THE DERWENT INITIATIVE

promoting an inter-agency response to sexual offending

THE MENTAL HEALTH NEEDS OF YOUNG PEOPLE WHO OFFEND

January 2007

Registered Charity Number 1045502

THE DERWENT INITIATIVE

The Derwent Initiative (TDI) is an independent charity founded in 1993 which works to improve public protection, especially of children, by promoting joined up thinking about the problems of sexual offending. Working across all sectors and agencies, with professionals and non-professionals, it brings people together to identify and resolve problems with an ethos of mutual understanding and respect.

TDI uses its independent status to develop a comprehensive overview of the problems caused by sexual offending, to identify those issues where inter-agency working can produce results, to secure management support in general and agreement to particular developments, and to facilitate co-operation by professionals from the widest possible range of agencies and organizations in devising practical responses. It also plays a vital role in the implementation of plans and projects, making sure that communication is effective, that results are monitored and that new practices and working methods are supported and sustained.

Our strategic aims are:

- To identify gaps and problems
- To devise strategies for filing gaps and solving problems
- To implement solutions
- To monitor and evaluate solutions
- To ensure that changes in practice are enshrined in organizational structures

Based in Newcastle upon Tyne, but working throughout he UK, TDI offers consultancy, training, project design and a number of public protection programmes tailored to specific situations.

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Research Team

Research Director	Eric Wade	The Open University
Researchers	Ruth Andrews	Northumberland and Tyne and Wear NHS Trust
	Hilary Jupp	The Open University
	Mairi Spanswick	Northumberland and Tyne and Wear NHS Trust
	Susan Winfield	Independent Consultant
Administrator	Lynda Young	The Derwent Initiative

ACRONYMS AND ABBREVIATIONS

ADHD	Attention Deficit Hyperactivity Disorder
CAF	Common Assessment Framework
CAMHS	Child and Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CPN	Community Psychiatric Nurse
CYPP	Children and Young Person's Plans
DfES	Department for Education and Skills
DTO	Detention and Training Order
HASCAS	Health and Social Care Advisory Service
HAS	Health Advisory Service
JSEI	Juvenile Secure Estate Institution
LASCH	Local Authority Secure Children's Home
LDP	Local Delivery Plan
LSC	Learning and Skills Council
NORSCORE	Northern Specialised Commissioning Core Team
NSCG	Northern Specialist Commissioning Group
NSF	National Service Framework
OCD	Obsessive Compulsive Disorder
PCT	Primary Care Trust
PTSD	Post-Traumatic Stress Disorder
RAP	Resettlement and Aftercare Projects
SEN	Statement of Educational Needs
SHA	Strategic Health Authority
SIfA	Screening Interview for Adolescents
SNASA	Salford Needs Assessment Schedule for Adolescents
SQIfA	Screening Questionnaire Interview for Adolescents
STC	Secure Training Centre
TDI	The Derwent Initiative
UNCRC	United Nations Convention on the Rights of the Child
WHO	World Health Organisation
YJB	Youth Justice Board
YOI	Youth Offenders' Institution
YOT	Youth Offending Team

EXECUTIVE SUMMARY

The Derwent Initiative (TDI) has maintained an interest in the issues surrounding young people who sexually abuse since the inception of the organisation in the early 1990's. Earlier pieces of work have investigated the services available to young people who sexually abuse and TDI continues to focus two work programmes on young people and sexual offending, and on people with learning difficulties with sexually challenging behaviour, both within and without the criminal justice system.

This study, which has a wider brief than former TDI work, focussing as it does on the mental health needs of all young offenders rather than exclusively those with a history of sexual abuse, was initiated following an approach to The Derwent Initiative by Wallace Wilson, Regional Manager (North East), Youth Justice Board for England and Wales. Funding was provided by The Northern Rock foundation and the work has been carried out by a research team on behalf of TDI. The specific aim of this piece of work is to assist commissioning bodies within the health and youth justice systems by providing a clear picture of needs, priorities and gaps in current arrangements for meeting the mental health and learning disability needs of young offenders. Although the focus of this report was the North East of England, it is likely that lessons learned in this region will be transferable to other areas of England and Wales, and it is hoped that the findings may be of use to a wider audience.

The research for this report was carried out during 2005-6. The key tasks were:

- To identify the numbers of young offenders in the youth justice system in the North East of England who have mental health, learning difficulty and learning disability needs

- To describe the range of emotional and mental health problems in the target population
- To describe current mental health screening and assessment processes
- To identify what services are currently available to meet mental health or learning disability concerns and to describe interventions currently undertaken
- To identify gaps in provision or use of services
- To make recommendations to improve services to ensure that they more effectively meet identified needs.

Methodology

The report is divided into five sections:

1. Background and approach
2. Context of Research
3. Qualitative Research
4. Quantitative Research
5. Discussion, Conclusions and Recommendations

This reflects the methodology of the research which comprised four stages:

1. Formulative
2. Qualitative: semi-structured interviews were carried out with key stakeholders including youth offending staff, managers and staff within secure establishments throughout the North East of England
3. Quantitative: structured data collection was carried out with the co-operation of youth offending teams and secure establishments within the region. Data was collected in relation to 1814 open Assets on young offenders (1673 in YOTs and 141 in secure estates)
4. Analysis

Key Findings

As will be seen from a more detailed reading of the full report and the itemised findings listed therein, there are considerable and justifiable concerns within the youth justice field that the needs of young offenders with mental health or learning disability problems are not being met fully. At the end of each of Sections 1-4 key findings are set out.

In 86% of cases young offenders are involved with YOTs for less than one year and interviewees felt that this was often insufficient time for effective intervention with mental health issues.

26% of those in our study presented with a violent offence, against 14% of young offenders overall identified by Youth Justice Board statistics.

Many of the generic workers in YOTs and the secure estate expressed uncertainty about the technicalities of mental health issues and valued the support of mental health professionals in their teams. They often felt more comfortable in using an informal referral route for intervention. There was a unanimous call for training on mental health issues and working across agencies.

Perhaps unsurprisingly, the research demonstrates many complex individual and social factors amongst this target group of young offenders. 35% of the group had complex family up-bringing, rising to 64% in the secure estate. 50% of the group had substance misuse problems, rising to 63% in custody. 65% of young offenders with mental health concerns were also formally identified as vulnerable (defined in Asset as “the possibility of the young person being harmed – either physically or emotionally”) rising to 69% in secure establishments, but worryingly, in 21% of cases it would seem that secure establishments do not know from the Asset form whether a young person in their care is vulnerable or not.

The identification and definition of learning disability and special educational needs continues to be problematic. Overall, 33% of young offenders with a mental health concern have been identified as having special needs, but only 24% were identified because they had a Statement. In the community 30% were identified as having special needs, but 20% had a Statement. This suggests that the completion of the Asset alone does not necessarily provide adequate identification of special educational needs. Indeed, it became apparent that most YOTs in the region were not identifying learning disability.

When it comes to mental health problems, only 15% of the report's sample had a formal mental health diagnosis, the largest category being Attention Deficit Hyperactivity Disorder (ADHD), but a far higher proportion of the sample were considered by the professionals working in the field to have mental health concerns. In the YOTs, 52% and in the secure establishments 90% of young offenders were considered by professionals to have formally undiagnosed mental health issues. Irrespective of whether there was a diagnosis 46% did receive some intervention. The report's findings certainly suggest a considerable amount of non-clinically diagnosed mental health needs, which can generally be related to interventions at second and third tier.

Amongst the YOTs and secure establishments in the region, a variety of screening and assessment tools are in use, with varying degrees of thoroughness, ranging from partial screening to identify past psychiatric interventions and risk of suicide or self-harm, to full mental health assessment where indicated by initial screening or for young offenders committed to longer sentences. However we were re-assured that when screening and assessment was being undertaken more YOTs were using some form of structured screening and assessment than was reported to us in the early stages of our research.

The findings of the report suggest that there were inconsistencies in both type and application of screenings. There was also ambiguity around the definitions of tiers relating to interventions. Both are causes for concern. As

an illustration 53% of those young offenders identified by staff as having a mental health concern were not screened. Of these some refused or disengaged, and some were sentenced to secure provision. In one secure unit no automatic screening for mental health problems is carried out, although there is an informal system by which members of staff with concerns about an individual may request a screening process.

Overall 38% of young offenders in YOTs with identified mental health needs were having their needs met and 73% in the secure estate. 69% of community based interventions are carried out by a mental health worker, with a figure of 46% in the secure estate.

Next Steps

TDI will disseminate this report in both printed and electronic forms to commissioners, providers and practitioners within the North East of England, and further afield on demand.

A workshop for commissioners will be held in the region at the end of March 2007, at which support will be sought for the report's recommendations, and will also address TDI's continuing interest in young offenders who sexually offend

TDI will continue to engage in research and project creation in relation to young people who sexually offend.

Key Recommendations (see detail at end of full report)

1. a strategic and integrated approach to the development of primary and specialist mental health services for young people, and within it young offenders, across all tiers.
2. a partnership approach including health, children's services, criminal justice agencies and voluntary agencies
3. a regional commissioning strategy for CAMHS covering all four tiers
4. one regional commissioner for tier 4 services
5. forensic services to sit within the overall commissioning strategy
6. a framework for other commissioners such as PCTs
7. much closer working between YOTs and JSEIs and CAMHS and Children's Trusts and NHS Commissioners at a strategic and local level
8. promote and formalise pro-active information sharing and dialogue between agencies, providers, commissioners and users
9. revise and rationalise screening and assessment processes to identify mental health and learning disability needs to take account of identified inadequacies
10. in the interim, identify a minimum core dataset relating to each young person to aid commissioning
11. a communication strategy to ensure the effective use of information between YOTs, health services and secure estate
12. review and revise regional structures for strategy, training and development for practitioners and decision makers and ensure accountability of each group is defined
13. research and resolve the causes of reluctance amongst young offenders to engage in screening and assessment processes
14. create a widely based regional strategy group tasked with undertaking the above recommendations
15. identify and resource a strategic leadership post to address gaps in provision relating to learning disabilities within youth justice

SECTION 1

1. Background and Approach

1.1 Introduction

This research study was undertaken by The Derwent Initiative at the request of the Youth Justice Board, North East England, and funded by The Northern Rock Foundation.

1.2 Background

1.2.1 In 2005 the Regional Manager, Youth Justice Board (YJB), North East England, identified the need to audit the current arrangements for the provision of mental health screening, assessment and treatment of young offenders in the region and to explore provision for young offenders with learning disabilities.

1.2.2 The YJB places 'a high priority on meeting the mental health needs of young people at risk of re-offending as part of its statutory aim to prevent offending'. (Dimond et al, 2004). The Youth Offending Teams (YOTs) are the practitioner bodies responsible for carrying out this policy.

1.2.3 The Youth Justice Board's mandate to meet the mental health needs of young offenders "partly overlaps with the role of mental health staff ….. who are bound to provide for the mental health of young people." (Dimond et al, 2004)

1.2.4 The work of the YJB and Health Services are frequently and necessarily intertwined and the relationship between the two is examined in this report.

1.2.5 They carry out their work within a wide framework including policy-making, strategic and legislative bodies, all of which impact upon their activities. These are also identified within this report.

1.2.6 For the purposes of this study young offenders were defined as young people aged 10-18 in contact with Youth Justice services. This differs from definitions of young offenders elsewhere (e.g. in the secure estate where those aged 10-18 are referred to as juveniles and those aged 18-21 are termed young offenders).

1.3 Geographical and Demographic Scope

1.3.1 The research project is based within the North East Youth Justice region which contains 13 Local Authorities, 11 Youth Offending Teams and 4 secure establishments. Each YOT is co-terminus with its local authority area (except the South Tees team which covers two local authorities) within a total population area of 2,539,000 (see Appendix A).

1.3.2 At the time of writing there were two SHAs operating over this region, County Durham and Tees Valley SHA and Northumberland, Tyne and Wear SHA

In July 2006 these two SHAs were combined into a single strategic health authority – NHS North East.

1.3.3 The four Juvenile Secure Estate Institutions (JSEI) for young offenders in North East England are:

- Aycliffe Young Persons' Centre (Secure Services)
- Castington Youth Offenders' Institution (YOI),
- Hassockfield Secure Training Centre (STC),
- Kyloe House, Local Authority Secure Children's Home (LASCH).

1.3.4 They each operate under contracts from the National Youth Justice Board and provide approximately 240 beds, (North East Youth Resettlement Framework for Action, 2005, p. 5). Young offenders from the North East account for the bulk of the young offenders in these four establishments, but offenders from further afield are also located in the north-east.

1.3.5 The core population and the number of offences are set out in the table below.

SHA	**Population 10-19[1]**	**Offences[2]**
1	178,890	12,665
2	174,939	8,340
Total	353,825	21,005

Key: SHA 1 = Northumberland,Tyne and Wear
SHA 2 = County Durham and Tees Valley
[1] Data derived from 2001 Census
[2] 2004-5

It can be seen that while the population covered is roughly equal over both areas, more (20.6%) offences were identified in SHA 1 than SHA 2. Owing to the scope of this research study we do

not explore the differences in offending between the two strategic health authorities.

1.3.6 The population of 10 to 18 year olds within this region is 266,893. (source 2001 census**).** For a full demographic and offence breakdown of the region see Appendix A.

1.3.7 This report provides data on the 1814 young offenders aged 13-18 in contact with Youth Justice Services between ***November 2005 and January 2006***

1.4 Aims and Objectives

1.4.1 The main purpose of the study was to audit the present arrangements for identifying and meeting the mental health and learning disability needs of young offenders in order that the commissioning bodies in Health and Youth Justice have a clear picture of needs and priorities.

1.4.2 The objectives directed to fulfilling this aim were to :

i) identify the numbers of young offenders in the youth justice system in the North East with mental health, learning difficulty and learning disability needs;

ii) describe the range of emotional and mental health problems in the target population;

iii) describe current mental health screening and assessment processes;

iv) identify services available to meet the needs of young offenders with a mental health or learning disability

concern and to describe interventions currently undertaken;

v) identify gaps in provision or use of services;

vi) make recommendations to improve services to ensure that they more adequately meet the mental health and learning disability needs of young offenders.

1.5 Methodology

1.5.1 The Research Study was divided into four phases:

- Formulative
- Qualitative – through semi-structured interviews
- Quantitative by structured data collection
- Analysis

1.5.2 The methodological approach was founded on the belief that much was to be gained through talking to the people who work with young offenders at an operational level and to the people working at a managerial level, tasked with implementing youth justice and health policies. Throughout the year-long research period, discussions were held with key stakeholders.

1.5.3 To meet the aims of the research project it was decided to gather hard quantitative data to supplement the rich qualitative data which would be gained through conducting semi-structured interviews.

1.5.4 So far as possible, those with knowledge of mental health issues for young offenders across both YOTs and the secure establishments were involved in shaping these two aspects of

enquiry. It was established that all of the contact (essentially this is information taken to complete the *Asset,* the YJB assessment tool*)* that professionals have with adolescent offenders is required to be recorded on the YOT database (either Careworks or YOIs). Health and mental health professionals similarly record the outcome of assessments and any subsequent action.

1.5.5 The research team considered that it would be appropriate to request YOTs assiduously to record processes of mental health screening, assessment and intervention during a three-month period so that we would have a complete dataset of their model of service provision. Guidance was provided and discussed with YOTs prior to the data collection period. Discussions with secure establishments led to adaptations of this procedure.

1.5.6 Consideration was given to engaging with young offenders during the course of the study and it was decided to assess this at the point when base-line data were being analysed.

1.5.7 Plans to set up the qualitative phase with a mental health support group, made up of mental health workers from the youth offender services representing key interests, did not materialise, and in order that no more time was lost, the research team decided that the project would have four phases:

1.6 Phase 1 - Formulative

1.6.1 This began with a literature search, agreement as to the terminology of the mental health problems to be examined and an analysis of the legal and policy frameworks surrounding the work of the YJB. At least one meeting with each of the eleven YOTs and each of the four JSEIs was held. A letter of introduction setting out the scope of the research was sent to each YOT manager followed up with a telephone call to set up individual meetings. The letter explained the strands to the data collection process and that the meeting was to discuss what data would be readily available**.** (see Appendix B).

1.6.2 These initial meetings were short and informal. In the majority of cases we met with the YOT manager or his/her deputy, or with the mental health or general health worker. In each case, staff were very helpful and agreed that the quantitative data collection (as outlined on the information and guidance sheet – see Appendix D) seemed feasible. Dates were also agreed for the follow-up, semi-structured qualitative interviews

1.6.3 The meetings in the secure estate were scheduled towards the end of this phase in order to build in information gained from the initial interviews in the YOTs and to adapt the interviews accordingly.

1.7 Phase 2 - Qualitative

1.7.1 Drawing on the information gained during the formulative phase and following Harrington & Bailey (2005), an interview guide was designed. The semi-structured interview was divided into three main areas: current experience, knowledge and service

structures. Thus, questions were formulated to allow respondents to discuss screening, assessment and referral processes, the nature of mental health or learning disability needs, interventions, inter-agency relationships, training and service structures.

1.7.2 The interview was designed to be conducted with someone at managerial level in the YOT, a generic case manager and the health/mental health worker. It was felt that much of the interview would be appropriate also for interviews with relevant staff in the secure establishments. (see Appendix C for copy of interview guide).

1.7.3 The nature of the semi- structured interview facilitated a flexible approach so that themes which emerged could be pursued, while at the same time ensuring that as far as possible the areas identified in the schedule were covered at some point.

1.7.4 This phase was not without difficulties which were similar to those encountered in phase 1 because of scheduling meetings with individuals in extremely busy organisations. When the meetings took place they were invariably positive. We found that staff gave generously of their time and provided invaluable information. The findings from this phase are detailed in section 3 of our report.

1.7.5 This phase was completed by 3rd February 2006

1.8 Phase 3 - Quantitative

1.8.1 The aim of this phase was to translate the quantitative data that was being collected into a structure which could be analysed to enable the aims of the research project to be realised.

1.8.2 The specific requirements for the collection of the relevant information were drafted and shared with members of the North East Mental Health Strategy group. We sought information, to be collected over a 3 month period, on the total numbers of cases (individuals aged 12 and 18) within the YOTs, then an individual breakdown in relation to numbers screened, assessed, and referred, together with the nature of mental health and learning disability needs and the extent to which needs were or were not met.

1.8.3 The original time scale was to collect the data over a three month period from September to December 2005. Other burdens on the YOTs meant that this timetable had to be adjusted. The majority of YOTs completed the process during the period 1st November 2005 to 31st January 2006. This resulted in some slippage in the project's intended completion date. (see Appendix D for a copy of the Quantitative Data Guidance). The requirements were adapted to meet the different circumstances of the secure establishments.

1.8.4 YOT managers through their information officers gave full co-operation. The mental health workers faced difficulties in that the information they gather from the young people they see is not stored on the same system or in the same format as the other information from *Asset*. All YOT managers were written to in January to confirm the data collation process (See Appendix

E). The research team's assistant psychologist devised a template to convert the data into an analysable format and made regular contact with YOTs to support them in this procedure. Similar information was sought by auditing information held in the various locations of the secure estate. (See Appendix F for a copy of the template).

1.8.5 Our findings from this phase are detailed in section 4 of the report.

1.8.6 A final cut off point for the return of the data was set at 31st March 2006. All but one YOT and one secure establishment met this deadline. This phase was completed by 31st March 2006.

1.9 Phase 4 - Analysis

1.9.1 Since the end of March the research team has been considering the data from both phases 2 and 3 and preparing our findings. We returned to the issue of the involvement of young offenders in the research study. Although still attracted to this approach we concluded that it could not properly be addressed during the limited time available. To the data analysis section we have added our discussions and recommendations. This phase is detailed in section 5 of our report.

1.9.2 This phase was completed by 26th June 2006.

1.10 Comments on research methods issues

1.10.1 The Quantitative Data Collection Guide appeared to provide sufficient information to meet the needs of the research and was piloted with one or two YOTs during the qualitative phase. However, it emerged that there were some difficulties for YOT staff in collating the data from the *Asset* with health data. (Appendix D).

1.10.2 The design of the standardised template facilitated the analysis of the data that had been collected. (Appendix F).

1.10.3 During the process of the research study, it became clear that additional information about risk and vulnerability would be invaluable. The template allowed participants to provide more information of this sort. However, those who collected the data found the process time-consuming.

1.10.4 There was some ambiguity around information required in certain columns in the template, for example, Learning Disability Action; Mental Health Problem Identified (no discrimination between mental health issues with/without psychiatric diagnosis); Other Mental Health Category; and Intervention Type. It was felt that a series or list of Yes/No/Don't Know would have enabled standardised and comprehensive responses.

1.11. Key Findings

i) Our early discussions at this formulative stage across the various organisations and also across the community and secure sectors of youth justice, gave us clear evidence that there were different definitions and perspectives of the mental health needs of young offenders and how they could be met.

ii) Carrying out our work across two strategic health authorities (now 1 but 2 at the time of our investigations), 13 local authorities and 11 YOTs, it was soon clear that there were differences between organisations in their collection and use of information. This was why we decided to design our own data collection process.

iii) As far as the data collection process was concerned, despite meetings held and written confirmation being sent from the research team, followed up with telephone calls, there was evidence of lack of communication within YOTs about the research project and the need for and type of data collection.

SECTION 2

2. Context of Research

2.1 Introduction

2.1.1 This section looks at the definitions of terms used in identifying different aspects of mental health, the estimated prevalence of mental health problems in the youth offending population and discusses the legal and policy frameworks surrounding the work of the YJB.

2.2. Definitions

2.2.1 It is recognised that how young people come to be defined as young offenders has shifted over time, just as definitions of juvenile crime vary according to prevailing political models. For the purposes of this research, young offenders are taken to refer to young people aged between 10 and 18 years in contact with the youth justice system.

2.2.2 In order to achieve clarity on what is meant by mental health difficulties, it is useful to highlight initially how *mental health* has been defined. The World Health Organisation (WHO) offers a broad definition: 'Mental health is not simply the absence of mental disorders and the absence of mental disablement (i.e. impairments, disabilities and handicaps) but is also the mental and social well-being of the individual'. Further research has sought to specify major components of mental health, (Warr, 1987; Uestuen, 1998).

2.2.3 In relation to the mental health of children and young people, the Health Advisory Service defines the following developmental capacities:

- to develop psychologically, emotionally, intellectually and spiritually;
- to initiate, develop and sustain mutually satisfying personal relationships;
- to be aware of others and to empathise with them;
- to overcome psychological distress

(taken from YJB Key Elements of Effective Practice – mental health, 2003)

2.2.4 It is common for a variety of terms covering mental health needs and issues to be used interchangeably and it is clear that varying interpretations of behaviour and experience can impact on interactions with adolescent offenders. Furthermore, framing problems in terms of needs can lead to an expectation that these will be met.

2.2.5 Here we define broad categories of emotional and mental health difficulties.

i) A clinically diagnosed *mental disorder* is a persistent and severe pathological psychological process typically associated with distress and/or with interference with personal functions. Social deviance or conflict if found in isolation, without personal dysfunction, is normally excluded from mental disorder diagnosis.

ii) *Mental illness* refers to a small subgroup of severe disorders such as severe depression or schizophrenia.

iii) The term *mental health problem* describes emotional or behavioural difficulties that are less severe than mental disorder. Following Hagell (2002) a mental health problem is indicated by 'a level of symptoms of mental ill health that have led to impairment in day-to-day life'.

Iv) *Learning difficulty* reflects **specific** cognitive impairment (or a **specific** problem in, for example, attention, memory, understanding, expression). It is often related to educational difficulties which may be the product of bio-psycho-social factors.

v) *Learning disability* involves **significant global** impairment of cognitive and adaptive/social functioning.

2.3 Prevalence

2.3.1 There is a considerable body of literature exploring the characteristics of adolescents who offend. Within this literature there is general agreement that young offenders experience a range of problems. These include mental illness, substance abuse, family discord, and difficulties with education including school exclusion, poor levels of attainment and low cognitive abilities (Harrington and Bailey, 2005; Nicol et al, 2000). Studies which focus on identification of risk and protective factors associated with offending behaviour have tended to locate these within family, school, community, individual/peers without explicitly acknowledging the incidence of mental health issues (Armstrong et al, 2005).

2.3.2 Whilst there is variation in the estimated incidence of mental health difficulty identified in a number of studies, for example, 31% in the Harrington and Bailey study; 95% in Lader et al (2000), there is much agreement that rates of mental health problems are at a higher level than in the general population, perhaps three times as high (Hagell, 2002). It is suggested that these different estimates are an artefact of differing methodologies, sample size and the populations being considered (Hagell, 2002). The recent report into health needs at HMYOI Feltham noted that 60 – 70% of young offenders were using drugs and 70% experienced two mental disorders (Edwards and Halley, 2005).

