs.”
1.2.4 Effectiveness of interventions for children in custody

- **Intervening effectively in CAMH**

What is known of the effectiveness of interventions across the field of child and adolescent mental health has been systematically reviewed by Fonagy et al (2002). A shorter guide, derived from these systematic reviews, has also been published, focusing on effectiveness in clinical work (Wolpert et al 2002). It has now been well established, across the board, that effective interventions depend crucially upon the style of delivery: showing respect for the child; promoting their self efficacy; and gaining their active participation in the intervention, often by dealing first with issues that are important to them, such as worries about a parent’s mental illness. Because mental health is inextricably linked with overall health and well-being, it is important to note that mental health interventions may show their effectiveness in a number of different domains in a child’s life. Interventions for young people in the secure estate are generally targeted at reducing recidivism and it is now known that success in this respect is often linked to achieving good outcomes with regard to education, family and peer relationships and substance misuse – all of which may be dependent on meeting mental health needs effectively.

- **Interventions for those in custody**

In their evaluation of the Medway Secure Training Centre, Hagell and colleagues (2000, p12-13) note the many findings from previous research that indicate that custody is relatively ineffectual in reducing offending. They make three main points:

1. The way in which an institution is run can affect outcomes for children sheltered. The Department of Health (1998) emphasises the importance of clear objectives. Sinclair and Gibbs (1998) restate the findings of a body of work showing the value of family participation in the residential experience. Research on other children in need demonstrates the benefits of inter-agency cooperation and, for children who are locked up, of linking the custodial and community parts of a sentence.

2. There is some consensus, too, on the types of activity most likely to alter the trajectories of young offenders. Rutter and colleagues (1998) found that while the deterrent and incapacitation effects of incarceration were negligible, beneficial effects on behaviour were most likely when:
   - education and training opened up new opportunities after custody,
   - help was offered with drug misuse and there was no access to drugs during custody,
   - a pro-social ethos with good relationships and models for behaviour were maintained,
   - there were chances for the young person to make a change in mind-set, leading to a greater sense of self-efficacy and control over life, and
   - strong and regular links with families were encouraged.

3. Thus, in the prison system, effective intervention to meet mental health needs should include:
   - mental health promotion,
   - expert assessment,
   - targeted preventive approaches for those with risk factors,
   - interventions for specific conditions (co-working with specialists),
   - work with the family,
   - integrated holistic approaches (with Education, OT), and
• active participation in setting up continuing provision if needed after discharge.

The recent custody and community study mentioned above (Harrington & Bailey 2005) includes the results of a literature review of available databases and an analysis of the relevance of particular interventions when applied to the youth justice system. They report as follows:

- “An initial structured assessment of risk and mental health needs of the young person is an important basis for planning interventions. A finding also clearly evidenced from this study is that the most common reason for unmet need was the failure to adequately assess and review the needs of a young person.

- Interventions should be tailored to the young person’s needs and abilities (one in four offenders were found to have learning difficulties), focusing on the dynamic aspects of risk.

- Cognitive behavioural and problem solving skills therapies are most effective, particularly multimodal approaches that include the individual, peer group and family.

- There is limited evidence for brief unimodal interventions such as anger management or social skills training.

- There is evidence to support a number of interventions for treating child and adolescent mental health problems, but not all have been fully evaluated on samples of young offenders.

- There is empirical support that cognitive behavioural therapy programmes and problem solving skills training designed to reduce antisocial behaviour may also have a beneficial effect on mild to moderate emotional symptoms (anxiety and depression).

- Young offenders with moderate to severe mental health needs should be identified by a structured screening process and referred to the appropriate professional or agency, as co-existing mental health problems are likely to influence the success of any offence reduction work.”

1.3 CONTENT OF THE REPORT

Section 1 has set the scene for our mapping exercise.

Section 2 describes the methodology used.

Section 3 describes the mental health needs and problems of juveniles held in the secure estate, as explained by staff in questionnaires and interviews.

Section 4 describes staffing found in the Mental Health In-Reach Teams.

Section 5 describes the interventions provided – to respond to children with particular mental health problems, to provide a protective environment for those too vulnerable to survive on the wings, and to promote mental health generally.

Section 6 describes the issues raised by staff in relation to needs and interventions.
2 METHODOLOGY

2.1 MAPPING EXERCISE

A specially designed questionnaire (key questions are listed at Appendix 4) was sent to the 17 YOI sites in October 2004. This had been designed in collaboration with the National Children’s Bureau, which was working on a parallel exercise regarding the physical health needs of juveniles in the secure estate. That work, a longer project than the mental health mapping exercise described here, is due to report fully in 2006 (NCB 2005a).

The questionnaire used open-ended questions to collect information about four aspects of the work occurring in sites. These were:

1. The specific mental health problems of young people in the site, including tools used for identifying and assessing need.
2. Current interventions in response to juveniles identified as having a mental health need. We asked for a description of the aim, content and organisation of programmes and any research evidence relied on or evaluation conducted.
3. Current provision for mental health promotion, with prompts on 14 aspects of a young person’s life in custody, and including links with local health, mental health and health promotion services.
4. Staff views about achievements and aspirations.

### Defining mental health

The working definition of mental health, set out in the questionnaire, is that used by YoungMinds, the national voluntary sector organisation for children’s mental health:

“Mental health means much more than just the absence of mental illness. It is about physical and emotional well-being, about having the strength and capacity to live a full and creative life, and also about the flexibility to deal with its ups and downs.” (YM 2004)

This definition summarises the more detailed descriptions of mental health arrived at by a group of experts, set out in Chapter 2 of the Department of Health document Together We Stand (NHS HAS 1995):

“Mental health in young people is indicated … by:
- A capacity to enter into and sustain mutually satisfying personal relationships.
- Continuing progression of psychological development.
- An ability to play and learn so that attainments are appropriate for age and intellectual level.
- A developing moral sense of right and wrong.
- The degree of psychological distress and maladaptive behaviour being within normal limits for the child’s age and context.”

“To an extent, what is meant by mental health is culture-bound and will change over time and in different situations but, for the most part, it includes freedom from problems with emotions, behaviour or social relationships that are sufficiently marked or prolonged to lead to suffering or risk to optimal development in the child, or to distress or disturbance in the family or community.” (Kurtz 1992)
The questionnaire was sent out for the attention of the Head of Healthcare. It invited a response that included the views of colleagues in relevant departments (especially Learning and Skills, Psychology, Residence, and Throughcare) and outside agencies. Some Heads convened a meeting to complete the questionnaire whilst others distributed it for comment from different disciplines. Two sites did not complete their questionnaire at that stage and a third confined its response to its inpatient unit.

A follow-up visit was made to all but two sites in November and December 2004, for discussion with the Head of Healthcare and other staff, including those in Mental Health In-Reach Teams, specialist nurses for juveniles, forensic and clinical psychologists, a psychiatrist, and prison officers. The sites not visited were contacted by telephone, to check and supplement questionnaire responses.

While there were a few initial reservations about the project, because of the hours needed to give a considered reply, all sites were generous with their time - completing the questionnaire, arranging interviews, and dealing with queries.

The following chart describes the responses received and the staff involved.

<table>
<thead>
<tr>
<th>SITE</th>
<th>QN</th>
<th>VISIT</th>
<th>RESPONSES FROM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ashfield</td>
<td>√</td>
<td>√</td>
<td>8 - Assistant Clinical Manager; consultant psychiatrist; CAMHS Forensic Nurse Specialist; trainee forensic psychologist; custody office manager; practice nurse; senior psychologist; anti-bullying co-ordinator</td>
</tr>
<tr>
<td>Brinsford</td>
<td>√</td>
<td>√</td>
<td>2 - Head of Healthcare; staff nurse RMN</td>
</tr>
<tr>
<td>Castington</td>
<td>√</td>
<td>√</td>
<td>2 – Mental Health In Reach co-ordinator (RMN); CPN</td>
</tr>
<tr>
<td>Feltham</td>
<td>√</td>
<td>√</td>
<td>6 - Head of Healthcare; MH team leader (RMN); Consultant psychologist; Clinical Nurse Manager; OT; Offending Behaviour Programme Manager</td>
</tr>
<tr>
<td>Hindley</td>
<td>√</td>
<td>√</td>
<td>4 - Head of Healthcare; Head of Education &amp; Skills; Head of Juveniles; Team Leader MH (RMN)</td>
</tr>
<tr>
<td>Huntercombe</td>
<td>X</td>
<td>√</td>
<td>3 - Head of Healthcare; Consultant CAMH and forensic psychiatrist; CAMH clinical psychologist</td>
</tr>
<tr>
<td>Lancaster Farms</td>
<td>√</td>
<td>√</td>
<td>5 - Lead Nurse YP in Healthcare; Governors; forensic psychologist; Nurse Manager</td>
</tr>
<tr>
<td>Parc</td>
<td>√</td>
<td>√</td>
<td>4 – Healthcare manager; Head of the Juvenile Wing; senior manager; juvenile admin manager</td>
</tr>
<tr>
<td>Stoke Heath</td>
<td>√</td>
<td>√</td>
<td>5 - Head of Healthcare; Clinical psychologist in MHIRT; CPN; Juvenile Governor; Head of Learning</td>
</tr>
<tr>
<td>Thorn Cross</td>
<td>√</td>
<td>√</td>
<td>6 - Head of Healthcare; Head of Education; personal officer; healthcare officer; psychologist; teacher</td>
</tr>
<tr>
<td>Warren Hill</td>
<td>√</td>
<td>√</td>
<td>3 – Healthcare Manager; CAMH MH nurse; MH nurse manager</td>
</tr>
<tr>
<td>Werrington</td>
<td>√</td>
<td>√</td>
<td>4 - Head of Healthcare; RGN; RMN; clinical psychologist in MHIRT</td>
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<tr>
<td>Wetherby</td>
<td>√</td>
<td>√</td>
<td>3 - Head of Healthcare; Head of Resettlement; Clinical Services Manager</td>
</tr>
<tr>
<td>Bullwood Hall</td>
<td>√</td>
<td>√</td>
<td>5 - MHIRT co-ordinator (RMN); Head of Psychology; Head of Juveniles and Lifers; MHIRT administrator; psychologist and counsellor</td>
</tr>
<tr>
<td>New Hall</td>
<td>√</td>
<td>√</td>
<td>4 - Head of Healthcare; Head of Psychology/Resettlement; Governor for Juveniles; CPA co-ordinator</td>
</tr>
<tr>
<td>Eastwood Park</td>
<td>X</td>
<td>X</td>
<td>1 - Head of Juveniles (phone conversation)</td>
</tr>
<tr>
<td>Holloway</td>
<td>√</td>
<td>X</td>
<td>1 – MH In-Reach Manager (adult services)</td>
</tr>
</tbody>
</table>
2.2 LITERATURE REVIEW

A brief review of the literature was conducted, to identify what is currently known about the mental health of young people in custody and about the effectiveness of interventions for meeting their mental health needs. With this in mind, the study findings could then be analysed to identify promising developments and good practice in current provision.

2.3 ANALYSIS

The study findings were analysed in early 2005 under four main headings - the mental health needs of juveniles, the mental health staff available in the YOIs, the interventions provided, and issues arising. The analysis was both quantitative and qualitative. A simple coding was applied to the completed questionnaires and interview notes and this provided summary information about the frequency with which similar points were raised across sites. All the responses were also read several times by both researchers (Mary Ryan and Jo Tunnard), to extract and agree recurring themes. Sites were invited to comment on the draft report and the final report was completed in September 2005.
3 MENTAL HEALTH PROBLEMS IDENTIFIED

3.1 INTRODUCTION

The YOIs were asked to describe the different mental health needs of the children in their care, using their own words rather than having a list from which to select. The results have been aggregated into the summary points and chart below.

- The initial response from several sites – “we have the whole range of mental health needs” – broadly reflects the information collected from all sites. There was considerable overlap in the types of needs or problems identified and these are similar to the needs identified by research studies of children and young people in custodial settings (Hagell 2002, Harrington & Bailey 2005).

- In follow-up interviews staff from almost all sites said that the majority of children had some form of mental health need. There was also a widespread view that a high proportion of the children had significant mental health problems.

- Other sites commented on the extent of co-morbidity, where children experience two or more mental health problems at the same time.

- All sites referred to the damaging and distressing previous life experiences of many of the children. These include neglect, rejection, abuse, exposure to violence, separation and loss, and the lack of a consistent or significant adult. The experiences both contributed to their committing offences and underlay their mental health problems.

- Sites commented on the continuum of severity of need. All had children with needs (generally low level) arising from the experience of being in prison. Threats of self-harm or actual low-level injury, anxiety, depression, bullying, and outbursts of anger could arise from being locked up; from boredom; from missing relatives and loved ones, including babies and children; from the upset caused when a relative did not visit; from worry that a parent’s behaviour at a review might affect their release date (in a case where a mother had a drink problem); from concern about the safety of others at home (especially where children had the role of protecting their mother and younger siblings from domestic violence); and from concern about the safety and well-being of parents with mental health or substance misuse problems.

- For many other children needs were more severe and entrenched, linked to longer-term problems or traumatic experiences. These included the experiences of asylum seekers; neglect and rejection; physical and sexual abuse and worry that younger siblings at home were being exposed to similar abuse; and loss, bereavement and separation, including young women whose baby had been removed from them for child protection reasons.

- Most sites made the point that diagnosis of specific disorders is difficult with this age group (15 to 17). There is the added complication of assessing the extent to which the need arises from being in custody, as mentioned above.
3.2 SUMMARY OF NEEDS

- The chart below clusters mental health problems according to the frequency with which they were mentioned. The fact that a site did not mention a disorder or problem is not necessarily an indication that the site has not had experience of that disorder or problem. It may simply reflect the lack of specific reference in questionnaires and interviews. The only exception to this is in relation to psychosis - two sites were clear that they had no experience of such severe disorders.

- **Problems experienced in all sites** - and with high numbers of young people experiencing them and a continuum from low to high-level need - include anxiety, bereavement or loss, the impact of bullying, conduct disorder, depression, post-traumatic stress disorder (PTSD), self-harm, and substance misuse.

  Substance misuse is included because of its frequent association with mental health problems. Sites reported a high level of children misusing substances, with the most common problems relating to alcohol use combined with cannabis and/or ecstasy. There was concern that not enough attention is paid to problem alcohol use.

- **Problems mentioned in most sites** - Psychotic disorders and emerging psychosis (including schizophrenia) were mentioned by all sites except two, neither of which has a Mental Health In-Reach Team (MHIRT). One (Thorn Cross) is the open site, and the other (Parc) until recently held only juveniles on remand. All other sites have experience of young people with psychotic disorders or emerging psychosis, although these were less common than disorders such as adjustment disorder, attention deficit hyperactivity disorder (ADHD), and the impact of learning difficulties.

  Young people with ADHD featured in all but three sites. These are three of the four sites that hold girls and young women. Concerns were raised, both about the manner in which children had previously been assessed and about whether the diagnosis accurately reflected their condition. Similar concern was raised in relation to children diagnosed with Asperger Syndrome. In contrast, one of the sites for girls was concerned at the apparent failure to diagnose ADHD in a high proportion of girls.

  Adjustment disorders were mentioned, either specifically or with descriptions of need that indicated this disorder. As with anxiety and depression, sites said that children had such needs often as a result of being in prison, and with a continuum of need from low to high level.

  Learning disability (LD) is included here because of the high prevalence of mental health problems among those with LD. Considerable concern was expressed about the presence in the secure estate of learning disabled children and young people.

