Chapter 12

Youth justice

Chapter authors
Charlotte Lennox[1], Lorraine Khan[2,3]

1 Research Associate, Manchester Academic Health Science Centre, Centre for Mental Health and Risk, Offender Health Research Network, University of Manchester
2 Associate Director, Children and Young People, Centre for Mental Health
3 Senior Research Fellow, Institute of Psychiatry, King's College, London

Key statistics

- The number of children and young people in custody has fallen by just over 50% in the last five years.[1]
- The rate of suicide in boys aged 15–17 who have been sentenced and remanded in custody in England and Wales may be as much as 18 times higher than the rate of suicide in boys aged 15–17 in the general population.[2]
- Some 18% of 13–18 year olds in custody have depression, 10% have anxiety, 9% have post-traumatic stress disorder and 5% have psychotic symptoms.[3]
- Of children and young people on community orders, 43% have emotional and mental health needs.[4]
- Over a quarter of children and young people in the youth justice system have a learning disability.[5] Some 60% of boys in custody have specific difficulties in relation to speech, language or communication.[6]
- Looked-after children make up 30% of boys and 44% of girls in custody.[7]
- One in 10 girls in custody have been paid for sex.[8]
- Around 39% of children and young people in custody have been on the child protection register or experienced neglect or abuse.[9]
- One in eight children and young people in custody have experienced the death of a parent or sibling.[9]
- Some 40% of children and young people in custody have previously been homeless.[10]
- Over half of children and young people who offend have themselves been victims of crime.[11]

Overview

Children and young people in contact with the youth justice system are more likely to have mental health problems than those who are not, and to have more than one mental health problem alongside a range of other challenges. Many of their health and social care needs go unrecognised and unmet. Yet the **costs of failing to respond are high: the lifetime costs of crime amount to around £1.5 million for each prolific offender**.

The last decade has seen a reduction in the number of children and young people entering the youth justice system, but this reduction is not uniform and there is **evidence of growing levels of multiple, complex and damaging health and social needs among those who come into contact with the youth justice system**.

Children face a stepping-stone pattern of risk, where risks during infancy increase the chances of antisocial behaviour during childhood, which in turn amplify the likelihood of convictions during adolescence.

To counter these risks, **it is important to take a life course approach and to strengthen the protective factors in children themselves and their surrounding environment**. Many opportunities exist to change the trajectories of children's lives. These start before birth, providing high-risk expectant mothers with support to reduce stress and foster healthy attachment styles.

Early child development and school readiness checks provide opportunities to track not just physical development milestones but also communication, neurodevelopmental, behavioural and emotional health. Children communicate distress, frustration or developmental difficulties through their behaviour. Behavioural problems also represent one of our most common childhood mental health problems.

High-quality parenting programmes and school-based interventions can prevent or mitigate behavioural problems among children who are at risk.

For those who have not benefitted from early intervention, **Youth Offending Teams offer an opportunity to turn around the lives of children with multiple and complex needs**. Effective screening and assessment should be followed by the provision of effective interventions such as multidimensional treatment foster care, functional family therapy and multisystemic therapy.

Current trends and prevalence

The youth justice system in England and Wales is different and largely separate from that for adults, with much more emphasis on preventing offending and re-offending and a wider range of ways of dealing with those who offend. The Children Act 1989 allocated duties to local authorities, police, courts, parents and other agencies in the UK to ensure that children are safeguarded and their welfare is promoted.

The last decade has seen a significant reduction in the number of children and young people (aged 10–18) in contact with all parts of the youth justice system. Since 2000–2001, arrests have fallen by 34%; the number of first-time entrants into the youth justice system by 59%; offences committed by young people on the youth offending team caseload by 47%; and the population in custody by 30%.[12]

There are a number of factors that may have contributed to this trend, including the removal of the offences brought to justice target (a performance measure for the police), work by Youth Offending Teams and other partners to divert young people into alternatives, such as Youth Restorative Disposals, triage, liaison and diversion screening for health, and the introduction of the Youth Rehabilitation Order; but it is not possible to attribute direct causality to any of these factors or to quantify the size of the effect from each.[13]

Reductions, however, have not been uniform across all groups of children and young people. The greatest reductions have been seen for younger children (under-15s), girls and first-time entrants into the youth justice system. Smaller reductions have been seen for older boys and black and minority ethnic children. For example, from 2007–2008 to 2010–2011, the percentage fall in the numbers of black and minority ethnic children in custody was 16%, compared with 37% for white children.[13]

More recent changes also have the potential to reduce the custody population further. The Legal Aid, Sentencing and Punishment of Offenders Act 2012 aims to simplify the remand framework so that all children and young people (aged 12–17) are subject to the same remand provisions. The status of 'looked-after child' will be applied to all children and young people on remand and the costs of keeping a young person in custody on remand will be transferred to local authorities in order to provide an incentive to use remand more sparingly and to develop more robust community-based alternative/bail support packages. These community-based alternatives need to be evidence based.