2.3.3 There has been less research into the incidence of learning difficulties and learning disabilities within the young offending population. Studies considering both significant impairment of cognitive and social functioning (required to fulfil diagnosis of learning disability) are rare. As a result, various prevalence figures are discussed in the literature, ranging to almost 32% (Raynor et al, 2005). Most recently, Harrington and Bailey (2005) examined the mental health needs of young offenders in both the community and custodial services of youth justice in England and Wales, and reported that 23% of adolescents met the criteria for Learning Difficulty in terms of IQ (<70), and a further 36% had an IQ in the Borderline Learning Disability range (70-79). This estimate was determined by an abbreviated measure of IQ. This study did not consider measures of adaptive functioning.

2.3.4 Ford, Hardingham et al (2006) (unpublished) sought to evaluate a Learning Disability screening tool (the Hayes Ability Screening Inventory). Although the study provided a poor estimate of prevalence owing to sampling biases, it stands alone in assessing cognitive and adaptive functioning.

2.3.5 Harrington and Bailey found that *Asset* completion in youth offending teams was variable and that only 15% of young people were identified with mental health problems through completion of *Asset* forms, about half of those identified by them using the Salford Needs Assessment Schedule for Adolescents (SNASA).

2.3.6 The Youth Justice Board's national standards relating to prison service secure institutions instruct that '…staff must undertake a reception interview within one hour of the offender's arrival that assesses the offender's needs and level of vulnerability' (YJB, 2004 para 11.3). However, Goldson's research reports that the reality of reception practice can be far removed: 'More often than not …. I don't really interview them properly at all…' (Goldson, 2002). It is suggested that lack of mental health training and a focus on immediate serious risk concerns may contribute to the likelihood that mental health difficulties will be missed. It is also acknowledged that new inmates may not be amenable to assessment on reception.

2.3.7 Encouragingly, a mental health screening tool is being piloted for the youth justice secure estate (Durcan, 2006).

Lord Carlile's recent inquiry into the treatment of children in penal custody commented not only on the inappropriate use of restraints but also on the lack of appropriate exercise facilities:

'The lack of exercise and daylight would seem to me to contribute to depression and conflict amongst adolescents'. (Howard League for Penal Reform Press Release, February 2006).

2.4 The Legislative and Policy Frameworks

2.4.1 The United Nations Convention on the Rights of the Child (UNCRC) was ratified by the UK Government in 1991 and set out 'principles and detailed standards for the rights of children, the care of children, laws, policies and practices which impact on children, and for formal and informal relationships with children.' (Goldson 2004).

2.4.2 This section provides a brief summary of relevant aspects of the major piece of legislation that led to the development of the 'new' youth justice, the Crime and Disorder Act (1998). We then refer briefly to the introduction of key legislation relating to children and young people. In then briefly outlining the Youth Justice Board's general assessment framework and how that relates to the particular role of child and adolescent mental health services, we aim to acknowledge potential challenges for youth justice services in meeting the mental health needs of young offenders within the framework of a system which is required to intervene at an individual level in order to change offending behaviour.

2.4.3 The Crime and Disorder Act (1998) established the Youth Justice Board of England and Wales to promote national and local measures to prevent offending. The Act required local authorities to create Youth Offending Teams (YOTs), each YOT consisting of, on a statutory basis, 'representatives from social services, probation, police, health and education

authorities.' (Muncie 2004, p. 274). YOTs now also include representatives from drugs and alcohol services, and may include housing officers.

i) The statutory duty of YOTs is to 'prevent offending by children and young people'. To achieve this principal aim, professionals adopting an inter-agency approach are required to abide by the six key objectives of the Youth Justice Board:

1. the swift administration of justice.
2. confronting the young offenders with the consequences of their offending.
3. intervention to tackle the particular factors (personal, family, social, educational or health) which put the young person at risk of offending and which strengthens 'protective factors'.
4. punishment proportionate to the offence.
5. encouraging reparation to victims by young offenders.
6. reinforcing the responsibilities of parents.

(taken from Crime & Disorder Act 1998: Framework document)

ii) These objectives emphasise themes of punishment, reparation and responsibility (YJB for England and Wales, 1999). The impetus for much work undertaken in Youth Offending Teams comes from the Referral Order, the standard sentence imposed on children and young people who have been convicted of an offence for the first time. This order came into being with the passing of the Youth Justice and Criminal Evidence Act, 1999.

iii) It should be noted that this Government has introduced an enormous amount of legislation in the criminal justice field for professionals and practitioners to grapple with.

iv) Increasingly also, youth offending teams work with children younger than 10 years who have been identified as 'at risk of offending'.

v) Somewhat paradoxically, the creation of *multi-agency* Youth Offending Teams has served to distance youth justice services in England and Wales from mainstream child welfare services.

vi) Youth Offending Teams are managed locally and tie into local authority crime reduction and community safety strategies. It is argued that these structures, along with the objectives of the Youth Justice Board referred to above, may bring with them tendencies to regard young people as offenders first, rather than, say a pupil with educational problems or a patient in need of health services (Drakeford & McCarthy, 2000).

vii) Nationally, youth justice services are no longer part of 'the Department of Health's portfolio or more latterly The Department for Education and Skills (DfES) ' (Goldson & Muncie 2006 p 215).

2.4.4 However, it is the DfES which is coordinating the 'Every Child Matters' agenda.

i) The Government's "Every Child Matters: Change for Children" (2004) is underpinned by the Children Act 2004

and aims to prioritise health, education, social care and justice so that 'every child, whatever their background or their circumstances' has the support they need to:

- be healthy
- stay safe
- enjoy and achieve
- make a positive contribution
- achieve economic well-being

ii) Local authorities are setting up Children's Trusts to focus on these five outcomes. Children's Trusts will have a key role in commissioning services for children and young people, and in supporting services through multi-disciplinary teams located in extended schools or children's centres. (www.everychildmatters.gov.uk).

2.4.5 Although youth offending teams sit outside the remit of the Department for Education and Skills, youth justice personnel will be required to develop statutory Children and Young Persons' Plans (CYPPs) and to describe how joined-up services will be provided.

2.4.6 In its publication 'Sustaining Success' the Youth Justice Board provides a protocol framework for YOTs for the promotion of the 'provision of mainstream services to meet the needs of young people' and it also states that YOTs 'must plan in advance with Children's Services the rehabilitation and resettlement process for children and young people leaving custody'. (NE Youth Resettlement Framework for Action, October 2005).

2.4.7 The Youth Justice Board has recently commissioned a research study by the National Children's Bureau to investigate relationships between YOTs and Children's Trusts.

2.4.8 The Every Child Matters agenda represents a much more integrated approach to children's development requiring that all agencies work together to enable children to achieve their potential. Therefore the YJS, with its focus on offending behaviour, may have to resolve tensions between potentially conflicting objectives.

2.4.9 However the YJB *Asset* assessment framework does take a holistic approach to a young offender's life and recognises positive and negative features (protective and risk factors).

2.5 Assessment

2.5.1 The primary assessment tool used by YOTs in England and Wales to inform their work with young offenders, the *Asset* is a structured method applied to "all young offenders who came into contact with the criminal justice system". The aim of *Asset* is "to look at the young person's offence and to identify a multitude of factors and circumstances – ranging from lack of educational attainment to mental health problems – which may have contributed to such behaviour". Information should be used to assist intervention programmes, to address needs or difficulties, and to help "measure changes in needs and risk of re-offending over time". (www.yjb.gov.uk)

2.5.2 Completion of *Asset* also includes assessing general health (section 7) and emotional and mental health (section 8), where a score of 2 or more leads to a specific mental health screening tool and where appropriate, to a comprehensive mental health assessment.

2.6 Mental Health

2.6.1 We have already noted in the introduction that part of the Youth Justice Board's statutory aim to prevent offending includes meeting the mental health needs of young people at risk of re-offending and that this objective 'partly overlaps with the role of mental health staff …. who are bound to provide for the mental health needs of young people…' *(Dimond et al, 2004)*

2.6.2 In 1995 The Health Advisory Service (HAS) introduced a model to address the mental health of children and adolescents identifying services ranging from primary care services to highly specialist services. These Child and Adolescent Mental Health Services (CAMHS) are commissioned by Primary Care Trusts (PCTs) and operate within a four-tier framework.

Tier 1 — A primary level of care in which non-specialist Staff (e.g. GPs, school nurses, youth justice workers) identify mental health problems; offer general advice, treatment for less severe mental health problems; promote mental health and work to prevent mental health problems.

Tier 2 — Service provided by uni-professional groups, relating to others through a network (e.g. clinical child psychologists, community nurses, educational psychologists, YOT mental health workers). Referred to as CAMHS professionals, they offer training and consultation; outreach to identify complex needs; assessment which may trigger treatment in this tier or another.

Tier 3 A specialist CAMHS service for more severe, complex and persistent disorders. Professional groupings include clinical psychologists; occupational therapists; child and adolescent psychiatrists; social workers; community psychiatric nurses; child psychotherapists and child adolescent psychologists. The service offers assessment, treatment and referrals to Tier 4. It also contributes to training, services and consultation at Tiers 1 and 2.

Tier 4 Essential tertiary services for adolescents who are severely mentally ill or at suicidal risk. These more specialist CAMHS include forensic out-patient teams assessing risk and offering offence-specific treatments; services for young people with learning difficulties, and in-patient units including secure forensic units.

2.6.3 In the narrow sense, CAMHS refers to services provided by multi-disciplinary teams working within NHS Trusts (psychologists, nurses and other therapists working with child psychiatrists assessing and intervening into behavioural, emotional and psychiatric difficulties). In the broader sense, CAMHS has come to refer to all services which address the mental health needs of children and adolescents. This encompasses preventative and mental health promotion services from the NHS, as well as assessment and intervention services from within the local authority and voluntary and independent sectors. Comprehensive CAMHS, therefore, require effective partnership working both at a local level and at a regional level to ensure comprehensive and consistent

commissioning and development across a wider geographical area.

2.6.4 The two previous Strategic Health Authorities (SHAs) covered in this report both have regional strategies for CAMHS. They also hold considerable information about referral patterns and interventions.

2.6.5 Nationally there has been significant investment in CAMHS social and health care. Budgets for expenditure on CAMHS rose by 19% nationally from 2004/5 to 2005/6. This growth in resources is reflected in an 8% increase in cases nationally and an 11% increase in the total number of staff employed in CAMHS teams over the same period. (NCAMHS Mapping Exercise 2005, figs. 1.4, 1.5, 1.6). National policy development includes the target for every PCT to have a comprehensive CAMHS by December 2006 with a 10% increase in staff and resources to achieve this. All eight CAMHS partnerships across the current sixteen PCTs in the North East (16 reducing to 12 on 1st October 2006) have a local CAMHS strategy prioritising their spend and action plan. Youth Offending services are stakeholders within those local strategies. Local strategies should feed into the SHA-wide strategies.

2.6.6. There are varying arrangements for CAMHS activity across the country, from a range of generic teams to targeted teams, dedicated worker teams and tier 4 teams. Dedicated worker teams are fully trained CAMHS professionals who are out-posted in teams such as YOTS. In 2005 there were no such teams in the County Durham and Tees Valley SHA; in the Northumberland, Tyne and Wear SHA there were six dedicated worker teams, two of which were identified in a Youth Offending Team, one in Education, one in Primary Health, one in Social

Services and one in Other. It is difficult to draw any significant conclusion about resourcing arrangements from this data. (NCAMHS Mapping Exercise 2005 fig. 2.3b).

2.6.7 Standard 9 of the National Service Framework for Children, Young People and Maternity Services (2004), which addresses mental health needs, states that:

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

(Standard 9, CAMHS, NSF for Children, Young People and Maternity Services, DoH, October 2004).

2.6.8 Ten 'must-dos' are listed, although for the December 2006 deadline only **three** proxies are essential:

- **availability of 24/7 services**:
  From the NCAMHS Mapping Exercise 2005 the position then was that in County Durham and Tees Valley SHA out of the two CAMHS services, one provided exclusive on-call and the other provided next working day appointment. In Northumberland, Tyne and Wear SHA with six CAMHS, four provided on call (and in two of those this was exclusive CAMHS on call) and in two there was next working day appointment". (NCAMHS Mapping Exercise 2005 fig. 2.6).

- **availability of services for 16-17 year olds:**
  In County Durham and Tees Valley SHA there were nine teams offering specialist services for 16/17 year olds and eighteen teams in Northumberland, Tyne and Wear SHA, however there was a range of different teams from generic to tier 4. No more detailed information about use of those services was available. (NCAMHS Mapping Exercise 2005, fig 2.7b).

- **access to learning disability CAMHS:**
  In the 2005 mapping data there was evidence of strong growth in the number of services providing specialist provision for children and young people with both learning difficulty and mental health problems, but care is needed in interpreting the data as some services may only be accessing provision through a partnership arrangement with another trust. In Northumberland, Tyne and Wear there were four CAHMS providing specialist services and two with no specialist services; in County Durham and Tees Valley there were two specialist services (NCAMHS Mapping Exercise 2005, 2.8a).

2.6.9 Tier 1 to 3 CAMHS are provided in PCT localities; Tier 4 services are provided by acute or specialist NHS Trusts across all the localities. Because of the complex nature of commissioning and provision of Tier 4 services there is a risk that they may not be effectively integrated with the provision of locally delivered tiers.

2.7. General

2.7.1 NORSCORE (an SHA-wide commissioning group for the very specialist, small volume areas of work such as Tier 4 CAMHS) is reviewing current arrangements with a view to improvements. At the same time HASCAS (Health and Social Care Advisory Service) has been commissioned to produce a report on the future requirements at Tier 4, and has been working with all stakeholders (including Youth Offending Services) to give a wider than health perspective to what is needed. Their draft report was delivered to NHS North East in July 2006.

2.7.2 This report identified areas of concern around:

- Poor access to tier 4 services in an emergency
- The large gap in the therapeutic interventions available within tier 4 services and those in tier 3
- The lack of reliable information about the tier 4 services and the outcomes achieved, and the lack of clear specifications about the services to be provided
- Limited input from service users about their experiences of the services

The constraints faced by the providers of tier 4 services were recognised around the severe limitations of premises no longer fit for purpose, case-mix problems in a poor environment, services having been developed by providers which met need but which had not been formally commissioned, and the difficulties in dealing with several commissioners.

For the purposes of our report the first recommendation is key:

PCTs should agree that one commissioner across the North East (and North Cumbria) will take the lead in commissioning CAMHs tier 4 services and equivalent services for children and young people with a learning disability. This single commissioner should work closely with those commissioning tier 3 services and local authority partners to further the other recommendations in the Review.

One other of the 10 recommendations is of particular significance to our work:

The single commissioner should work with tier 4 providers and commissioners and providers in tier 3 to develop clear pathways/protocols of admission and discharge between the tiers. They should also work collaboratively on the interventions/therapies to be available based on best practice and the outcome data and other information to be routinely collected and on future plans for increasing tier 3 and tier 3+ services.

2.7.3 National guidance states that delivery of comprehensive CAMHS should be addressed within the children's policy agenda under the auspices of the local Children and Young People's Strategic Partnerships. However, PCTs as commissioners are responsible for leading the process (CAMHS Guidance 2004). Financial allocations are identified within each PCT's Local Delivery Plan. Nationally, significant investment has been made to CAMHS with direct allocations to both local authorities and PCTs with guidance that funding should be pooled to support joint planning and development. Such

allocations can be vulnerable at times of financial constraints in either organisation. However, local allocations to CAMHS are monitored through the LDP process by SHAs in their performance management role. Against a national increase of 19% in the CAMHS budget, County Durham and Tees Valley was predicting a 22.8% increase between 04/05 and 05/06, and in Northumberland, Tyne and Wear the predicted increase was of 13.4% [NCAMHS Mapping Exercise 2005, Table 3.1]. There is a large variation between the spend per child. In 04/05 in County Durham and Tees Valley it was £43 and in Northumberland, Tyne and Wear it was £65 against a national figure of £46.33 (op.cit Map 3.3).

It was beyond the scope of this study to explore how such resource translates into provision for young offenders with mental health and learning disability needs.

2.7.4 With learning disabilities it seems that progress is not so robust, with some PCTs only at the stage of having plans to develop access to CAMHS for those with learning disabilities. Nationally, clinical pathways are being developed to assist local development and the possibility of a regional network to share good practice has been suggested.

2.7.5 As stated before, Youth Justice Board Standards already include a requirement for young offenders to have access to appropriate levels of Child and Adolescent Mental Health Services. However, the processes through which this is achieved have taken some time to develop.

2.7.6 Nationally there was an increase of 9% in the number of teams specifically targeting support for young offenders (NCAMHS Mapping Exercise 2005, fig. 1.3e). 5% of the total national

CAMHS caseload was young offenders. In County Durham and Tees Valley the young offenders caseload was 4% of the total in the area, and in Northumberland, Tyne and Wear it was 8% (NCAMHS Mapping Exercise, Table 2.10 by SHA).

2.8 Key Findings

i) Different definitions of mental health problems affect the approach of different organisations towards recognising and assessing mental health needs of young people and subsequent intervention. This inevitably impacted on our work and added to the complexity of the issues we addressed.

ii) Working with young offenders with mental health needs is not the responsibility of any one organisation; their differing organisational structures, priorities and targets create a variety of tensions and made it difficult to carry out this study. We wondered if this also impacted on the functioning of the youth justice services. As noted before, statutory duties require a focus on offending behaviour., yet there seemed to be no overview regarding young offenders with mental health issues. On a number of occasions we were surprised to learn of other studies or activity in the region directed nationally which was relevant but not widely known. At a national level there needs to be some attention paid to how these various activities are co-ordinated and communicated. There seemed to be no overview regarding young offenders with mental health issues.

iii) It is encouraging that there are a range of national initiatives and funding directed to improve children's services in general and the delivery of mental health services to them in particular (e.g. Children's Trusts and NSF for Children, Young People and Maternity Services). However, it will require significant work across local organisational boundaries to produce effective whole systems implementation of these developments.

SECTION 3

3. The Qualitative Research

This section of the report summarises key findings from the semi-structured interviews. An initial short interview with the YOT manager or mental health worker was followed up with a longer interview based on an interview schedule provided in advance (see Appendix C). The research team sought to interview the YOT manager, a generic case worker and the mental health worker. It emerged that in some cases poor communication within YOTs resulted in information about the requirements of this research study not being passed on to relevant staff.

Interviews were carried out in the secure estate with the manager and where possible, with relevant mental health or social work professionals.

3.1 Staff Working with Young Offenders with Emotional, Mental Health and Learning Disability Problems in the Youth Justice System

3.1.1 As previously stated in this report, all YOTs include a statutory representative from health services. The eleven YOTs in North East England have at least one health worker or mental health worker. Other staff who may undertake such work with adolescent offenders include case managers and substance misuse workers. (YOTs vary in their use of titles: YOT officer/case manager/worker, mental health worker/adviser etc.)

3.1.2 In some cases the health professional works within the YOT and has links with the local CAMHS (and forensic CAMHS services); in some cases the health professional is based at the CAMHS with links into the YOT. In one instance the health professionals

are clinical psychologists. In the other YOTs the health professional is a qualified nurse, in some cases a mental health specialist, in other cases a general nurse, often with additional mental health qualifications, including postgraduate qualifications in the health or criminal justice field.

3.1.3 Where YOTs have a general health worker there tends to be a greater emphasis on ensuring that all young offenders referred to them receive an automatic assessment of general physical health. All YOTs are required to have a substance misuse worker on the team, and often this post is occupied by a nurse.

3.1.4 There is less clear provision for those with learning disabilities or learning difficulties. However, at least three of the YOTs have a member of staff with some background of working with learning disabled individuals.

3.1.5 In the secure estate nursing staff will assess and address the general health needs of the young people in their care. There are professionals on site who can address psychosocial needs where these are identified, to some extent. This is with the exception of Kyloe House where support is provided via tier 4 services and staff at Kyloe. Criminogenic needs are addressed to some extent via this tier 4 inreach programme. At Castington YOI there is community psychiatric nurse (CPN) provision for dealing with emotional and mental health problems, partly by an inreach programme and partly by staff working within the institution.

3.1.6 The secure establishments have staff and departments to address substance misuse.

3.1.7 Castington YOI employs one nurse with learning disability qualifications. All providers receive a mental health but not learning disability assessment service via the regional tier 4 (Forensic CAMHS) provision. At Kyloe and Aycliffe all young people receive a mental health screening via this inreach service.

3.2 Health Issues

3.2.1 Many young offenders have poorer physical health than the general population (Bardone et al, 1998; Anderson et al, 2004), and there are other health-related factors which may impact on their mental well-being. Substance misuse is a prominent feature; it frequently co-exists with one or more mental health problems (Millin et al, 1991; Riggs et al, 1995, Rutter et al, 1998).

3.2.2 In the interviews YOT and secure estate staff commented on the majority of young offenders having emotional difficulties; they suggested that many of these are related to early damaging experiences, including physical or sexual abuse, social deprivation and neglect.

3.2.3 They gave examples of young people experiencing mental illness such as clinical depression and psychosis. They said learning difficulties and learning disability were not well detected or differentiated.

3.2.4 They referred to the presence of a number of the following:

Anxiety; depression; self harm; Attention Deficit Hyperactivity Disorder (ADHD); 'conduct' disorder; impulsivity; attachment problems; grief; habit disorders, e.g. substance misuse; autism

spectrum disorders; Post-Traumatic Stress Disorder (PTSD), eating disorders.

3.2.5 In more than one instance they reported that increasing numbers of young persons are presenting with ADHD and that there are difficulties in accessing appropriate treatment.

3.2.6 However, there was no confirmation about how many of these experiences and behaviours had been clinically diagnosed.

3.3. Use of *Asset*, SQIfA, SIfA, Tracking and Referral Procedures

3.3.1 Asset

i) As previously identified, *Asset* represents the initial point of formal assessment when a young person enters the youth justice system, that is, when the individual comes into contact with a worker from their youth offending team, (Youth Justice Board, 2000). This section focuses initially on comments about use of *Asset* in the community.

ii) *Asset* is generally perceived as a valuable assessment framework: useful if completed fully and accurately for seeing the distance travelled, offering a measure of progress. It is also perceived as being a good tool for the assessment of risk, particularly in terms of reoffending behaviour.

iii) It is however cumbersome and bureaucratic: An *Asset* must be completed at the start, midway through and at the end of an order for each individual. Indeed, it is reported that *Asset* completion is seen as secondary to completion of the Pre-Sentence Report and this also

affects attitudes towards the *Asset* form. Additionally, it is a requirement that a new *Asset* must be completed when any substantial change has occurred in the circumstances of the adolescent offender (e.g. breach of order).

iv) These demands can lead to the practice of 'cloning' *Assets,* meaning that the End *Asset* is no different from the Start *Asset* and therefore the necessary reviewing process does not actually update the information held about a young person. Whilst it is understood that pressure of work can be the cause of this, it was acknowledged that it is problematic to base interventions on inaccurate information: including the current emotional or mental health state of the young person. In interviews, YOT managers referred to plans or strategies for overcoming problems of 'cloning'.

v) Scoring on *Asset* sections is subjective and idiosyncratic. Whilst we were told that some teams' meetings establish nonetheless that a considerable level of agreement exists regarding assessment of individuals, it was admitted that professionals' judgements about a young person's needs sometimes resulted in manipulation of scores. This was usually done in order to ensure that a young person received additional attention, for example, further assessment leading to a useful plan of working with the individual. (see Baker et al, 2005, p. 6 where it is stated that 'YOT staff may be allocating ratings on the basis of perceived problems rather than the extent to which these were associated with a likelihood of further offending'.) However, it does suggest that the *Asset* form may not be sufficiently sensitive. Moreover, with regard to accurate

and reliable screening for mental health need, research elsewhere suggests that the experience and awareness of the worker would be a significant factor (Hagell, 2002). Harrington & Bailey, (2005) concluded that *Asset* screening under-estimated the level of mental health need in their sample. They also attributed levels of unmet need in their study to inadequate screening.

vi) Experienced case workers typically take account of information provided via a range of sources to inform completion of all sections of *Asset*, including section 8: Emotional and Mental Health. However, the view was also expressed to us that there is some difficulty around scoring section 8 particularly. This is explained in terms of the nature of the topic – leading to diffidence or embarrassment. The concern is that this may lead to an emotional or mental health difficulty being missed which should be subsequently screened for.

vii) Crucially, learning disability is not specifically asked about in any section of *Asset*. However, learning difficulties are asked about in the Education part of the form: section 3, in respect of a Statement (SEN) and in respect of literacy and numeracy.

viii) The 'What Do You Think?' section on *Asset* is seen as valuable for gaining relevant information from the young person and for involving the young person in the general assessment process.