- **Problems mentioned in fewer sites** - Attachment disorders were mentioned specifically by just under a third of sites but comments made in questionnaires and interviews about children’s disrupted family backgrounds and past experience of abuse and neglect indicates that this is an issue for children in all sites.
Only two sites, both of which hold girls, raised eating disorder. One respondent was concerned that this was a poorly identified disorder, often treated as a disciplinary issue rather than a mental health problem.
### 3.3 CHART OF MENTAL HEALTH PROBLEMS

<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>FREQUENCY OF MENTION</th>
<th>COMMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All sites</td>
<td>Most sites</td>
</tr>
<tr>
<td>Anxiety</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sites stressed the continuum of need, from low to high level. For some children, the need arose from being in prison.</td>
<td></td>
</tr>
<tr>
<td>Bereavement or loss</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mentioned in most questionnaire responses, with staff interviews indicating it is an issue in all sites. More of a focus on bereavement than other loss.</td>
<td></td>
</tr>
<tr>
<td>Bullying – needs arising from experience of bullying or being bullied</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Referred to by all sites in interview, but raised as an issue initially by only 2 sites. The majority of healthcare staff or in-reach teams provide a service to the victims of bullying rather than those doing the bullying.</td>
<td></td>
</tr>
<tr>
<td>Conduct disorder, oppositional defiant disorder, emerging personality disorder</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td></td>
<td>An issue for all sites, although only 3 referred specifically to emerging personality disorder.</td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td></td>
<td>All sites, with a continuum from mild to severe.</td>
<td></td>
</tr>
<tr>
<td>PTSD - post traumatic stress disorder</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specifically referred to by just over half the sites, but interviews indicated that all sites had experience of this.</td>
<td></td>
</tr>
<tr>
<td>Self-harm</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Raised by all sites, with a continuum of need. Healthcare and in-reach staff focus on more serious and persistent self-harmers.</td>
<td></td>
</tr>
<tr>
<td>Substance misuse - needs arising from, or contributing to, problem use of alcohol or other drugs</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mentioned by all sites, with alcohol misuse deemed to be more common than other drug misuse.</td>
<td></td>
</tr>
<tr>
<td>Adjustment disorder or reaction</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mentioned by a majority of sites, with a continuum of need, and some needs arising from being in prison.</td>
<td></td>
</tr>
<tr>
<td>ADHD &amp; hyperkinetic disorder</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mentioned by a majority of sites, including one for girls. The 3 other sites for girls did not raise it.</td>
<td></td>
</tr>
<tr>
<td>Psychosis &amp; emerging psychosis, including bipolar disorder</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Experienced by most sites. The 2 with no experience were the open prison, and one that has only recently taken sentenced juveniles and has no access to a child and adolescent psychiatrist. Bipolar disorder was mentioned by a quarter of sites.</td>
<td></td>
</tr>
<tr>
<td>LD – needs arising from learning difficulty</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mentioned by over half the sites, with some stressing that LD itself is not a mental health problem.</td>
<td></td>
</tr>
<tr>
<td>ASD – autism spectrum disorder &amp; asperger syndrome</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mentioned by just under half the sites.</td>
<td></td>
</tr>
<tr>
<td>Attachment disorder</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mentioned specifically by just under a</td>
<td></td>
</tr>
</tbody>
</table>
third of sites, but interviews with healthcare staff indicate that it is a problem all sites encounter.

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Mentioned by</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>OCD – obsessive compulsive disorder</td>
<td>√</td>
<td>Mentioned by a quarter of sites.</td>
</tr>
<tr>
<td>Developmental disorder – dyslexia, dyspraxia</td>
<td>√</td>
<td>Mentioned by just under a quarter of sites.</td>
</tr>
<tr>
<td>Eating disorder</td>
<td>√</td>
<td>Mentioned by 2 sites, both for girls.</td>
</tr>
</tbody>
</table>
4 MENTAL HEALTH IN-REACH STAFF

4.1 INTRODUCTION

In this section we set out details collected about mental health staffing arrangements. The information is extracted from questionnaires and interview notes. It is probably incomplete, and staff appointments and departures mean that information soon becomes out of date. The information has been aggregated into the summary points and chart below.

Additional information about child and adolescent mental health staffing in the secure juvenile estate is available from the report of a parallel exercise (OHCS 2004), which included 12 of the 17 sites in our study and had the specific brief of reviewing CAMH service delivery across the juvenile estate.

4.2 SUMMARY OF STAFFING AND STAFF ISSUES

• All but 3 of the 17 sites had a Mental Health In-Reach Team (MHIRT). The ones without were Holloway, Parc and Thorn Cross.

• Most of the MHIRTs are very small indeed and not all staff are based on site. Even where teams included several staff, the total number of sessions provided was often fewer than the equivalent of two full-time posts. The challenges facing these teams is apparent when the size of teams is compared with the number of juveniles, young offenders and adults on site (see chart at 4.3).

• These small MHIRTs work with both juveniles and young offenders in all but four of the sites for boys (Huntercombe, Warren Hill, Werrington and Wetherby). In the four units holding girls at the time of our field work (Bullwood Hall, Eastwood Park, Holloway and New Hall) any available mental health resources were for the whole age range - juveniles, young offenders and adults.

• Only 5 of the 14 MHIRTs have staff who are linked with local CAMHS – either seconded from CAMHS or working both in the community and in the secure estate. These are in Ashfield, Brinsford, Huntercombe, Lancaster Farms and Eastwood Park. Two other sites, Castington and Hindley, have close links with a local specialist adolescent forensic service. In the remaining 10 sites, one (Warren Hill) has reasonably good informal links with local CAMHS and another (Stoke Heath) has one session per week from a CAMHS psychiatrist.

• In relation to help from psychiatrists, 5 sites had a consultant visiting for at least one day per week and the site with a national rather than local inpatient unit (Feltham) has considerably more than that. Of the rest, 1 site had one session per week; 3 sites had one day per fortnight; 3 sites one day per month; 3 sites call upon a psychiatrist as and when needed; and details are less clear for the remaining 2 sites. In relation to psychology input, 7 sites had dedicated time from a clinical psychologist and 3 others could call on the services of local forensic or CAMH psychologists who were able to offer varying amounts of time. Dedicated time from a psychotherapist was available to 2 sites.
• In a third of sites the psychiatrist working with juveniles was an adult psychiatrist. It could be difficult to get the help of a child and adolescent psychiatrist when an urgent assessment was needed of a young person displaying signs of mental illness.

• A key issue in most sites was the small number of staff with experience of working with children and adolescents. This applied not only to the MHIRTs, but also to Healthcare and to forensic psychologists and prison officers. A conclusion of the OHCS report, mentioned above, was that only just over a third of establishments surveyed had staff in the healthcare team with a CAMH qualification or with previous experience of working in a CAMHS setting.

• There were various ways of allocating work between mental health staff. In most sites with an MHIRT any staff member can make a referral and some teams accept self-referrals too. Most referral systems are informal, though a few sites have developed or are developing referral forms. In most sites RMNs then triage the referral and allocate the young person to a team member or recommend the involvement of an outside specialist. Some case allocation takes place in multi-disciplinary meetings.

• In most sites one-to-one work with a child tended to consist of 5 or 6 sessions, each lasting up to an hour. But flexibility would enable more sessions to be offered, or for the work to finish earlier.

• A few sites offer group work and others were hoping to do so in the future. Some sites were waiting for staffing levels to increase, whilst another saw group work as a possible answer to staff shortages and growing waiting lists. In one site OTs were training prison officers and nurses to lead some group work in the inpatient unit so that the OTs could begin to develop work with young people on the wings.

• There are difficulties of recruitment and retention of relevant staff. We were told in most places of the general recruitment difficulties facing CAMH services and of those services working to maximum capacity. There was the extra problem – for the YOIs - that CAMH staff were perceived as rather reluctant to become involved with supporting young people in the secure estate. Other staff posts described as hard to fill were CPNs and RMNs. The psychologist at one site, and the psychiatrist at another, said that an important aspect of their team’s role was to help ensure that good staff stayed on. Another aspect was to provide guidance and support to the many healthcare bank and agency staff in post.

• The YOIs have no identified lead person for juvenile mental health. For this reason our questionnaire was sent to the Head of Healthcare who might, or might not, have mental health experience.
### 4.3 CHART OF MHIRT STAFF

<table>
<thead>
<tr>
<th>SITE &amp; numbers, including juveniles at 27.9.05</th>
<th>STAFF</th>
<th>LINKED TO LOCAL CAMHS?</th>
<th>INPATIENT UNIT ON SITE?</th>
</tr>
</thead>
</table>
| Ashfield                                      | • Consultant adult forensic psychiatrist, visits every 2 wks.  
• Consultant psychiatrist.  
• Forensic nurse specialist pt from Bristol forensic CAMHS.  
• OT pt.  
• Access to consultant psychologist as needed. | Yes – Bristol forensic CAMHS team. | Yes – 8 beds |
| Brinsford                                     | • Clinical forensic psychologist 1 dpw.  
• 2 RMNs 6 sessions pw.  
• CAMHS forensic psychiatrist 1 dpw.  
• Planning to recruit ft SW. | Yes – South Birmingham forensic CAMHS. | Yes - 11 beds, for both young offenders and juveniles |
| Castington                                    | • RMN ft.  
• 2 CPNs 6 sessions pw.  
• Psychiatrist 1 dpw.  
• Psychology team at St Nicholas as needed. | No - but linked to NHS Adolescent Forensic Unit at St Nicholas’ Hospital, Gosforth. | Yes – 7 beds |
| Feltham                                       | Inpatients:  
• 3 CMH nurses.  
• 3 F grade nurses.  
• 13 E grade nurses.  
• 3 B grade nurses.  
• 20 prison officers.  
• 2 OTs ft + sessions from visitors.  
Plus, for whole site:  
• Consultant psychologist 1 dpw.  
• Psychologist 2 dpw & rolling programme of trainees.  
• Consultant psychiatrist – equivalent of 1.6 full-time posts. | No – MH team provided by West London MH Trust. | Yes – 20 beds. The unit is a national rather than a local resource. |
| Hindley                                       | • Only 2 of 6 possible MHIRT posts filled – by community mental health workers.  
• Call on forensic psychiatrist from | No - but Forensic Adolescent Team is being set up. Shortage of CAMHS staff locally. | No |

Age range: 15-21  
No: 400+, including 301 juveniles  

Age range: 15-21  
No: 493, including 165 juveniles  

Age range: 15-21  
No: 406, including 101 juveniles  

Age range 15-21  
No: 761, including 216 juveniles  

Holds all ages including adults
<table>
<thead>
<tr>
<th>Facility</th>
<th>Juniors or adults</th>
<th>Age range:</th>
<th>Number:</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Huntercombe</td>
<td>Teenagers only</td>
<td>15-21</td>
<td>314</td>
<td></td>
</tr>
<tr>
<td>Lancaster Farms</td>
<td></td>
<td>15-21</td>
<td>527</td>
<td></td>
</tr>
<tr>
<td>Parc</td>
<td>Teenage wing in adult prison</td>
<td>15-21</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Stoke Heath</td>
<td></td>
<td>15-21</td>
<td>646</td>
<td></td>
</tr>
<tr>
<td>Thorn Cross</td>
<td></td>
<td>15-21</td>
<td>316</td>
<td></td>
</tr>
<tr>
<td>Warren Hill</td>
<td>Teenagers only</td>
<td></td>
<td>171</td>
<td></td>
</tr>
<tr>
<td>Werrington</td>
<td>Teenagers only</td>
<td></td>
<td>143</td>
<td></td>
</tr>
<tr>
<td>Wetherby</td>
<td>Teenagers only</td>
<td></td>
<td>143</td>
<td></td>
</tr>
</tbody>
</table>

**Huntercombe**
- Consultant ch&ad psychiatrist I dpw.
- Clinical forensic psychologist 4 dpw.
- CPN & mental health worker fte.
- Yes – all MHIRT also work for CAMHS and with YOT.
- No

**Lancaster Farms**
- Co-ordinator of in-reach seconded from CAMHS but not based on site.
- 2 MH workers.
- OT pt 3 dpw.
- Adult psychiatrist 1 dpw, will bring ch&ad psychiatrist as needed.
- Yes - but shortage of CAMHS staff locally.
- Yes – 14 beds (8 for MH patients)

**Parc**
- No in-reach team.
- Have nurse attached to juvenile wing.
- No - severe lack of CAMHS in Wales.
- Yes – but mainly for adults. 3 beds for juveniles.

**Stoke Heath**
- Clinical psychologist ft.
- CPN ft.
- OT pt.
- Appointing another CPN and pt psychologist.
- Serve both juveniles and young offenders.
- CAMHS psychiatrist 1 session pw – not nearly enough.
- No – from PCT. Get one session from CAMHS psychiatrist. Have money for more but CAMHS say don’t have staff to provide more.
- Yes - 8 beds

**Thorn Cross**
- No in-reach team.
- Link with psychiatrist from Gatehouse assessment centre as needed.
- No - trying to improve links with CAMHS.
- No

**Warren Hill**
- Ch&ad specialist nurse ft.
- Ch&ad psychiatrist once a month.
- Hoping to recruit to 2 other posts in team.
- No – not formal. CAMHS have visited site and are helpful. Specialist nurse uses CPA system.
- No

**Werrington**
- Clinical psychologist.
- S&LT.
- 2 RMNs.
- Ch&ad psychiatrist once a fortnight.
- No

**Wetherby**
- Psychotherapist pt.
- Drama therapist 2 dpw.
- OT 3 dpw.
- Counsellor 3 dpw.
- No - but took advice from CAMHS when deciding which model of therapeutic services
- Day hospital service – 6 beds
| No: 305 | • Recruiting for 2 ft posts.  
• Adult psychiatrist once a fortnight with senior registrar, equivalent of 1 dpw. | to adopt. |  |
| Bullwood Hall – girls | • Co-ordinator ft – nurse with ch&ad background.  
• Nurse 1 session pw.  
• Nurse/psychotherapist - adults.  
• OT - adults.  
• RMN.  
• Psychologist.  
• Psychiatrist (male) for adults once per month; Psychiatrist (female) for adults 3 sessions per month  
• Mainly deal with adults. On the whole juveniles dealt with by psychotherapist in forensic psychology team. | No, from local forensic team, only one member of staff has child and adolescent experience – and local CAMHS overwhelmed. | Yes – 3 beds |
| Age range: 17 – adult |  |
| No: 184, including 12 juveniles |  |
| New Hall – girls | • CPA co-ordinator ft.  
• MH practitioners ft.  
• CNS 6 sessions, shared with adults.  
• Adult psychologist, shared with adult prisoners.  
• Consultant adult forensic psychiatrist. | No – and poor links with CAMHS. | Yes - 19 beds |
| Age range: 17 to adult |  |
| No: 422, including 39 juveniles |  |
| Eastwood Park – girls | • RMN 2 dpw.  
• OT pt.  
• Ch&ad psychiatrist once a month.  
• Psychologist from CAMHS as needed but very limited - 1 session per fortnight. | Yes, shared with Ashfield, see above, and possibly for young people up to age 21. | Yes – 12 beds |
| Age range: 17-adult |  |
| No: 346, including 11 juveniles |  |
| Holloway – girls | • No in-reach team.  
• Site no longer used for juveniles. |  |  |
5 INTERVENTIONS IDENTIFIED

5.1 INTRODUCTION

Sites were asked to describe any interventions provided either to address the mental health needs of juveniles or as part of their mental health promotion work. Interventions were defined as any direct work done with the children to help them recover from, or cope with, mental health difficulties. It could include both individual and group work and could be offered by YOI staff or visiting personnel. We also asked for details of research evidence that underpinned the interventions provided.

The questionnaire used open-ended questions, leaving sites free to include whatever interventions they considered relevant. The follow-up visits provided extra information and then, where time allowed, we checked gaps arising from staff uncertainty about the work of their colleagues. We also drew on the November 2003 audit of programmes for juveniles, conducted by Sonya Weise of the YJB Effective Interventions Team. Those programmes are included here unless our study indicated that they were no longer available.

A dilemma to resolve was how to cluster the data collected. After testing various options, we decided to use the headings (1-4, below) from the YJB Effective Practice booklet on mental health (YJB 2003), on the grounds that this would be familiar to site practitioners and managers. We have included extra headings (5-6, below) for interventions that fall outside this format.

The interventions have been clustered as follows:

1. Psychological treatments or psychotherapies
   These are generally provided by mental health professionals and healthcare staff, and mainly consist of individual work with children.

2. Medication (and complementary therapies)
   Medication is prescribed by visiting psychiatrists and administered by healthcare nurses. Complementary therapies are provided by healthcare and other staff.

3. Skills training
   This includes general activities and support groups led by healthcare and mental health staff and a range of other prison staff. It also includes offending behaviour programmes, which include approaches relevant to the mental health needs identified in children and which tend to be run by forensic psychologists and/or prison officers and other staff not directly linked to the mental health or healthcare teams.

4. Systematic, multi-level and psychosocial interventions
   There is little to include in this section because such interventions are not provided in YOIs. However, there is considerable evidence from community-based studies to support this type of approach in responding to the needs identified in children in the study sites.

5. Provision for children deemed vulnerable on the wings
   These are interventions provided for those deemed unable to live safely on the wings – the response is multi-agency, including healthcare, education, mental health and other disciplines. They also include specialist anti-bullying projects developed in some of the sites. All these programmes are clearly directed at the children’s mental health needs.
6. Mental health promotion
These are a mix of group and one-to-one interventions provided by a wide range of staff groups.