Although the Youth Offending Team caseload and custody population have reduced year-on-year, children and young people in contact with the youth justice system have very high levels of multiple health and social inequalities (see Key statistics and Box 12.1), and their level of complexity (e.g. offence history and health needs) may have actually increased. UK data on the prevalence of psychiatric morbidity in children and young people in the youth justice system are out of date and do not reflect recent significant changes in the youth justice population; equally, other studies focusing on the broader health and social care needs of those within the wider youth justice system are smaller in scale or suffer methodological problems. **There is, therefore, a real need for robust representative prevalence data on the health and social care needs of children and young people in all sectors of the youth justice system**.

Also, despite the declining custodial population, there are ongoing concerns that England and Wales are failing to use

custody as a 'last resort', in line with the United Nations Convention on the Rights of the Child. Questions also remain about the appropriateness and effectiveness of custodial regimes as a response to children and young people with multiple vulnerabilities. Further work is required to establish an evidence base for effective alternatives to custody. **Despite improvements by custodial establishments and the Youth Justice Board, reports (such as the recent inspection report of HMP Young Offenders Institution Feltham[14]) continue to highlight custodial regimes characterised by excessive levels of violence and where children and young people often report feeling unsafe.**[15]

Faces watching a fight showing a lack of reaction to violence
Source: Kids Company

Children and young people in contact with the youth justice system are more likely to have mental health problems than those who are not.[23] They are also more likely to have more than one mental health problem, to have neurodevelopmental and learning disabilities/difficulties, to have problematic drug and alcohol misuse and to have experienced a range of other challenges, such as exclusion from school, homelessness, bereavement, trauma and being in care. Many of these health and social care needs go unrecognised and unmet. There is, therefore, a need for comprehensive screening and assessment throughout the youth justice system. Unmet needs persist into late adolescence/adulthood and can lead to a wide range of adverse outcomes, such as continuing/worsening mental health problems, unemployment, teenage parenthood, marital problems, suicide and self-harm and further criminal activity. The costs to society are also immense. For example, the lifetime cost of crime committed by a single prolific offender is around £1.5 million.[24]

Risk and protective factors affecting involvement in the youth justice system

Life course studies, tracking children's development and circumstances over time, identify many factors which increase the likelihood of poor outcomes (see Figure 12.1) as well as those associated with a reduced chance of children experiencing negative outcomes (see Table 12.1).

Box 12.1 Additional evidence for health and social inequalities for children and young people in the youth justice system