3.3.2 SQIfA

i) The next stage in the process regarding identification of mental health problems is completion of the SQIfA, the Youth Justice Board's mental health screening tool, designed to be completed by general YOT workers, (this was suggested to be largely case managers) where a score of 2+ has been generated from completion of section 8 on *Asset*.

ii) The questionnaire, entitled The Mental Health Screening Questionnaire Interview for Adolescents, asks young people about behaviours, thoughts and experiences deemed to be problematic. It addresses 8 areas : Alcohol use, Drug use, Depression, Traumatic experiences (PTSD), Anxiety/Excessive worries/Stress, Self harm, ADHD/Hyperactivity, Psychotic symptoms. (Youth Justice Board: Effective Practice In-Service Training Tutor Pack: mental health).

iii) We were told that in the main this form is not liked although some YOTs do use it as a means of identifying mental health problems. In other cases, health/mental health workers may provide an alternative screening tool.

iv) SQIfA was perceived as being problematic on a number of counts.

v) The process is mechanistic; there is a focus on identifying acute/urgent issues, leading to other problems being missed. The questions are too direct and may be seen to be threatening to the young person and to the officer administering the questionnaire.

vi) Whilst section 8 in *Asset* asks about, for example, eating/sleep disorders, grief, sadness, and Obsessive Compulsive Disorder (OCD), the SQIfA does not follow through with these issues.

vii) The list of disorders, conditions and experiences in SQIfA omits some other commonly found problems, for example, enuresis, anger, sexual/physical abuse, autism spectrum disorder, sexual identity, relationship problems and learning disability.

viii) Perversely, there is some repetition of issues that are routinely asked about in another section of *Asset*. For example, alcohol and drug use are asked about (in the context of anger, depression and anxiety) and these are covered in section 6 of *Asset*. Their inclusion in the SQIfA also indicates the acceptance of these experiences as signifying a mental health problem.

ix) The inconsistencies identified bring into question the value of the questionnaire as an effective screening tool.

x) Mostly, the preferred practice amongst YOT staff we spoke to for achieving a mental health assessment was to express a concern to the health/mental health professional in the team. This was largely perceived as appropriate, though there were also concerns that the introduction of health professionals into YOTs serves to fuel fears amongst general staff around uncovering mental health problems. This can lead to a dependence on 'experts'. Moreover, case managers under pressure to proceed with cases speedily can place unrealistic

demands on the shoulders of, often, a single health worker. Some YOT health and mental health professionals felt that general staff have too high expectations of their role.

xi) YOTs varied in the extent to which robust mechanisms were employed to track the outcomes of screening and assessments. Some YOTs placed much emphasis on routine auditing of *Assets* at a managerial level; in other YOTs, health workers took it upon themselves to track back through *Assets* and to check non-referrals. The Youth Justice Board does require YOTs to undertake quality assurance self–assessment exercises, including for mental health, looking at issues of assessment, communication, service delivery, training, management, service delivery etc. as part of its Key Element of Effective Practice processes. (YJB 2003)

3.3.3 SIfA

i) The SIfA is the Youth Justice Board's mental health assessment tool. It is based on the Salford Needs Assessment Schedule for Adolescents (S.N.A.S.A.), and it is designed to be completed by specialist health or mental health professionals where a young person has scored 3/4 on SQIfA. The SIfA addresses the same areas as the SQIfA with a greater number of follow-up questions.

ii) In all cases we were advised that this assessment interview schedule is not used on its own; the majority of health workers used either an adaptation of SIfA which they have constructed themselves, or abandoned it

entirely relying on assessment forms from CAMHS. The SIfA was found to be narrow and unimaginative; there was a preference to use CAMHS-type assessments partly as it was felt these would be accepted more readily when seeking referrals to CAMH specialist services.

3.4 Screening and Initial Assessment in the Secure Estate

3.4.1 At present the secure establishments do not complete an *Asset* form: they rely on the *Asset* coming with the young person. 'Secure establishments who do not receive an *Asset* on the reception of a young person must follow this up with the YOT concerned within one hour, and must treat the young person as at risk of self harm until the information is received'. (YJB, 2004, National Standards, para 10.11). Baker et al (2005, p. 66) refer to the usefulness of an initiative 'being piloted and/or evaluated by the YJB, such as the *Asset* Sentence Management Project, which facilitates the use of *Asset* by the secure estate as the basis for sentence planning…'

3.4.2 The secure establishments reported that in almost one hundred per cent of cases young people arrived with an *Asset*; however, it may be incomplete, thus not reflecting an up-to-date picture of the individual.

3.4.3 As Harrington & Bailey (2005, p. 21) point out '… reliance on past assessments also fails to reflect the changing needs of young people.'

3.4.4 Furthermore, and worryingly, it was reported in Castington YOI that there were instances of inadequate completion of the Indicators of Vulnerability section in *Asset* leading to a possible misrepresentation of a young person's mental state at a time when they could be most vulnerable, either just having been

received into custody or transferred from another custodial establishment.

3.4.5 All adolescents should be screened on arrival at a secure establishment to identify issues of immediate concern such as likelihood to self-harm or risk of suicide. There will be a follow-up health assessment although this does not necessarily entail a mental health assessment in all establishments.

3.4.6 Learning disability is not part of initial screening processes although learning difficulties may be picked up if there is evidence of previous CAMHS engagement or a Special Educational Needs (SEN) Statement.

3.4.7 Young people may be referred to a mental health professional (CPN, psychologist or psychiatrist) where a need is identified. For example at Castington YOI there is general healthcare provision and mental healthcare input via CPNs from 9-5, Monday to Friday. It is possible to refer to in-reach CPNs provided by the tier 4 forensic service and also to Forensic Child and Adolescent Psychiatry. It is also possible to seek clinical psychology opinions. There is a Forensic Psychology department within the YOI, but this does not provide mental health input per se. Referral to appropriate services, can, however, be ad hoc.

3.5 Assessments, Interventions and Referrals

3.5.1 As noted, there are differing views and practices on the use of YJB standard screening and assessment tools and the accuracy of scoring. The general view amongst the health professionals attached to YOTs was that the young person's needs are paramount, and actual scores are irrelevant. Thus, it was

believed that any concern will be taken seriously. This is not the same as saying that no mental health problems are missed. Views were expressed by some that all young people should be screened and, if necessary assessed, for the presence of emotional, mental health or learning disability problems. This of course has resource implications at each stage of the process, not least when interventions are considered.

3.5.2 Health and mental health workers reported that they ensure young persons are assessed and referred within the YJB timescales (see Appendix A), however performance targets do not measure the time taken to access services following assessment, where it was reported that delays can occur because CAMHS operate a waiting list system. It appears that the usual waiting lists for CAMHS fall well outside YJB targets.

3.5.3 Following assessment by health workers interventions are put in place where required. As a principle, it was felt that rather than adopting a 'scattergun' approach, it was necessary to seek to meet a young person's needs and respond to statutory duties through considering first what is 'doable'. In many cases it was recognised that the presence of emotional, learning difficulty, learning disability, substance misuse or mental health problems would hinder the development and effective use of offending behaviour programmes.

3.5.4 Thus in devising intervention plans, many case managers embraced welfare imperatives as well as taking account of requirements to work on reducing offending behaviour. *(see Muncie 2004).*

3.5.5 Generally, consultation takes place between relevant staff, led by the case manager assigned to the young person's case, to draw up an intervention plan.

3.5.6 Prioritisation of health and mental health concerns was seen to be a valuable way of developing motivation and willingness to engage on the part of young people, which can have positive effects more broadly. However, it was recognised that lack of engagement affected work on meeting mental health needs too.

3.5.7 It was reported that in some cases the young person would decline intervention from the YOT mental health worker but would be willing to undertake therapy through voluntary organisations or Children's Services.

3.5.8 It was felt that there may be a role for general mental health promotion, that is, raising awareness of the importance of mental HEALTH amongst young people.

3.5.9 We were told of much liaison and effective cooperation amongst health workers and substance misuse workers to devise appropriate in-house interventions or to refer to other relevant agencies, including voluntary sector organisations, for suitable programmes.

3.5.10 Health workers reported the implementation of an eclectic mix of interventions, depending upon the particular problems identified. The interventions included motivational work, problem-solving approaches, anger management work, cognitive behavioural therapy (CBT), family and individual psychotherapy. The majority of interventions to meet the needs of young offenders with emotional or mental health problems were classed as tier 1 and 2. Where learning difficulties (based on low IQ scores)

were identified – perhaps through lack of education – programmes could be adapted.

3.5.11 Middlesbrough (South Tees) YOS reported receiving support from the Learning and Skills Council (LSC) for young offenders with special educational needs.

3.5.12 The qualifications, experience and particular expertise of the health and mental health workers in YOTs had some bearing on the extent to which they comfortably undertook interventions at tier 3. It was also the case that health professionals felt under some pressure to work at this level and this is partly because there was ambiguity about differences between Tier 2 and Tier 3 working. Also, under-resourcing, heavy workloads and waiting lists in CAMHS were given as reasons for health workers attached to YOTs being expected to carry such caseloads.

3.5.13 With regard to clinically diagnosed learning disabilities, serious mental health difficulties or serious offending behaviour linked to mental health problems, referrals are made to specialist services.

3.5.14 On the basis of assessments and understandings about tiers of services, health workers confidently refer appropriate cases. Where health workers were also members of the local CAMHS team referrals may be to themselves and programmes would be put in place, working at tier 3.

3.5.15 Alternatively, good links with relevant clinicians often led to fast-tracking of urgent cases. Generally, we were advised that acute cases received timely intervention. In several cases, Learning Disability Services linked to CAMHS were identified as being

available, although as already noted, initial identification and formal assessment can prove difficult.

3.5.16 There continued to be issues in some YOTs where health professionals found that CAMH services were less than helpful. There were examples given where criteria were employed which appeared to serve to exclude certain cases, on relatively flimsy grounds; or where it was believed that certain categories of young people (e.g. looked after) were privileged over young offenders; or where cases were referred back, following assessment, to the YOT where apparently no intervention had been given and no suggestion for how to proceed was made; or, frequently, the rigidity of appointments systems failed to take account of the chaotic lives of young offenders and their families. It was reported that psychiatrists might close cases if appointments were missed. YOT health workers reported the practice of physically accompanying young people to CAMHS appointments. It was thought that waiting lists for non-acute cases affected motivation to engage; past experiences may also have contributed to disaffection with services.

3.5.17 Referrals to forensic CAMHS were few in number and judging the appropriateness of such referrals to these tier 4 services was usually straightforward. There could still be problems however in ensuring that seriously troubled and troublesome young people were seen without delay, or were dealt with in line with the judgement of YOT staff. Examples were quoted where YOT staff identified severe need, yet referrals met the response that YOTs could cope. Delays were mostly connected with the necessity to gain access to confidential information outwith the YOT before clinicians would consider cases. YOT staff were put in vulnerable positions themselves when managing the care of such vulnerable young people.

3.6 Assessment and Interventions in the Secure Estate

3.6.1 Assessment and interventions within the secure estate are no less complex. At Castington YOI, the forensic psychologist primarily works on offending behaviour, addressing thinking skills and impulsivity, and does not offer therapy or routine assessment to meet emotional and mental health needs. However, there are two and a half CPN posts offering interventions, to address problems such as anxiety, stress and depression, addressing tier 1 and 2 needs, although, as mentioned earlier, lack of mental health awareness and ad hoc referral processes raise concerns that such needs are not always met. It was reported that between January and March 2006, 69% of referrals were assessed by CPN staff. Around 10% were not subsequently seen due to, for instance, completion of order or transfer. However, 20% were not seen because the young people were not retained on the wing for this purpose.

3.6.2 There is a referral route for tier 4 problems; these are picked up by a visiting psychologist/psychiatrist. The education department carries out literacy and numeracy assessments as part of the young offender's induction and may identify learning difficulties, although they do not feel competent to identify specifically what these might be. The lack of a learning disability screening tool, assessment, and treatment service means that this need is not met.

3.6.3 Of the secure establishments, Aycliffe, Kyloe and Hassockfield employ the most structured and holistic approach to assessment and intervention. Multi-disciplinary meetings involving social work, education, psychology and health staff determine how best to meet the needs of young persons.

3.6.4 At Aycliffe the keyworker takes responsibility and interventions may include work on reasoning skills and social skills.

3.6.5 The social worker role was central at Hassockfield. Responsibility was in the Social Work Department for the development of the care plan and also for carrying out interventions which address pscho-social needs.

3.6.6 The resident psychologist at Hassockfield worked on offending behaviour needs. Where mental health needs were identified, visiting CPNs carried out interventions, largely around coping strategies.

3.6.7 Relationships with the Regional Forensic CAMH service (tier 4) for handling more serious problems were deemed to be good; there is a good response to requests for services and support.

3.6.8 Whilst in general agreement with this experience, a concern was expressed by Aycliffe in a case where a female with a history of self harm was thought to be dealt with too slowly by the processes employed at the Kolvin Unit, and the psychotherapy treatment offered was considered likely to be ineffective as the young person was due to be released within a fortnight.

3.6.9 At Hassockfield we were told that there can be difficulties in finding appropriate educational space for supporting young persons with learning difficulties who need one to one attention.

3.6.10 Aycliffe, Hassockfield and Kyloe House reported that inadequate resources hamper their ability to respond to the existence of emotional and mental health problems amongst all of the young people they look after.

3.6.11 At Kyloe House, there is no facility for specifically screening for learning disabilities although the initial education assessment may pick up certain difficulties relating to literacy, numeracy and behaviour.

3.6.12 The tier 4 service provides input to address the mental health needs of YJB cases at Kyloe, however there is no specific input to address learning disability need. Staff carry out personal development work to address psychosocial need but it was emphasised that owing to the impact of low salaries on recruitment, new staff need to be trained to meet need.

3.6.13 The secure establishments reported concerns about receiving an increasing number of seriously disturbed young people who display high levels of aggressive behaviour and about their ability to manage them. They also reported that this group's mental health needs often approach but do not meet the criteria for admission to medium secure mental health provision, and therefore they are left within the establishment.

3.6.14 A summary of qualitative information regarding mental health provision and processes within the secure estate is shown in a tabular form (see Appendix G).

3.7 Training and Supervision

3.7.1 All of the eleven YOTs were given training on the use of SQIfA, the mental health screening questionnaire when it was introduced in 2003 (see Harrington & Bailey 2005).

3.7.2 There are rolling programmes of training provided for YOT staff covering different aspects of their work with young offenders, including updating on mental health issues.

3.7.3 Furthermore, it was clear that health staff and substance misuse workers undertake excellent local training on relevant issues, raising awareness of colleagues about mental health conditions and also providing information for the purposes of identification of mental health difficulties and/or substance misuse symptoms.

3.7.4 YOT management and health staff believed that upskilling general staff in the sphere of mental health, substance misuse and learning disability is a continuous and essential process,

3.7.5 Mental health professionals in some YOTs reported offering support to case managers or sharing cases with them where there was a substantial level of mental health difficulty, yet it was not identified as a predominant need of the young person..

3.7.6 In some YOTs there was a system of 'surgeries' for case managers to take mental health cases to the health professional for consultation and discussion.

3.7.7 Mental health workers reported that supervision is provided by CAMHS (or Child and Family Units attached to CAMHS). They are given opportunities to discuss cases on a regular basis to decide on appropriate action. Further, a regional forum organised and run by health and mental health workers working in the youth justice system, meets regularly; it is not clear if this interest group is in a position to report on issues discussed there to the North East Mental Health Strategy Group or to affect change. Health workers also reported receiving supervision from YOT operational managers.

3.7.8 Secure estate staff have limited access to training in mental health awareness, identification of mental health conditions, or implementation of appropriate interventions. Additionally, as suggested earlier, it was reported that staff would like to be better supported in the management of difficult young people.

3.8 Relationships Amongst Secure Estate and Community Services

3.8.1 This section refers particularly to transition arrangements where young offenders arrive in secure establishments and also on their subsequent return to the community.

3.8.2 Generally, YOT health staff reported that there is a need to reinvigorate protocols for ensuring that important information about a young person's emotional and mental health state reaches the appropriate department on arrival at Castington Young Offenders' Institution.

3.8.3 YOTs reported that there have been difficulties in contacting relevant staff, difficulties with how best to send confidential health information with the young person and lack of confidence about such vital information being passed on from main reception to the appropriate department.

3.8.4 Encouragingly, YOT staff advised us that good progress is being made to improve procedures and relationships.

3.8.5 YOT staff confirmed attendance at the planning meetings held in secure services to review interventions and to prepare the young person for return to the community. It was not clear the extent to which this included identifying continuing work on the

mental health needs of the young person. Such meetings may or may not include the health professional; this partly depends on which establishment the young offender is held in.

3.8.6 With regard to continuity of care, the secure estate encountered some problems with ensuring satisfactory care from social services, mental health services and the youth offending service when the young person leaves the establishment. This experience appears to compare with Harrington & Bailey (2005) who found that transitions between services were associated with poor communication between professionals, leading to young people missing out on necessary assessments. The North East Youth Resettlement Framework for Action (2005, p. 8) also commented that 'effective transfer of information between YOTs and the children & young persons' secure estate is currently an area of weakness.' Furthermore, whilst Resettlement and Aftercare Projects (RAP) operate in some YOTs, funding is not universally provided, leading to some YOTs feeling disadvantaged (NE Resettlement Framework for Action, 2005).

3.8.7 All of the secure establishments sent on community plans, i.e. recommendations about the needs of the young person but reported that they receive little information about the young person's progress on return to the community.

3.8.8 Hassockfield and Aycliffe were piloting processes to seek feedback post release from their establishments. However, these projects seemed to be operating in isolation and it could be that a regional approach to this would be of benefit.

3.9 Key Issues arising from the Qualitative Research

3.9.1 Fears Around Mental Health

There was a concern amongst some YOTs that fears can be aroused in generic staff during completion of section 8 in *Asset,* (and thus potentially the screening thereafter for mental health problems), that do not exist when addressing other sections of *Asset.* It was believed that staff may be unnecessarily concerned at not having specialist mental health experience or qualifications. It was argued however by health and mental health workers that these are not required for completion of the mental health screening questionnaire.

3.9.2 Training

i) YOT staff identified the need for continuing training programmes to demystify concepts of mental illness and learning disability to support staff in order to reduce fears and to raise confidence around handling emotional and mental health problems. Suggestions were made that general health, mental health and learning disability should automatically be screened and assessed for in every individual. It was also recognised that inability to provide appropriate services following assessment could have detrimental effects on young people.

ii) Whilst every YOT benefited from staff development workshops provided by its health or mental health workers, YOT staff would welcome more specialist input from CAMHS where much expertise could be put to good use. Clinicians could assist YOTs with understanding the nature of tier 3/4 interventions There were requests to

continue raising awareness about mental health issues – generally, and not just related to offending. There were requests for training on specific effective interventions that would lead to more provision being delivered within YOTs. There were requests for more resources to be provided to YOTs to improve mental health services generally, for example, specialist clinicians (psychologist/psychiatrist) working within YOTs.

iii) The secure estate made similar requests for more training to support staff and for actual input – more availability for assessment and support with interventions from forensic CAMHS

3.9.3 Relations with CAMHS

Notwithstanding some local difficulties, the majority of YOT mental health workers and YOT management staff have established good working relationships with CAMHS. The impetus has come from the YOTs with the introduction of health professionals. Previously, it was common for YOTs to be advised to go through the GP to access CAMHS for young offenders. Where YOTs are represented at CAMHS groups at strategic level, there are generally positive feelings about how the referral procedures and service level agreements operate.

A key message was that YOTs would like more input, greater flexibility and a quicker service from CAMHS.

3.9.4 Targets

Whilst views were expressed that reliance on performance measures reflects a narrow approach which needs to be balanced with a focus on quality of service to meet needs, it was

also felt that YJB targets are useful and needed – rapid responses are helpful to meet needs of young people and to encourage engagement. Therefore it was felt that effort should be put into addressing waiting lists at CAMHS.

3.9.5 Trends

i) The move towards changing terminology in some YOTs, e.g. Youth Engagement Services for example in Durham, and Community Safety Partnership in Darlington, seems to reflect recognition in some cases that the remit and brief of Youth Offending Services is increasingly wider than preventing and reducing offending. This is demonstrated in early intervention initiatives which encompass social inclusion goals. Early intervention may also highlight mental health problems at an earlier age and some YOT health workers found that they were dealing with younger people, i.e. below the age of 10.

ii) A view was expressed that engaging with young people at risk of offending may also lead to their criminalisation, particularly when associations are made with Youth *Offending* Teams. It is known also that current practice in the criminal justice system is to use more and more custodial sentences.

iii) However, engaging earlier with perceived 'vulnerable' young people reflects the desire that it could be possible to lower the numbers of young people the UK imprisons. Whilst custody numbers have 'flatlined' since 2002 - 'a credit to youth justice workers' (Morgan, 2006) – Rod Morgan, chair of the Youth Justice Board, is keen to reduce numbers, standing at 2,746 in May 2006. This will require more pre-court solutions to youth crime,

suggesting a greater input from 'agencies responsible for young people in the community'.

iv) Morgan identifies difficulties for 'the one-third of young prisoners with mental health problems' who need to be transferred out of prison into health facilities - owing to the health service funding crisis.

v) Efforts to meet the mental health needs of younger people in the wider community context can only have positive effects.

vi) The Extended Schools Service and the emergence of Community CAMHS reflect a commitment in Sunderland to work across boundaries, developing a model that fits well with a broader-based approach. Complex cases are discussed and shared across services.

vii) At the same time, the nature of disposals was questioned by some staff in the secure estate. It is believed that many young persons can receive care that generally improves their health and education, suggesting clear benefits to some secure provision. It was felt that secure care should not necessarily be seen as the last resort – as a 'residual repository for the containment of profoundly disadvantaged children' *(Goldson 2004 in Fink J ed (2004)).*

viii) The length of sentences such as Detention and Training Orders (DTOs) can militate against effective work with young persons in secure establishments where perhaps only two months of a sentence may be spent in custody.

ix) It was felt by a number of YOTs that mental health needs should be approached much as substance misuse is currently addressed; the drugs service appears to be more responsive and adaptable than CAMHS. Moreover the 'Key Indicators of Quality' identified in the Youth Justice Board's Key Elements of Effective Practice Quality Assurance booklet (2003) appear to indicate that more structured, formal and robust support mechanisms should be in place with regard to substance misuse. The indicators of quality delineated for mental health are less prescriptive

3.10 Key Findings

i) There was general agreement amongst individual workers from different professional backgrounds that young offenders exhibit emotional, social or familial problems, any of which might have a mental health component. There was uncertainty about what amounts to a significant mental health concern requiring intervention.

ii) The presence of a specified mental health worker within a YOT provides support to other workers, facilitates identification of need, provides advice and training and does seem to facilitate access to CAMHS.

iii) There is an acute shortage of staff with specific training and skills in learning disability either in the YOTs or the secure estate.

iv) Screening and assessment processes were being used although workers we talked to found the YJB tools

throw up too many problems to be useful. However, other tools, often designed and/or used by CAMHS, were the alternatives. Workers did not always use tools (*Asset,* mental health screening or assessment) in a dynamic way to monitor change over time.

v) There is no validated screening or assessment tool for learning disability routinely in use within the youth justice system. In secure settings other systems are in place.

vi) The preference of many workers in both YOTs and the secure estate was to use an informal referral to the mental health worker to assess someone. This inevitably results in incomplete data at the screening and assessment stage. The needs of an individual offender might be missed or the needs of one young person might be prioritised in an ad hoc manner over the needs of another.

vii) Where mental health provision was "bought in", usually within the secure estate, it did seem to offer a service which the purchaser was content with although all of the institutions we considered believed there were gaps in provision at one tier or another.

viii) Insufficient data was being shared between relevant bodies. Where data was being communicated it was likely to be incomplete. Without accurate sharing and transfer of data it is not possible to ensure comprehensive commissioning and provision of services.

ix) Everyone we spoke to emphasised how important training was to them, particularly to equip them with some understanding of mental health issues, inter-agency responsibilities and appropriate referral mechanisms. They felt that all of these played a part in making them more confident in their approach to working with young offenders.

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SECTION 4

4. Quantitative Research

4.1 This section summarises some key findings from nine of the eleven YOTS working in the community. Illness amongst staff at the time of the study prevented us from obtaining quantitative data from Gateshead YOT, and similarly Durham Youth Engagement Service was unable to supply a complete data set. Three of the four secure establishments supplied us with data for this study.

Table 1 illustrates the overall figures for data collected during the period November 2005 through to end January 2006. Data was collected in relation to 1,814 open Assets on young offenders (1,673 in YOTs and 141 in secure estates). 18% of these indicated a mental health concern, and out of these 47% had their mental health needs met, 35% did not have their needs met.