7. A note about substance misuse
As our study did not cover substance misuse (or dual diagnosis – those with learning disability and substance misuse) we describe the main findings of the YJB’s report into substance misuse across the estate (YJB 2004b).

5.2 SUMMARY OF INTERVENTIONS

All sites provide medication, and all describe mental health promotion activities provided by a range of different departments and people. They all provide, too, some specific interventions, namely cognitive behaviour therapy, bereavement counselling, and a sympathetic ear. In relation to offending behaviour programmes, all provide anger management courses.

About half the sites have added newer approaches to their repertoire. These include art, music and drama therapy, relaxation, acupuncture, and occupational therapy activities.

Smaller groups of sites (a third or fewer) described the particular responses developed for vulnerable children. Some relate to specific needs: dialectical behaviour therapy for those at risk of self-harm, speech and language therapy for those with communication problems, mental health groups to help cope with a particular diagnosis, and small units for those unable to cope on the wings. Some responses take a holistic approach to linking needs and problems, as in the new JETS pilot programmes to improve children’s thinking skills and apply lessons to daily experience. Still others focus on developing skills for life beyond custody – examples of these initiatives are opportunities to learn cooking, parenting and other life skills.

Key gaps in interventions identified include those for children who have committed sex offences, for those with learning difficulties or severe mental illness that preclude them from joining in other activities, and those that involve joint work with children and their parents.

5.3 CHART OF INTERVENTIONS

The charts of interventions for each cluster are set out below. At the end of all the charts we describe (in section 5.4) each intervention, explaining how it is delivered and by whom, and noting key messages from the literature about effectiveness.

5.3.1 Psychological treatments or psychotherapies

<table>
<thead>
<tr>
<th>INTERVENTION</th>
<th>NO. OF SITES</th>
<th>WHICH SITES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cognitive behaviour therapy – CBT</td>
<td>17</td>
<td>All</td>
</tr>
<tr>
<td>Dialectical behaviour therapy – DBT</td>
<td>3</td>
<td>Holloway, Ashfield (p), Huntercombe (p)</td>
</tr>
<tr>
<td>Other therapeutic approaches – including</td>
<td>17</td>
<td>All</td>
</tr>
<tr>
<td>behavioural, brief intervention and solution</td>
<td></td>
<td>Includes psychotherapy in 2 sites -</td>
</tr>
</tbody>
</table>
focused, person-centred, psychodynamic, integrative, Gestalt, transactional analysis, and individual dialectical therapy.

| Speech and language therapy | 2 | Brinsford, Werrington |

**Counselling**

| General counselling | 10 | Bullwood Hall, Eastwood Park, Holloway, Lancaster Farms, Parc, Stoke Heath, Thorn Cross, Warren Hill, Werrington, Wetherby |
| Bereavement counselling | 17 | All |
| A sympathetic ear | 17 | All |

**Creative therapies**

| Art therapy | 7 | Feltham, Hindley, Huntercombe, Lancaster Farms, New Hall, Parc, Stoke Heath (p) |
| Music therapy/activity | 4 | Feltham, Lancaster Farms, New Hall, Thorn Cross |
| Drama therapy | 7 | Feltham, Holloway, Huntercombe, Lancaster Farms, New Hall, Stoke Heath (p), Wetherby |

### 5.3.2 Medication and complementary therapies

**Medication**

| 17 | All – but no visiting psychiatrist at Parc or Thorn Cross |

**Complementary therapies**

| Relaxation therapy | 7 | Ashfield, Eastwood Park, Feltham, Holloway, Hindley, Lancaster Farms, New Hall |
| Reflexology | 1 | Parc |
| Yoga | 2 | Feltham, Lancaster Farms |
| Auricular acupuncture | 6 | Castington, Feltham, Holloway, Parc, Werrington, Wetherby |

### 5.3.3 Skills training

**Activities**

| Cooking | 5 | Feltham, Hindley, Huntercombe, Parc, Werrington |
| General life skills | 5 | Eastwood Park, Feltham, Parc, Lancaster Farms, Thorn Cross |
| Parenting groups | 7 | Feltham, Parc, Stoke Heath, Thorn Cross, Warren Hill (p), Werrington, Wetherby |
| Weekend trips/DoE/Princes Trust | 5 | Ashfield, Feltham, Lancaster Farms, Thorn Cross, Warren Hill |

**Support groups**

| Specific mental health problem | 1 | Brinsford (p) |
| Mental health awareness | 1 | Thorn Cross |
| Response to eating disorders | 1 | Bulwood Hall |
| Anxiety/stress management | 2 | Castington, Hindley |
| Self-harm reduction/alternatives | 2 | Holloway, New Hall (in revision) |
### Offending behaviour programmes - OBPs

<table>
<thead>
<tr>
<th>Intervention</th>
<th>No. of Sites</th>
<th>Which Sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anger management</td>
<td>17</td>
<td>All</td>
</tr>
<tr>
<td>Enhanced Thinking Skills – ETS</td>
<td>8</td>
<td>Brinsford, Bullwood Hall, Feltham, Lancaster Farms, New Hall, Thorn Cross, Werrington, Wetherby</td>
</tr>
<tr>
<td>Assertiveness &amp; Decision Making – short ETS</td>
<td>1</td>
<td>New Hall</td>
</tr>
<tr>
<td>Victim Awareness</td>
<td>6</td>
<td>Ashfield, Castington, Hindley, Huntercombe, Warren Hill, Wetherby</td>
</tr>
<tr>
<td>Crime &amp; its Consequences</td>
<td>4</td>
<td>Castington, Hindley, Huntercombe, Thorn Cross</td>
</tr>
<tr>
<td>Impact of Car Crime</td>
<td>4</td>
<td>Ashfield, Hindley, Lancaster Farms, Thorn Cross</td>
</tr>
<tr>
<td>Juvenile Estate Thinking Skills – JETS</td>
<td>3</td>
<td>Ashfield, Hindley, Wetherby (pilots)</td>
</tr>
<tr>
<td>Stop, Think, Act, Reflect – STAR</td>
<td>1</td>
<td>Feltham</td>
</tr>
<tr>
<td>For Sex Offenders</td>
<td>1</td>
<td>Warren Hill</td>
</tr>
</tbody>
</table>

### 5.3.4 Systematic, multi-level and psychosocial interventions

The YJB Effective Practice guidance describes these interventions as “approaches that focus on the young person in a wider social context. They tend to be based as much on systems theory as on psychological models of mental health.” (YJB 2003)

Sites gave us little data that could fit under this heading. Staff in about a third of sites explained the work that they would like to be doing with children and their families and one said that previous opportunities for family therapy work no longer existed. But contact was hard to maintain, family visits often difficult to arrange, and few sites had a Family Liaison Officer. As a result, the chance of seeing children and adults together was slim. There was a strong sense of frustration that the prison regime did not lend itself to approaches that were generally recognised as important. There was acknowledgement of the benefits of a strong and supportive family in helping young people keep away from crime, and of the importance of links in otherwise difficult families.

### 5.3.5 Provision for children deemed vulnerable on the wings

In this section we have grouped programmes for children deemed unable to survive on the wings and specialist programmes to respond to the needs of children who bully.

<table>
<thead>
<tr>
<th>Intervention</th>
<th>No. of Sites</th>
<th>Which Sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access, Access Plus</td>
<td>4</td>
<td>Ashfield, Thorn Cross, Warren Hill, Wetherby</td>
</tr>
<tr>
<td>Time Out</td>
<td>1</td>
<td>Warren Hill</td>
</tr>
<tr>
<td>Centrepoint</td>
<td>1</td>
<td>Werrington</td>
</tr>
<tr>
<td>Inclusive education for all</td>
<td>1</td>
<td>Hindley</td>
</tr>
<tr>
<td>Manwaring Unit</td>
<td>1</td>
<td>Huntercombe</td>
</tr>
<tr>
<td>Specialist anti-bullying programme</td>
<td>5</td>
<td>Ashfield, Brinsford, Hindley, Stoke Heath, Warren Hill</td>
</tr>
</tbody>
</table>
5.3.6 Mental health promotion

The questionnaire asked sites for a brief description of what they were able to provide under the headings in the charts below. A wide variety of sources of support, advice and guidance, activities, and education and training were listed. Many of the interventions or types of support reported were the same as those given as examples of particular mental health interventions, emphasising the clear link between mental health promotion and responding to specific mental health problems. In interviews it became very evident that staff availability determined whether services were available and, if so, to what extent.

<table>
<thead>
<tr>
<th>An independent adult to confide in</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most sites mentioned the IMB and the Samaritans, and over half listed the chaplaincy. A number of sites referred to staff in Healthcare, MHIRT, education or the YOT, and a small number referred to advocacy projects. One site referred to personal officers on the wings.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A befriending service</th>
</tr>
</thead>
<tbody>
<tr>
<td>The majority of sites listed the chaplaincy and the IMB and a smaller number the Samaritans. Two sites referred to peer support.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>An advocacy service</th>
</tr>
</thead>
<tbody>
<tr>
<td>A majority of sites had independent advocates for young people: this was provided in six sites by VCC, in five by NYAS, in one by the local MIND organisation, and in another by Connexions advisors. The remaining sites referred to MHIRT staff fulfilling this role to a certain extent, or to chaplains or the IMB. Two sites said there was no provision.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>To help children manage their behaviour</th>
</tr>
</thead>
<tbody>
<tr>
<td>A majority of sites referred to the work of mental health professionals in Healthcare or the MHIRT or to the offending behaviour programmes described earlier in the report. Also listed were prison officers, incentive schemes, and drug and alcohol awareness sessions provided by the Juvenile Substance Misuse Service (JSMS) or gym staff.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>To help children take part in decision making</th>
</tr>
</thead>
<tbody>
<tr>
<td>A majority of sites referred to young people attending their DTO reviews and also to offending behaviour programmes such as ETS or MORE. Others referred to work done by a range of staff in the prison, including Healthcare and MHIRT, chaplains, the YOT, and education. Four sites referred to trainee/staff committees.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>To help children engage in activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key here were gym and education staff, mentioned by a majority of sites, and wing staff. Other relevant staff or activities included YOT workers, the MHIRT and Healthcare. A couple of sites mentioned the Duke of Edinburgh award and one referred to enrichment groups (walking, camping, music, drama).</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>To help children improve their self-care</th>
</tr>
</thead>
<tbody>
<tr>
<td>A range of staff and services were mentioned here. A majority referred to the role played by prison officers in giving advice and guidance. Health and hygiene advice is given by a range of different staff. Substance misuse information and advice was mentioned, as were various specific health services such as dental, optical and sexual health.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>To improve their physical health</th>
</tr>
</thead>
<tbody>
<tr>
<td>The majority of sites referred to gym and education staff, followed by the Juvenile Substance Misuse Service (JSMS). Next in frequency were health services such as the GP and nursing staff. Two sites referred to the role of kitchen staff in producing a healthy diet.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>To enhance their sense of identity</th>
</tr>
</thead>
<tbody>
<tr>
<td>The majority of sites referred to the importance of the chaplaincy which in many, but not all, sites was described as multi-faith. Others referred to access to interpreters, and one site to</td>
</tr>
</tbody>
</table>
signers for the deaf. Three sites referred to “diversity awareness”, and one to family contact. A number of sites at interview referred to halal food being available.

<table>
<thead>
<tr>
<th>To continue with education or training now</th>
</tr>
</thead>
<tbody>
<tr>
<td>All sites listed education. A number also mentioned vocational courses, NVQs, and basic skills training. A few sites referred to Connexions and two to the YOT.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>To help children prepare for education, training, work later</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education was listed by all sites and half referred to Connexions too. Two sites referred to release on temporary licence for work placements, and three to interviews for jobs or work experience.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>To help children prepare for life after custody</th>
</tr>
</thead>
<tbody>
<tr>
<td>A majority referred to Connexions and the YOT. In addition, they referred to advice and information from a range of staff and from outside organisations - about health, substance misuse, parenting, benefits, and accommodation.</td>
</tr>
</tbody>
</table>

5.3.7 A note about substance misuse

The study questionnaire did not ask for specific information about substance misuse needs and interventions as this information was already available from other sources (NCBb forthcoming, YJB 2004b). See section 5.4.7 for summary information from the YJB report.
5.4 DETAIL OF INTERVENTIONS - DELIVERY AND RESEARCH EVIDENCE

In this section we provide additional information to supplement that set out earlier, in the intervention charts on pages 43-46. We describe what staff told us about the interventions and we include the rather few comments made about the evidence they relied on for interventions. We have also added some summary points about evidence of effectiveness, gleaned from recent systematic or literature reviews.

Unless otherwise referenced, these summary points are drawn from the following main sources:

- Bailey & Dolan (eds) 2004
- Fonagy et al 2002
- Harrington & Bailey 2005
- Harris B with Paterson S 2004

Of possible relevance, too, but not drawn on here, is the systematic review of the mental health literature, undertaken to inform developments in the adult prison service (Brooker 2002).

5.4.1 Psychological treatments or psychotherapies

COGNITIVE BEHAVIOUR THERAPY – CBT (see 5.3.1)

- CBT is provided in all sites, although in some places there is less offered to juveniles than to older younger people.

- It is usually provided as a series of 6-8 individual sessions, each lasting up to an hour, and delivered in the healthcare centre.

- A range of professionals provide it – including CPNs, RMNs, clinical psychologists, forensic psychologists (occasionally), psychiatrists, OTs.

- The evidence suggests that, for depression and anxiety, this – and interpersonal therapy - are treatments of first choice for mild to moderate conditions.

- The new guideline from NICE (2005) about depression in children and young people makes recommendations about CBT - and other approaches - as follows:
  
  o For moderate to severe depression children should be offered, as first-line treatment and for at least three months, a specific psychological therapy (individual CBT, interpersonal therapy or shorter-term family therapy). Antidepressants should not be offered except in combination with a concurrent psychological therapy.
  
  o For mild depression, antidepressants should not be used for initial treatment.
  
  o Children should be advised and encouraged about structured exercise, sleep hygiene and anxiety management, and nutrition and the benefits of a balanced diet.
Other problems that children have should be managed in sequence or in parallel with treatment for depression. Attention should be paid to the possible need for parents’ own psychiatric problems (particularly depression) to be treated in parallel. Psychological therapies should be provided by therapists who are also trained child and adolescent mental healthcare professionals.

DIALECTICAL BEHAVIOUR THERAPY – DBT (see 5.3.1)

- DBT is being planned in two sites, as group work organised by CPNs, other mental health workers and forensic psychologists.
- Two other sites have run DBT groups (for adult women, not juveniles) but funding was not provided beyond the pilot period.
- Some sites referred to the work of Hawton and colleagues (1998) on the efficacy of treatments for deliberate self-harm by young people (not in custodial settings). One acknowledged the lack of published research about DBT but said that anecdotal evidence indicates that it works.
- For young women in prison - A study in the USA (Trupin et al 2002) has shown that DBT is associated with significant decrease in the behaviour problems in young female offenders with mental illness (including suicidal and self-harm) and is effective in enabling them to participate in other services such as drug and alcohol treatment and employment, due in part to the reduction in behaviour problems. The study highlighted the difficulty of maintaining the treatment programme for individual young people because frequent transfer of new residents to the unit who were suicidal and/or aggressive meant that the overall rates of problem behaviours on the unit remained high. It also highlighted the importance of intensive training for motivated staff, especially to help reduce reliance on restrictive and punitive responses to disturbed behaviour. The programme showed very little effect on the young offenders who did not have mental health problems.

OTHER, INDIVIDUAL, THERAPEUTIC APPROACHES (see 5.3.1)

- Some type of other therapeutic approach is provided in all sites.
- As with CBT, it is usually provided as a series of 6-8 individual sessions, each lasting up to an hour, and delivered in the healthcare centre.
- It is described as offered to increase self-esteem, build confidence, develop coping skills and strategies, manage stress and anxiety, manage anger, or reduce self-harm.
- A range of professionals deliver these approaches - RMNs, CPNs, mental health workers, OTs, clinical psychologists, forensic psychologists, psychiatrists and Clinical Nurse Specialists.
- In two sites psychotherapy is offered by the psychotherapist based in the therapeutic team or the forensic psychology team.
- The evidence indicates that psychodynamic, psychoanalytic and non-directive therapy, and drama and play therapy, can be effective in reducing the psychological effects of child sexual abuse. For mild to moderate depression,
interpersonal therapy – and CBT – are treatments of first choice. See the NICE guideline about depression (under CBT, above) for new advice about interpersonal therapy and shorter-term family therapy.