- Young black and minority ethnic people, and girls, were most likely to present with post-traumatic stress disorder.[3]
- In 2011–2012 there were three deaths of young people in custody.[12]
- In 2011, there were 20 deaths in the community involving young people under Youth Offending Team supervision who died either through murder, suicide or accidental death.[12]
- There were 1,725 reported incidents of self-harm in the secure estate in 2011–2012, up 21% on 2010–2011.[12]
- There are around 200,000 children of adult prisoners in the UK, with a point prevalence of 90,000.[16] Children who have a parent in prison are three times more likely to have mental health problems[17] and 65% of boys with a convicted father go on to offend.[18] There is no official agency catering to the needs of prisoners' families and children and no support is routinely offered to them.
- Eight out of 10 children and young people disclosed problematic or risky substance misuse before entering custody. Three-quarters had used cannabis, around a third had used ecstasy or cocaine, 9% had used crack and 1% heroin. Poly-drug misuse was also high.[19,20]
- Prior to custody, 67% of young offenders got drunk at least once a week, and 16% were getting drunk every day.[19]
- Some 26% of young women in custody reported having three or more male sexual partners in the last year and only 15% stated that they always used a condom. Almost a quarter (23%) had at some time been diagnosed with a sexually transmitted
- The educational background of children and young people in custody is poor: 86% of boys and 82% of girls said they had been excluded from school and 42% said they were 14 years or younger when they were last in education.[21]
- Around 72% of incarcerated male young offenders reported suffering at least one traumatic brain injury of any severity, 41% reported experiencing a loss of consciousness and 46% reported suffering more than one injury.[22]
- The educational background of children and young people in custody is poor: 86% of boys and 82% of girls said they had been excluded from school and 42% said they were 14 years or younger when they were last in education.[21]
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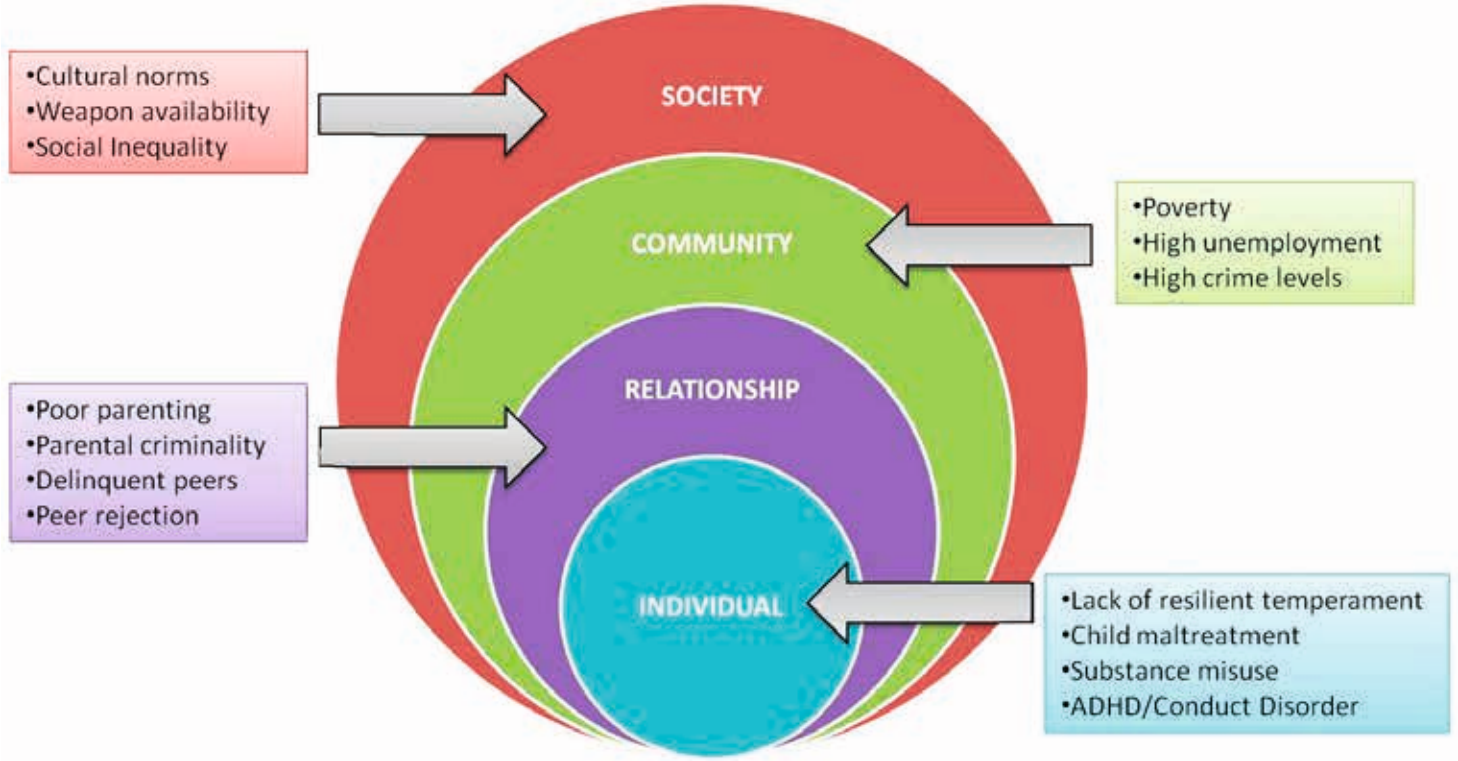
Figure 12.1 Examples of risk factors in childhood associated with prevention of offending and other adverse outcomes



Source: produced for this report by Lorraine Khan and Charlotte Lennox (2013)

Table 12.1 Protective factors in childhood associated with prevention of offending and other adverse outcomes