4.2 Demographic Data

4.2.1 Basic demographic information identifies that in the community the mean age of young offenders with a mental health concern is 15 years, whereas in the secure estate the mean age is 16 years (Table 2.1)

Table 1: Overall Figures

Location	*Asset Open*[1] N	% of *Asset Open*				% of MH Concern													
		MH Section of Asset: ≤2		*MH Concern*[2]		*MH Activity*[3]		Screened		Assessed		Received Intervention		Needs Met: Yes[4]		Needs Met: DK		Needs Met: No	
	N	N	%	*N*	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Darlington	*87*	20	23	*21*	24	16	76	9	43	15	71	13	62	11	52	3	14	7	33
Durham North	*74*	15	20	*n/a*	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/
Durham South	*131*	43	33	*n/a*	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/
Hartlepool	*39*	8	21	*8*	21	6	75	5	63	2	25	3	38	4	50	0	0	4	50
Newcastle	*236*	31	13	*31*	13	15	48	4	13	12	39	13	42	13	42	2	6	16	52
Nth'land	*146*	31	21	*39*	27	26	67	19	49	24	62	15	38	15	38	6	15	18	46
N Tyneside	*186*	35	19	*35*	19	16	46	16	46	12	34	12	34	12	34	14	40	9	26
S Tyneside	*294*	40	14	*40*	14	15	38	15	38	14	35	13	33	9	23	25	63	6	15
South Tees[5]	*132*	41	31	*12*	9	10	83	10	83	8	67	8	67	7	58	5	42	0	0
Stockton	*167*	27	16	*29*	17	28	97	27	93	12	41	11	38	15	52	0	0	14	48
Sunderland	*181*	37	20	*37*	20	27	73	25	68	16	43	15	41	11	30	0	0	26	70
Total	***1673***	**328**	**20**	***252***	**15**	**159**	**63**	**130**	**52**	**115**	**46**	**103**	**41**	**97**	**38**	**55**	**22**	**100**	**40**
Castington	*109*	51	47	*48*	44	41	85	n/a	n/a	41	85	19	40	34	71	5	10	9	19
Aycliffe	*27*	22	81	*27*	100	24	89	21	78	13	48	13	48	20	74	0	0	7	26
Kyloe	*5*	4	80	*5*	100	5	100	5	100	5	100	3	60	4	80	0	0	1	20
Total	***141***	**77**	**55**	***80***	**57**	**70**	**88**	**26**	**33**	**59**	**74**	**35**	**44**	**58**	**73**	**5**	**6**	**17**	**21**
Overall	***1814***	**405**	**22**	***332***	**18**	**229**	**69**	**156**	**47**	**174**	**52**	**138**	**42**	**155**	**47**	**60**	**18**	**117**	**35**

1. *Asset Open*: All 12-18yo in contact with YJB between Nov '05 - Jan '06 with an open Asset (i.e. excludes Police Reprimands)

2. MH Concern: All young people who scored 2+ on MH section of Asset PLUS those where a concern was raised pre or post Asset

3. MH Activity: All young people who have been screened, assessed or received intervention

4. Needs Met *Yes* includes '*In Process*'

5. *South Tees*: Detail is limited to those who were referred to a MH worker (12 YP)

4.2.2 The figures for the secure estate reflect the nature of the population. Castington YOI is a male-only establishment. During the period of the study, 48% of the young people at Aycliffe Secure Children's Home with mental health concerns were female (table 2.2).

4.2.3 The vast majority of this sample of young offenders with mental health concerns are white British (97%) (table 2.3), which reflects the Youth Justice system overall in this region, where ethnic minority groups account for 3% (see Appendix A).

4.3 Offence Information

4.3.1 Moving beyond demographic data, in the main the following summarises findings in relation to screening, assessment and intervention. However, we also provide findings of interest generally, for those working with young offenders with mental health problems and for those commissioning services to meet their needs.

4.3.2 Data about offence type and offence length was provided. Overall amongst our sample, 26% (Table 4.1) of young offenders with mental health or learning disability problems presented with a violent offence. This compares with Youth Justice Board (2005) statistics identifying violent offences in 14% of cases in North East England.

4.3.3 YOTs reported that in 60% of cases during the time of the study, young offenders were given orders lasting less than six months, and in 86% of cases young people are assigned to YOTs for a period of no longer than a year (table 4.2).

4.3.4 Whilst it is not surprising that in the secure estate 53% of young people are detained for longer periods – between one and nine years – nonetheless it was felt by interviewees during the qualitative phase of the research that short orders and sentences can militate against the ability to achieve effective results with regard to mental health problems. (table 4.2)

4.4. Risk Factors

4.4.1 There are no actuarial risk assessment tools validated for adolescents, however there is a wealth of literature relating to the factors which contribute to an increased likelihood of specified criminal behaviours occurring e.g. Farrington 2002, Rutter et al 1998, Armstrong et al 2005. A Youth Justice Board meta-analysis (2001) concluded that up to 20 risk factors may have a significant effect upon future offending behaviour for children. Likewise, a number of factors are likely to contribute to an individual's vulnerability or resilience to mental health difficulties.

4.4.2 Research has not found a direct or simple causal link between risk factors and offending behaviour nor between mental health needs and offending. Hagell (2002) discusses interrelationships between risk, mental health problems and offending behaviour and indicates that multiple factors are likely to operate (Hagell 2002).

4.4.3 This study obtained data on familial and social variables including "care giver" (table 3.1) and vulnerability (table 3.4). Findings are presented which highlight difficulties the young offenders experience in their lives.

4.4.4 The largest group of young people who were identified as having mental health problems were found to have complex family upbringing. This means that their upbringing is best described as 'shifting' between family members and a number of agency provisions. Overall, 35% of young people fall into this category. Within the secure estate this figure rises to 64%. Overall 29% of young people are brought up by their mothers alone.

4.4.5 YOTs identified high percentages of vulnerability (defined in *Asset* as "the possibility of the young person being harmed – either physically or emotionally" www.yjb.gov.uk). Amongst young people, 65% with mental health concerns were also identified as vulnerable and in one case (Darlington) 100% of young people were classified as vulnerable. Secure establishments reported 69% of young offenders with mental health concerns as being vulnerable (table 3.4). A major concern in secure establishments is that in one in five cases they do not know if a young person is vulnerable.

4.5 Related "Mental" Health problems

4.5.1 Our study, in line with other research literature, found that ambiguities in definitions and terminology impacted on our understanding of the relationship between mental health difficulties and offending behaviour.

4.5.2 For instance, the On Track Youth Lifestyles Surveys (2005) categorise substance use as a problem behaviour, along with anti-social and offending behaviours, whereas substance use (and misuse) is also defined as a mental health problem: drug and alcohol use feature in the Youth Justice Board's mental health screening and assessment tools; Hagell (2002) refers to

research projects on the prevalence of mental health problems in both incarcerated and non-incarcerated young offenders, in which substance abuse constitutes 30-40% of disorders measured; the Youth Justice Board's Key Elements of Effective Practice – mental health (source document) (2004) states that '… young offenders experience very high rates of mental health problems …. and will include: conduct disorder, substance misuse and learning disability'. That document also refers to generalised learning difficulties and specific learning difficulties, but not to learning disabilities.

4.6 Substance Misuse

4.6.1 Our findings showed that within YOTs half of those young offenders with a mental health concern also had substance misuse problems. (table 6.1) However, it must be noted that information about substance misuse as identified by *Asset* was somewhat deficient in particular YOTs. In custody, this comorbidity rose to 68%. The level of comorbidity identified is yet another example of the complexity of issues about which judgements need to be made to best meet a young person's needs.

4.6.2 The fact that the secure establishments reported substance misuse intervention being carried out in 85% of cases lends further support to the level of substance use amongst the young offending population (Table 6.1).

4.7 Learning Disability

4.7.1 The data (table 7.1) indicate that overall 33% of young offenders with a mental health concern were being identified as having learning difficulties or special educational needs. 24% had been

identified because they had a Statement. As far as the YOTs are concerned, 30% were identified as having learning difficulties and 20% already had a Statement. This suggests that completion of the Asset alone does not necessarily pick up special educational needs. Moreover, this figure of 30% (of the total YOT sample) is low compared with Stallard et al (2003) who identified that 52% of young people attending a Youth Offending Team had special educational needs.

4.7.2 In line with the comment made earlier, most YOTs were not identifying learning disability. (see table 7.2) The exceptions are:

a) Darlington where two young people (10%) were identified and were subsequently assessed and referred to Specialist Learning Disability Services.

b) Newcastle – three young people (10%)

c) Northumberland – one young person (3%)

The latter two YOTs were involved in the Learning Disability study recently completed by Ford et al 2006 (unpublished).

4.8 Mental Health Concerns

4.8.1 Overall, table 1 shows that of the total sample audited for the purposes of this study (1,814 open *Assets*) 18% were identified as having a mental health concern (defined as scoring 2 or more in Section 8 of *Asset* plus informal expressions of concern pre or post *Asset* in the community or secure estate). It must be noted that data is missing from Hassockfield Secure Training Centre, Gateshead and Durham North/South Youth Engagement Service (YOT). At the time of our study a greater percentage of mental health problems were being identified than in the Harrington and Bailey Study (2005) where they reported that of the 600 *Asset* forms evaluated, only 15% of young people were identified with mental health problems.

4.9 Mental Health Diagnosis/Diagnosed Mental Health Issues

4.9.1 The numbers of young offenders with a mental health diagnosis in our study is 15% (table 8.3), leaving 85% of those with a mental health concern not having a diagnosis. It may or may not be a matter of concern. However, 46% of those with a mental health concern did receive some intervention.

4.9.2 Of those young people who had a clinical diagnosis, the largest category was Attention Deficit Hyperactivity Disorder (ADHD) which accounted for 9% in the community and 5% in secure establishments (table 8.1). Harrington & Bailey (2005) found 7% of adolescent offenders with Hyperactivity in the community, compared with 6% in custody.

4.10 Undiagnosed Mental Health Issues

4.10.1 In line with other research and the qualitative data from this study, the figures in table 8.2 reflect a considerable amount of lower level (i.e. not clinically diagnosed) mental health need. This is found in the categories provided in the YJB screening instrument (SQIfA). Prior knowledge and other processes of assessment led to YOT and secure estate staff volunteering a range of behaviours and experiences which constitute emotional and mental health problems or needs. Of note is the high prevalence of bereavement and loss. These problem areas can generally be related to interventions needed at tier 2 and tier 3.

4.10.2 Table 8.3 summarises data from table 8.1 and table 8.2. This summary is revealing as it highlights the high proportion of undiagnosed mental health issues identified among young offenders. The table identifies that of the 252 young people in

YOTs about whom some mental health concern is expressed (as defined previously) 52% subsequently were found to have undiagnosed mental health issues. In secure establishments where 73 young offenders were assessed 90% had undiagnosed mental health issues. This high prevalence is similar to that quoted in Durcan et al (2006) i.e. 95%.

4.11 Screening, Assessments and Interventions

4.11.1 For the period of this study, six of the YOTs for which we have data screened for mental health problems using the YJB screening questionnaire (SQIfA) in 100% of cases. The remaining YOTs used alternative screening tools

4.11.2 At Castington YOI initial screening on entry to the establishment is designed to identify concerns around risk of self-harm or suicide and will include reference to 'past psychiatric involvement'. Screening does not otherwise identify mental health needs.

4.11.3 At Aycliffe and Kyloe House the data indicate that screening for mental health issues is carried out on all young people as part of the initial interview process although this is not defined as a full mental health assessment. (table 5.1). At Aycliffe a full mental health assessment is provided where this is indicated by the initial screening and for young people with longer sentences.

4.11.4 Of the 115 young people assessed for mental health problems in YOTs, 53% of cases were assessed via a CAMHS or joint CAMHS and YOT assessment tool. The YJB tool SIfA was used in 25% of cases (two YOTs in particular used the SIfA). Other methods were used in the remaining cases. In the secure estate

mental health assessment was conducted through an interview in 97% of cases.

4.11.5 These findings suggest that although reasons for particular decision-making processes within the YOTs are not always known, more YOTs than was previously thought are using structured screening and assessment tools to identify emotional and mental health problems.

4.11.6 Tables 9.1 and 9.2 lend support to this point that within the youth justice system, structures have been developed to enable screening for mental health problems to be conducted by generic workers and for assessment interviews for mental health problems to be conducted by specialist mental health practitioners.

4.11.7 The data illustrate the position that a large proportion of community based interventions were carried out by the mental health worker (61%). There were also some interventions being carried out by YOT officers or by the general health worker and/or substance misuse worker. Where referrals were made, these led to interventions being carried out by the specialist professional (25%).

4.11.8 This would appear to suggest a satisfactory state of affairs. It is the case however that some mental health workers in YOTs reported that they at times felt under pressure to undertake interventions at tier 3 which, according to their judgement, ought to have been dealt with by CAMHS or forensic CAMHS specialists. (see also the four-tier framework referred to earlier)

4.11.9 The figures for the secure estate appear to reflect the resources available. 46% of interventions were carried out by mental health workers; 37% were provided by psychologists or psychiatrists.

4.11.10 The aims of the research study suggested the importance of seeking data on intervention providers, tiers of provision and referral processes. Data from table 10.1 reflect variations of location and role : 49% of young people received interventions within the YOT and 31% received interventions in CAMHS. It was suggested to us that in certain cases young offenders receiving interventions in CAMHS were being dealt with by the same mental health professional who also delivered interventions within the YOT.

4.11.11 In relation to the figures for Aycliffe secure young person's centre, it appears to be the case that whilst 46% received intervention from the Kolvin Unit professionals attending the establishment, the remaining 6 young people received interventions provided at Aycliffe following training given by Kolvin specialists. One young person was referred to specialist learning disability services.

4.11.12 It is clear that the bulk of interventions were carried out at tier 2 and tier 3 as defined by health professionals. The data suggest a mixed economy operates in relation to who precisely delivered interventions, at which tier, and at which location. (table 10.3) The qualitative findings suggest there is some ambiguity and lack of clarity around definition of tiers and this is a cause for concern.

4.11.13 The data in table 10.4 indicate variations in the extent to which professionals referred young people outside either the YOT or the secure establishment. In some cases young people were already in contact with another service, so a new external referral would not occur.

4.12 Lack of Screening/Assessment

4.12.1 In identifying the numbers of young offenders with emotional and mental health needs who were screened and assessed during the research period it was also important to attempt to elucidate reasons why these processes did not occur for other young offenders.

4.12.2 The YOTs' findings indicate that 122 young people (out of 252 for whom mental health concern was identified) were not screened (table 11.1). Of these, 17% refused/disengaged and 14% were sentenced to secure provision. Additionally, the data indicate that in 25% of cases it is not known why screening for mental health problems did not occur although this figure is skewed owing to the return from South Tyneside where screening information was unavailable. The figures indicate some cause for concern at the level of the individual and at the level of the system.

4.12.3 These figures for the secure estate illustrate that at Castington no screening for mental health problems is carried out. Concern about individuals expressed by any member of staff can lead to referral for assessment.

4.12.4 Within YOTs, of 137 young people not assessed, 32% refused or disengaged.

4.12.5 These figures are of concern and could suggest a number of contributory factors. Young offenders are notoriously difficult to engage and to motivate. Additionally, it is known that mental health issues continue to hold a stigma. Furthermore, engaging with health and mental health professionals is a voluntary activity in the main even though young offenders are subject to a system within Youth Justice which imposes many requirements on them. There are few young people to whom compulsory assessment and intervention will apply.

4.12.6 The data indicate (table 11.3) that during the period of the study, 36% of young offenders assigned to YOTs were not yet assessed for interventions, although there is much variation between YOTs. The reasons for this relatively high percentage are not clear, though we do have some suggestions why this might be. It may have been due to lack of resource, compounded by pressure of work associated with this piece of research! Caution is needed to avoid complacency and naive acceptance of positive impressions given in some semi-structured interviews about the majority of young offenders with mental health problems being appropriately assessed and having their needs met effectively. There appear to be significant differences between YOTs in terms of the numbers of young people who refused/disengaged and hence did not have needs met (table 11.4). Overall, according to the data provided by YOTs 38% of young people with identified mental health concerns were having their needs met, 40% were not achieving this, and there were 22% 'don't knows'. With such small samples from each YOT we do not know if these differences are statistically significant. In the secure estate, the data suggests that 73% of young people were having their needs met, 21% were not and there were 6% of 'don't knows' (Table 1).

4.13 Key Findings

i) The research study revealed that from 1,814 Asset forms 18% of young people were “identified with mental health concerns”.

ii) In our study there was evidence that a large proportion of young people going through the youth justice services did not experience screening or assessment. This corresponds with findings in other studies. We have considered the factors that might contribute to this problem. Where assessment has not occurred there are concerns as to whether mental health needs are going undetected.

iii) Where assessment did identify mental health needs there was evidence that intervention was taking place, not in every case, but in sufficient quantity to re-assure us. Information that intervention has been helpful has to be seen in the context of the short time frame we were examining. There were wide ranging differences in practice as to where interventions were being provided i.e. from within the YOS or elsewhere.

SECTION 5

5. Discussion and Recommendations

5.1 Discussion

We were very aware throughout our work that the youth justice system does seem to sit very much on its own – outside mainstream local authority services, part of the criminal justice system, yet separate because of its accountability to the YJB. YOTs have had to build relationships with other agencies including health, social services and education.

5.2 Within the youth justice system, services appear to operate autonomously while adhering to standards and targets set from the centre. YOT managers report directly to the central Youth Justice Board while being influenced by the regional youth justice manager and to us it was not always clear where authority lay. In the secure estate there appeared to be several lines of accountability depending on the employment status of each individual worker.

5.3 Individual health workers sit between two organisations with different structures. Accountability at times seemed confusing. There appeared to be a tension between demands from health and from the YJB. There is a "can do mentality" which makes things work, but this is dependent on local relationships and personalities and thus consistency of service provision is vulnerable.

5.4 Similar tensions are present within the secure estate i.e. reflecting a criminal justice or health perspective. However, in those establishments retaining a strong identity with social services e.g. Aycliffe, where there is a separate in-reach programme grounded in a 'child first' culture there appears to be better integration of mental

health input. In the youth justice led organisations where the emphasis is on security, health input seems to sit alongside other work and seems less well integrated with problematic pathways and differing priorities between different parts of the organisation.

5.5 The culture is very different in individual organisations. In YOTs and the Secure Estate the drive is about compliance with national standards and compulsory attendance at programmes of intervention. However in some areas of the Health Service accessing services is seen as something that is optional and indeed those over 16 have the right to refuse intervention. YJB figures show that targets relating to timeframes for referral and assessment by CAMHs are being met, whereas in our discussions there were reports from some YOTs that CAMHs services were good, but they wanted more of it and quicker and there was mention of waiting lists being closed.

5.6 We are aware of at least two groups that meet to discuss mental health issues, the Regional Health Forum for practitioners and the North East Mental Health Strategy Group. In our experience the function between these groups and the wider Regional Youth Justice Forum is unclear.

5.7 It is possible that behaviour and problems identified as having a link to mental health needs once a young person comes into the world of the YOT may have either gone unnoticed or even been tolerated within the wider community and would not otherwise have attracted the attention of services. The criminal justice process can lead to problems being used to mitigate offending behaviour. Harrington and Bailey (2005) identify the difficulty in distinguishing between problems that emanate from an innate diagnosable mental health problem and those that are the result of social or other issues. Sometimes a causal link is assumed when this is not appropriate. This contributes to the complexities involved for workers making judgements about where to focus interventions relevant to reducing recidivism.

5.8 The commissioning and provision of mental health services for children and young people is a responsibility of the Health Service and it is only within the past few years that there has been a move to ensure that primary care commissioners are taking an overview of the range of needs for this group. CAMHs should be available both locally and regionally to meet every need, but it has to be recognised that many of their services are still in development.

5.9 We are still a long way from realising in practice the principle of mainstream access to comprehensive CAMH services for all children and young people, including young offenders. The needs of specialist groups including young offenders must be explicitly defined within local CAMHs strategies. Young people with learning disabilities are likely to be further marginalised than other groups.

5.10 Whilst there has been much progress in the area of partnership working between YOTs and other organisations (including CAMHs, social services and education) there does not seem to be a sufficiently robust interagency approach to addressing the issues of meeting the mental health needs of young offenders. Different statutory organisations work to different and sometimes conflicting agendas.

5.11 The context in which statutory and voluntary bodies are working with children and young people is fundamentally changing with the emergence of Children's Trusts and the commissioning of health provision is likely to be on a much bigger geographical scale because of SHA and PCT reconfigurations. Organisations are continually having to adjust to changes in legislation, new structures and new relationships, new funding streams and new partnerships. The importance of the need for these changes may be accepted but also the burden this process of change places on organisations and

individuals and the consequent impact this has on service delivery cannot be ignored.

5.12 Learning difficulties and learning disabilities are very much out on a limb. The YJB document "Key Elements of Effective Practice (Mental Health)" recommends consideration of intellectual ability but there is no evidence of a systematic process to do this. While that document recommends mapping local CAMHS to raise awareness of services, there is no such recommendation in relation to specialist services for young people with learning disabilities. Young offenders often fall out of the education system so early identification of learning difficulties or disabilities frequently does not occur. NSF targets in relation to the provision of services for young people with learning disabilities are only partially achieved. In short, the needs of young people with learning disabilities are missed and services to meet these needs are patchy. This is an area for further development. Within the community, the initial identification of difficulties usually sits within education but this group of young people are often not in touch with education services. For those in youth justice systems this seems to add yet another layer in terms of establishing appropriate methods of assessment, even before one gets to intervention.

5.13 There was some evidence that working towards targets can actually undermine attempts to provide mental health services. For example, in the secure estate, there are targets around delivering hours of education, but different targets around mental health service delivery. This meant on occasion a young person might miss a mental health assessment to attend education.

5.14 We found evidence of inconsistencies in the scoring of the *Asset* in relation to the supporting information being recorded in the assessment. This is supported by the Harrington and Bailey study. YJB screening and assessment tools are also not always complete.

This means that the data which the YJB uses to communicate about mental health needs is incomplete. This has implications for quality assurance and, more widely, commissioning.

5.15 Without routine screening and assessment, the need of a young person internalising their distress and difficulties may go undetected, This is important in the context of a peer group demonstrating other behavioural difficulties. Failure to identify a problem can have significant consequences for the individual and the service.

5.16 Transition between services either YOT to YOT or to and from the secure estate poses a risk of loss of information, missing out of needs being screened or assessed or interventions being delivered. Weaknesses in communication between organisations seemed to be the cause of these difficulties. RAP projects which are being piloted in some parts of the region might be the vehicle for resolving the problems of the transition between the secure estate and the community. There is no satisfactory feedback loop to track a young person's outcome at the end of YOT involvement on transition back to the community. This means that organisations cannot audit effective communication or whether recommendations have been carried out.

5.17 Although we had wide ranging information about availability of training, we also heard from many we spoke with in both the community and the secure estate, that they would welcome training not only in assessment and intervention, but also in how to work across organisations and improve their awareness of mental health issues.

5.18 Participants also believed that there was a large, unidentified and unmet need, as regards young people with learning disability. Within the secure estate the majority of staff working in the health care unit do not have mental health training, but the majority of young people

admitted to the health care unit are there to address a mental health need.

5.19 **Key Recommendations**

5.19.1 Within the region covered by the 11 YOTS and NHS North East there must be a strategic and integrated approach to the development of a comprehensive range of primary and specialised mental health services for young people across all the tiers. These services must meet the particular circumstances of young offenders.

5.19.2 The strategy and planning for these services must be based on a partnership approach which includes health, children's services (including Education), criminal justice agencies, especially the YOTS and the Juvenile Secure Estate, and also voluntary agencies.

5.19.3 The partnership approach must be underpinned by a regional commissioning strategy for CAMHS covering all four tiers within which commissioning for tier 4 services will sit, as recommended by the HASCAS draft. There should also be a framework for commissioning the other tiers by PCTs. Forensic services (which were not included in the HASCAS review) must also sit within the overall commissioning strategy.

5.19.4 YOTs and JSEIs must work more closely with CAMHS and Children's Trusts Commissioners at a strategic level. An important step in doing this is for YOTs to take every opportunity to be actively involved in local CAMHs strategy groups, the Children's Trusts and local Children's Partnerships as well as Learning Disability strategy groups. Through better use of these structures YOTs should feed in data to demonstrate the levels of need to inform decisions about provision of services at tiers 1-4.

5.19.5 Under the auspices of the Regional Youth Justice Mental Health Strategy Group, YOTs and the secure estate should work together much more closely to share and compile information about need and intervention outcomes to inform the commissioning process. This should fit into a dialogue between all agencies (providers, commissioners and users).

5.19.6 The screening and assessment process used within the Youth Justice system to identify mental health needs requires revision to take account of identified inadequacies. Following revision, these tools should be used across the YOTs and the secure estate. Whilst this needs to be a joint venture between health and youth justice with appropriate linkage between local and regional CAMHs, there will need to be clarity about the contributions of the YJB nationally and local youth justice and health organisations.