- For young people in prison – A US study indicates that structured group therapy may be helpful for imprisoned male juvenile offenders with PTSD (Ovaert et al 2003).

**SPEECH AND LANGUAGE THERAPY** (see 5.3.1)

- In two sites, speech and language therapists offer individual sessions, testing hearing and understanding, and providing treatment, as well as giving advice to other staff.

- David Ramsbottom, former Chief Inspector of Prisons, has commented on the existence of literature supporting the appointment and retention of SLTs for children in prison, to build confidence and communication skills and improve access to education opportunities. Literature reference not found.

**COUNSELLING** (see 5.3.1)

- **General counselling** is provided in 10 sites, with individual sessions, usually 6-8 in total, each lasting 30-60 minutes and provided in the healthcare centre. It is provided by a range of people - generic counsellors, prison officers trained and part of multi-disciplinary juvenile wing team, RMNs, CPNs, counsellors in MHIRTs, clinical psychologists in MHIRTs and sessional visiting counsellors.

- **Bereavement/loss counselling** is provided in all sites, as individual sessions. In most sites (14 sites) the chaplaincy does this work. In other sites it is done by resident or visiting counsellors, psychotherapists or Family Liaison Officers. One site is planning to run group work on the wider issues of loss (childhood, life style and negative peer influences), provided by the chaplain and mental health nurse.

- All sites provide what many healthcare staff described as a “sympathetic ear” – either formal sessions in the healthcare centre, or informal opportunities in the centre or on the wings to talk for a few minutes or longer during a crisis or following referral. A range of people provide this, including health staff in most sites but also discipline staff in a few others.

- **School-based crime prevention, including counselling** - A US review of 149 studies was undertaken to scrutinise what works, what doesn’t work and what is promising by way of interventions to help prevent crime or reduce risk factors for crime. Counselling students, particularly in a peer-group context, was shown not to work, in that there was a preponderance of evidence that was not positive in at least two reasonable-quality studies. Overall, the research suggested that programmes using multiple interventions worked better than single intervention strategies and that service development needed to focus on longer-term and broader-reaching programmes that were embedded in school capacity-building activities (Wilson et al 2003, and in Stevens 2003).

**CREATIVE THERAPIES – ART, MUSIC, DRAMA** (see 5.3.1)
• Ten sites provide one or more creative therapies.

• **Art therapy** is provided in seven of the sites, for particular young people such as those on the vulnerable persons’ wing, those in the inpatient unit or those who were receiving the therapy before admitted to their current site. It is provided by OTs, a visiting therapist, a generic counsellor in the multi-disciplinary juvenile wing team, or the YMCA.

• **Music therapy or activity** is provided in four of the sites, including one site where it is just for those in the inpatient unit. It is provided by an outside therapist, the chaplain, or the YMCA.

• **Drama therapy** is provided in seven of the sites, for those on the vulnerable persons’ wing or inpatient unit. It is provided by OTs, the drama therapist in the MHIRT, an outside therapist, or the YMCA.

• A recent review has provided a meta-analysis of data about the effectiveness of arts interventions (including therapies) in 400 custodial and community schemes, including a few for juveniles and young offenders (Hughes 2005). Whilst stressing the lack of robust evaluation in this area of activity, the lack of a causal link between creative therapies and reduced offending, and the difficulty of incorporating evaluation into arts interventions, the review highlights some promising results from UK, North American and Australian projects. Key findings for young offenders in the UK are about a greater understanding of the impact of personal trauma and its link with past events, a reduction in uncontrolled anger, and improved relationships with staff. It is suggested that interventions are successful because they offer a non-traditional and non-institutional social and emotional treatment, use a non-judgemental and un-authoritarian method of engagement, offer young people the chance to get involved in a creative process that involves structure and freedom, and require people to take responsibility, co-operate and show respect for others.

• The YMCA ran a programme in 2002 in Wetherby YOI that included rap, poetry, drama and music. It was similar to the Duke of Edinburgh scheme in that four challenges had to be completed for each award (bronze, silver and gold). It was run by two full-time youth work staff and four volunteers and evaluated by peer assessment (YMCA website).

• There is some evidence that drama therapy is effective in reducing the psychological effects of child sexual abuse.
5.4.2 Medication and complementary therapies

MEDICATION (see 5.3.2)

- All except two sites had access to a visiting psychiatrist who would, when needed, assess and prescribe medication, as would happen for a young person in the community.

- Several sites had detox services, usually provided in the inpatient unit, but with "regulars" in one site detoxing in their cells because they can manage that. Detox usually involves a mixture of drugs – to help relieve pain and stomach cramps and to help with sleep problems.

- Two sites could not take children on Ritalin because they were unable to provide simultaneous cover by the 2 qualified nursing staff needed for administering the drug.

- In two of the sites holding girls, concern was expressed about the high level of medication prescribed for depression and anxiety. In one site staff had reduced medication for depression by two thirds after introducing a protocol for screening and providing alternative therapies.

- For ADHD, the NICE guidance (2000) indicates that medication is more effective than behavioural intervention but there is also evidence, of relatively good quality, which suggests that the addition of medication to behavioural treatment programmes is beneficial. For co-morbid conditions, current opinion is that pharmacological therapies have a role in treating co-morbid mental illness such as ADHD, psychotic illnesses and depression. For learning disability, there is some limited evidence that, for adolescents, mood stabilisers and neuroleptics may produce short-term reduction in aggressive behaviour. See the NICE guideline about depression (under CBT, above) for new advice about medication.

COMPLEMENTARY THERAPIES (see 5.3.2)

- Twelve sites provide some form of complementary therapy.

- Relaxation therapy is provided in seven of the sites, including two sites where it is just for those in the Healthcare inpatient unit. It is provided by mental health nurses, OTs and a chaplain.

- Reflexology is provided in one site, by the generic counsellor who is part of the multi-disciplinary juvenile wing team.

- Yoga is provided in two sites, with one being regular groups for inpatients only. It is provided by prison officers and a chaplain.

- Auricular acupuncture has been introduced in six sites, provided by a generic counsellor in the multi-disciplinary juvenile wing team, RMNs, RGNs and staff in the substance misuse team.

- Acupuncture for children – a recent small pilot study has shown promising results for adolescents excluded from school. The study included six boys aged 15 and 16, excluded from a county state school because of severe
emotional and behavioural difficulties and where drug use had contributed to their worsening behaviour. The sessions were delivered by a therapist from the local youth drug treatment service, with informal interviews after each session and formal interviews at the end. Boys and teachers reported success – including increased concentration, the ability to discuss problems rather than respond with aggression, and improved sleeping and feeling relaxed. Weekly treatment continued after the pilot study and three teachers have been funded to train to deliver the treatment (Omega 2004).

• Acupuncture for adult prisoners – a 1993 USA study involving parolees with drug misuse problems led to plans to introduce the treatment into 2 local prisons. The study was about whether acupuncture would enable outpatients to cope with the initial stages of withdrawal symptoms and stay longer in treatment. Those who had acupuncture stayed in treatment nearly twice as long as the comparison group; they made more use of other services (individual counselling, group counselling, ancillary services, and employment referrals); and were more likely to stay off drugs after starting the treatment (90 per cent compared to 69 per cent). Reservations amongst those who did not volunteer for the pilot – or dropped out - included fear of needles, fear of dependence on the treatment, headaches or other symptoms, or no positive experience from the treatment (Miller undated).
5.4.3 Skills training (see 5.3.3)

- All the sites provided some sort of skills training.

- **Cooking** was mentioned by five sites, provided by OTs for those on the vulnerable wing, multi-disciplinary staff on the juvenile wing, RMNs, resettlement officers or education.

- **General life skills** were also mentioned by five sites, provided in group sessions, and delivered by OTs, education, forensics psychologists, the YMCA and visitors from relevant voluntary and statutory agencies (e.g., the Benefits Agency, to show boys how to complete claim forms). In one of the sites the group runs for 4 or 5 sessions, covering mental health, bullying, self-esteem and sexual health. It is used to identify those in need of further support from substance misuse or anger management groups and to assess their readiness to change.

- **Parenting groups** are run by chaplains, healthcare, education, healthcare in conjunction with education and the chaplain, and the local voluntary organisation NCH. Several sites commented that they used to run parenting groups but no longer do so. On the other hand, one site was planning to introduce parenting work, in conjunction with local health visitors and Sure Start programmes.

- A national parenting course for young offenders was piloted by YOIs in 2002 by three trained volunteers. The course consisted of 6 sessions of 2 hours per week. The topics included choice re pregnancy, birth, keeping children safe, child development, and practical matters such as bathing, changing nappies and communicating with babies. The sessions provided parents and children with informal time together, playing and eating, as well as enabling partners to work together. The study found that the sessions helped reduce the barriers to parenting experienced by young offenders – they were helped to maintain links with their child, to make appointments for visits, to work out finances, and to move closer to their family. Recommendations were made about asking young people routinely if they were a parent, so that support could be put in place, and increasing the links between parenting work in YOIs and family services in the community (Prison Reform Trust website).

- **Weekend trips, and schemes under the Duke of Edinburgh Award and Princes Trust**, operate in five sites, run by prison officers and gym staff.

- **Mental health support groups** are provided or being planned in seven sites. These include the following:
  - for a **specific mental health problem** – a half-day session, delivered by an RMN, with visiting volunteers from voluntary organisations.
  - for **mental health awareness** – a group run by a Health Improvement Specialist.
  - for **eating disorders** – a group is being planned, run by visiting volunteers from a national agency who will work with the MHIRT to identify those in need, make referrals, and help staff run the group.
- **for anxiety/stress management** – these are closed groups, for one hour per week over 6 weeks, run by forensic psychologists, with evaluation via pre- and post-group questionnaires. One is at the planning stage and will be run by the CPN in the MHIRT, using a course developed by the local MH Trust.

- **for self-harm reduction or alternatives** – these groups are run by forensic psychologists or RMNs.

**Offending Behaviour Programmes** (see 5.3.3) - All sites referred to one or more of the range of programmes used in the secure estate to address offending behaviour. Ten Offending Behaviour Programmes (OBPs) were reported, including one, JETS, which was about to start as a pilot. Half the sites offered four or five OBPs, with the rest using one, two or three. The programme referred to most was about anger management – some version of this runs in all sites. Next in frequency were two programmes about problem solving – a short course called Motivating Offenders to Rethink Everything (MORE), and a longer programme called Enhanced Thinking Skills (ETS). Other programmes - about victim awareness, assertiveness, and the specific offences of car crimes and sex offences – were mentioned least.

What the programmes have in common is the aim of challenging the thinking, attitudes and behaviour that are deemed to have led to the young person committing an offence. They are designed to be delivered mainly as group activities, and almost all have some input from the on-site forensic psychologists. The work of these psychologists tends to be separate from that of the clinical psychologists linked to mental health and healthcare departments, and with varying degrees of communication between the different teams.

Several sites identified problems in relation to OBPs:

- Staff shortages and recruitment difficulties make it difficult to run some programmes regularly.
- A more widespread comment was the unsuitability of the programmes for the young people: for those who cannot cope with group sessions, or lack the intellectual capacity to follow the ideas, or have insufficient English or literacy skills, or have a specific mental health problem, disorder or illness.
- There is the added concern that individual behaviour problems in adolescents may worsen rather than improve after some group treatments, possibly due to negative peer influence (Dishion & Andrews 1995).
- A final concern is that young people do not stay long enough to complete courses, although a few sites have adapted some programmes in order to respond to this problem. We were not able to gauge the extent to which young people may drop out of courses and we did not explore the specific difficulties of conducting evaluation of particular programmes.

A programme for sex offenders was provided in one site only, and its absence in the other sites was a recurring theme during site visits. There is a sense that more individual work is now being done with young sex offenders, either by psychiatrists working with young people in segregation, or by psychologists to whom young people are referred for other reasons. But there was general agreement that much more needs to be done, and that current arrangements make this impossible. A particular concern was the practice of
accommodating young sex offenders with other young people deemed vulnerable, some of whom will have been abused themselves. Another problem is the difficulty of accommodating together those convicted of sex offences with others who are on remand for such offences, because work cannot be started with those who have not been convicted.

- There are some overall messages from the relatively few reports about the effectiveness of OBPs, or of cognitive skills’ work designed to lead on to OBPs:
  o the focus of research has been, almost exclusively, on adult offenders rather than children
  o the likelihood of negative peer influences, of young people's dislike of group programmes, and of the low baseline in terms of their literacy and cognitive skills, may render group programmes unsuitable for juveniles
  o the climate in which interventions is delivered is important. Both children and staff need to feel confident about what is on offer.

<table>
<thead>
<tr>
<th>OBP - ANGER MANAGEMENT</th>
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<tbody>
<tr>
<td><strong>SITES</strong></td>
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<tr>
<td><strong>AIM</strong></td>
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<tr>
<td><strong>DELIVERY</strong></td>
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<td></td>
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<tr>
<td></td>
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<tr>
<td><strong>PROVIDER</strong></td>
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</table>
Research - There is very limited evidence for the effectiveness of brief uni-modal interventions such as anger management or social skills training. As aggression is determined multi-factorially, it is likely that an intervention targeted at just one problem (and of limited intensity and duration) is not sufficiently powerful (Harrington & Bailey 2005).

**OBP - MORE - MOTIVATING OFFENDERS TO RETHINK EVERYTHING**

**SITES**
12 – Ashfield, Brinsford, Bullwood Hall, Castington, Huntercombe, Lancaster Farms, New Hall, Stoke Heath, Thorn Cross, Warren Hill, Werrington, Wetherby

**AIM**
Aims to encourage offenders to re-think their situation and evaluate the extent to which they need to change their thinking and behaviour. Offers a “kick start” to change, and a toolkit with which to improve thinking skills. Encourages offenders to see how beliefs influence actions. Motivates them to listen, consider alternatives, set goals, and develop problem-solving skills. Modules help challenge egocentric and rigid thinking, encourage solution-focused rather than reactive methods of dealing with problems, and provide information about the process of change. The methods used are non-confrontational and designed to engage offenders about the issues deemed to be at the core of blocking change in many offenders.

**DELIVERY**
4 group sessions, of 1.5 hours, spread over a week or month

**PROVIDER**
Various:
- Forensic psychologists
- Psychologists plus dedicated group of trained POs
- 2 trained POs
- PE staff

**CRITERIA**
Various:
- DTO servers prioritised
- Those with incentive for early release
- Those who are close-minded, reactive thinkers
- Anyone

**EVIDENCE**
Evaluation:
- Pre-post informal assessment of stage of change
- Evaluation form at end, plus interview 2 weeks later
- Psychologists administer pre-post scales

Research - YJB research department reports none available.

**OBP - ETS – ENHANCED THINKING SKILLS**

**SITES**
8 - Brinsford, Bullwood Hall, Feltham, Lancaster Farms, New Hall, Thorn Cross, Werrington, Wetherby

**AIM**
Aims to change offenders’ thinking and behaviour by teaching a strategy for working through problems, and social skills to implement effective solutions. Encourages reflective and rational thinking and increased self-control. Raises awareness of value systems and encourages consistency between values and behaviour. The focus is problem solving, including taking into consideration the perspective of others. Open questions are used to elicit ideas from the young people, using games with learning points, debates about moral issues, role shifts, and practice of social skills.

A cognitive behaviour programme developed specifically for use in prisons in England and Wales.

**DELIVERY**
20-22 group sessions, each lasting 2-2.5 hours, over 4-10 weeks

**PROVIDER**
Various:
- Forensic psychologists
- Psychologists and trained POs
## CRITERIA
- To help meet target for early release
- For those at medium to high risk of re-offending
- Not for those with current mental illness, or IQ below 80, or limited use or comprehension of English, or severe literacy difficulties

## EVIDENCE
**Evaluation (if any):**
- Psychometric assessment pre-post and 8 weeks later
- Pre-post questionnaire

Research - A study of ETS and another CBT programme (R&R) found a significantly reduced reconviction rate one year after release for young people who completed the programme, but the difference was not maintained two years after release. It is not clear whether any of the young people were under 18 (Cann et al 2003).

A later study of ETS – including adult prisoners only – identified benefits other than non-reconviction, including increased pro-social behaviour, self-confidence, literacy skills, and interpersonal skills. Institutional support, the ethos created by programme managers, and prisoner motivation to change were identified as key factors (Clarke et al 2004).