Individual characteristics	Parents and their parenting style	Family factors and life events	Community factors
Social skills	Competent, stable care	Family harmony	Positive bond with peers, teachers, neighbours and neighbourhood.
Easy temperament	Breastfeeding	Positive relationships with extended family	Teachers who encourage aspiration
At least average intelligence	Healthy attachment	Small family size	Access to positive opportunities (e.g. education)
Attachment to family	Positive (non-harsh) parenting style	Spacing of siblings by more than two years	Pro-social peers and community values
Independence	Religious faith		Participation in community activities
Good problem-solving skills	Effective supervision of child during teenage years		Safe neighbourhood
	Supportive relationships with other adults	Supportive relationships with other adults	Supportive relationships with other adults
	Clear boundaries and expectations	Clear boundaries and expectations	Clear boundaries and expectations

Source: produced for this report by Lorraine Khan and Charlotte Lennox (2013)

The more risks that children accumulate, the greater the probability of:

- offending
- persistent offending
- poor mental health, poor educational and employment performance, violence, lower life expectancy and poor physical health.[25,26]

A stepping-stone pattern of risk is commonly observed; risks during infancy increase the chance of antisocial behaviour and health and social inequalities during mid-childhood which in turn amplify the likelihood of convictions during adolescence.[27]

However, some children and young people exposed to risk never offend; or if they do they eventually desist. **Protective factors (see Table 12.1) moderate the detrimental effects of risk factors; either preventing them from developing in the first place or interacting with risk factors to block adverse effects.**

Individual or temperament-based factors

Research suggests that risk is associated with individual child characteristics; for example, being female protects against offending. Research also suggests that children with resilient temperaments, good problem-solving skills, an ability to plan ahead, a positive outgoing disposition and higher intelligence are protected against the risks of adverse circumstances.[28–31] It is also likely that resilient children who are temperamentally outgoing and likeable are generally easier to raise than those who are unsure of themselves, pessimistic or socially awkward. Attachment bonds with parents are therefore more likely to be reinforced and positive experiences at school will increase their sense of self-esteem and self-efficacy.

Temperamental differences can be associated with antenatal exposure to risk and/or to subtle genetic and neurodevelopmental differences. Temperament alone does not predict poor outcomes; **future life chances are heavily influenced by a complex interplay between biological, caretaking and environmental factors with outcomes for 'at-risk' children considerably improved with the right protective environment, care and support**.[32,33]

Individual difficulties such as persistently challenging, hyperactive or aggressive behaviours during early childhood are key risk factors for a range of adverse life chances.

Family-based factors

Family-based influences also play an important part in protecting or predisposing children towards early behavioural problems and later crime. A strong attachment with one or both parents/caregivers, characterised by a stable, warm, affectionate relationship, has been shown to protect children from offending.

On the other hand, risks for antisocial behaviour and crime include:

- exposure in the womb to antenatal maternal stress
- being a child of a teenage parent
- parental mental illness, substance use and/or offending
- attachment issues – particularly insecure, ambivalent (linked to anxiety and poor relationship-forming skills) and disorganised attachments (characterised by impulsivity, emotional volatility, disruptive behaviour, aggression and poor concentration)
- poor parenting
- maltreatment, neglect and exposure to violence/conflict in the home.[34–43]

School-based factors

Some children start school already disadvantaged by a range of individual and family-based risk factors which compromise achievement and amplify disadvantage. Poor emotional wellbeing and mental health (particularly early attentionl and behavioural problems) are linked with poor educational attainment.[44] Poor family support for academic success and aspiration along with income inequality contribute further to a widening gap in achievement,[45] increasing chances of poor motivation, dropout and exclusion. **School exclusion rates are particularly high for Afro-Caribbean boys.**[46]

On the other hand, a positive social attitude/commitment to school can help to protect young people. Encouraging all pupils to fulfil their potential, setting clear rules and applying them consistently reduce disruptive behaviour.[47]

Peer-related factors

Bullying others, peer rejection and having antisocial peers are associated with a higher risk of offending,[48] whereas having a non-delinquent peer group with pro-social attitudes can be a strong protective force for young people's prospects.[49] Poor relationships and experiences of victimisation seem to have a particular impact on young women's pathway into criminality.[50]

Neighbourhood and community

Children and young people living in deprived neighbourhoods are more than twice as likely to have serious behavioural problems as children living in less deprived areas. High levels of community deprivation have been noted as a particular feature of some black and minority ethnic children and young people's developmental experiences. **Strengthening attachments in communities and reducing social inequalities are particularly important mechanisms for preventing violence and offending.**[51]