5.19.7 A clear strategy to address the lack of screening, assessment and intervention provision for learning disabilities throughout the region's youth justice services must be developed nationally and within the region. We include this as a separate recommendation to draw attention to an area of need which is often overlooked. There is a clear role for an individual to take a lead in this work and a need for resources to develop services to meet the need. This could build on the recent study undertaken in the region which demonstrated the benefit of an assessment service. Work is continuing to identify appropriate screening processes and is being carried out in liaison with youth justice services, tier 4 forensic services and tier 4 and 3 learning disability services.

5.19.8 Wherever possible, and information systems permitting, in the absence of a standardised assessment tool for all agencies and all young persons, work needs to be done to identify a minimum core dataset that should be shared for the benefit of the young person and to aid

commissioning. This might include a shared identifying number, information about whether a mental health or learning disability concern has been identified and information to aid tracking of activity around the person as he or she passes through and remains in contact with the system.

5.19.9 A communication strategy should be developed to ensure use of the improved information systems proposed above between YOTs, health services (at all tiers) and in and out of the secure estate. Good communication at points of transition is essential and improvements to practice are required to ensure continuity of care. The processes need to be audited and systems to make them more effective need to be implemented.

5.19.10 At a regional level the structures for practitioners and those taking a strategic view must be realigned. Clarification of purpose and regularity of membership groups within those structures should be established. The accountability of these groups should be defined, and formal evaluation processes should be implemented. These structures should include fora for considering the needs of young offenders with learning disabilities.

5.19.11 Working to implement national requirements such as Youth Justice targets, CAMHs targets and the NSF standards must remain a priority for all agencies. They should ensure they are working together to achieve best results for the well-being of the young person.

5.19.12 There needs to be a structured regional and organisational approach towards the development and training requirements of practitioners, managers and teams working together on mental health and learning disability needs of young offenders. This will ensure that youth offender and health staff, whether working with YOTs or in the secure estate, feel more competent and confident in addressing the needs of

young offenders and more aware of the expectations of their respective services.

5.19.13 Consideration should be given to why young offenders are reluctant to engage in screening and assessment processes. We recommend that there should be a review of the research into effective strategies and necessary processes for engaging adolescents in mental health assessment and intervention. Depending on the outcome of this research a further study could be undertaken to consider their views about the processes of screening, assessment and intervention. This would help identify some practical strategies for managing this problem and also good practice guidelines which could be shared and developed amongst practitioners.

5.19.14 All of the above recommendations absolutely depend upon an inter-agency, inter-disciplinary approach so that all of those working at every level address the issues raised and the recommendations in this report. We would strongly recommend that he responsibility for taking this forward should not just be given to the commissioners. This responsibility should sit within a wider strategy group tasked with overseeing:

- The regional-wide CAMHS strategy
- The development of effective screening and assessment tools in youth justice and health services
- Improvements to information, communication systems and monitoring and evaluation processes to establish the effectiveness of provision
- The establishment of a regional training and development programme for practitioners and managers.

SECTION 6

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- Screening for Mental Disorder in the Youth Justice System – manual
- Onset Guidance and Assessment
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Appendices

A YOT Region Demographic and Young Offending Information

B Letter to YOTs dated 13th September 2005

C Interview Guide for follow up meeting with YOTs

D Quantitative Data Collection 1.11.05 – 31.1.06

E Letter to YOTS dated 15th January 2006

F YOT Data Collection Template

G A summary of qualitative information regarding mental health provision and processes within the secure estate

H Tables

Appendix A – YOT Region Demographical Young Offenders Information

	North East Total	Darlington	Durham	Gateshead	Hartlepool	Newcastle
Demographics (2001 Census)						
Geographical Area (sq km)	8573	197	2226	142	94	113
Strategic Health Authority	n/a	County Durham & Tees Valley	County Durham & Tees Valley	Northumberland, Tyne and Wear	County Durham & Tees Valley	Northumberland, Tyne and Wear
Total Population	2539000	98000	494000	191000	90000	267000
Density (people per sq km)	296	497	222	1342	961	2350
Unemployment (Spring 2004)	5.6%	4.0%	2.8%	4.0%	5.5%	4.7%
10 – 19 Population	353889	12383	63560	23925	12361	34262
% of Total population	13.9%	12.6%	12.9%	12.5%	13.7%	12.8%
Female	163365	6121	30840	11791	6149	17178
Male	168077	6262	32720	12134	6212	17084
Ethnic Group: White / White British	343430	11929	62570	23424	12184	31036
Ethnic Group: Black / Black British	458	20	35	36	3	121
Ethnic Group: Asian / Asian British	5260	152	250	187	70	2185
Ethnic Group: Chinese / Other	1727	77	298	118	20	431
Ethnic Group: Mixed	3014	205	407	160	84	489
Key Performance Targets Oct – Dec '05						
Acute MH – CAMHS Ass. <5 days	n/a	n/a	100%	100%	100%	n/a
Non-acute MH - <15 days	n/a	100%	80%	100%	100%	100%
SM Needs - Ass <5 days	n/a	71%	-100%	100%	100%	62%
SM Early Int. & Treatment <10days	n/a	83%	-100%	100%	100%	100%
Offence Information **(10 – 17yo)**	(2004/5)					
No. of Offences	21005	814	3362	1213	677	3154
Male	17148	635	2794	1014	560	2562
% Male	81.6%	78.0%	83.1%	83.6%	82.7%	81.2%
Male Peak Years (Mode)	17	17	17	17	17	17
Female	3857	179	568	199	117	592
% Female	18.4%	22.0%	16.9%	16.4%	17.3%	18.8%
Female Peak Years (Mode)	17	17	17	17	17	17
Ethnic Group: White / White British	20442	809	3331	1197	666	2993
Ethnic Group: Black / Black British	34	1	1	0	6	7
Ethnic Group: Asian / Asian British	157	1	2	2	5	55
Ethnic Group: Chinese / Other	43	0	0	0	0	6
Ethnic Group: Mixed	100	0	6	0	0	35
Ethnic Group: Not Known	229	3	22	14	0	58

YOT Region Demographical Young Offenders Information (continued)

	North Tyneside	Northumberland	South Tees	South Tyneside	Stockton	Sunderland
Demographics (2001 Census)						
Geographical Area (sq km)	82	5013	299	64	204	137
Strategic Health Authority	Northumberland, Tyne and Wear	Northumberland, Tyne and Wear	County Durham & Tees Valley	Northumberland, Tyne and Wear	County Durham & Tees Valley	Northumberland, Tyne and Wear
Total Population	191000	309000	278000	152000	186000	283000
Density (people per sq km)	2316	62	930	2355	914	2060
Unemployment (Spring 2004)	4.1%	3.7%	5.7%	6.3%	5.0%	4.8%
10 – 19 Population	23408	38440	61848	20420	24787	38495
% of Total population	12.3%	12.4%	22.2%	13.4%	13.3%	13.6%
Female	11653	18699	30352	10102	12203	19062
Male	11755	19741	31496	10318	12584	19433
Ethnic Group: White / White British	22706	37919	60625	19636	23815	37586
Ethnic Group: Black / Black British	67	23	90	12	23	28
Ethnic Group: Asian / Asian British	258	203	471	426	571	480
Ethnic Group: Chinese / Other	155	91	246	76	76	139
Ethnic Group: Mixed	212	204	416	273	302	262
Key Performance Targets Oct – Dec '05						
Acute MH – CAMHS Ass. <5 days	100%	100%	n/a	100%	33%	100%
Non-acute MH - <15 days	100%	92%	100%	100%	100%	100%
SM Needs - Ass <5 days	95%	97%	100%	90%	20%	100%
SM Early Int. & Treatment <10days	89%	98%	88%	100%	67%	100%
Offence Information (10 – 17yo)						
No. of Offences	2082	1994	2521	1504	966	2718
Male	1613	1696	2168	1159	825	2122
% Male	77.5%	85.1%	86.0%	77.1%	85.4%	78.1%
Male Peak Years (Mode)	17	17	17	17	17	17
Female	469	298	353	345	141	596
% Female	22.5%	14.9%	14.0%	22.9%	14.6%	21.9%
Female Peak Years (Mode)	17	17	17	17	17	17
Ethnic Group: White / White British	1956	1981	2411	1466	949	2683
Ethnic Group: Black / Black British	0	3	9	1	0	6
Ethnic Group: Asian / Asian British	5	1	55	10	3	18
Ethnic Group: Chinese / Other	15	8	3	5	1	5
Ethnic Group: Mixed	4	1	26	9	13	6
Ethnic Group: Not Known	102	0	17	13	0	0

YOT Region Demographical Young Offenders Information (continued)

	North East Total	Darlington	Durham	Gateshead	Hartlepool	Newcastle
Offence Type (2004/5)						
Arson	78	1	25	4	0	16
Breach of Bail	592	13	60	38	10	78
Breach of Conditional Discharge	164	9	31	10	5	19
Breach of Statutory Order	920	73	102	65	22	134
Criminal Damage	2777	85	501	142	85	404
Death Or Injury By Reckless Driving	11	0	0	2	0	0
Domestic Burglary	385	21	80	19	15	56
Drugs Offences	776	22	94	63	17	105
Fraud & Forgery	160	0	35	10	2	21
Motoring Offences	3575	118	756	256	160	457
Non Domestic Burglary	416	29	81	19	8	59
Other	727	45	140	33	20	167
Public Order	2740	81	407	153	32	424
Racially Aggravated Offences	142	1	25	16	2	33
Robbery	131	3	9	2	6	18
Sexual Offences	147	11	42	14	2	15
Theft & Handling	3734	158	448	160	159	723
Vehicle Theft	660	47	66	34	28	72
Violence Against Person	2870	97	460	173	104	353
Total	21005	814	3362	1213	677	3154
Disposals (2004/5)						
Pre-Court (Final Warnings / Reprimands	6769	252	899	282	233	865
First Tier (Cond./Abs. Discharge/Fine/other)	6117	214	781	357	148	1133
Community Penalties	2260	78	305	156	64	263
Custodial Sentence	285	19	44	18	10	35
Custodial Remand	363	19	41	20	5	49
Reoffending after 24 months						
(Oct – Dec, 2002 Cohort)						
Pre-Court	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
First Tier Penalties	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Community Penalties	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Custody	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

YOT Region Demographical Young Offenders Information (continued)

	North Tyneside	Northumberland	South Tees	South Tyneside	Stockton	Sunderland
Offence Type (2004/5)						
Arson	1	10	9	3	7	2
Breach of Bail	128	33	87	62	14	69
Breach of Conditional Discharge	22	6	23	12	8	19
Breach of Statutory Order	183	20	138	79	22	82
Criminal Damage	254	306	229	237	161	373
Death Or Injury By Reckless Driving	2	4	0	0	0	3
Domestic Burglary	25	36	45	26	19	43
Drugs Offences	80	95	63	87	44	106
Fraud & Forgery	29	16	7	11	1	28
Motoring Offences	255	291	561	178	175	368
Non Domestic Burglary	35	48	45	29	18	45
Other	64	51	61	36	29	81
Public Order	304	273	294	233	110	429
Racially Aggravated Offences	22	8	9	6	1	19
Robbery	23	4	35	13	4	14
Sexual Offences	8	18	12	7	3	15
Theft & Handling	348	374	446	268	146	504
Vehicle Theft	45	70	165	30	34	69
Violence Against Person	254	331	292	187	170	449
Total	2082	1994	2521	1504	966	2718
Disposals (2004/5)						
Pre-Court (Final Warnings / Reprimands	507	897	791	614	392	1037
First Tier (Cond./Abs. Discharge/Fine/other)	640	566	684	414	250	930
Community Penalties	420	132	360	195	65	222
Custodial Sentence	29	10	50	23	15	32
Custodial Remand	37	23	65	42	18	44
Reoffending after 24 months						
(Oct – Dec, 2002 Cohort)						
Pre-Court	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
First Tier Penalties	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Community Penalties	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Custody	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Appendix B

Tuesday, 13th September 2005

To: Youth Offending Teams

Dear

The Mental Health and Learning Disability Needs of Young Offenders in North East England

We are seeking your help with this study which is attempting to identify the mental health and learning disability needs of young people in the youth justice system and the effectiveness of service provision to meet these needs.

The research has been commissioned by Wallace Wilson, the regional manager of the North East Youth Justice Board. This letter confirms the agreed co-operation and support of youth offending teams in the collection of data: YOTs are particularly affected by the issues and it is hoped that they will benefit from the findings. Furthermore, there is agreement of the need to proceed with data collection as a matter of urgency and in this regard we are authorised by Wallace Wilson to make immediate direct contact with youth offending teams.

The research team consists of Dr Eric Wade, research director, Sue Winfield, senior research consultant, Dr Ruth Andrews, senior research consultant, and Hilary Jupp, research associate.

It is known that there are young offenders with a range of mental health needs. We have been asked to obtain data on:

- The extent of the mental health need in this group
- The screening, assessment and referral of mental health needs
- The range of service provision that exists to meet such needs
- The gaps in service provision
- Recommendations to improve matters

For the purposes of this study **'mental health need'** is defined broadly. It includes classified mental disorders and learning disabilities, as well as those mental health problems resulting from the effects of substance, alcohol or sexual abuse.

We would like to arrange a meeting with you as soon as possible to discuss what relevant data would be readily available in your service. We are hoping to collect two types of data:

1. Numbers of young people with a range of mental health needs and the services available to them.

    a) Ideally, we would like to propose that for a given period, say 1st November 2005 to 31st January 2006, your team carries out the SQIFA mental health screening questionnaire on **all** young people scoring 2 or more in section 9 of ASSET (Emotional and Mental Health), and records the outcome on the person's case file. For those young people who score 3 or 4 on the SQUIFA, we would ask for the full SIFA interview to be completed and all outcomes recorded on the young person's file, i.e. the mental health problem(s) and learning disabilities identified, decisions to proceed with further assessment or referral, and decisions to take alternative action or no action.

    Also, we would ask for the outcomes of these decisions to be noted – we would discuss with you the types of information that will be useful for this study and that would also be of interest to yourselves,

    WE would then audit the files to access the information.

    b) If the above procedure looks impossible to achieve, we would seek to carry out an audit of existing case files for the purpose of extracting and analysing the relevant data. We would be able to clarify with you what is required.

2. We would also like to discuss with you information describing the demographics of the team's catchment area.

    Importantly, we would like to discuss with you at an appropriate point during the study your team's perceptions of how mental health problems in young offenders are being addressed, what issues concern you, what you feel would constitute 'ideal' mental health provision, and so on.

We will be contacting you in the next few days to make an appointment to meet up.

Yours sincerely,

Wallace Wilson
Regional Manager

Dr Eric Wade
Research Director

Appendix C

Mental Health and Learning Disability Needs of Young Offenders – Interview Guide for follow-up meeting with YOTs

CURRENT EXPERIENCE

1. Can you describe the skills mix in the YOT? e.g your named substance misuse worker? Your health/mental health practitioner? How do you address learning disability needs – do you have a named education worker?
2. Can you take me through the process of completing Asset?
   When Where takes place Who does it How long Does yp get more than one Asset Is yp alone/accompanied
   What criteria/triggers lead you to a mental health screening – can you specify; if no mental health screening done, how does this affect services/interventions?

2a. What, for you, constitutes mental health problems/needs?

3. What kind of mental health screening do you use (SQIFA?)
   When, where, who, how etc. Are there any issues Does this identify learning disabilities
   The SQIFA refers to alcohol and drug use – how are decisions made about subsequent interventions?
4. Can you take me through the mental health assessment that you use (SifA?)
   Where, who, how etc. Does this identify learning disabilities Scoring
5. How are the screening and assessment processes documented?

- Who has access? What happens next, who decides about interventions?

6. Can you tell me about the interventions to meet mental health/learning disabilities needs provided in the YOT/the community?
   - Tier Who provides
   - Nature of services/interventions: eg anger management, CBT to relieve depression/anxiety, length of involvement etc. one to one/group, with whom?

   Take up How effectiveness measured
7. Can you tell me about the referrals process (to CAMHs/Forensic CAMHs?)
   Young people with mental health needs Young people with learning disability need Routine referrals/emergencies
   Waiting lists Tracking Other issues

7a. How helpful do you find CAMHs and Forensic CAMHs services?

8. What about, generally, the links and relationships between different agencies/service providers (including the secure estate)?
   What does YOT actually pay for? What other sources of funding do you draw on? For what purposes?
   Information sharing
   Work undertaken – comparisons
   How do mental health services slot in compared with other services
   Do you have regular meetings with CAMHs managers?
   How do you manage the processes of identifying need/making referrals/providing services (contracts) and buying resources compared with expecting the resource to be provided

KNOWLEDGE

9. How confident are you in identifying mental health/learning disability needs?
10. How confident are you in meeting these needs?
11. What training have you had? (was this specifically on YJB screening/assessment tools? How was this financed?
    How recent Did this focus on knowledge about 'conditions' Did this focus on skills for working with people Both
    Did this provide knowledge about available service

SERVICE STRUCTURES

12. How did your model of screening/assessment/service provision develop?
    Impetus (failure to meet needs/YJB targets/recognition of need to respond to National Service Framework for Children)
    Funding
    Previous situation
    Barriers to this service
    Effect of service currently available
    What mechanisms do you have for checking how well the model works:
    Who's doing what?
    Regular audits?
13. What are the strengths and weaknesses of your model?
    What works well, why
    What is not working, why
    Does model meet mental health/learning disability needs of young people you support
14. How do you think this work should operate?
    What should be done
    What gaps exist
    How can it be improved
    Implications (funding/resource/input other agencies)
15. How do you think the different services (eg YOTs, secure, CAMHs, education, social services etc.) can work together more effectively/consistently?
    How involved are YOTs in decision making forums (e.g. Children's Trusts) to represent needs?
16. Who should take the lead?
17. Would you like to add anything else

Appendix D

QUANTITATIVE DATA COLLECTION FOR PERIOD 1ST NOVEMBER 2005-31ST JANUARY 2006

Requirements:

- The information needs to be collected for each person and also allow total numbers for various categories over the period to be analysed
- In every appropriate instance, please provide breakdown according to age, gender and ethnicity
- Please advise how the research team can access the data:
  - YOT database (Careworks or YOIS)
  - Young person's file
  - Provided by YOT/accessed by research team

1. Record total number of young persons referred to YOT during period: i.e. total number of ASSETs started for that period
2. Record numbers of young people scoring 2 or more on Section 8 of ASSET: Emotional and Mental Health
3. Identify mental health screening methods used:
   - SQIFA
   - Other screening tool (including learning disability tool)
   - Conversation with health/mental health practitioner
4. Record numbers of young people screened as having emotional/mental health problem (including learning disabilities) identified
5. Record number of young people in each category of emotional/mental health problem (including learning disabilities) identified
6. Identify mental health assessment interview used:
   - SQIFA
   - SWIFA
   - CAHMS
7. Record numbers of young people assessed as having emotional/mental health/learning disability problems
8. Record numbers of young people assessed as not having a problem
9. Record numbers of young people in each category of need (as above)
10. Record numbers of people who have need met
11. Record numbers of people who do not have need met
12. Identify which problems are responded to, e.g.
    - Alcohol use yes/no
    - Drug use yes/no
    - Depression yes/no
    - Anxiety yes/no
    - Self Harm yes/no
    - PTSD yes/no
    - Learning Disability yes/no
    - ADHD yes/no
    - Psychotic symptoms yes/no

    and so on
13. Record how identified problem is responded to:

Emotional/mental health issues/learning disability	Type of intervention (eg. anxiety management)	Service accessed	Tier of service

    (egs. Of services accessed: YOT provision, other agency intervention, referral to CAMHS, to Forensic CAMHS, to Learning Disability Services, Other.
14. Identify how need is not met:
    - Service not available
    - Waiting list
    - Unwillingness of young person
    - Other

Appendix E
Letter to YOTs

The Derwent Initiative
391 West Road
Newcastle upon Tyne
NE15 7PY

15th January 2006

Dear

Research Into The Mental Health Needs of Young Offenders
Quantitative Data Collection Phase:
(1st November 2005 – 31st January 2006)

We are nearing the end of the quantitative data collection phase of the research project and as we know, these findings are vital for providing hard evidence to support the aims of the research. Together with the qualitative evidence we have obtained from our interviews with you and your staff, we hope that the data will be used to support future commissioning of mental health services which in turn should help to meet the needs of young people within the youth justice system.

It's now necessary to confirm the arrangements for pulling the data together, according to the guidelines issued and agreed with you. Based on our previous meetings with you, we've identified that some data is readily available on your database and that other data is held in paper files by the health worker. We need to bring the two elements together.

We have been fortunate to recently appoint Mairi Spanswick, assistant psychologist, who has produced a template for this purpose. She has successfully piloted its use with one Yot and it will be made available for everyone's use in the very near future.

Mairi has some time in February to support the collation of relevant data from your Service. We anticipate that she will need to work closely with one or two people in your team (e.g. information officer, health/mental health adviser). Where Yots have advised us that their own staff can extract the data for us, Mairi's involvement will be limited to meeting with relevant staff and receiving the data in a standardised format based on the template; in other cases she may need to have access to the Yot's database and to work alongside staff.

Mairi will contact you in the next few days. Please would you suggest to her the most appropriate person to liaise with. Mairi will then confirm with that person the procedures for obtaining the research data.

With many thanks for your continued support.
Best wishes.

Yours sincerely,

Dr Eric Wade
Research Director

Hilary Jupp
Research Associate

Appendix F

YOT Mental Health Quantitative Data Collection: Template : 1st November 2005 - 31st Jan., 2006

Demographics				Background				Offence & Order		
Client Ref.	Age	Gender	Ethnicity	Caregiver	Abuse	Domestic Violence	Loss / Bereavement	Offence Type	Length of Order	Type of Order

Asset					Learning Disability Presence			Mental Health Screening		
Carried out by	Section 8 (MH) Score	Section 6 (SM) Score	Vulnerability	Action	SEN identified	Statement of SEN of SEN	Action	Carried out by	Tool Used	Action

Mental Health Assessment											
Carried out by	Tool Used	Problem identified									
		Alcohol	Drugs	Depression	PTSD	Anxiety	Self harm	ADHD	Psychotic	LD	Other

Intervention						Needs Met	
Action	Type	Location	Carried out by	Tier	Complete?	Have you noticed an improvement?	Reason needs not met

Appendix G

A summary of qualitative information regarding mental health provision and processes within the secure estate

	Screening Process	Referral Process	Assessment Process	Interventions	Mental Health Provision within the Institution	Inreach services	Strengths and Difficulties
Kyloe Secure children's home	All young people screened by mental health professionals from Tier 4 Forensic service – clinical assessment	Screening triggers referral as required to inreach team	Clinical Assessment by psychiatrist or psychologist	Delivered by Kyloe Staff supervised by inreach psychologist or some intervention by inreach psychologist.	No qualified mental health workers within Kyloe. Care staff have varying experience and deliver psychoeducational interventions Tier 2	Psychiatry and clinical psychology input via Tier 4 Forensic services. Can refer on to specialist members of their outpatient team. Tier 4	Provides a child centred approach, but would like to access other therapies eg creative and play therapy. Staff have varying levels of experience, but work hard to meet mental health needs, especially relating to personality disorder and mental illness. Good support from tier 4 service but would like more of it. No service to meet learning disability needs.

A summary of qualitative information regarding mental health provision and processes within the secure estate

Aycliffe Secure Children's home	Screened by health care within 24 hours. All young people screened by Tier 4 Forensic CPNS within 7 days – clinical assessment	Screening triggers referral to inreach team psychiatry and psychology. Section 91 are all assessed as part of contract.	Clinical assessment by psychiatrist or psychologist	Needs discussed at planning meetings. Interventions available across tiers as employ a school counselor, psychoeducational work delivered by Aycliffe staff and psychotherapies available for some via tier 4 inreach programme.	Staff at Aycliffe deliver psychoeducational packages and counselor available Tier 2	CPN, psychiatry, forensic psychology and psychotherapy. Tier 3 to 4	Has provision across all tiers, but finds it difficult to address needs of those who approximate tier 4 but do not quite fulfill criteria. Has team meetings to co-ordinate input. Good tier 4 input, but sometimes reports do not arrive on time to fit into process. Is looking to develop learning disability input. Plan to employ own CPN (possibly RMN/LD trained) via tier 4 service.
Hassockfield Secure Training Centre	All young people screened by health care on reception to assess risk for first 72 hours and then by health care within 5 days – in house assessment tool	Screening triggers referral to Tier 4 inreach service	Clinical assessment by cpn or where necessary by psychiatrist	Care plan developed at multi disciplinary meeting. Anger management and sexual abuse work via inreach CPN. Medication available via psychiatry. Social workers do resilience and life story work within 10 days	Forensic psychologists deliver criminogenic work. Social workers look at social need. Tier 2	Psychiatry and CPN Tier 3 to 4	Describes robust screening and assessment process. LD needs not identified or addressed. Input from Tier 4 Forensic service is highly valued. Would like to purchase more input at other tiers eg counselors etc Would like resources to offer more groups or individual support.