There is emerging evidence, from a small-scale development project, about children’s lack of engagement with OBPs (Hart 2004).

### OBP - ASSERTIVENESS & DECISION MAKING

<table>
<thead>
<tr>
<th>SITES</th>
<th>1 – New Hall</th>
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</thead>
</table>

**AIM**
A shorter version of ETS (see above).

To help individuals improve their thinking skills, make them more effective in their dealings with others, and reduce impulsivity. Sessions include identifying tasks associated with making a decision, describing different types of behaviour (passive, aggressive and assertive), identifying skills that can aid assertive behaviour, understanding strategies to limit the effect of emotions on thinking, and learning ways to compromise.

**DELIVERY**
8 group sessions over 4 weeks

**PROVIDER**
Forensic psychologists

**CRITERIA**
Those without time to do ETS proper, or with lower risk level than for ETS

**EVIDENCE**
Post-programme evaluation

Research - None found, but see earlier chart on ETS.

### OBP – VICTIM AWARENESS

<table>
<thead>
<tr>
<th>SITES</th>
<th>6 – Ashfield, Castington, Hindley, Huntercombe, Warren Hill, Wetherby</th>
</tr>
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</table>

**AIM**
Aims to help people recognise how their offending behaviour damages other people’s lives as well as their own, and to demonstrate empathy with victims of crime, by challenging notions of victimless crime and egocentricity. Sessions include identifying the victims of crime and the emotional and practical impact on victims, and looking at victims’ rights and the impact these will have on offenders. One site focuses on why people offend, how they justify their offending, when they are most at risk of doing so, the possible link between substance misuse and offending, alternatives to offending, and how to plan ahead.

**DELIVERY**
4 or 5 group sessions. In one site all sessions are provided in one week in order to accommodate those with a short sentence.

**PROVIDER**
Various:
- Forensic psychologists
- Psychologists and YOT worker
- PO responsible for bullying and safety
### OBP – CRIME & ITS CONSEQUENCES

<table>
<thead>
<tr>
<th>SITES</th>
<th>4 – Castington, Hindley, Huntercombe, Thorn Cross</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIM</td>
<td>Aims to examine individual’s particular offences and encourage them to think about alternative ways of behaving and dealing with problems. Sessions cover the long-term and short-term losses of actions, the link between anger/aggression and offending, and the factors that might lower the individual’s risk of re-offending. The focus is on a flexible and personalised look at problems, and on the risks, choices and decisions involved. Some sites focus on challenging attitudes and encouraging victim empathy.</td>
</tr>
</tbody>
</table>
| DELIVERY | Various:  
- 6 group sessions, one hour long, with 2 sessions delivered each day over 3 days  
- 1:1 work in some sites, using aspects of the course |
| PROVIDER | Various, including POs and education |
| CRITERIA | Anyone |
| EVIDENCE | Evaluation:  
- Feedback from trainees  
- Feedback from trainees and tutors  
- Pre- and post-course questionnaire  
- Tutor observation, plus completion of work in own time to clarify understanding of course content  
- Psychological evaluation |
| Research | YJB research department reports none available |

### OBP - IMPACT OF CAR CRIME

<table>
<thead>
<tr>
<th>SITES</th>
<th>4 – Ashfield, Hindley, Lancaster Farms, Thorn Cross</th>
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</thead>
<tbody>
<tr>
<td>AIM</td>
<td>Aims to look at the impact of car crime on offenders and their victims, and to encourage safe driving.</td>
</tr>
</tbody>
</table>
| DELIVERY | Various:  
- Single session including discussion and video  
- One-day course about safe driving  
- 12-week intensive course  
- 1:1 in serious cases involving death by driving |
| PROVIDER | Various:  
- Fire Service (off site)  
- Local police  
- POs |
| CRITERIA | Anyone involved in car crime |
| EVIDENCE | YJB research department reports none available |

### OBP - STAR – STOP, THINK, ACT, REFLECT

<table>
<thead>
<tr>
<th>SITES</th>
<th>1 – Feltham</th>
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<tbody>
<tr>
<td>AIM</td>
<td>Aims to tackle the thinking and attitudes that underpin anti-social and criminal behaviour, in order to enable young people to understand and learn skills to...</td>
</tr>
</tbody>
</table>
reduce their offending behaviour, substance misuse or violence. The focus is on using material from real-life situations, and setting tasks to be completed before the next session. With parallel sessions on victim work, family matters, peers and the community.

**DELIVERY**

1:1 programme of 15-25 sessions, each lasting up to 2 hours, and delivered as 1-3 sessions per week

**PROVIDER**

Offending Behaviour Team and YOT staff

**CRITERIA**

For those whose offending is related to:
- property, damage and/or public order offences, or
- stealing or dealing to pay for drugs or committing offences under the influence of drugs, or
- aggressive or violent behaviour

Not for those with domestic violence or sex offences because the programme does not address specific features of their offending

**EVIDENCE**

Evaluation - Pre-post psychometric testing

Research - This is a pilot project, developed for the YJB, with follow-up evaluation planned after 2 years, to measure the impact on re-offending behaviour.

Use of the programme in a YOT (with a very small sample) indicates some promising results, in terms of perceived risk of re-offending. It is hard to complete sessions in custody. (Beverley 2001)

**OBP - JETS – JUVENILE ESTATE THINKING SKILLS**

**SITES**

3 pilots starting in 2005 – Ashfield, Hindley, Wetherby

**AIM**

Aims to offer an integrated approach to improving the skills and behaviour of young people exhibiting anti-social behaviour. Sessions include interpersonal and problem-solving skills, self-control, cognitive style, social perspective taking, and critical and moral reasoning.

It is a new programme, adapted from ETS (see above). Adaptations include behaviour management additions, generalising lessons learnt to other settings, individual work in parallel with group sessions, and a mentoring element during and after custody, and using structured opportunities for all staff to reinforce the skills and behaviour taught.

**DELIVERY**

25 group sessions, with no more than one session delivered in a day.

**PROVIDER**

Staff trained in motivational skills, juvenile development, and group and behaviour management skills

**CRITERIA**

Referrals based on ASSET scores and other criteria

**EVIDENCE**

December 2003 (unpublished) report of post-course interviews in pilot area. Promising results in terms of trainees finding the course enjoyable and useful, and being able to generalise skills beyond the sessions.
<table>
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<tr>
<th><strong>OBP – FOR SEX OFFENDERS</strong></th>
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<tr>
<td><strong>SITES</strong></td>
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<td><strong>AIM</strong></td>
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<td><strong>NOTE</strong></td>
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<td><strong>DELIVERY</strong></td>
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5.4.4 Systematic, multi-level and psychosocial interventions (see 5.3.4)

As mentioned earlier, there is little to include in this section by way of interventions currently in operation because such interventions are not provided in YOIs. There is, however, some evidence to indicate the value of trying to move in this direction. The main sources drawn on are listed on page 48.

- There is considerable evidence from community-based studies to support this type of approach for responding to the needs identified in children in the study sites.

- For adolescents who show severe antisocial behaviour and are at highest risk of developing adult personality disorder, multi-modal approaches that include the individual, peer group and family, and draw on cognitive behavioural and problem-solving skills therapies, are the most effective approaches. Programmes should be skills-oriented wherever possible, identifying and targeting the specific skills that are lacking or poorly developed.

- Family therapy is considered to be worth contemplating for PTSD (Finkelhor & Berliner 1995) and - if family problems are an obvious contributory factor - for depression (Harrington et al 1998) and substance misuse (Elliott et al 2003).

- For serious juvenile offenders – Multi-Systemic Therapy (MST) is the most effective treatment in reducing recidivism and ameliorating the individual and family problems of delinquent adolescents. RCTs indicate that offending rates are cut by half. It is substantially more effective than individual treatment, and effective even for quite troubled and disorganised families. The family is seen as the core focus of the intervention. The overriding goals are to empower parents with the skills and resources needed to address the inevitable difficulties that arise in raising adolescents and to empower adolescents to cope with problems both within and outside their family. There is a clear focus on the strengths of the various systems (child, peers, family, community), and the therapist acts as the family’s advocate with outside agencies. There is a recognition that to intervene successfully in the lives of young people it is necessary to direct interventions not only at the young people themselves but also at the social contexts in which they live. Problem behaviour is considered to be a function of difficulty within or between any of the young person’s systems.

There are various treatment principles that must be adhered to, including clear assessment of need, positive and frequent contact with workers, clarity of objectives, written feedback from multiple sources, and a commitment by the therapist to overcome obstacles to family engagement. Service guidelines include low case-loads (5 per worker), delivery in community settings, treatment for 4–6 months, access to crisis intervention at any time, and comprehensive services to address identified needs (Henggeler et al 1998, Borduin et al 1995, and in Fonagy et al 2002, Harrington & Bailey 2005). MST is currently being piloted in several YOT areas in England, including Cambridgeshire and the London boroughs of Camden and Haringey.

- Functional Family Therapy (FFT) has been shown to reduce re-offending rates by about half. It works to improve communication between parents and the young person, and to increase supervision, consistency and negotiated
rules and sanctions. USA studies on Treatment Foster Care (TFC) – where foster carers receive special training in effective techniques - are also reported as showing promising results (Stephen Scott, p107, in Bailey & Dolan 2004).

• For juvenile offenders leaving custody – From 1999 NACRO ran a programme of pre-release key workers for vulnerable young people aged 16 and 17. Staff identified relevant young people, generally those in care, those with weak family relationships and those with nowhere to live. The key workers enabled them to access information and support during custody, helped them prepare for release, and then met them regularly after release. The aim was to help young people identify likely problems, and then draw up and implement an action plan. Young people valued the informal, non-traditional relationship with their key worker. Staff reported that workers offered a role model as well as practical and emotional support. There was a reduced reconviction rate – 38 per cent as opposed to 90 per cent for the age group (SEU 2002 p166).

• For children in residential settings - Results are best if there is a structured programme lasting more than a year, a warm atmosphere, high expectations, and positive relationships between young people and staff (Harris DP et al 1987).
5.4.5 Provision for children deemed vulnerable on the wings (see 5.3.5)

As mentioned earlier, this section is about programmes for two groups of children, those deemed unable to cope on the wings and those who bully. We have grouped the programmes together because they are responses that staff drew to our attention as being particularly relevant to the mental health needs of the most vulnerable children in their care. The programmes have different names, are run by different staff groups, and operate over different time scales. What most have in common is an approach that combines group and individual work and a commitment to give young people the opportunity to engage in mainstream activities, but from within a protective environment.

The boxes include information about the style of delivery and what, if anything, is known about their effectiveness.

ACCESS, and ACCESS PLUS

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<thead>
<tr>
<th>SITES</th>
<th>4 – Ashfield, Thorn Cross, Warren Hill, Wetherby</th>
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**AIM**
Aims to improve confidence and self esteem, especially in those who find it hard to cope with the prison environment and are at raised risk of self-harm and bullying. The programme gives access to mainstream activities but away from other young people. There is a focus on problem solving, communication and assertiveness. A common feature is the combination of classroom and gym sessions, with group work in the classroom on – for example – the process of problem solving, and then time in the gym to practice the process by – for example - negotiating an obstacle course or refereeing a short game. The gym sessions also promote the use of relaxation and exercise to reduce stress.

**DELIVERY**
Group sessions
In one site there are 12 sessions, each consisting of an hour in the classroom, a half-hour break, and an hour in the gym. The first 6 sessions are about problem solving, communication and assertiveness; the next 3 are about working through realistic problems and using their skills to help others; and the final 3 are about setting goals and accessing opportunities on offer in the prison and after release.

In another site there are daily sessions for 8 weeks, with special rooms for the education and gym work. The focus of work includes assertiveness, anger, social skills, health promotion and exercise.

**PROVIDER**
Psychology and PE staff

**CRITERIA**
Various:
- Poor copers, including those at risk of self-harm and bullying
- Those with learning difficulties
- Those on the autistic spectrum

**EVIDENCE**
Has been accredited for juveniles.
Evaluated by re-post psychometric testing, and sometimes 6 weeks later also.

Evaluation results are reported as published in the Prison Service Journal and Forensic Update (journal of the forensic division of BPS - British Psychological Society). Results draw on psychometric testing, measurement of self-harm, length of time on self-harm report, number of adjudications.
**TIME OUT**

**SITES**
1 – Warren Hill

**AIM**
A half day that gives boys who find it hard to join in mainstream activities time away from the wings and the chance to do some work (and games) on coping skills and prison life.

**DELIVERY**
Group session, including 1:1 work

**PROVIDER**
Psychologist and chaplain

**CRITERIA**
Those finding it hard to cope on the wings

**EVIDENCE**

---

**CENTRE POINT**

**SITES**
1 – Werrington

**AIM**
Aims to teach young people some of the skills they lack, and offer the opportunity to practice them in a supportive and encouraging environment. Skills include communication, emotions, relationships, self-awareness, awareness of others, empathy, and numeracy and literacy. The focus of sessions is to help boys feel good about themselves, communicate effectively with others, and increase their network of friends. Sessions are designed to be positive, fun and uplifting, with games and activities used for learning and practising new skills. Each trainee has an Individual Education Plan.

**DELIVERY**
Group setting with 1:1 support, running each morning for 8 weeks, and with the option of boys staying longer if necessary.

The work is underpinned by attachment theory. The combination of a group setting and 1:1 support is deemed ideal for this sort of programme as the boys are constantly interacting with one another whilst learning and practising new skills, but have individual support at hand if they get into difficulties.

**PROVIDER**
Education staff (SENCO, learning support assistant, speech and language therapist) and clinical psychologists

**CRITERIA**
Those with greater levels of difficulties – history of poor parenting, disturbed attachments, self-harm, being bullied, poor speech and language

**EVIDENCE**
Pre-post psychometric testing, self-report evaluation form, attendance records, and educational outcomes eg. improved literacy.

Programme relies on 3 school-based programmes designed for children with anxiety/separation disorders, depression, and anger management and social skills’ problems – FRIENDS (Barrett et al 2001), STOP THINK DO (Day et al 1999) and RAP (Montague & Shochet 2001). The programme also draws on Nurture Group work in schools.

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**INCLUSIVE EDUCATION FOR ALL**

**SITES**
1 – Hindley

**AIM**
Aims to support boys with learning difficulties – on the wings, in workshops, or in the learning and skills centre. Work focuses on strategies to address need, as described in their Individual Education Plan.

**DELIVERY**
Group or 1:1, consisting of 3 half-hour sessions over a week

**PROVIDER**
SENCO and learning support assistants

**CRITERIA**

**EVIDENCE**
Evaluation - progress assessed at weekly meetings with named key worker and DTO meetings, and behaviour monitored

---

**MANWARING UNIT**

**SITES**
1 – Huntercombe

**AIM**
Aims to enable boys to join in other activities.
### DELIVERY
Starts with 1:1 work, leading to encouragement to work with others in the unit. There are 6 places, usually with 2 or 3 boys at a time. A range of activities includes cooking and art. The visiting psychologist goes to talk to the boys and may suggest referral to the MHIRT. It is a unit near the Education Centre.

### PROVIDER
Unit run by a permanent staff member, employed by Prison Service but funded by the Joseph Rowntree Foundation. Current post holder has an education background.