A summary of qualitative information regarding mental health provision and processes within the secure estate

Castington	Screening on reception for risk of self harm and previous contact with mental health services - Grubin	Referrals from many sources; eg officers, chaplin or health care assessment	Clinical assessment by CPN's (inreach or health care)	Psychiatric assessment and intervention available if required. CPN's deliver some psychotherapeutic interventions. Limited psychology available as required via inreach	CPN's deliver a range of interventions (Tier 2 to 3)	CPN, psychiatry and clinical psychology Tier 3 to 4	Health care seems separate to rest of institution and sometimes priorities conflict eg young people cannot attend appointments because of other demands in the system. Majority of young people in health care unit are there for mental health need, but most staff are not experienced in this. Requires 24 hour mental health input. Also require funding to meet needs at tiers 1 and 2. LD needs not addressed. Have found mechanism for getting mental health training into prison staff induction.

Appendix H

TABLES

Overall

Demographics

Background

Offence Information

Screening and Assessment Tools

Substance Misuse

Learning Difficulties and Learning Disability

7.1 Learning Difficulties Highlighted by Asset or YOT workers

7.2 Learning Disability Identified by YOT

Mental Health

8.1 Mental Health Diagnoses

8.2 Mental Health Issues with no clinical diagnosis

8.3 Mental Health Issues Overall

Professional Roles

9.1 Screening Provider

9.2 Assessment Provider

9.3 Intervention Provider

Intervention

10.1 Source of Intervention Provider

10.2 Intervention Type

10.3 Intervention Tier

10.4 External Mental Health Input

Reasons for No Further Action/Unmet Need

11.1 Reasons for No Screening

11.2 Reasons for No Assessment

11.3 Reasons for No Intervention

11.4 Reasons for Unmet Need

Table 1: Overall Figures

		% of *Asset Open*				% of MH Concern													
														Needs Met					
	Asset Open[1]	MH Section of Asset: ≤2		*MH Concern*[2]		*MH Activity*[3]		Screened		Assessed		Received Intervention		Yes[4]		DK		No	
Location	***N***	**N**	**%**	***N***	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Darlington	*87*	20	23	*21*	24	16	76	9	43	15	71	13	62	11	52	3	14	7	33
Durham North	*74*	15	20	*n/a*	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/
Durham South	*131*	43	33	*n/a*	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/
Hartlepool	*39*	8	21	*8*	21	6	75	5	63	2	25	3	38	4	50	0	0	4	50
Newcastle	*236*	31	13	*31*	13	15	48	4	13	12	39	13	42	13	42	2	6	16	52
Nth'land	*146*	31	21	*39*	27	26	67	19	49	24	62	15	38	15	38	6	15	18	46
N Tyneside	*186*	35	19	*35*	19	16	46	16	46	12	34	12	34	12	34	14	40	9	26
S Tyneside	*294*	40	14	*40*	14	15	38	15	38	14	35	13	33	9	23	25	63	6	15
South Tees[5]	*132*	41	31	*12*	9	10	83	10	83	8	67	8	67	7	58	5	42	0	0
Stockton	*167*	27	16	*29*	17	28	97	27	93	12	41	11	38	15	52	0	0	14	48
Sunderland	*181*	37	20	*37*	20	27	73	25	68	16	43	15	41	11	30	0	0	26	70
Total	***1673***	**328**	**20**	***252***	**15**	**159**	**63**	**130**	**52**	**115**	**46**	**103**	**41**	**97**	**38**	**55**	**22**	**100**	**40**
Castington	*109*	51	47	*48*	44	41	85	n/a	n/a	41	85	19	40	34	71	5	10	9	19
Aycliffe	*27*	22	81	*27*	100	24	89	21	78	13	48	13	48	20	74	0	0	7	26
Kyloe	*5*	4	80	*5*	100	5	100	5	100	5	100	3	60	4	80	0	0	1	20
Total	***141***	**77**	**55**	***80***	**57**	**70**	**88**	**26**	**33**	**59**	**74**	**35**	**44**	**58**	**73**	**5**	**6**	**17**	**21**
Overall	***1814***	**405**	**22**	***332***	**18**	**229**	**69**	**156**	**47**	**174**	**52**	**138**	**42**	**155**	**47**	**60**	**18**	**117**	**35**

1. *Asset Open:* All 12 – 18yo in contact with YJB between Nov '05 – Jan '06 with an open Asset (i.e. excludes 'Police Reprimands')
2. *MH Concern:* All young people who scored 2+ on MH Section of Asset PLUS those where a concern was raised pre / post Asset
   Castington MH Concerned: All young people referred to the MH Inreach Team
3. *MH Activity:* All young people who have been screened, assessed or received intervention
4. *Needs Met:* *Yes* includes '*In Process*'
5. *South Tees*: Detail is limited to those who were referred to a MH worker (12 YP)

Table 2.1: Age

Location	*MH Concern* *N*	12 N	12 %	13 N	13 %	14 N	14 %	15 N	15 %	16 N	16 %	17 N	17 %	18 N	18 %	Mean
Darlington	*21*	1	5	0	0	4	19	6	29	4	19	5	24	1	5	15
North Durham*	*15*	1	7	3	20	0	0	6	40	3	20	2	13	0	0	15
South Durham*	*43*	2	5	3	7	7	16	9	21	11	26	11	26	0	0	15
Hartlepool	*8*	0	0	1	13	0	0	2	25	5	63	0	0	0	0	15
Newcastle	*31*	1	3	2	6	4	13	12	39	5	16	5	16	1	3	15
Nth'land	*39*	4	10	3	8	3	8	9	23	7	18	10	26	3	8	15
N Tyneside	*35*	0	0	6	17	10	29	6	17	5	14	8	23	0	0	15
S Tyneside	*40*	1	3	2	5	3	8	12	30	3	8	16	40	2	5	16
South Tees	*12*	1	8	1	8	3	25	2	17	3	25	1	8	1	8	15
Stockton	*29*	2	7	0	0	5	17	6	21	4	14	9	31	3	10	16
Sunderland	*37*	6	16	10	27	5	14	4	11	4	11	7	19	1	3	14
Total	***310***	**19**	**6**	**31**	**10**	**44**	**14**	**74**	**24**	**54**	**17**	**74**	**24**	**12**	**4**	**15**
Castington	*48*	0	0	0	0	0	0	3	6	15	23	24	50	6	13	17
Aycliffe	*27*	2	7	0	0	7	26	10	37	5	19	3	11	0	0	15
Kyloe	*5*	0	0	1	20	1	20	1	20	0	0	2	40	0	0	15
Total	***80***	**2**	**3**	**1**	**1**	**8**	**10**	**14**	**18**	**20**	**25**	**29**	**36**	**6**	**8**	**16**
Overall	***390***	**21**	**5**	**32**	**8**	**52**	**13**	**88**	**23**	**74**	**19**	**103**	**26**	**18**	**5**	**15**

*Durham North & South: No MH Concern Data, figures are the number of young people who scored ≤2 on the MH section of the Asset
Newcastle & South Tyneside have one 11yo

Table 2.2:Gender

Location	*MH Concern* *N*	Male N	Male %	Female N	Female %
Darlington	*21*	15	71	6	29
North Durham*	*15*	12	80	3	20
South Durham*	*43*	31	72	12	28
Hartlepool	*8*	8	100	0	0
Newcastle	*31*	26	84	5	16
Nth'land	*39*	29	74	10	26
N Tyneside	*35*	23	66	12	34
S Tyneside	*40*	29	73	11	28
South Tees	*12*	6	50	6	50
Stockton	*29*	22	76	7	24
Sunderland	*37*	24	65	13	35
Total	***310***	**225**	**73**	**85**	**27**
Castington*	*48*	48	100	0	0
Aycliffe	*27*	14	52	13	48
Kyloe	*5*	2	40	3	60
Total	***80***	**64**	**80**	**16**	**20**
Overall	***390***	**289**	**74**	**101**	**26**

*Durham North & South: No MH Concern Data, figures are the number of young people who scored ≤2 on the MH section of the Asset
*Castington: All male YOI

Table 2.3: Ethnicity

Location	*MH Concern*	White / White British		Black / Black British		Asian / Asian British		Chinese / Other		Mixed	
	N	N	%	N	%	N	%	N	%	N	%
Darlington	*21*	21	100	0	0	0	0	0	0	0	0
Durham North*	*15*	15	100	0	0	0	0	0	0	0	0
Durham South*	*43*	43	100	0	0	0	0	0	0	0	0
Hartlepool	*8*	8	100	0	0	0	0	0	0	0	0
Newcastle	*31*	30	97	0	0	1	3	0	0	0	0
Nth'land	*39*	38	97	1	3	0	0	0	0	0	0
N Tyneside	*35*	34	97	0	0	0	0	0	0	1	3
S Tyneside	*40*	39	98	1	3	0	0	0	0	0	0
South Tees	*12*	12	100	0	0	0	0	0	0	0	0
Stockton	*29*	29	100	0	0	0	0	0	0	0	0
Sunderland	*37*	37	100	0	0	0	0	0	0	0	0
Total	***310***	**306**	**99**	**2**	**1**	**1**	**0**	**0**	**0**	**1**	**0**
Castington	*48*	44	92	4	8	0	0	0	0	0	0
Aycliffe	*27*	25	93	1	4	0	0	0	0	1	4
Kyloe	*5*	5	100	0	0	0	0	0	0	0	0
Total	***80***	**74**	**93**	**5**	**6**	**0**	**0**	**0**	**0**	**1**	**1**
Overall	***390***	**380**	**97**	**7**	**2**	**1**	**0**	**0**	**0**	**2**	**1**

*Durham North & South: No MH Concern Data, figures are the number of young people who scored ≤2 on the MH section of the Asset

Table 3.1: Caregiver (Who brought the young person up)

Location	*MH Concern*	Parents		Mother		Father		Foster Carer		Other Family		Care Home		Other	
	N	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Darlington	*21*	3	14	4	19	1	5	0	0	0	0	0	0	0	0
Hartlepool	*8*	1	13	1	13	1	13	0	0	0	0	0	0	0	0
Newcastle	*31*	5	16	16	52	1	3	2	6	2	6	1	3	2	6
Nth'land	*39*	11	28	7	18	1	3	2	5	1	3	5	13	0	0
N Tyneside	*35*	6	17	15	43	1	3	1	3	1	3	4	11	0	0
S Tyneside	*40*	3	8	7	18	0	0	0	0	0	0	0	0	0	0
South Tees	*12*	0	0	6	50	1	8	1	8	1	8	3	25	0	0
Stockton	*29*	1	3	19	66	1	3	0	0	0	0	0	0	3	10
Sunderland	*37*	11	30	8	22	1	3	0	0	1	3	3	8	0	0
Total	***252***	**41**	**16**	**83**	**33**	**8**	**3**	**6**	**2**	**6**	**2**	**16**	**6**	**5**	**2**
Castington	*48*	6	13	11	23	0	0	0	0	2	4	0	0	0	0
Aycliffe	*27*	3	11	2	7	1	4	0	0	0	0	0	0	0	0
Kyloe	*5*	0	0	1	20	0	0	0	0	0	0	0	0	0	0
Total	***80***	**9**	**11**	**14**	**18**	**1**	**1**	**0**	**0**	**2**	**3**	**0**	**0**	**0**	**0**
Overall	***332***	**50**	**15**	**97**	**29**	**9**	**3**	**6**	**2**	**8**	**2**	**16**	**5**	**5**	**2**

Table 3.1(cont.): Caregiver (Who brought the young person up)

Location	*MH Concern*	Mother & Stepfather		Father & Stepmother		Adoptive Parent/s		Complex Family		Complex Agency		Complex Between		Complex Total	
	N	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Darlington	*21*	2	10	0	0	1	5	3	14	1	5	7	33	11	52
Hartlepool	*8*	3	38	1	13	1	13	0	0	0	0	0	0	0	0
Newcastle	*31*	0	0	0	0	0	0	0	0	0	0	2	6	2	6
Nth'land	*39*	1	3	1	3	2	5	6	15	2	5	0	0	8	21
N Tyneside	*35*	5	14	0	0	0	0	1	3	0	0	1	3	2	6
S Tyneside	*40*	4	10	2	5	0	0	14	35	6	15	4	10	24	60
South Tees	*12*	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Stockton	*29*	0	0	0	0	0	0	0	0	0	0	5	17	5	17
Sunderland	*37*	1	3	0	0	0	0	1	3	1	3	10	27	12	32
Total	***252***	**16**	**6**	**4**	**2**	**4**	**2**	**25**	**10**	**10**	**4**	**29**	**12**	**64**	**25**
Castington*	*48*	1	2	0	0	0	0	7	15	0	0	20	42	1	2
Aycliffe	*27*	1	4	0	0	0	0	4	15	0	0	16	59	20	74
Kyloe	*5*	0	0	0	0	0	0	1	20	0	0	3	60	4	80
Total	***80***	**2**	**3**	**0**	**0**	**0**	**0**	**12**	**15**	**0**	**0**	**39**	**49**	**51**	**64**
Overall	***332***	**18**	**5**	**4**	**1**	**4**	**1**	**37**	**11**	**10**	**3**	**68**	**20**	**115**	**35**

*Castington: 6 cases where 'Caregiver' is unknown

Table 3.2: Abuse; Domestic Violence; Bereavement / Loss

Location	*MH Concern*	Abuse						Domestic Violence						Bereavement / Loss					
		Yes		No		DK		Yes		No		DK		Yes		No		DK	
	N	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Darlington	*21*	9	43	7	33	5	24	7	33	11	52	3	14	14	67	5	24	2	10
Hartlepool	*8*	3	38	5	63	0	0	3	38	5	63	0	0	1	13	7	88	0	0
Newcastle	*31*	5	16	14	45	12	39	7	23	12	39	12	39	7	23	16	52	8	26
Nth'land	*39*	19	49	17	44	3	8	5	13	23	59	11	28	18	46	16	41	5	13
N Tyneside	*35*	11	31	20	57	4	11	6	17	14	40	5	14	17	49	15	43	3	9
S Tyneside	*40*	21	53	12	30	7	18	16	40	12	30	12	30	17	43	12	30	11	28
South Tees	*12*	6	50	6	50	0	0	6	50	6	50	0	0	4	33	8	67	0	0
Stockton	*29*	16	55	13	45	0	0	18	62	11	38	0	0	13	45	16	55	0	0
Sunderland	*37*	22	59	14	38	11	30	17	46	19	51	1	3	21	57	16	43	0	0
Total	***252***	**112**	**44**	**108**	**43**	**42**	**17**	**85**	**34**	**113**	**45**	**44**	**17**	**112**	**44**	**111**	**44**	**29**	**12**
Castington	*48*	26	54	9	19	13	27	23	48	9	19	16	33	16	33	18	38	14	29
Aycliffe	*27*	11	41	6	22	10	37	10	37	6	22	11	41	9	33	12	44	6	22
Kyloe	*5*	4	80	0	0	1	20	3	60	0	0	2	40	2	40	2	40	1	20
Total	***80***	**41**	**51**	**15**	**19**	**24**	**30**	**36**	**45**	**15**	**19**	**29**	**36**	**27**	**34**	**32**	**40**	**21**	**26**
Overall	***332***	**153**	**46**	**123**	**37**	**66**	**20**	**121**	**36**	**128**	**39**	**73**	**22**	**139**	**42**	**143**	**43**	**50**	**15**

Table 3.3: Vulnerability (specific)

Location	*MH Concern*	Vulnerable to Other People						Vulnerable to Other Events						Vulnerable to Own Behaviour						Vulnerable to Self Harm / Suicide					
		Yes		No		DK		Yes		No		DK		Yes		No		DK		Yes		No		DK	
	N	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Darlington	*21*	5	24	16	76	0	0	5	24	16	76	0	0	5	24	16	76	0	0	4	19	17	81	0	0
Hartlepool	*8*	2	25	4	50	2	25	1	13	5	63	2	25	3	38	4	50	1	13	6	75	1	13	1	13
Newcastle	*31*	8	26	15	48	8	26	4	13	17	55	10	32	9	29	12	39	10	32	6	19	18	58	7	23
Nth'land	*39*	7	18	18	46	14	36	8	21	20	51	11	28	12	31	16	41	11	28	8	21	18	46	13	33
N Tyneside	*35*	17	49	14	40	4	11	9	26	21	60	5	14	21	60	11	31	3	8.6	11	31	19	54	5	14
S Tyneside	*40*	13	33	15	38	12	30	17	43	13	33	10	25	17	43	12	30	11	28	16	40	8	20	16	40
South Tees	*12*	0	0	0	0	12	100	0	0	0	0	12	100	0	0	0	0	12	100	0	0	0	0	12	100
Stockton	*29*	9	31	20	69	0	0	4	14	25	86	0	0	14	48	15	52	0	0	6	21	23	79	0	0
Sunderland	*37*	1	2.7	24	65	12	32	3	8.1	22	59	12	32	7	19	9	24	11	30	3	8.1	23	62	11	30
Total	***252***	**62**	**25**	**126**	**50**	**64**	**25**	**51**	**20**	**139**	**55**	**62**	**25**	**88**	**35**	**95**	**38**	**59**	**23**	**60**	**24**	**127**	**50**	**65**	**26**
Castington	*48*	21	44	17	35	10	21	18	38	20	42	10	21	24	50	14	29	10	21	16	33	19	40	13	27
Aycliffe	*27*	9	33	9	33	9	33	10	37	8	30	9	33	16	59	3	11	8	30	6	22	14	52	7	26
Kyloe	*5*	2	40	2	40	1	20	2	40	2	40	1	20	3	60	1	20	1	20	3	60	1	20	1	20
Total	***80***	**32**	**40**	**28**	**35**	**20**	**25**	**30**	**38**	**30**	**38**	**20**	**25**	**43**	**54**	**18**	**23**	**19**	**24**	**25**	**31**	**34**	**43**	**21**	**26**
Overall	***332***	**94**	**28**	**154**	**46**	**84**	**25**	**81**	**24**	**169**	**51**	**82**	**25**	**131**	**39**	**113**	**34**	**78**	**23**	**85**	**26**	**161**	**48**	**86**	**26**

Table 3.4: Vulnerability Overall

Location	*MH Concern*	Vulnerable					
		Yes		No		DK	
	N	N	%	N	%	N	%
Darlington	*21*	21	100	0	0	0	0
Hartlepool	*8*	3	38	5	63	0	0
Newcastle	*31*	15	48	8	26	8	26
Nth'land	*39*	20	51	9	23	10	26
N Tyneside	*35*	27	77	5	14	3	9
S Tyneside	*40*	28	70	2	5	10	25
South Tees	*12*	10	83	2	17	0	0
Stockton	*29*	17	59	12	41	0	0
Sunderland	*37*	23	62	13	35	1	3
Total	***252***	**164**	**65**	**56**	**22**	**32**	**13**
Castington	*48*	33	69	6	13	9	19
Aycliffe	*27*	19	70	1	4	7	26
Kyloe	*5*	3	60	1	20	1	20
Total	***80***	**55**	**69**	**8**	**10**	**17**	**21**
Overall	***332***	**219**	**66**	**64**	**19**	**49**	**15**

Table 4.1: Offence Type

Location	*MH Concern*	Violence		Sexual		Public Order		Burglary		Robbery		Vehicle Theft		Other Motoring		Theft / Handling		Fraud / Forgery	
	N	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Darlington	*21*	6	29	2	10	0	0	4	19	0	0	0	0	2	10	4	19	0	0
North Durham*	*15*	4	27	0	0	3	20	1	7	0	0	0	0	1	7	5	33	0	0
South Durham*	*43*	15	35	1	2	2	5	5	12	0	0	0	0	0	0	10	23	0	0
Hartlepool	*8*	3	38	0	0	0	0	3	38	0	0	0	0	0	0	1	13	0	0
Newcastle	*31*	4	13	1	3	2	6	5	16	0	0	1	3	2	6	7	23	0	0
Nth'land	*39*	9	23	0	0	4	10	4	10	0	0	4	10	0	0	6	15	0	0
N Tyneside	*35*	8	23	1	3	2	6	0	0	0	0	0	0	0	0	2	6	0	0
S Tyneside	*40*	5	13	0	0	4	10	1	3	3	8	1	3	0	0	6	15	0	0
South Tees	*12*	6	50	0	0	0	0	0	0	0	0	0	0	0	0	2	17	0	0
Stockton	*29*	15	52	0	0	1	3	1	3	0	0	1	3	2	7	5	17	0	0
Sunderland	*37*	4	11	1	3	4	11	1	3	0	0	0	0	0	0	9	24	0	0
Total	***310***	**79**	**25**	**6**	**2**	**22**	**7**	**25**	**8**	**3**	**1**	**7**	**2**	**7**	**2**	**57**	**18**	**0**	**0**
Castington	*48*	9	19	7	15	0	0	7	15	9	19	1	2	1	2	3	6	0	0
Aycliffe	*27*	10	37	3	11	0	0	5	19	3	11	0	0	0	0	1	4	0	0
Kyloe	*5*	2	40	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	***80***	**21**	**26**	**10**	**13**	**0**	**0**	**12**	**15**	**12**	**15**	**1**	**1**	**1**	**1**	**4**	**5**	**0**	**0**
Overall	***390***	**100**	**26**	**16**	**4**	**22**	**6**	**37**	**9**	**15**	**4**	**8**	**2**	**8**	**2**	**61**	**16**	**0**	**0**

*Durham North & South: No MH Concern Data, figures are the number of young people who scored ≤2 on the MH section of the Asset

Table 4.1(cont.): Offence Type

Location	*MH Concern*	Criminal Damage		Drugs Offences		Breach of Court Order		Murder / Mansl'ter		Arson		Poss / Off / Weapon		Harassment		Other Offences		Multiple Offences	
	N	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Darlington	*21*	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	10	1	5
North Durham*	*15*	1	7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
South Durham*	*43*	3	7	1	2	3	7	0	0	0	0	1	2	1	2	1	2	0	0
Hartlepool	*8*	1	13	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Newcastle	*31*	7	23	0	0	0	0	0	0	0	0	2	6	0	0	0	0	0	0
Nth'land	*39*	1	3	6	15	2	5	0	0	0	0	1	3	1	3	1	3	0	0
N Tyneside	*35*	5	14	0	0	7	20	0	0	0	0	2	6	1	3	0	0	7	20
S Tyneside	*40*	5	13	0	0	6	15	0	0	0	0	1	3	4	10	2	5	2	5
South Tees	*12*	2	17	1	8	1	8	0	0	0	0	0	0	0	0	0	0	0	0
Stockton	*29*	2	7	0	0	0	0	0	0	1	3	1	3	0	0	0	0	0	0
Sunderland	*37*	6	16	0	0	4	11	0	0	0	0	2	5	1	3	1	3	4	11
Total	***310***	**33**	**11**	**8**	**3**	**23**	**7**	**0**	**0**	**1**	**0**	**10**	**3**	**8**	**3**	**7**	**2**	**14**	**5**
Castington	*48*	0	0	0	0	2	4	4	8	1	2	2	4	1	2	1	2	0	0
Aycliffe	*27*	1	4	0	0	0	0	0	0	3	11	1	4	0	0	0	0	0	0
Kyloe	*5*	0	0	0	0	2	40	0	0	1	20	0	0	0	0	0	0	0	0
Total	***80***	**1**	**1**	**0**	**0**	**4**	**5**	**4**	**5**	**5**	**6**	**3**	**4**	**1**	**1**	**1**	**1**	**0**	**0**
Overall	***390***	**34**	**9**	**8**	**2**	**27**	**7**	**4**	**1**	**6**	**2**	**13**	**3**	**9**	**2**	**8**	**2**	**14**	**4**

*Durham North & South: No MH Concern Data, figures are the number of young people who scored ≤2 on the MH section of the Asset

Table 4.2: Order Length

Location	*MH Concern*	Dismissed		Pending		Remand		Hours / Days		Months		Years		Lifer	
	N	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Darlington	*21*	0	0	0	0	0	0	0	0	18	86	3	14	0	0
North Durham*	*15*	0	0	0	0	0	0	0	0	15	100	0	0	0	0
South Durham*	*43*	0	0	0	0	0	0	0	0	41	95	2	5	0	0
Hartlepool	*8*	0	0	0	0	0	0	0	0	6	75	2	25	0	0
Newcastle	*31*	0	0	3	10	0	0	1	3	26	84	1	3	0	0
Nth'land	*39*	2	5	4	10	0	0	0	0	32	82	1	3	0	0
N Tyneside	*35*	0	0	1	3	0	0	0	0	33	94	1	3	0	0
S Tyneside	*40*	0	0	2	5	0	0	4	10	29	73	5	13	0	0
South Tees	*12*	0	0	0	0	0	0	0	0	11	92	1	8	0	0
Stockton	*29*	1	3	0	0	0	0	0	0	25	86	3	10	0	0
Sunderland	*37*	0	0	0	0	0	0	3	8	32	86	2	5	0	0
Total	***310***	**3**	**1**	**10**	**3**	**0**	**0**	**8**	**3**	**268**	**86**	**21**	**7**	**0**	**0**
Castington	*48*	0	0	0	0	0	0	0	0	11	23	31	65	6	13
Aycliffe	*27*	0	0	0	0	2	7	0	0	15	56	9	33	1	4
Kyloe	*5*	0	0	0	0	1	20	0	0	2	40	2	40	0	0
Total	***80***	**0**	**0**	**0**	**0**	**3**	**4**	**0**	**0**	**28**	**35**	**42**	**53**	**7**	**9**
Overall	***390***	**3**	**1**	**10**	**3**	**3**	**1**	**8**	**2**	**296**	**76**	**63**	**16**	**7**	**2**