### CRITERIA
Boys not coping on the wings, unwilling to come out of cells or join activities.

### EVIDENCE

#### ANTI-BULLYING PROGRAMMES

<table>
<thead>
<tr>
<th>SITES</th>
<th>5 – Ashfield, Brinsford, Hindley, Stoke Heath, Warren Hill</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIM</td>
<td>Aims to raise awareness of bullying, and challenge and change bullying and anti-social behaviour. Contents include what bullying means, why it starts, the consequences of bullying, how to avoid, empathy with victims. 5 specialist programmes are described below.</td>
</tr>
<tr>
<td>DELIVERY</td>
<td>Various:</td>
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<tr>
<td></td>
<td>• An ongoing two-week programme of offending behaviour programmes, education and gym sessions, delivered in a specialised Juvenile Personal Development Unit (JPDU), via group and 1:1 work.</td>
</tr>
<tr>
<td></td>
<td>• 4 modules of 2 hours each, delivered via group sessions in the Induction and Throughcare Support Unit (ITSU).</td>
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<tr>
<td></td>
<td>• Individual work as soon as bullying detected – completion of a 25 page book on cognitive thinking and discussion with wing officer. At next stage, individual work that is trainee specific, related to the type of bullying (eg racist). Delivered by anti-bullying co-ordinator.</td>
</tr>
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<td></td>
<td>• 4-stage programme of group sessions and video, devised by Kidscape and the NSPCC and piloted nationwide. Delivered by intervention officer.</td>
</tr>
<tr>
<td></td>
<td>• Citizenship Programme of 3 group sessions, one a week lasting 2 hours each, including education and thinking skills.</td>
</tr>
<tr>
<td>PROVIDER</td>
<td>Various:</td>
</tr>
<tr>
<td></td>
<td>• JPDU (see above) - a dedicated team of 8 prison officers, with assistance from the on-site YOT, education and gym.</td>
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<tr>
<td></td>
<td>• ITSU (see above) – prison officers who have had special training.</td>
</tr>
<tr>
<td></td>
<td>• Dedicated anti-bullying co-ordinator or intervention officer.</td>
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<tr>
<td></td>
<td>• Prison officers and other staff.</td>
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<tr>
<td></td>
<td>• Citizenship Programme (see above) – 2 education staff, with mentoring by prison officer.</td>
</tr>
<tr>
<td>CRITERIA</td>
<td>Various:</td>
</tr>
<tr>
<td></td>
<td>• Referral determined by a multi-disciplinary team, with input from YOT, personal officer, education and family.</td>
</tr>
<tr>
<td></td>
<td>• Immediate referral to anti-bullying officer.</td>
</tr>
<tr>
<td></td>
<td>• Referral from any staff, with decisions by multi-disciplinary team.</td>
</tr>
<tr>
<td>EVIDENCE</td>
<td>Evaluation:</td>
</tr>
<tr>
<td></td>
<td>• JPDU - feedback from trainees at review meetings and about their application of learning on normal location. Levels of reported incidents. Observation of their behaviour.</td>
</tr>
<tr>
<td></td>
<td>• Anti-bullying co-ordinator - exit interviews, complaints from parents about bullying, reported incidents.</td>
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<tr>
<td></td>
<td>• Citizenship Programme - assessment by prison officer acting as mentor, incidents after course, participation in regime.</td>
</tr>
<tr>
<td></td>
<td>No published evidence relating to custodial settings.</td>
</tr>
</tbody>
</table>
5.4.6 Mental health promotion (see 5.3.6)

The study did not allow time to research all the mental health promotion programmes mentioned by sites. We include below some details of recent initiatives that are, or may be, of relevance for this particular age and client group.

• Basic skills – numeracy and literacy

There is recent evidence of the effectiveness of basic skills training (numeracy and literacy) for juveniles. A 15-month longitudinal study of change in literacy and numeracy skills after people had followed basic skills training in prison included 464 prisoners, of whom 38 per cent were juveniles. They were assessed at reception using a standardised scale and assessed by training co-ordinators at the end of training. Juveniles were more likely than adults to receive training that was embedded in other activities rather than delivered via class lessons. Most trainees progressed to Level 1 competence – the equivalent of the skill of an average 11 year old. The greatest chance of making progress in reading, numeracy and spelling was having regular sessions which amount to more than 30 hours’ training in total. The findings suggest an advantage in providing juveniles with intensive training of this sort during short custodial stays (Stewart 2005).

• A healthy life-style: outdoor activity

A study makes a link between outdoor education and the development of children’s self-esteem, confidence, behaviour and co-operation with others (Fox & Avramidis 2003). Outdoor education is defined as activity “in, about and for the outdoors” and as something that can take place in an urban setting. The evaluation was of outdoor activities in a special school, with three different groups of pupils, and using a control group and pre- and post-intervention testing. It found that outdoor activities promoted positive behaviour and was enjoyed by pupils, with some indication of academic improvement. The researchers conclude that outdoor education, whilst not a solution to problem behaviour, is a powerful and underused tool.

The issue of outdoor activities is relevant for sites keen to take account of the growing public debate about children’s health. The White Paper on Health (DH 2004b) has sections about children’s health, and the Green Paper on the future of Youth Services (DfES 2005) makes proposals for national standards, including two hours per week sport or physical activity.

It links, too, with comments by the former Chief Inspector of Prisons of the singular importance of physical activity for growing children and of their being able to “see the ground and the sky” each day (HMIP 1999).

• A healthy life-style: exercise

There are some lessons to be drawn from both recent and older studies. Depression can be managed by identifying and reducing current life problems or stresses. Exercise, a good sleep pattern and a balanced diet are helpful (NICE 2005). For anxiety, learning skills to reduce the effects of stress is the most effective relief (not sedative medication) (Shear & Schulberg 1995). Activities that are relaxing, pleasurable or confidence building are helpful. Exercise may be helpful too (Glenister 1996, McCann & Holmes 1984).

• A healthy life-style: diet and nutrition
A recent study makes a link between diet and anti-social behaviour. Young adult prisoners (18-21) were given active capsules of vitamins, minerals and fatty acids or placebo capsules in an RCT over 9 months. Those receiving active capsules had just over a quarter fewer offences recorded than the control group. Recommendations include the reassessment of dietary standards and consideration of how to encourage healthy food choices in custodial settings (Gesch et al 2003).

Various other studies have made the link between the intake of fatty acids and children’s behaviour, with deficiencies or imbalances of omega-3 increasingly associated with childhood developmental and psychiatric disorders including ADHD, dyslexia, dyspraxia and autistic spectrum disorder. Recent findings from the Oxford Durham study indicate enhanced concentration skills in young children taking omega-3 supplements (Richardson 2004).

**Note**

See the NICE guideline about depression (under CBT, on p48) for new advice about exercise and nutrition.
5.4.7 A note about substance misuse (see 5.3.7)

The YJB report about substance misuse (2004b) covered juveniles across the whole secure estate, in STCs and LASCHs as well as YOIs. Substance misuse services at all tiers are described – covering prevention and education, support and programmes, and detoxification and treatment. Staff wanted more attention to alcohol misuse, because they saw that as a major concern, and to dual diagnosis, because they found it unhelpful that mental health work was generally done in isolation from drug misuse work. They were concerned, too, that mental health needs were under-recorded, because of the practice of entering a relatively low score on the ASSET form unless the mental health needs were deemed to be highly associated with the child’s offending behaviour.

The report’s main recommendations for interventions included the following:

• **A shift in culture** – to a child-centred approach, with a focus away from punishment, and to a strengths-based treatment model.

• **Screening and assessment** – that enable staff to uncover and understand a child’s pattern and severity of substance use as well as their reasons, needs and knowledge.

• **Prevention and education** – with programmes that enable staff to encourage children’s progress at all levels, are suited to age and understanding, provide a co-ordinated response when children move within the secure estate, and with attention to community resources such as mentoring, multi-systemic therapy, basic skills, and opportunities to find and stay in work.

• **Treatment services** – that match a child’s goals and motivation, avoid being judgmental, and cover all drugs – including tobacco, alcohol and solvents.

• **Better communication** – to reduce bureaucracy and paperwork, disseminate good practice ideas, improve inter-disciplinary discussion and planning, and see the young person’s active involvement as a service enhancement rather than an annoyance.

• **Staff training** – so that those working closely with the children understand the nature of young people's substance misuse, adolescent psychology and the link between substance misuse and mental health problems, and can develop skills in engaging with young people, dealing with conflict, and encouraging safe practice.

• **Parental involvement** – including pre-release sessions for all parents to help them understand “the gains their children may have made in custody, how best to support them on release, how to help them avoid the most common triggers for relapse, and where to go for help and support”.

6 NEEDS AND INTERVENTIONS - ISSUES ARISING

6.1 IDENTIFYING NEEDS

6.1.1 Screening, assessment and referral

• Mental health needs are identified in a range of ways in the different sites.

• All sites use a similar initial screening tool, developed by Grubin for adult offenders, occasionally with modifications. In just one site the staff have separated the mental health questions from the general health questions and, if responses to the mental health questions cause concern, a more detailed mental health primary screening tool is completed at that point. In the other sites more detailed screening is prompted by a referral to Healthcare or the mental health team.

• There is less consistency in relation to the tool used for secondary screening.

• In only a minority of sites is an RMN present for both first and second screenings.

• Some respondents expressed concern about both the timing and nature of the first and secondary screenings and their effectiveness in identifying mental health needs. They considered that a secondary mental health screening should be done for all young people, by a mental health professional, and using a semi-structured interview rather than a tick-box or psychometric method.

• Referrals from the above screenings may be made into Healthcare or the MHIRT. They can be made by any member of staff and, in the majority of sites, self-referrals are accepted also. Most sites do not have a standardised referral process, but two have developed a referral form, a number have developed procedures for dealing with referrals, and others are currently revising forms and procedures. Part of the aim of this work is to ensure that sufficient and relevant information comes with each referral.

• Once a young person has been referred, further assessment takes place. If a referral has lacked detail, staff from Healthcare or the MHIRT may speak briefly to the young person and the referrer to collect further information. In the majority of sites with a MHIRT, RMNs or CPNs then carry out a further assessment, triage the case and either refer on to other professionals or allocate the case to themselves. In two sites the MHIRT has developed a detailed assessment tool to be used once a young person has been referred to the Team. Further mental health assessments can be carried out by a range of professionals, using various standardised tools (those mentioned by sites are listed at Appendix 2). Most tools have been developed from work with adults, though in some places staff have made them more appropriate for work with juveniles.

• In five sites the local Mental Health Trust’s CPA assessment and case recording documentation – also developed initially for adult clients – has been adapted for work with juveniles or has a clear influence on the work of the mental health staff. This is in line with the good practice advocated in the
Children’s NSF (DH 2004a) in relation to children leaving inpatient care or transferring to adult services.

6.1.2 Sources of information from outside

- Mental health professionals in healthcare and staff in MHIRT make use of information on young people contained in court reports and information collected for ASSET forms. All sites said that the majority of young people (70-98 per cent) now come with ASSET forms, although the MHIRT in some sites had difficulty getting hold of these. The mental health nurse in one site has solved this problem by collecting ASSET forms from the on-site YOT office each morning.

- In addition, mental health professionals spend time collecting information on young people from a range of different professionals and agencies. YOT teams are seen as helpful, in the main, in providing this background information and contact is also made, with the young person’s consent, with social workers, GPs, local CAMH and other services, as well as the young person’s family.

6.1.3 Multi-disciplinary meetings as sources of information about need

- A range of multi-disciplinary meetings are held in different sites.

- Some are regular meetings of staff in the MHIRT. Others are multi-disciplinary meetings, held frequently or on an ad-hoc basis, for staff from the MHIRT and other departments. There are also case conferences about particular young people, or multi-disciplinary reviews in cases where young people are at risk of self-harm or suicide or are self-harming.

- All these meetings are seen as good forums for identifying needs.

6.1.4 Awareness of mental health needs among non-mental health staff

- Prison officers in some sites were described as acting promptly if they had concerns about vulnerable young people. Other sites were concerned that prison officers and other staff, including education, were not always alert to possible mental health needs and tended to regard difficult behaviour as a matter for discipline rather than support.

- In one site the MHIRT were planning an audit of need of young people in the Intervention and Assessment Unit (on Stage 3 of their anti-bullying strategy) because of concern that mental health issues might not have been identified.

- Respondents in some sites had the impression that there was a tendency to refer young people with the most obviously difficult behaviour to the MHIRT or Healthcare, whilst others thought that difficult (externalising) behaviour tended to be treated as a disciplinary issue, and withdrawn or upset (internalising) behaviour more likely to be referred into the MHIRT.

- In a few sites prison officers were thought to be reluctant at times to identify mental health needs or make a referral to the MHIRT because they were wary of young people then being “labelled” with a particular disorder.
• All sites acknowledged the need for training and support to help increase staff ability to recognise mental health needs and provide a better and more consistent response.

• A number of respondents noted that non-healthcare staff had difficulty describing the specific needs or behaviour that were causing them concern. But in other sites, as noted above, the concern was more that mental health needs were simply not being spotted.
6.2 IDENTIFYING HELPFUL APPROACHES

6.2.1 Developing a therapeutic milieu

- A recurring theme in discussions was the importance of promoting and developing an ethos and environment that was more supportive of juveniles. Some staff were acutely aware that they are dealing with children. They commented on how distant the young people were – often for the first time - from their family, home and familiar surroundings. They said that the loss of freedom should not lead to the loss of respect and dignity.

- Steps have been taken in some sites to actively promote a more therapeutic atmosphere. Some Healthcare centres were seen as a safe place to chill out and drop the defences used by young people to hold their own on the wings. In a majority of sites mental health nurses and psychologists made a point of spending time on the wings to make it easier for young people to get to know them. They also created opportunities for discussions with other staff, to help generate a more responsive approach to young people's needs.

- There was an acknowledgement in a number of sites that attitudes to the young people in prison had improved in recent years, with more officers recognising that better results were likely with young people if time was spent interacting with them rather than restraining them.

- Improvements in the physical environment in some sites have contributed to a more relaxed atmosphere. These include a modern and well-equipped relaxation room that is conducive to young people calming down and talking about problems, a therapy room that is being refurbished with cushions and low lighting, new Healthcare units that are bright and clean, and newly-decorated wings for juveniles.

- The one open site provides a stark and positive contrast to all other establishments – with freer movement between buildings, low-build residential units, pleasant garden borders, and boys milling around as they might in a large children's home.

- But there are numerous obstacles to creating the therapeutic environment to which staff aspired.

- One key problem is the lack of general recognition that more attention should be focused on why the young people have ended up in custody, and on the similarity between the causes of offending and the causes of mental health problems.

- Another is that mental health needs are not seen as everyone's business.

- A third is the negative impact that the prison regime itself has on people's attempts to be responsive to needs.

- The focus on security, and especially on the requirement for young people to be escorted everywhere by prison officers, creates enormous problems. Healthcare staff referred to the focus as “an obsession” and to its impact as “a nightmare”. The result is that young people miss appointments with visiting specialists, suffer the embarrassment of being singled out when escorts
interrupt lessons or other activities, have to wait in cramped conditions in holding cells until it is their turn to be seen, and are locked in a cell immediately after a therapy session, until an escort back is available. All these practices militate against children beginning to make choices for themselves and taking responsibility for being in the right place at the right time. In some sites Healthcare and MHIRT staff ignore some security rules: they escort young people themselves if they are satisfied there is no risk, thus reducing the number of missed appointments. Other security issues include the practice of counting young people, often twice, when a gate has been left unlocked, again leading to missed appointments.

- Other negative aspects of the prison regime were also mentioned. These included weekends, when young people spend time on prison chores rather than interesting activities, or are simply locked in cells with nothing to do. Concern was raised in some sites about young people being left unattended in cells during the week because they could not cope with group activities, and in one or two sites Healthcare staff said it was difficult to gain access to young people who have been placed in segregation units because of their behaviour.

- Another problem was that difficult young people are suddenly moved to another site without notice to them or the professionals involved in treating them. This can mean that the issues leading to problem behaviour fail to get addressed, or that a therapeutic intervention is disrupted and the supportive relationship with a professional ended prematurely.

- Other change is disruptive, too. It was striking how often we heard about services on hold or discontinued, vacant posts (in forensic psychology, gym staff, prison officers and education), and staff departures to other sites or other employment. It feels like change is the order of the day – sites told us, for instance, that they used to do counselling work, or work with parents or families, or run parenting classes or group programmes, or hold regular staff meetings to discuss cases. Other problems are that waiting lists build up and only a limited number of young people can be worked with. The ability of MHIRTs to raise issues about mental health promotion with other staff is also affected. So, too, are aspirations to provide training and support to other staff so that low-level mental health needs and mental health promotion work can be done by others. There was also concern that staff would lose confidence in new mental health services if they made referrals but then discovered that there were long delays in accessing what had been offered.

- Prison procedures are unhelpful, too, for some of the most vulnerable young people: in one site, those self-harming were routinely subject to intensive scrutiny deemed counter productive for someone under stress. An example given was of girls placed in isolation cells and peered into every 15 minutes by male officers, despite the fact that childhood abuse might be at the root of their emotional difficulties.

- Finally, a recurring theme in discussions was that locking children up gets in the way of providing a therapeutic environment for work that might help them. The information collected during this brief mapping exercise reflects findings from earlier and more recent studies about aspects of the juvenile secure estate. When planning the way forward it may be helpful to consider any interim findings from the current NCB studies, especially those about health (NCB 2005a) and about looked-after children in custody (Hart 2004).
6.2.2 Viewing staff as “carers”

- Some sites took the view that, since the juvenile sites of the secure estate are accommodating children, the approach of those charged with the responsibility for caring for them should be modelled on the role of substitute parents or carers.