*Durham North & South: No MH Concern Data, figures are the number of young people who scored ≤2 on the MH section of the Asset

Castington - 1 YP is Detained for Public Protection - Included in "Lifer"

Table 4.3: Order Length - More Detailed Breakdown

Location	*MH Concern*	Months						Years							
		0 - 6		6 - 12		Total		1 - 3		3 - 9		Total		Lifer	
	N	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Darlington	*21*	10	48	8	38	18	86	0	0	3	14	3	14	0	0
North Durham*	*15*	9	60	6	40	15	100	0	0	0	0	0	0	0	0
South Durham*	*43*	29	67	12	28	41	95	2	5	0	0	2	5	0	0
Hartlepool	*8*	3	38	3	38	6	75	0	0	2	25	2	25	0	0
Newcastle	*31*	19	61	7	23	26	84	1	3	0	0	1	3	0	0
Nth'land	*39*	28	72	4	10	32	82	1	3	0	0	1	3	0	0
N Tyneside	*35*	29	83	4	11	33	94	1	3	0	0	1	3	0	0
S Tyneside	*40*	18	45	11	28	29	73	5	13	0	0	5	13	0	0
South Tees	*12*	6	50	5	42	11	92	1	8	0	0	1	8	0	0
Stockton	*29*	6	21	19	66	25	86	3	10	0	0	3	10	0	0
Sunderland	*37*	28	76	4	11	32	86	2	5	0	0	2	5	0	0
Total	***310***	**185**	**60**	**83**	**27**	**268**	**86**	**16**	**5**	**5**	**2**	**21**	**7**	**0**	**0**
Castington	*48*	6	13	4	8	11	23	14	29	17	35	31	65	6	13
Aycliffe	*27*	5	19	10	37	15	56	4	15	5	19	9	33	1	4
Kyloe	*5*	1	20	1	20	2	40	2	40	0	0	2	40	0	0
Total	***80***	**12**	**15**	**15**	**19**	**28**	**35**	**20**	**25**	**22**	**28**	**42**	**53**	**7**	**9**
Overall	***390***	**197**	**51**	**98**	**25**	**296**	**76**	**36**	**9**	**27**	**7**	**63**	**16**	**7**	**2**

*Durham North & South: No MH Concern Data, figures are the number of young people who scored ≤2 on the MH section of the Asset

Castington - 1 YP is Detained for Public Protection - Included in "Lifer"

Table 4.4: Disposal Order

Location		Community												Custodial							
	MH Concern	Dismissed		Pending		Remand		Con / Abs Discharge; Fine; Reprimand		Final Warning		Community Order (Inc. Multiple Orders)		DTO		Sec 91 / 92 / 93		Recalled		Ext'd / Detained for Public Protection	
	N	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Darlington	*21*	0	0	0	0	0	0	0	0	0	0	13	62	6	29	2	10	0	0	0	0
North Durham*	*15*	0	0	0	0	0	0	0	0	1	7	12	80	2	13	0	0	0	0	0	0
South Durham*	*43*	0	0	0	0	0	0	0	0	16	37	23	53	4	9	0	0	0	0	0	0
Hartlepool	*8*	0	0	0	0	0	0	0	0	0	0	6	75	0	0	2	25	0	0	0	0
Newcastle	*31*	0	0	3	10	0	0	0	0	6	19	19	61	3	10	0	0	0	0	0	0
Nth'land	*39*	2	5	4	10	0	0	1	3	18	46	12	31	2	5	0	0	0	0	0	0
N Tyneside	*35*	0	0	1	3	0	0	2	6	4	11	22	63	6	17	0	0	0	0	0	0
S Tyneside	*40*	0	0	2	5	0	0	0	0	8	20	24	60	4	10	2	5	0	0	0	0
South Tees	*12*	0	0	0	0	0	0	0	0	4	33	7	58	1	8	0	0	0	0	0	0
Stockton	*29*	0	0	0	0	0	0	1	3	1	3	25	86	2	7	0	0	0	0	0	0
Sunderland	*37*	0	0	0	0	0	0	0	0	11	30	23	62	3	8	0	0	0	0	0	0
Total	***310***	**2**	**1**	**10**	**3**	**0**	**0**	**4**	**1**	**69**	**22**	**186**	**60**	**33**	**11**	**6**	**2**	**0**	**0**	**0**	**0**
Castington*	*48*	0	0	0	0	0	0	0	0	0	0	0	0	22	46	23	48	1	2	2	4
Aycliffe	*27*	0	0	0	0	2	7	0	0	0	0	0	0	17	63	8	30	0	0	0	0
Kyloe	*5*	0	0	0	0	1	20	0	0	0	0	0	0	4	80	0	0	0	0	0	0
Total	***80***	**0**	**0**	**0**	**0**	**3**	**4**	**0**	**0**	**0**	**0**	**0**	**0**	**43**	**54**	**31**	**39**	**1**	**1**	**2**	**3**
Overall	***390***	**2**	**1**	**10**	**3**	**3**	**1**	**4**	**1**	**69**	**18**	**186**	**48**	**76**	**19**	**37**	**9**	**1**	**0**	**2**	**1**

*Durham North & South: No MH Concern Data, figures are the number of young people who scored ≤2 on the MH section of the Asset *Castington: No remand information

Table 5.1: Screening Tools

Location	*Screened*	Interview*		SQIFA		CAMHS Tool		Joint CAMHS & YOT Tool		Joint MH & SM Tool		Other	
	N	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Darlington	*9*	0	0	0	0	0	0	0	0	9	100	0	0
Hartlepool	*5*	0	0	5	100	0	0	0	0	0	0	0	0
Newcastle	*4*	0	0	4	100	0	0	0	0	0	0	0	0
Nth'land	*19*	0	0	18	95	0	0	0	0	0	0	1	5
N Tyneside	*16*	0	0	16	100	0	0	0	0	0	0	0	0
S Tyneside	*15*	0	0	15	100	0	0	0	0	0	0	0	0
South Tees	*10*	0	0	0	0	4	40	6	60	0	0	0	0
Stockton	*27*	0	0	27	100	0	0	0	0	0	0	0	0
Sunderland	*25*	0	0	25	100	0	0	0	0	0	0	0	0
Total	***130***	**0**	**0**	**110**	**85**	**4**	**3**	**6**	**5**	**9**	**7**	**1**	**1**
Castington	*n/a*	/	/	/	/	/	/	/	/	/	/	/	/
Aycliffe	*21*	21	100	0	0	0	0	0	0	0	0	0	0
Kyloe	*5*	5	100	0	0	0	0	0	0	0	0	0	0
Total	***26***	**26**	**100**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Overall	***156***	**26**	**17**	**110**	**71**	**4**	**3**	**6**	**4**	**9**	**6**	**1**	**1**

*Interview: crried out by MH Worker

Table 5.2: Assessment Tools

Location	*Assessed*	Interview*		SIFA		CAMHS Tool		Joint CAMHS & YOT Tool		Other	
	N	N	%	N	%	N	%	N	%	N	%
Darlington	*15*	3	20	0	0	0	0	12	80	0	0
Hartlepool	*2*	0	0	1	50	1	50	0	0	0	0
Newcastle	*12*	0	0	11	92	0	0	0	0	1	8
Nth'land	*24*	2	8	17	71	1	4	0	0	4	17
N Tyneside	*12*	0	0	0	0	12	100	0	0	0	0
S Tyneside	*14*	0	0	0	0	0	0	0	0	14	100
South Tees	*8*	0	0	0	0	8	100	0	0	0	0
Stockton	*12*	0	0	0	0	12	100	0	0	0	0
Sunderland	*16*	1	6	0	0	15	94	0	0	0	0
Total	***115***	**6**	**5**	**29**	**25**	**49**	**43**	**12**	**10**	**19**	**17**
Castington	*41*	39	95	0	0	0	0	0	0	2	5
Aycliffe	*13*	13	100	0	0	0	0	0	0	0	0
Kyloe	*5*	5	100	0	0	0	0	0	0	0	0
Total	***59***	**57**	**97**	**0**	**0**	**0**	**0**	**0**	**0**	**2**	**3**
Overall	***174***	**63**	**36**	**29**	**17**	**49**	**28**	**12**	**7**	**21**	**12**

*Interview carried out by MH Worker
Castington - 41 = Those referred for assessment by the MH Inreach Team

Table 6.1: Substance Misuse

Location	*MH Concern*	Substance Misuse Section of Asset: 2+		Substance Misuse Identified		Alcohol		Drugs		Substance Misuse Intervention		Intervention: Substance Misuse Tier							
												1		2		3		4	
	N	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Darlington	*21*	11	52	16	76	13	62	13	62	7	33	0	0	7	33	0	0	0	0
Hartlepool	*8*	4	50	4	50	4	50	3	50	2	25	0	0	2	25	0	0	0	0
Newcastle	*31*	19	61	n/a	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/
Nth'land	*39*	13	33	13	33	8	21	10	26	4	10	0	0	1	3	3	8	0	0
N Tyneside	*35*	18	51	9	26	9	26	5	14	6	17	0	0	5	14	1	3	0	0
S Tyneside	*40*	22	55	13	33	13	33	11	28	n/a	/	/	/	/	/	/	/	/	/
South Tees	*12*	4	33	4	33	4	33	3	25	3	25	1	8	1	8	1	8	0	0
Stockton	*29*	20	69	18	62	16	55	12	41	9	31	0	0	8	28	1	3	0	0
Sunderland	*37*	16	43	14	38	/	/	/	/	7	19	1	3	2	5	4	11	0	0
Total	***252***	**127**	**50**	**91**	**36**	**67**	**27**	**57**	**23**	**38**	**15**	**2**	**1**	**26**	**10**	**10**	**4**	**0**	**0**
Castington	*48*	34	71	33	69	/	/	/	/	41	85	6	13	7	15	13	27	14	29
Aycliffe	*27*	16	59	n/a	/	/	/	/	/	25	93	0	0	20	74	5	19	0	0
Kyloe	*5*	4	80	2	40	1	20	1	20	2	40	0	0	2	40	0	0	0	0
Total	***80***	**54**	**68**	**35**	**44**	**1**	**1**	**1**	**1**	**68**	**85**	**6**	**8**	**29**	**36**	**18**	**23**	**14**	**18**
Overall	***332***	**181**	**55**	**126**	**38**	**68**	**20**	**58**	**17**	**106**	**32**	**8**	**2**	**55**	**17**	**28**	**8**	**14**	**4**

Table 7.1: Learning Difficulties Highlighted by Asset or YOT Worker

Location	*MH Concern*	Special Educational Needs Identified						Statement of Special Educational Needs						Evidence of Action				Statement & E. of Action	
		Yes		No		DK		Yes		No		DK		Yes		No			
	N	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Darlington	21	6	29	15	71	0	0	5	24	16	76	0	0	7	33	14	67	5	24
Hartlepool	8	3	38	5	63	0	0	0	0	8	100	0	0	3	38	5	63	0	0
Newcastle	31	8	26	11	35	12	39	6	19	13	42	12	39	7	23	24	77	5	16
Nth'land	39	11	28	26	67	2	5	9	23	28	72	2	5	13	33	26	67	4	10
N Tyneside	35	13	37	21	60	1	3	9	26	22	63	4	11	16	46	19	54	8	23
S Tyneside	40	10	25	4	10	26	65	5	13	7	18	28	70	12	30	28	70	4	10
South Tees	12	3	25	9	75	0	0	3	25	9	75	0	0	2	17	10	83	3	25
Stockton	29	14	48	15	52	0	0	10	34	19	66	0	0	4	14	25	86	4	14
Sunderland	37	7	19	26	70	4	11	4	11	28	76	5	14	4	11	33	89	4	11
Total	**252**	**75**	**30**	**132**	**52**	**45**	**18**	**51**	**20**	**150**	**60**	**51**	**20**	**68**	**27**	**184**	**73**	**37**	**15**
Castington	48	19	40	19	40	10	21	12	25	24	50	12	25	10	21	38	79	7	15
Aycliffe	27	12	44	12	44	3	11	14	52	11	41	2	7	11	41	16	59	10	37
Kyloe	5	3	60	1	20	1	20	3	60	1	20	1	20	3	60	2	40	3	60
Total	**80**	**34**	**43**	**32**	**40**	**14**	**18**	**29**	**36**	**36**	**45**	**15**	**19**	**24**	**30**	**56**	**70**	**20**	**25**
Overall	**332**	**109**	**33**	**164**	**49**	**59**	**18**	**80**	**24**	**186**	**56**	**66**	**20**	**92**	**28**	**240**	**72**	**57**	**17**

Table 7.2: Number of Young People Identified with a Learning Disability by YOT

Location	*MH Concern*	Learning Disability Diagnosis Identified by YOT		Referral to Specialist Learning Disability Service		Needs Met*	
						Of those "Identified"	
	N	**N**	**%**	**N**	**%**	**N**	**%**
Darlington	*21*	2	10	2	10	2	100
Hartlepool	*8*	0	0	0	0	n/a	n/a
Newcastle	*31*	3	10	1	3	1	33
Nth'land	*39*	1	3	1	3	1	100
N Tyneside	*35*	0	0	0	0	n/a	n/a
S Tyneside	*40*	0	0	0	0	n/a	n/a
South Tees	*12*	0	0	0	0	n/a	n/a
Stockton	*29*	0	0	0	0	n/a	n/a
Sunderland	*37*	0	0	1	3	0	n/a
Total	***252***	**6**	**2**	**5**	**2**	**4**	**67**
Castington	*48*	0	0	0	0	n/a	n/a
Aycliffe	*27*	4	15	1	4	3	75
Kyloe	*5*	1	20	1	20	1	100
Total	***80***	**5**	**6**	**2**	**3**	**4**	**80**
Overall	***332***	**11**	**3**	**7**	**2**	**8**	**73**

*Needs Met includes "in process"

Ruth Andrews & Greta Ford's Research found 2 YP in Newcastle and 1 YP in Northumberland as appropriate for further assessment by LD Services

Darlington LD Diagnosis: Both YP received assessment at Tier 4 Service Level and also have a diagnosis of ADHD

Table 8.1: Mental Health Diagnoses

Location	*MH Concern*	Depression		PTSD		Anxiety Disorder		ADHD		Psychotic Disorder		Learning Disability	
	N	N	%	N	%	N	%	N	%	N	%	N	%
Darlington	*21*	0	0	0	0	0	0	4	19	0	0	2	10
Hartlepool	*8*	0	0	0	0	0	0	1	13	0	0	0	0
Newcastle	*31*	1	3	1	3	0	0	5	16	0	0	3	10
Nth'land	*39*	0	0	0	0	0	0	4	10	0	0	1	3
N Tyneside	*35*	0	0	0	0	0	0	3	9	0	0	0	0
S Tyneside*	*40*	0	0	0	0	0	0	0	0	0	0	0	0
South Tees	*12*	0	0	0	0	1	8	3	25	0	0	0	0
Stockton	*29*	2	7	0	0	0	0	3	10	0	0	0	0
Sunderland	*37*	0	0	0	0	0	0	0	0	0	0	0	0
Total	***252***	**3**	**1**	**1**	**0**	**1**	**0**	**23**	**9**	**0**	**0**	**6**	**2**
Castington	*41*	0	0	0	0	0	0	1	2	1	2	0	0
Aycliffe	*27*	0	0	0	0	0	0	3	11	0	0	4	15
Kyloe	*5*	1	20	0	0	0	0	0	0	0	0	2	40
Total	***73***	**1**	**1**	**0**	**0**	**0**	**0**	**4**	**5**	**1**	**1**	**6**	**8**
Overall	***325***	**4**	**1**	**1**	**0**	**1**	**0**	**27**	**8**	**1**	**0**	**12**	**4**

Castington - 41 = Those referred for assessment by the MH Inreach Team
*South Tyneside: No Info. on MH diagnosis except Emotional Disorder

Table 8.1 (cont.): Mental Health Diagnoses

Location	*MH Concern*	Behavioural Disorder		Eating Disorder		Attachment Disorder		Autism Spectrum Disorder		Emotional Disorder		Other	
	N	N	%	N	%	N	%	N	%	N	%	N	%
Darlington	*21*	0	0	0	0	0	0	0	0	0	0	0	0
Hartlepool	*8*	0	0	0	0	0	0	0	0	0	0	0	0
Newcastle	*31*	0	0	0	0	0	0	0	0	1	3	1	3
Nth'land	*39*	0	0	1	3	0	0	0	0	0	0	0	0
N Tyneside	*35*	0	0	0	0	0	0	0	0	0	0	0	0
S Tyneside*	*40*	0	0	0	0	0	0	0	0	3	8	0	0
South Tees	*12*	0	0	0	0	0	0	0	0	0	0	0	0
Stockton	*29*	3	10	0	0	1	3	2	7	0	0	0	0
Sunderland	*37*	0	0	0	0	0	0	0	0	0	0	0	0
Total	***252***	**3**	**1**	**1**	**0**	**1**	**0**	**2**	**1**	**4**	**2**	**1**	**0**
Castington	*41*	1	2	0	0	0	0	0	0	0	0	1	2
Aycliffe	*27*	0	0	0	0	0	0	0	0	0	0	0	0
Kyloe	*5*	0	0	0	0	0	0	0	0	0	0	0	0
Total	***73***	**1**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**1**
Overall	***325***	**4**	**1**	**1**	**0**	**1**	**0**	**2**	**1**	**4**	**1**	**2**	**1**

Castington - 41 = Those referred and assessed

*South Tyneside: No Info. on MH diagnosis except Emotional Disorder

Table 8.2: Mental Health Issues with No Clinical Diagnosis

Location	*MH Concern*	Depression		PTSD		Anxiety		ADHD		Psychotic		LD		Self Harm		Ber. / Loss		Eating Disorder		Anger	
	N	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Darlington	*21*	1	5	6	29	7	33	0	0	0	0	0	0	7	33	12	57	1	5	1	5
Hartlepool	*8*	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Newcastle	*31*	1	3	1	3	1	3	3	10	0	0	0	0	3	10	1	3	0	0	0	0
Nth'land	*39*	8	21	2	5	6	15	2	5	0	0	3	8	4	10	3	8	0	0	4	10
N Tyneside	*35*	4	11	3	9	5	14	0	0	0	0	1	3	3	9	1	3	0	0	3	9
S Tyneside	*40*	6	15	3	8	8	20	1	3	1	3	0	0	6	15	0	0	0	0	0	0
South Tees	*12*	1	8	0	0	1	8	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Stockton	*29*	4	14	5	17	8	28	2	7	1	3	3	10	7	24	1	3	0	0	2	7
Sunderland	*37*	0	0	0	0	1	3	4	11	0	0	0	0	3	8	2	5	0	0	1	3
Total	***252***	**25**	**10**	**20**	**8**	**37**	**15**	**12**	**5**	**2**	**1**	**7**	**3**	**33**	**13**	**20**	**8**	**1**	**0**	**11**	**4**
Castington	*41*	5	12	7	17	7	17	1	2	6	15	0	0	17	41	8	20	0	0	10	24
Aycliffe	*27*	1	4	1	4	0	0	2	7	2	7	1	4	4	15	1	4	0	0	5	19
Kyloe	*5*	0	0	0	0	0	0	0	0	0	0	0	0	2	40	1	20	0	0	0	0
Total	***73***	**6**	**8**	**8**	**11**	**7**	**10**	**3**	**4**	**8**	**11**	**1**	**1**	**23**	**32**	**10**	**14**	**0**	**0**	**15**	**21**
Overall	***325***	**31**	**10**	**28**	**9**	**44**	**14**	**15**	**5**	**10**	**3**	**8**	**2**	**56**	**17**	**30**	**9**	**1**	**0**	**26**	**8**

Castington - 41 = Those referred and assessed

Table 8.2 (cont.): Mental Health Issues with No Clinical Diagnosis

Location	*MH Concern*	Personality		Sexual Abuse		Physical Abuse		Behavioural		Relationship		Parenting		ASD		Sexual Identity		Emotional		Other	
	N	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Darlington	*21*	2	10	1	5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Hartlepool	*8*	0	0	0	0	0	0	1	13	0	0	0	0	0	0	0	0	0	0	0	0
Newcastle	*31*	0	0	0	0	0	0	2	6	1	3	1	3	0	0	2	6	2	6	2	6
Nth'land	*39*	0	0	0	0	1	3	2	5	2	5	2	5	0	0	0	0	3	8	3	8
N Tyneside	*35*	2	6	0	0	1	3	0	0	3	9	1	3	0	0	0	0	4	11	4	11
S Tyneside	*40*	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	8	0	0
South Tees	*12*	0	0	0	0	0	0	8	67	0	0	0	0	0	0	0	0	0	0	0	0
Stockton	*29*	0	0	0	0	0	0	2	7	0	0	0	0	0	0	0	0	1	3	1	3
Sunderland	*37*	0	0	1	3	0	0	6	16	1	3	5	14	0	0	0	0	4	11	4	11
Total	***252***	**4**	**2**	**2**	**1**	**2**	**1**	**21**	**8**	**7**	**3**	**9**	**4**	**0**	**0**	**2**	**1**	**17**	**7**	**14**	**6**
Castington	*41*	0	0	0	0	2	5	3	7	1	2	0	0	0	0	0	0	0	0	0	0
Aycliffe	*27*	1	4	2	7	0	0	3	11	1	4	0	0	0	0	0	0	4	15	4	15
Kyloe	*5*	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	***73***	**1**	**1**	**2**	**3**	**2**	**3**	**6**	**8**	**2**	**3**	**0**	**0**	**0**	**0**	**0**	**0**	**4**	**5**	**4**	**5**
Overall	***325***	**5**	**2**	**4**	**1**	**4**	**1**	**27**	**8**	**9**	**3**	**9**	**3**	**0**	**0**	**2**	**1**	**21**	**6**	**18**	**6**

Castington - 41 = Those referred and assessed

Table 8.3: Mental Health Issues: Overall

Location	*MH Concern*	MH Diagnosis		MH Issue with No Clinical Diagnosis		MH Issue (Diagnosis / No Diagnosis)	
	N	**N**	**%**	**N**	**%**	**N**	**%**
Darlington	*21*	4	19	15	71	15	71
Hartlepool	*8*	1	13	1	13	2	25
Newcastle	*31*	9	29	8	26	15	48
Nth'land	*39*	6	15	18	46	23	59
N Tyneside	*35*	3	9	13	37	15	43
S Tyneside	*40*	3	8	14	35	14	35
South Tees	*12*	4	33	10	83	11	92
Stockton	*29*	8	28	17	59	20	69
Sunderland	*37*	0	0	16	43	16	43
Total	***252***	**38**	**15**	**112**	**44**	**131**	**52**
Castington*	*41*	3	7	35	85	47	115
Aycliffe	*27*	4	15	12	44	15	56
Kyloe	*5*	3	60	3	60	4	80
Total	***73***	**10**	**14**	**50**	**68**	**66**	**90**
Overall	***325***	**48**	**15**	**162**	**50**	**197**	**61**

*Castington MH Issue (Diagnosis / No Diagnosis) = 115% as MH issues picked up from asset but not referred

Castington - 41 = Those referred and assessed

Table 9.1: Role of Professional who Provided Screening

Location	*Screened*	Generic Worker		Social Worker		Health Worker		MH Worker		SM Worker		Clinical Psychologist	
	N	N	%	N	%	N	%	N	%	N	%	N	%
Darlington	*9*	9	100	0	0	0	0	0	0	0	0	0	0
Hartlepool	*5*	4	80	1	20	0	0	0	0	0	0	0	0
Newcastle	*4*	4	100	0	0	0	0	0	0	0	0	0	0
Nth'land	*19*	19	100	0	0	0	0	0	0	0	0	0	0
N Tyneside	*16*	16	100	0	0	0	0	0	0	0	0	0	0
S Tyneside*	*15*	15	100	0	0	0	0	0	0	0	0	0	0
South Tees	*10*	0	0	4	40	0	0	6	60	0	0	0	0
Stockton	*27*	9	33	1	4	14	52	0	0	3	11	0	0
Sunderland	*25*	25	100	0	0	0	0	0	0	0	0	0	0
Total	***130***	**101**	**78**	**6**	**5**	**14**	**11**	**6**	**5**	**3**	**2**	**0**	**0**
Castington	*n/a*	/	/	/	/	/	/	/	/	/	/	/	/
Aycliffe	*21*	0	0	0	0	0	0	21	100	0	0	0	0
Kyloe	*5*	0	0	0	0	0	0	0	0	0	0	5	100
Total	***26***	**0**	**0**	**0**	**0**	**0**	**0**	**21**	**81**	**0**	**0**	**5**	**19**
Overall	***156***	**101**	**65**	**6**	**4**	**14**	**9**	**27**	**17**	**3**	**2**	**5**	**3**

*South Tyneside: No info re: screening (numbers screened = numbers offered assessment)

Table 9.2: Role of Professional who Provided Assessment

Location	*Assessed*	Health Worker		MH Worker		SM Worker		Forensic Psychologist		Clinical Psychologist		Psychiatrist	
	N	N	%	N	%	N	%	N	%	N	%	N	%
Darlington	*15*	0	0	12	80	0	0	0	0	0	0	3	20
Hartlepool	*2*	0	0	1	50	1	50	0	0	0	0	0	0
Newcastle	*12*	0	0	12	100	0	0	0	0	0	0	0	0
Nth'land	*24*	0	0	22	92	0	0	0	0	0	0	2	8
N Tyneside	*12*	0	0	12	100	0	0	0	0	0	0	0	0
S Tyneside	*14*	0	0	14	100	0	0	0	0	0	0	0	0
South Tees	*8*	0	0	8	100	0	0	0	0	0	0	0	0
Stockton	*12*	8	67	3	25	0	0	0	0	0	0	1	8
Sunderland	*16*	0	0	15	94	0	0	0	0	0	0	1	6
Total	***115***	**8**	**7**	**99**	**86**	**1**	**1**	**0**	**0**	**0**	**0**	**7**	**6**
Castington	*41*	2	5	34	83	0	0	0	0	0	0	5	12
Aycliffe	*13*	0	0	2	15	0	0	5	38	0	0	6	46
Kyloe	*5*	0	0	0	0	0	0	0	0	4	80	1	20
Total	***59***	**2**	**3**	**36**	**61**	**0**	**0**	**5**	**8**	**4**	**7**	**12**	**20**
Overall	***174***	**10**	**6**	**135**	**78**	**1**	**1**	**5**	**3**	**4**	**2**	**19**	**11**

Table 9.3: Role of Professional who Provided Intervention

Location	*Intervention*	Generic Worker		Social Worker		Health / SM Worker*		MH Worker		Forensic Psychologist		Clinical Psychologist		Psychiatrist		LD Psychiatrist		GP	
	N	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Darlington	*13*	2	15	0	0	0	0	6	46	0	0	1	8	3	23	1	8	0	0
Hartlepool	*3*	1	33	0	0	0	0	1	33	0	0	0	0	1	33	0	0	0	0
Newcastle	*13*	0	0	0	0	0	0	10	77	0	0	0	0	2	15	0	0	1	8
Nth'land	*15*	1	7	2	13	2	13	4	27	0	0	2	13	3	20	0	0	1	7
N Tyneside	*12*	0	0	0	0	0	0	12	100	0	0	0	0	0	0	0	0	0	0
S Tyneside	*13*	0	0	1	8	0	0	10	77	0	0	1	8	1	8	0	0	0	0
South Tees	*8*	0	0	0	0	0	0	8	100	0	0	0	0	0	0	0	0	0	0
Stockton	*11*	0	0	0	0	6	55	2	18	0	0	0	0	3	27	0	0	0	0
Sunderland	*15*	0	0	0	0	0	0	10	67	0	0	2	13	3	20	0	0	0	0
Total	***103***	**4**	**4**	**3**	**3**	**8**	**8**	**63**	**61**	**0**	**0**	**6**	**6**	**16**	**16**	**1**	**1**	**2**	**2**
Castington	*19*	1	5	0	0	1	5	14	74	2	11	0	0	1	5	0	0	0	0
Aycliffe	*13*	3	23	0	0	0	0	2	15	4	31	0	0	3	23	0	0	1	8
Kyloe	*3*	0	0	0	0	0	0	0	0	0	0	1	33	2	67	0	0	0	0
Total	***35***	**4**	**11**	**0**	**0**	**1**	**3**	**16**	**46**	**6**	**17**	**1**	**3**	**6**	**17**	**0**	**0**	**1**	**3**
Overall	***138***	**8**	**6**	**3**	**2**	**9**	**7**	**79**	**57**	**6**	**4**	**7**	**5**	**22**	**16**	**1**	**1**	**3**	**2**

*Health & SM Worker actually contains just 1 SM worker for Stockton

Table 10.1: Source of Intervention Provider

Location	*Received Intervention*	YOT		Institution		CAMHS		Kolvin	
	N	N	%	N	%	N	%	N	%
Darlington	13	5	38	1	8	4	31	1	8
Hartlepool	3	1	33	0	0	1	33	0	0
Newcastle	13	5	38	0	0	7	54	0	0
Nth'land	15	3	20	0	0	8	53	0	0
N Tyneside	12	12	100	0	0	0	0	0	0
S Tyneside	13	6	46	1	8	2	15	2	15
South Tees	8	4	50	0	0	3	38	0	0
Stockton	11	6	55	0	0	5	45	0	0
Sunderland	15	8	53	0	0	2	13	1	7
Total	**103**	**50**	**49**	**2**	**2**	**32**	**31**	**4**	**4**
Castington	19	0	0	18	95	1	5	0	0
Aycliffe	13	0	0	6	46	0	0	6	46
Kyloe	3	0	0	0	0	0	0	3	100
Total	**35**	**0**	**0**	**24**	**69**	**1**	**3**	**9**	**26**
Overall	**138**	**50**	**36**	**26**	**19**	**33**	**24**	**13**	**9**

Table 10.1 (cont.): Source of Intervention Provider

Location	*Received Intervention*	Social Services		Specialist LD Service		Child & Family CAMHS		Primary Care	
	N	N	%	N	%	N	%	N	%
Darlington	13	0	0	2	15	0	0	0	0
Hartlepool	3	1	33	0	0	0	0	0	0
Newcastle	13	0	0	0	0	0	0	1	8
Nth'land	15	2	13	1	7	0	0	1	7
N Tyneside	12	0	0	0	0	0	0	0	0
S Tyneside	13	1	8	0	0	1	8	0	0
South Tees	8	1	13	0	0	0	0	0	0
Stockton	11	0	0	0	0	0	0	0	0
Sunderland	15	0	0	1	7	3	20	0	0
Total	**103**	**5**	**5**	**4**	**4**	**4**	**4**	**2**	**2**
Castington	19	0	0	0	0	0	0	0	0
Aycliffe	13	0	0	1	8	0	0	0	0
Kyloe	3	0	0	0	0	0	0	0	0
Total	**35**	**0**	**0**	**1**	**3**	**0**	**0**	**0**	**0**
Overall	**138**	**5**	**4**	**5**	**4**	**4**	**3**	**2**	**1**

Table 10.2: Intervention Type

Location	*Interventions*	Cognitive Behavioural Therapy		Solution Focused Therapy		Psychotherapy		Behavioural Therapy		Counselling		Medication	
	N	N	%	N	%	N	%	N	%	N	%	N	%
Darlington	17	3	18	0	0	0	0	0	0	4	24	1	6
Hartlepool	4	1	25	0	0	0	0	0	0	1	25	1	25
Newcastle	15	1	7	0	0	0	0	0	0	0	0	3	20
Nth'land	17	1	6	3	18	0	0	0	0	2	12	4	24
N Tyneside	19	6	32	1	5	0	0	0	0	1	5	0	0
S Tyneside	n/a	/	/	/	/	/	/	/	/	/	/	/	/
South Tees	8	8	100	0	0	0	0	0	0	0	0	0	0
Stockton	22	2	9	1	5	0	0	1	5	0	0	1	5
Sunderland	21	0	0	0	0	0	0	0	0	3	14	1	5
Total	**123**	**22**	**18**	**5**	**4**	**0**	**0**	**1**	**1**	**11**	**9**	**11**	**9**
Castington	27	1	4	0	0	0	0	0	0	5	19	3	11
Aycliffe	25	1	4	0	0	1	4	0	0	3	12	1	4
Kyloe	3	0	0	0	0	0	0	0	0	0	0	1	33
Total	**55**	**2**	**4**	**0**	**0**	**1**	**2**	**0**	**0**	**8**	**15**	**5**	**9**
Overall	**178**	**24**	**13**	**5**	**3**	**1**	**1**	**1**	**1**	**19**	**11**	**16**	**9**

Table 10.3: Intervention Tier

Location	*Received Intervention*	1		2		3		4		2/3		3/4	
	N	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Darlington	13	0	0	4	31	3	23	1	8	4	31	1	8
Hartlepool	3	2	67	1	33	0	0	0	0	0	0	0	0
Newcastle	13	0	0	2	15	10	77	0	0	0	0	0	0
Nth'land	15	0	0	6	40	9	60	0	0	0	0	0	0
N Tyneside	12	1	8	6	50	2	17	0	0	3	25	0	0
S Tyneside	13	0	0	7	54	4	31	2	15	0	0	0	0
South Tees	8	0	0	2	25	6	75	0	0	0	0	0	0
Stockton	11	0	0	4	36	7	64	0	0	0	0	0	0
Sunderland	15	0	0	10	67	4	27	0	0	1	7	0	0
Total	**103**	**3**	**3**	**42**	**41**	**45**	**44**	**3**	**3**	**8**	**8**	**1**	**1**
Castington	19	1	5	15	79	3	16	0	0	0	0	0	0
Aycliffe	13	1	8	4	31	4	31	2	15	1	8	1	8
Kyloe	3	0	0	0	0	3	100	0	0	0	0	0	0
Total	**35**	**2**	**6**	**19**	**54**	**10**	**29**	**2**	**6**	**1**	**3**	**1**	**3**
Overall	**138**	**5**	**4**	**61**	**44**	**55**	**40**	**5**	**4**	**9**	**7**	**2**	**1**

Newcastle: 1 YP Tier Unknown as still in process

Table 10.4: External Mental Health Input

Location	*MH Concern*	Referred outside YOT / Institution		Needs Met (% of those referred outside YOT/institution)						Already in contact with another service		Needs Met (% of those already in contact with another service)					
				Yes		No		DK				Yes		No		DK	
	N	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Darlington	21	11	52	5	45	4	36	2	18	0	0	n/a	/	/	/	/	/
Hartlepool	8	2	25	2	100	0	0	0	0	1	13	1	100	0	0	0	0
Newcastle	31	1	3	0	0	1	100	0	0	13	42	8	62	3	23	2	15
Nth'land	39	14	36	7	50	7	50	0	0	8	21	2	25	2	25	4	50
N Tyneside	35	0	0	n/a	/	/	/	/	/	9	26	0	0	0	0	9	100
S Tyneside*	40	6	15	5	83	1	17	0	0	0	0	n/a	/	/	/	/	/
South Tees*	12	3	25	3	100	0	0	0	0	7	58	3	43	4	57	0	0
Stockton	29	7	24	7	100	0	0	0	0	4	14	2	50	2	50	0	0
Sunderland	37	14	38	9	64	5	36	0	0	1	3	0	0	1	100	0	0
Total	**252**	**58**	**23**	**38**	66	**18**	31	**2**	3	**43**	**17**	**16**	37	**12**	28	**15**	35
Castington	41	6	15	3	50	1	17	2	33	0	0	n/a	/	/	/	/	/
Aycliffe	27	11	41	9	82	2	18	0	0	0	0	n/a	/	/	/	/	/
Kyloe	5	5	100	4	80	1	20	0	0	0	0	n/a	/	/	/	/	/
Total	**73**	**22**	**30**	**16**	**73**	**4**	**18**	**2**	**9**	**0**	**0**	**n/a**	/	**/**	/	**/**	/
Overall	**325**	**80**	**25**	**54**	**68**	**22**	**28**	**4**	**5**	**43**	**13**	**16**	**37**	**12**	**28**	**15**	**35**

*South Tyneside & South Tees: Limited Information on MH Contact outwith those referred to the YOT MH Worker
Castington - 41 = Those referred for assessment by the MH Inreach Team

Table 11.1: Reasons for No Screening

Location	*No Screening*	Refused / Disengaged		Custody / Community / Transferred		Moved Area		Ongoing Court Process		Asset Wrongly Scored		Already Open to Another Service	
	N	N	%	N	%	N	%	N	%	N	%	N	%
Darlington	*12*	1	8	3	25	0	0	0	0	0	0	0	0
Hartlepool	*3*	0	0	2	67	0	0	0	0	0	0	0	0
Newcastle	*27*	3	11	3	11	1	4	0	0	3	11	13	48
Nth'land	*20*	4	20	2	10	0	0	0	0	1	5	5	25
N Tyneside	*19*	4	21	4	21	0	0	0	0	1	5	8	42
S Tyneside*	*25*	0	0	0	0	0	0	0	0	0	0	0	0
South Tees	*2*	0	0	0	0	0	0	1	50	0	0	1	50
Stockton	*2*	1	50	0	0	0	0	0	0	0	0	0	0
Sunderland	*12*	8	67	3	25	0	0	0	0	0	0	1	8
Total	***122***	**21**	**17**	**17**	**14**	**1**	**1**	**1**	**1**	**5**	**4**	**28**	**23**
Castington	*109*	0	0	0	0	0	0	0	0	0	0	0	0
Aycliffe	*6*	1	17	1	17	0	0	0	0	0	0	0	0
Kyloe	*0*	/	/	/	/	/	/	/	/	/	/	/	/
Total	***115***	**1**	**1**	**1**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Overall	***237***	**22**	**9**	**18**	**8**	**1**	**0**	**1**	**0**	**5**	**2**	**28**	**12**

*South Tyneside:No Screening Information

Table 11.1 (cont.): Reasons for No Screening

Location	*No Screening*	Referred to CAMHS		Assessment Required		Awaiting / Incomplete		Not Required by Asset		DK		Castington - No Screening	
	N	N	%	N	%	N	%	N	%	N	%	N	%
Darlington	*12*	0	0	8	67	0	0	0	0	0	0	0	0
Hartlepool	*3*	0	0	0	0	1	33	0	0	0	0	0	0
Newcastle	*27*	1	4	0	0	2	7	0	0	1	4	0	0
Nth'land	*20*	2	10	1	5	0	0	2	10	3	15	0	0
N Tyneside	*19*	0	0	0	0	1	5	0	0	1	5	0	0
S Tyneside*	*25*	0	0	0	0	0	0	0	0	25	100	0	0
South Tees	*2*	0	0	0	0	0	0	0	0	0	0	0	0
Stockton	*2*	0	0	1	50	0	0	0	0	0	0	0	0
Sunderland	*12*	0	0	0	0	0	0	0	0	0	0	0	0
Total	***122***	**3**	**2**	**10**	**8**	**4**	**3**	**2**	**2**	**30**	**25**	**0**	**0**
Castington	*109*	0	0	0	0	0	0	0	0	0	0	109	100
Aycliffe	*6*	0	0	3	50	1	17	0	0	0	0	0	0
Kyloe	*0*	/	/	/	/	/	/	/	/	/	/	/	/
Total	***115***	**0**	**0**	**3**	**3**	**1**	**1**	**0**	**0**	**0**	**0**	**109**	**95**
Overall	***237***	**3**	**1**	**13**	**5**	**5**	**2**	**2**	**1**	**30**	**13**	**109**	**46**

*South Tyneside:No Screening Information

Table 11.2: Reasons for No Assessment

Location	*No Assessment*	No MH Issues		Refused / Disengaged		Custody / Community / Transferred		Moved Area		Ongoing Court Process	
	N	N	%	N	%	N	%	N	%	N	%
Darlington	*6*	0	0	3	50	3	50	0	0	0	0
Hartlepool	*6*	1	17	1	17	2	33	0	0	0	0
Newcastle	*19*	3	16	4	21	3	16	2	11	0	0
Nth'land	*15*	0	0	5	33	0	0	3	20	0	0
N Tyneside	*23*	1	4	5	22	5	22	0	0	1	4
S Tyneside	*26*	0	0	1	4	0	0	0	0	0	0
South Tees	*4*	0	0	0	0	0	0	0	0	1	25
Stockton	*17*	4	24	12	71	0	0	0	0	0	0
Sunderland	*21*	0	0	13	62	3	14	0	0	0	0
Total	***137***	**9**	**7**	**44**	**32**	**16**	**12**	**5**	**4**	**2**	**1**
Castington	*68*	62	91	1	1	3	4	0	0	0	0
Aycliffe	*14*	9	64	2	14	1	7	0	0	1	7
Kyloe	*0*	/	/	/	/	/	/	/	/	/	/
Total	***82***	**71**	**87**	**3**	**4**	**4**	**5**	**0**	**0**	**1**	**1**
Overall	***219***	**80**	**37**	**47**	**21**	**20**	**9**	**5**	**2**	**3**	**1**

Table 11.2 (cont.): Reasons for No Assessment

Location	*No Assessment*	Asset Wrongly Scored		Already Open to Another Service		Referred to CAMHS		Awaiting / Incomplete		DK	
	N	N	%	N	%	N	%	N	%	N	%
Darlington	*6*	0	0	0	0	0	0	0	0	0	0
Hartlepool	*6*	0	0	0	0	0	0	2	33	0	0
Newcastle	*19*	0	0	3	16	1	5	3	16	0	0
Nth'land	*15*	1	7	2	13	0	0	1	7	3	20
N Tyneside	*23*	0	0	9	39	0	0	1	4	1	4
S Tyneside*	*26*	0	0	0	0	0	0	0	0	25	96
South Tees	*4*	0	0	3	75	0	0	0	0	0	0
Stockton	*17*	0	0	0	0	0	0	1	6	0	0
Sunderland	*21*	0	0	1	5	0	0	4	19	0	0
Total	***137***	**1**	**1**	**18**	**13**	**1**	**1**	**12**	**9**	**29**	**21**
Castington*	*68*	0	0	0	0	0	0	2	3	0	0
Aycliffe	*14*	0	0	0	0	0	0	1	7	0	0
Kyloe	*0*	/	/	/	/	/	/	/	/	/	/
Total	***82***	**0**	**0**	**0**	**0**	**0**	**0**	**3**	**4**	**0**	**0**
Overall	***219***	**1**	**0**	**18**	**8**	**1**	**0**	**15**	**7**	**29**	**13**

*South Tyneside (25 = DK as no screening information)

*Castington 1 Awaiting is unavailable due to non-retainment

Table 11.3: Reason for No Intervention

Location	*No Intervention*	No MH Issues		Not Yet Assessed		Refused / Disengaged		Custody / Community / Transferred		Moved Area	
	N	N	%	N	%	N	%	N	%	N	%
Darlington	*8*	2	25	2	25	2	25	2	25	0	0
Hartlepool	*5*	1	20	2	40	0	0	2	40	0	0
Newcastle	*18*	3	17	9	50	2	11	2	11	2	11
Nth'land	*24*	5	21	2	8	7	29	2	8	4	17
N Tyneside	*23*	1	4	8	35	0	0	5	22	0	0
S Tyneside	*27*	0	0	1	4	1	4	0	0	0	0
South Tees	*4*	0	0	0	0	1	25	1	25	1	25
Stockton	*18*	5	28	11	61	1	6	0	0	0	0
Sunderland	*22*	0	0	18	82	1	5	3	14	0	0
Total	***149***	**17**	**11**	**53**	**36**	**15**	**10**	**17**	**11**	**7**	**5**
Castington	*90*	78	87	4	4	4	4	3	3	0	0
Aycliffe	*14*	9	64	1	7	2	14	1	7	0	0
Kyloe	*2*	2	100	0	0	0	0	0	0	0	0
Total	***106***	**89**	**84**	**5**	**5**	**6**	**6**	**4**	**4**	**0**	**0**
Overall	***255***	**106**	**42**	**58**	**23**	**21**	**8**	**21**	**8**	**7**	**3**

Table 11.3 (cont.): Reason for No Intervention

Location	*No Intervention*	Ongoing Court Process		Awaiting CAMHS Intervention		Another Service - No Information		SM First		DK	
	N	N	%	N	%	N	%	N	%	N	%
Darlington	*8*	0	0	0	0	0	0	0	0	0	0
Hartlepool	*5*	0	0	0	0	0	0	0	0	0	0
Newcastle	*18*	0	0	0	0	0	0	0	0	0	0
Nth'land	*24*	0	0	1	4	2	8	0	0	1	4
N Tyneside	*23*	0	0	0	0	9	39	0	0	0	0
S Tyneside	*27*	0	0	0	0	0	0	0	0	25	93
South Tees	*4*	1	25	0	0	0	0	0	0	0	0
Stockton	*18*	0	0	0	0	0	0	1	6	0	0
Sunderland	*22*	0	0	0	0	0	0	0	0	0	0
Total	***149***	**1**	**1**	**1**	**1**	**11**	**7**	**1**	**1**	**26**	**17**
Castington	*90*	0	0	1	1	0	0	0	0	0	0
Aycliffe	*14*	0	0	1	7	0	0	0	0	0	0
Kyloe	*2*	0	0	0	0	0	0	0	0	0	0
Total	***106***	**0**	**0**	**2**	**2**	**0**	**0**	**0**	**0**	**0**	**0**
Overall	***255***	**1**	**0**	**3**	**1**	**11**	**4**	**1**	**0**	**26**	**10**

South Tyneside (25 = DK as no screening information)

Table 11.4: Reasons for Unmet Need

Location	*Needs Not Met*	Not Yet Assessed		Refused / Disengaged		Custody / Community / Transferred		Moved Area		Ongoing Court Process	
	N	N	%	N	%	N	%	N	%	N	%
Darlington	*10*	0	0	4	40	5	50	1	10	0	0
Hartlepool	*4*	1	25	1	25	2	50	0	0	0	0
Newcastle	*18*	4	22	8	44	3	17	2	11	0	0
Nth'land	*24*	1	4	9	38	1	4	4	17	0	0
N Tyneside	*23*	3	13	5	22	5	22	0	0	1	4
S Tyneside	*31*	0	0	6	19	0	0	0	0	0	0
South Tees	*5*	0	0	2	40	1	20	1	20	1	20
Stockton	*14*	1	7	12	86	0	0	1	7	0	0
Sunderland	*26*	5	19	18	69	3	12	0	0	0	0
Total	***155***	**15**	**10**	**65**	**42**	**20**	**13**	**9**	**6**	**2**	**1**
Castington	*14*	0	0	6	43	7	50	0	0	0	0
Aycliffe	*7*	1	14	2	29	3	43	0	0	0	0
Kyloe	*1*	0	0	1	100	0	0	0	0	0	0
Total	***22***	**1**	**5**	**9**	**41**	**10**	**45**	**0**	**0**	**0**	**0**
Overall	***177***	**16**	**9**	**74**	**42**	**30**	**17**	**9**	**5**	**2**	**1**

Table 11.4 (cont.): Reasons for Unmet Need

Location	*Needs Not Met*	Another Service - No Information		Awaiting CAMHS Intervention		No Future Support		Awaiting / Incomplete		DK	
	N	N	%	N	%	N	%	N	%	N	%
Darlington	*10*	0	0	0	0	0	0	0	0	0	0
Hartlepool	*4*	0	0	0	0	0	0	0	0	0	0
Newcastle	*18*	1	6	0	0	0	0	0	0	0	0
Nth'land	*24*	2	8	1	4	2	8	0	0	4	17
N Tyneside	*23*	9	39	0	0	0	0	0	0	0	0
S Tyneside	*31*	0	0	0	0	0	0	0	0	25	81
South Tees	*5*	0	0	0	0	0	0	0	0	0	0
Stockton	*14*	0	0	0	0	0	0	0	0	0	0
Sunderland	*26*	0	0	0	0	0	0	0	0	0	0
Total	***155***	**12**	**8**	**1**	**1**	**2**	**1**	**0**	**0**	**29**	**19**
Castington	*14*	0	0	0	0	0	0	1	6	0	0
Aycliffe	*7*	0	0	1	14	0	0	0	0	0	0
Kyloe	*1*	0	0	0	0	0	0	0	0	0	0
Total	***22***	**0**	**0**	**1**	**5**	**0**	**0**	**1**	**5**	**0**	**0**
Overall	***177***	**12**	**7**	**2**	**1**	**2**	**1**	**1**	**1**	**29**	**16**

South Tyneside (25 = DK as no screening information)

The Derwent Initiative
391 West Road
Newcastle upon Tyne
NE15 7PY

Tel: (0191) 274 5858 Fax: (0191) 274 5959
Email: enquiries@thederwentiniative.org.uk
Web: www.thederwentinitiative.org.uk