- This philosophy is already evident in one or two sites, and is aspired to in others. In the smallest unit for boys, staff are recruited and trained for the particular age group. The juvenile wing is run by an integrated multi-disciplinary team (including health but not mental health) and the relaxed atmosphere fostered has resulted in low levels of bullying and self-harm, and a willingness among young people to talk to a range of staff about their problems, including disclosing past abuse.

- The ethos is similar to that of staff in the open site who said they consider themselves to be working in a children’s home rather than a prison, and by those in some other sites, who described their establishment as more akin to a training college or school.

- What this means in practice is that staff have, or aim to have, an understanding of child development, are able to recognise and tolerate normal adolescent behaviour, and – indeed – enjoy the challenge of working with this particular age group. They do not react badly when young people make demands or shout at them or swear or make rude comments. They stick by the young people, spend time with them, say they will come back to check on them and always do so. They build up trust with the young people.

- Staff identified what would help make this approach more widespread. Training and support for non-mental health staff is seen as crucial: to help them identify needs and have more confidence in responding to them; to enable them to work more creatively with this age group and manage their behaviour better; and to promote the change in culture such that mental health is viewed as everyone’s business. Other practical suggestions were made. Some sites suggested that juvenile wings should be a base for a multi-disciplinary team that would respond to low-level mental health needs and refer more serious problems to the MHIRT. This early response team might include a nurse and a primary mental health worker (PMHW) and another professional with relevant experience in psychology, occupational therapy or social work.

- Finally, staff talked of other changes that would help foster the caring role. These included speaking to children by their first name, staff wearing casual clothes rather than uniforms, children being given clothes that fit them, not referring to the establishment as prison or jail. Other ideas were about different ways of dealing with behaviour – placing children on wings where particular prison officers knew how to deal with their particular needs (such as ADHD), helping children resolve conflict rather than referring them for disciplinary action, taking time to understand why children were self-harming or bullying. It was felt important, too, that everyone was puling in the same direction, offering a consistent message, as good parents and carers would try to do.
6.2.3 Communication and co-ordination

- Communication within the MHIRTs was recognised as important in relation to the allocation of cases, discussion about appropriate interventions, and advice and support in delivering interventions and overcoming difficulties. A number of MHIRTs have regular multi-disciplinary meetings at which referrals are allocated and ongoing cases are discussed, but some struggle to find the time for such meetings.

- A number of sites spoke of efforts by MHIRTs to establish regular communication with other staff and departments. This was for various reasons – to explain and promote the mental health service, to agree protocols for referrals, to plan and review work with individual young people, and to offer formal and informal training on mental health symptoms and responses.

- Good communication systems were described in several sites, and some commented on marked improvements in recent years, albeit from a very low start point. In one site weekly multi-disciplinary meetings involve other staff, such as forensic psychologists, the speech and language therapist, the YOT worker based in the prison, and the educational psychologist. All referrals into their different services are discussed at these meetings. In another site the multi-disciplinary team who run the juvenile wing meet every day to discuss all the young people on the wing. The team includes prison officers, education staff, a counsellor, substance misuse workers, a family support worker, the chaplain, a nurse, a psychologist and a social worker (the last two posts currently vacant). In one site regular contact between the MHIRT staff and other staff, and taster sessions about the therapies on offer, had led to a steady increase in referrals to the MHIRT.

- Respondents in a number of sites said that although there were no formal multi-disciplinary meetings on a regular basis with staff outside the MHIRT, there were good informal relations and communication. Others, though, were concerned about the poor levels of communication between MHIRT/Healthcare and other professionals such as forensic psychologists and education. In one site there was poor communication between the MHIRT and the Healthcare team and in this same site there were also serious concerns about the lack of communication between members of the MHIRT and two of the three psychiatrists linked with the prison. In another site MHIRT staff expressed concern that their advice to other staff about treatment was sometimes ignored.

- In a number of sites multi-disciplinary case conferences are held in relation to young people who are causing particular concern. Information is shared and a plan of action agreed by all relevant staff. In all sites reviews of Form 2052 (self-harm) cases involve a range of different professionals. But in a number of sites there were concerns that relevant staff were not always able to attend these or other multi-disciplinary meetings. Nor, in some sites, do relevant staff get invited to the meetings.

- In some sites it was noted that, if disciplinary staff had a concern about a young person, there was a tendency to refer to a wide range of possible sources of support within the prison, and it was therefore important for all those various sources of support to communicate with each other in order to ensure a co-ordinated response.
• A number of sites were concerned that the lack of such co-ordination could result in young people receiving a number of conflicting interventions.

• Poor communication could also mean that young people missed appointments with mental health professionals because they had other appointments to attend or because legal or family visits had been arranged.

6.2.4 Joint working

• Examples of joint work were described in several sites, and the benefits of such an approach highlighted. The one site with a multi-disciplinary team running the juvenile wing has already been mentioned.

• In other sites, involving prison officers in group programmes meant that their detailed knowledge of individual juveniles could be harnessed. They were involved, for instance, in co-running some offender behaviour programmes. In one site the MHIRT worked with prison officers on the wing to plan for individual young people once the wing staff had delivered a behaviour management programme.

• In another site regular meetings between the MHIRT and the forensic psychology team were paving the way for co-working opportunities using both individual and group work. In two other sites the forensic psychology team played an important role in supporting both staff and young people in cases of self harm: they collected data on levels of self harm and the response to it, and provided helpful feedback to prison officers.

• Groups run jointly with YOT staff had the added value of provided continuity for young people, as the YOT worker’s responsibilities straddled life in custody and the community.

• The regular presence of mental health staff on the wings provided informal opportunities for mental health promotion, for boosting the confidence of disciplinary officers, and for mental health workers becoming accepted as part of the staff team rather than being viewed as distant specialists. Many sites wanted to see the further development of this approach, with healthcare and mental health support more routinely provided on the wings.

• Despite these and other examples of good practice, much remains to be done. There are legacies to overcome in different sites – of poor relationships between healthcare, education and forensic psychology; of mistrust between mental health and healthcare teams; and of lack of knowledge of the work done by forensic psychologists. Respondents were keen to move forward on all these issues.
6.2.5 Training and supervision

- A number of MHIRTs were planning to develop formal training for other staff on the recognition of mental health problems.

- One site had developed a specific training programme, which had been delivered to about 30 colleagues, and one group of RMNs were providing sessions on mental health issues as part of prison officer training programmes.

- One MHIRT had been running training sessions for some time, but found that attendance was variable, with some sessions over subscribed and others so under subscribed that they had to be cancelled. In this site MHIRT staff had also offered supervision to other staff, particularly to support them in dealing with young people who were self-harming, but take-up was low.

- The MHIRT and forensic psychology team in one site were keen to train other staff in managing difficult behaviour among juveniles, in order to help develop a culture where there was an expectation of respect and an ability to negotiate.

- A number of other sites felt that prison officers were too ready to take disciplinary action against juveniles and that this arose from a lack of understanding of how to work with young people, or from poor knowledge about ADHD and other mental health disorders.

- In one site the consultant psychologist runs regular weekly sessions for staff working with inpatients, to boost confidence and team discussion and to foster a therapeutic atmosphere.

- Other sites had developed, or were planning to develop, supervision and support services, initially for RMNs in the Healthcare team, but hopefully for other staff too. This was seen as an opportunity to motivate staff and also to encourage them to stay in their jobs. Informal contact with other staff was seen as important, particularly with prison officers. Respondents from many sites referred to the importance of MHIRT staff being visible on the wings and accessible to staff and young people. Regular conversations with other staff, both informally and in multi-disciplinary meetings, was seen as an important way of raising people’s knowledge and understanding of mental health problems.

- The site with a multi-disciplinary team running the juvenile wing ensures that the prison officers who work there have first attended specialist training in working with juveniles. In addition, they have commissioned training from an outside agency that trains foster carers because there is an expectation that staff will view their work in this way. A number of the prison officers have also received training in counselling.

- Other training initiatives were described. Some sites have brought in outside trainers, for staff sessions on child and adolescent development and on mental health awareness. Other Healthcare staff said they wanted colleagues to shadow professionals in other settings, or do work exchanges, as a means of extending their knowledge and confidence in dealing with unfamiliar mental health needs.
• Comments were made about the need for staff to have the opportunity to develop new skills in their current post, rather than having to move on in order to further their career prospects.

6.2.6 Responding to different levels of need

• Staff in MHIRTs see their role as responding to young people with higher-level mental health needs. The language used to describe this varied: those linked to CAMHS talked about Tier 3 and 4 work, while those linked to either adult or adolescent forensic work talked about secondary-level needs.

• But all recognised that they were in fact providing a service to young people with a wide range of needs, and that they needed to have this flexible approach, to ensure that young people were assessed properly and were offered some support to meet their needs.

• In some sites positive action was being taken to enable other staff to respond to low-level needs. In one site the OTs had trained nurses and prison officers to run some of the groups for inpatients, freeing up their time to work more with young people on the wings. In another site plans to recruit different grades of RMN was part of a move to build up a staff group that could both respond to lower-level needs and support other staff (initially in Healthcare) in doing so. Elsewhere, the CPN and mental health worker from the MHIRT were seen as partly fulfilling a primary mental health worker role, although it was recognised that all staff in the MHIRTs did some of this kind of work.

6.2.7 Flexibility in approach

• MHIRT staff and mental health professionals in Healthcare saw it as important to respond to all referrals and requests for help, including responding better to low-level needs. For example, they had a flexible approach to how long they were prepared to work with a young person – keeping cases open, being available for as long as necessary, and being prepared to go back to young people who had not attended for sessions or who had dropped out, to keep encouraging them to take advantage of what was on offer.

• In some sites they were developing peer support systems, as well as looking at ways of supporting wing staff in responding to needs. Many examples were given of young people who had been referred to mental health professionals (because of self-harm, bullying, depression or anxiety) and where a conversation with the young person revealed that the root of the problem was concern about an ill parent, or upset over a missed visit, or lack of news from family members, or worry about how family members were coping. Often all that was needed was the organisation of a phone call home, or the arrangement of a social visit from relatives.

• MHIRTs were, in the main, keen to develop more group interventions as well as continuing with their one-to-one work, and to develop this in partnership with other staff. They wanted to respond to needs as they arose, for example by quickly providing evening sessions if several young people had sleep problems.
• Some teams wanted more access to creative therapies, particularly art therapy, as well as getting more involved in life-skills groups and creating opportunities for young people to learn cooking, parenting and other practical skills.

• Having a wide range of skills to draw on was welcomed. The two sites with a speech and language therapist were very positive about their work, both in identifying previously undiagnosed issues like hearing impairment and mild learning difficulties and in the work they were able to do with young people frustrated by communication difficulties. Several sites considered that having educational psychologists available was – or would be - helpful, especially for assessing need and working with children with learning difficulties.

• There was a recognition that in a prison setting it was difficult to provide ‘pure’ interventions – often because of time constraints, or because of the difficulty in obtaining consistency of approach when young people were on the wings and being seen by a range of different officers. Long-term work was also impossible with many young people. As a result, where young people were experiencing PTSD as a result of sexual abuse as a child, staff – in the main - saw their role as helping them use coping strategies and giving them information about support they could access on release and what that support or therapy might entail. There were a few exceptions to this: work on past abuse was being done in a couple of sites where professionals were experienced and knew that young people would be with them for a long enough period.

6.2.8 Looking beyond the secure estate, and links with local services

• The majority of juveniles are in prison for short periods, either on remand or serving a short sentence, before returning home or to their community. It was reported that it makes sense that those caring for them bring to their interventions a focus on life beyond the prison gates, so that young people have constant reminders of their links with the outside world.

• Staff in some sites are very clear about the importance of this approach. Mention has been made already of some outside trainers for staff. External individuals and organisations are well used in some parts for direct work with young people, too. Chaplains bring in voluntary agencies for specific pieces of work, as well as linking isolated young people with visiting befrienders. Healthcare staff use outsiders for group work on specific mental health problems and therapeutic remedies. Substance misuse programmes include local parents to talk about their experiences of children using drugs. A local YMCA was praised for housing advice work, and a local Benefits Agency for helping young people with forms and eligibility criteria.

• Another aspect of this outward-looking approach is gearing interventions to what will be most useful when young people have left the site. Examples include group work on coping skills for those with imminent release dates; work about aspects of loss such as the loss of childhood and moving on from negative influences; and helping young people to value peer friendships, by encouraging them in the support given to and received from other young people on the site. Important, too, is the wish to spend time boosting young people’s confidence so that they develop the ability to make choices and think and act for themselves in the future.
• Staff in MHIRTs spend a lot of time making contact with, and referrals into, relevant services in the young person’s home area. Staff see this as an important aspect of the work they do with young people, and some said they thought it was the most important help they could offer young people who would soon be moving on. Most – but not all - YOT teams were thought helpful in facilitating links with outside services.

• More needs to be done, with staff pressing for greater opportunities to develop links in the community, both to increase young people’s knowledge of services and to add variety to prison life. They wanted, too, to give young people a good experience of mental health services in the hope that they might use them after their release. No site had a system for receiving feedback on whether or not this actually happened.

6.2.9 Acknowledging the central importance of families

• Staff in all sites commented on the links that young people had with their family and/or other important people such as foster carers. There was an acknowledgement of the importance of these links, and of the distress and misery experienced by many young people at being separated from parents and others. There was also concern at the plight of parents – an understanding of their feelings of guilt and, for some, of relief at having some respite from fraught times with their child. Home life may be chaotic, or otherwise difficult, but this does not necessarily mean that there are not strong ties between children and families.

• Another common theme in discussion was of the family losses that were felt to be at the heart of the problems that had propelled young people into custody. Particular examples included the death of grandparents who had acted as carers, parental separation, the death of a parent or other close relative in tragic circumstances, and young mothers losing their baby or child into the care system.

• Some sites have found ways of acting on these concerns. Family Liaison Officers (FLOs) were generally praised for the efforts taken to make and sustain links with families. Examples were given of their determined work to revive contact with a parent not seen for years, and to help people renegotiate difficult relationships. Family days, organised in the main by chaplaincies, were described as successful activities that merit the time taken to organise them. Of particular value is the focus of these on strengthening links between juveniles who have become a parent, and their partner, new baby and extended family members.

• A few mental health nurses contact young people’s parents as a matter of routine, both to get background information about schooling, health and relationships and to reassure parents of the importance of their continuing role as parents. Others said that parents contact them frequently for updates on their child’s health and progress. Some described the importance of a single phone call home, made by them or the young person – this could ease anxiety about an impending review meeting, or relieve the burden carried by a young person of what is happening at home for siblings they used to care for or whom they tried to protect from abuse. One site had gone further. Worried about the lack of contact from a boy’s local services, and by the constant calls from his mother, they had provided travel and accommodation costs so that
she could visit the site overnight and be involved in discussions about the boy’s mental health problems.

• All these positive activities are, however, much outweighed by the negatives surrounding family contact and involvement. All sites commented on the difficulties inherent in family visits – long distance from home, sites impossible to access easily by public transport, and costly journeys that have to be paid for in advance and cash help claimed later.

• Some staff who wanted to involve families in diagnosis or treatment were beginning to do so. They tried to catch parents at the start or end of review meetings, or planned to talk to them during the time allocated for weekend family visits. Others struggled to know how best to proceed. One mental health nurse wanted the opportunity to do psychosocial work with parents, to help them understand practical ways of responding to their child, an important consideration for particular mental health problems such as schizophrenia and eating disorders. A psychiatrist wanted to start family therapy work. A Head of Healthcare wanted to start group work using a family therapy approach. A psychologist and nurse commented, separately, about the loss to the establishment following the termination of a contract for family therapy sessions from an outside agency.

• One mental health in-reach worker in one site had a particular brief for outreach work with families and communities, and this was described by staff as a welcome addition. On the other hand, FLO activities were said to be constrained by post holders being called away to concentrate on disciplinary duties, and the employment of FLOs was generally limited across the estate. Surprisingly, they did not feature in the female sites, where more young offenders were likely to be parents.

6.2.10 Accessing hospital beds for children with psychotic disorders

• All sites with experience of young people with psychotic disorders expressed concern about situations when young people were psychotic but refusing medication, when they were unable to administer medication without consent, and when there were extreme delays in obtaining assessments by psychiatrists and then further delays in finding hospital beds for these young people. Only two sites did not experience severe delays in accessing beds: they were fortunate in having good links with a nearby Forensic Adolescent Unit.

• The delays in finding hospital beds in all other sites ranged from six months to nearly two years. There were long delays even in sites with no inpatient facility and where young people were therefore being contained on the wings. Where inpatient facilities did exist the delays could be even longer. Respondents were of the opinion that these cases were not treated with the urgency they deserved because of the shortage of beds for young people generally and because these young people were at least being contained, even if the provision was inappropriate for their condition.

• Staff views echoed the frequent complaints in Inspection Reports about severely distressed and ill young people being kept in prison when they should be in hospital.
• Apart from causing distress, this situation had an adverse impact on other young people. Staff are less available for them when, for instance, two mental health nurses are needed to provide constant care and attention to one patient. There is the added problem of staff wasting time trying to find details of NHS and private hospital placements for mentally ill young people. A plea was made for the Department of Health to issue up-to-date information.

6.2.11 Children with learning disabilities

• Over half the sites specified learning disability (LD) among the mental health needs of young people in their sites.

• In interviews, respondents were clear that these were not mental health problems as such, but young people with learning disabilities were referred to them because of concerns over behaviour, self-harm or coping difficulties, or families were in contact with Healthcare or the MHIRT because they were worried about their children.

• The majority of sites, irrespective of whether they had raised this as a mental health need, expressed concerns about the presence of young people with LD in YOIs. In cases of more severe disability there was frequently-expressed incredulity that the young person had been brought before the court and that the YJB had chosen a prison placement.

• The main concerns were that these young people were not well supported in YOIs. Some were obvious targets for bullying. Where there were behaviour problems or extreme distress there was often little that staff in Healthcare or the MHIRT could do because they lacked skills and experience in working with their needs. In addition, there was little access to professionals qualified to diagnose and assess LD. And the diagnosis of possible mild LD was complicated by the fact that a young person may have spent long periods out of education.

• Some sites benefited from having RMNs with specialist knowledge, albeit gained from working with adults with LD. The few sites with speech and language therapists or educational psychologists found them helpful both with diagnosis and advising on or providing support. One site had attempted to get assistance with diagnosis and advice about appropriate support from the local learning disability team, but the team was overstretched and so unable to help.

• The overall and overwhelming view was that young people with learning disability should not be in a YOI.

6.2.12 Issues of identity

• In relation to mental health promotion, respondents were specifically asked what was available to support and enhance young people’s sense of identity. It was noticeable that very few written responses were given in relation to this section, and not much was added during interviews.

• One site referred to the use of specialist signers for deaf young people. All sites had access to interpreters but seemed to use them mainly in circumstances where young people spoke no English at all. A few sites
referred to the provision of halal food, and around half the sites spoke about having a multi-faith chaplaincy.

- Two sites referred to the particular problems facing young asylum seekers – of the depression and self-harm that sets in once they have survived the trauma of reaching this country, and of their isolation in custody. One of the sites spoke of its proactive attempts to bring together young people who spoke the same language.

### 6.2.13 Evaluating what works

- There has been very little formal evaluation of interventions for juveniles in custody. As a result, evidence about the effectiveness of different approaches is limited. Some staff expressed criticism of the lack of accredited programmes from the Youth Justice Board and the difficulty of getting approval for implementing programmes that had not been accredited. More widespread was the criticism about the dearth of programmes for work with sex offenders.

- Given the gaps that exist, staff with an interest in evaluation do what they can to find and use evidence – examples given were of browsing websites, dissecting NICE guidelines, and using the NIMHE report on interventions for personality disorder (NIMHE 2003).

- There is staff interest, too, in evaluating their own packages. The report from a new therapeutic services manager to the Head of Healthcare recommended the introduction of a formal evaluation process to monitor and record the effectiveness of the talking and creative therapies now available. Another site could point to fairly robust evidence of the effectiveness of its anti-bullying strategy, in that there was congruence from various perspectives – young people in exit interviews could describe the procedure well, complaints from parents showed a marked reduction in those about bullying, there were few bullying incidents reported in the last quarter from common bullying sites (especially the gym), and general acceptance among young people that bullying was neither cool nor acceptable.

- Outcomes for individual young people are also of interest, though evidence tends to be limited to informal feedback rather than pre- and post-course measurement using standardised scales. Some sites described feedback from trainees and staff, others mentioned positive feedback from psychologists to other staff at the closure of individual self-harm reports.

- There is staff interest in developing evaluation work, and a keen appreciation of the problems posed. A central question is about the purpose of intervention – is the wish to alleviate mental health problems, or to reduce the risk of re-offending, or both? Other issues are more practical: some interventions are hard to monitor because the desired outcomes are difficult to measure. The prison setting is problematic, too, given the difficulty of monitoring young people on the wings. On the other hand, some argue that a consistent approach from the range of staff linked to the young person might offer a better chance of success than for a young person living in the community.

- A final question is about applying lessons across settings. Local innovations may provide useful models for other sites to follow, though caution is needed
about assuming that lessons can be generalised. Hence the importance of sites conducting their own evaluations, to build up the knowledge base about what works and in what circumstances. Programmes that work in the general population may have relevance but these, too, will pose dilemmas when tested in the secure estate, especially those that rely heavily on family involvement.
REFERENCES


Brooker C et al (2002) This is a systematic review of the mental health literature, to inform the development of services for (adult) prisoners with mental disorders, in light of the 2001 DH Modernising Strategy. Department of Health.


Engage – the research study is due to be published in February 2006, with a national conference the following month (Johanna.Hilton@ssh-tr.nhs.uk). Engage is one of the partners in a new project (Choice in CAMHS) of the South Staffordshire Healthcare NHS Trust to extend user choice in CAMH services. The area covered by the project includes 3 YOIs – Brinsford, Stoke Heath and Werrington.


Hughes J (2005) (eds Miles A & McLewin A) Doing the Arts Justice – A Review of Research Literature, Practice and Theory. The Unit for the Arts and Offenders, Centre for Applied Theatre Research, University of Manchester. Commissioned by Arts Council England, the Department for Culture, Media and Sport, and the Offenders' Learning and Skills Unit at the DfES.


NCB – National Children’s Bureau (2005a) ‘Healthier Inside’: Key findings and recommendations from the first stage of NCB’s national development project focused on the health and well-being of young people in custody.


NICE (2000) Guidance on the use of methylphenidate (Ritalin, Equasym) for Attention Deficit Hyperactivity Disorder (ADHD) in childhood. For those up to age 16. For details of this, and of current work on a guideline for pharmacological and psychological interventions in children, young people and adults, see the NICE website www.nice.org.uk.


OHCS - Offender Health Care Strategies (2004) A review of CAMHS Provision Within the Young Offender Estate. OHCS (Emerson House, Albert Street, Eccles, Manchester M30 0BG).


YMCA – www.ymca.org.uk (prison work). See also YAA - www.ukyouthorg.uk.


YJB – Youth Justice Board (2004b) Substance Misuse and the Juvenile Secure Estate: A summary of the study of the prevalence and nature of substance misuse among young offenders in custody and the services available to them within custody and on leaving it. See website, above.
## APPENDIX 1 – THE STUDY SITES

<table>
<thead>
<tr>
<th>YOI name &amp; location</th>
<th>Boys or girls</th>
<th>No. of juveniles at time of fieldwork 1 Nov 04</th>
<th>No. of juveniles now 27 Sep 05</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ashfield</td>
<td>B</td>
<td>259</td>
<td>301</td>
<td></td>
</tr>
<tr>
<td>Brinsford</td>
<td>B</td>
<td>185</td>
<td>165</td>
<td></td>
</tr>
<tr>
<td>Castington</td>
<td>B</td>
<td>130</td>
<td>101</td>
<td></td>
</tr>
<tr>
<td>Feltham</td>
<td>B</td>
<td>274</td>
<td>216</td>
<td></td>
</tr>
<tr>
<td>Hindley</td>
<td>B</td>
<td>166</td>
<td>161</td>
<td></td>
</tr>
<tr>
<td>Huntercombe</td>
<td>B</td>
<td>278</td>
<td>314</td>
<td></td>
</tr>
<tr>
<td>Lancaster Farms</td>
<td>B</td>
<td>197</td>
<td>201</td>
<td></td>
</tr>
<tr>
<td>Parc</td>
<td>B</td>
<td>17</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Stoke Heath</td>
<td>B</td>
<td>177</td>
<td>168</td>
<td></td>
</tr>
<tr>
<td>Thorn Cross</td>
<td>B</td>
<td>36</td>
<td>8</td>
<td>The only open site</td>
</tr>
<tr>
<td>Warren Hill</td>
<td>B</td>
<td>183</td>
<td>171</td>
<td></td>
</tr>
<tr>
<td>Werrington</td>
<td>B</td>
<td>129</td>
<td>143</td>
<td></td>
</tr>
<tr>
<td>Wetherby</td>
<td>B</td>
<td>302</td>
<td>305</td>
<td></td>
</tr>
<tr>
<td>Bullwood Hall</td>
<td>G</td>
<td>20</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Eastwood Park</td>
<td>G</td>
<td>10</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Holloway</td>
<td>G</td>
<td>5</td>
<td>0</td>
<td>No longer used for juveniles</td>
</tr>
<tr>
<td>New Hall</td>
<td>G</td>
<td>34</td>
<td>39</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>2402</strong></td>
<td><strong>2346</strong></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX 2 – STANDARDISED ASSESSMENT TOOLS USED

The following standardised tools were mentioned by sites in questionnaire responses:

<table>
<thead>
<tr>
<th>TOOL</th>
<th>SITES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beck Depression Scale</td>
<td>3</td>
</tr>
<tr>
<td>CGAS – Children’s Global Assessment Scale</td>
<td>1</td>
</tr>
<tr>
<td>Conner’s Rating Scale (ADHD)</td>
<td>2</td>
</tr>
<tr>
<td>FACE - Functional Analysis of Core Environments</td>
<td>2</td>
</tr>
<tr>
<td>Grubin</td>
<td>17</td>
</tr>
<tr>
<td>HADS – Hospital Anxiety &amp; Depression Scale</td>
<td>1</td>
</tr>
<tr>
<td>Risk Assessment and Risk Management Plans</td>
<td>2</td>
</tr>
<tr>
<td>Sainsbury’s</td>
<td>1</td>
</tr>
<tr>
<td>SQUIFA and SIFA (2003) - mental health questionnaire</td>
<td>1</td>
</tr>
<tr>
<td>(SQUIFA) and interview (SIFA) tools that accompany</td>
<td></td>
</tr>
<tr>
<td>ASSET and are available on the YJB website</td>
<td></td>
</tr>
</tbody>
</table>

Note

The YJB is currently piloting a combined screening and assessment method and care pathway for use during a young person’s initial two weeks in custody. It has three parts – mental health, physical health, and substance misuse. The six pilot areas include four YOIs: Hindley, Feltham, New Hall and Wetherby.

“Development of a Combined Identification and Assessment Method for Mental Health, Physical Health and Substance Misuse of Young People in the Juvenile Estate”

Contact person louisecrompton@yjb.gov.uk
**APPENDIX 3 – GLOSSARY**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASSET</td>
<td>An assessment profile, completed by the YOT before a child’s court appearance, and intended to inform subsequent work, in and out of custody.</td>
</tr>
<tr>
<td>ADHD</td>
<td>Attention Deficit Hyperactivity Disorder</td>
</tr>
<tr>
<td>CAMHS</td>
<td>Child and Adolescent Mental Health Services</td>
</tr>
<tr>
<td>CBT</td>
<td>Cognitive Behaviour Therapy</td>
</tr>
<tr>
<td>CPA</td>
<td>Care Planning Approach</td>
</tr>
<tr>
<td>CPN</td>
<td>Community Psychiatric Nurse</td>
</tr>
<tr>
<td>CSA</td>
<td>Children’s Service Authority (introduced by Children Act 2004)</td>
</tr>
<tr>
<td>DBT</td>
<td>Dialectical Behaviour Therapy</td>
</tr>
<tr>
<td>FLO</td>
<td>Family Liaison Officer</td>
</tr>
<tr>
<td>F2052SH</td>
<td>The form opened when a juvenile self-harms or threatens self-harm or suicide (now replaced in some sites by the ACCT folder)</td>
</tr>
<tr>
<td>IMB</td>
<td>Independent Monitoring Board</td>
</tr>
<tr>
<td>LA</td>
<td>Local Authority</td>
</tr>
<tr>
<td>LASCH</td>
<td>Local Authority Secure Children’s Home</td>
</tr>
<tr>
<td>LD</td>
<td>Learning Disability</td>
</tr>
<tr>
<td>MHIRT</td>
<td>Mental Health In-Reach Team</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute for Clinical Excellence</td>
</tr>
<tr>
<td>NIMHE</td>
<td>National Institute for Mental Health in England</td>
</tr>
<tr>
<td>NSCAG</td>
<td>National Secure Commissioning Advisory Group</td>
</tr>
<tr>
<td>NYAS</td>
<td>National Youth Advocacy Service</td>
</tr>
<tr>
<td>OBP</td>
<td>Offending Behaviour Programme</td>
</tr>
<tr>
<td>OHCS</td>
<td>Offender Health Care Strategies</td>
</tr>
<tr>
<td>OT</td>
<td>Occupational Therapist</td>
</tr>
<tr>
<td>PMHW</td>
<td>Primary Mental Health Worker</td>
</tr>
<tr>
<td>PTSD</td>
<td>Post Traumatic Stress Disorder</td>
</tr>
<tr>
<td>RGM</td>
<td>Registered General Nurse</td>
</tr>
<tr>
<td>RMN</td>
<td>Registered Mental Health Nurse</td>
</tr>
<tr>
<td>SFMHS</td>
<td>Secure Forensic Mental Health Service</td>
</tr>
<tr>
<td>SENCO</td>
<td>Special Educational Needs Co-ordinator</td>
</tr>
<tr>
<td>STC</td>
<td>Secure Training Centre</td>
</tr>
<tr>
<td>VCC</td>
<td>Voice for the Child in Care</td>
</tr>
<tr>
<td>YJB</td>
<td>Youth Justice Board</td>
</tr>
<tr>
<td>YOI</td>
<td>Young Offender Institution</td>
</tr>
<tr>
<td>YOT</td>
<td>Youth Offending Team</td>
</tr>
</tbody>
</table>
APPENDIX 4 – STUDY QUESTIONS (as in the questionnaire)

SECTION 1 – current responses to mental health needs
Aim and content of each intervention
Who is the intervention, programme or service for?
Is it delivered in a group or one-to-one?
How long does it last (a) per session and (b) overall?
Which on-site staff deliver it?
Which visiting staff or organisation delivers it?
Is the intervention based on a standardised programme, and do you know of any research
evidence of its effectiveness?
How do you evaluate the effectiveness of the programme?
How much have you used this programme in the past 2 years?
Who is involved (a) in deciding on this approach and (b) in planning the intervention?

SECTION 2 - current provision for promoting good mental health
Please give a brief description of any of the following that you provide:
- An independent adult to confide in
- A befriending service
- An advocacy service
- To help young people manage their behaviour
- To help young people take part in decision-making
- To help young people engage in activities
- To help young people improve their self-care
- To improve their physical health
- To help enhance their sense of identity
- To continue with education or training now
- To help young people prepare for education, training, work later
- To help young people prepare for life after prison
- To help young people maintain relationships and contact with family and friends
- Specific work with parents, carers or other family members of young people
Do local primary care services and the local health promotion service have any involvement
with the institution in relation to mental health needs?
Does the local CAMHS have any involvement with the institution?

SECTION 3 - current assessment of mental health needs
Please list the range of different specific mental health needs that young people have when
they arrive at your site.
How do you identify which mental health needs each young person has?
What tool, if any, do you use to assess mental health needs?
If you do not use a too, do you have a standard format for recording needs?
For what proportion of young people do you have ASSET information at admission or later?
And/or do you rely on a clinical interview?

SECTION 4 – your achievements and aspirations
Are there particular mental health needs that you do well in addressing? Please explain.
Are there some needs where you succeed less well? Please explain.
Are there particular programmes, services, interventions that you run well? Please explain.
Are there some where you do less well? Please explain.
What mental health needs are you not able to provide for?
Are there some situations that you work best/least well in (eg. when the young person has
been with you for a long time, or is close to home)?
What else would you like to be providing, and what would it require for you to do so?
Do you distinguish in any way between young offenders who are under 18 and those you may
work with who are over 18? Please explain.

Please list details of staff member(s) who co-ordinated the completion of this questionnaire.
Please list details of any other staff member(s) or outside workers who contributed to the
completion of the questionnaire.