A young person's description of their past: 'This is my past. I have lived a cold life and I saw a lot of blood. People stabbed you in the back'
Source: Kids Company

Opportunities for changing children's life course

Understanding risk factors helps to identify children and young people at risk of experiencing poor life chances; however, building resilience and strengthening protective factors are critical. **Children and young people exposed to multiple risk factors face the worst prospects but can be protected by mobilising strengths in families, schools or communities providing critical 'turning points'.**

There is increasing evidence that early fetal and infant experiences are important shapers of robust child mental health and life chances. Many multi-agency opportunities exist to change the trajectories of children's lives and their risk of offending. These start before birth, providing high-risk expectant mothers with engaging support to:

- improve healthy lifestyle choices
- reduce the impact of stress and toxic stress on children's development
- develop good quality early communication between mothers and babies to 'jump-start' electrical activity in the brain
- foster healthy attachment styles.[52–54]

Early childhood behavioural problems are often a manifestation of unmet needs (e.g. speech and communication needs and abuse) and can cause professionals to focus on the symptoms rather than the underlying cause. **Reducing child neglect and maltreatment is critical to reducing childhood behavioural problems. All sectors should be alert to signs with clear systems in place to access early, engaging and evidence-based support;** without early intervention, there is a risk that children are left to accumulate risks, later moving into more expensive crisis-orientated services. Examples of promising prevention initiatives in this area include Triple P, which helps parents pick up positive parenting techniques. In one US state, systematic availability of Triple P parenting programmes led to significant reductions in child protection registrations as well as out-of-home placements.[55]

Early intervention

Early child development and school readiness checks provide opportunities to track not just physical child developmental milestones but also communication skills, and neurodevelopmental, behavioural and emotional health and wellbeing. There are particular advantages in responding early to the very first signs of poor child mental health/early behavioural problems,[56,57] helping affected families to link up with well-implemented and engaging positive parenting programmes such as The Incredible Years[58] and Triple P.[59–61] However, there is also a need for larger, more robust independent evaluations of such parenting programmes with a particular focus on following up children's behavioural outcomes in the longer term.[62,63]

Targeted pre-school programmes (such as the HighScope Perry Preschool Program targeted towards low-income 3–4 year olds) using active participatory learning approaches demonstrate positive effects on a range of child outcomes (including criminality), improving broader prospects as well as generating significant savings.[64]

Educational settings have the potential to mobilise a range of compensatory support to help children to attain and prevent criminality. According to the World Health Organization, a health-promoting school draws together a spectrum of support, including proven universal evidence-based programmes, in-house support and strong relationships with community resources to support children's development and wellbeing.[47] Particular attention is required for those at risk of exclusion; these children need prompt and full holistic assessment to identify and address hidden disabilities (such as learning disabilities, traumatic brain injury or speech and communication problems) affecting their progress.

Youth justice opportunities

Some children may miss opportunities for early identification and intervention or may need additional support over the years. Effective health screening and assessment are critical to ensure that children and young people entering the youth justice system get the help they need. A newly introduced youth justice system health needs assessment tool (called the Comprehensive Health Assessment Tool[65]) provides a vital opportunity for the holistic assessment of children and young people's health needs. In addition, the recent publication of the Healthcare Standards for Children and Young People in Secure Settings[66] provides an excellent opportunity to identify and make real improvements. For gains to be sustained, these assessments will need to be combined with robust commissioning in local areas to meet the multiplicity of needs faced by these children as they return home.

International legislation[67] places a duty on governments to use the formal youth justice system and custody as a last resort for children – with evidence suggesting that processing

Case study

Youth liaison and diversion schemes

Liaison and diversion services are intended to improve health and justice outcomes for children and young people who come into contact with the youth justice system, where a range of complex needs are identified as factors in their offending. Liaison and diversion is not itself a treatment service, but an identification, assessment and referral service. It uses assessments to make appropriate referrals for treatment and support, and ensures that youth justice practitioners and other relevant agencies are notified of specific health requirements and vulnerabilities which can be taken into account when decisions about charging and sentencing are made. Liaison and diversion services are particularly useful for earlier identification of children and young people with mental health, safeguarding and other vulnerabilities. Subject to approval of a business case, liaison and diversion services will be trialled over the next two years and evaluated with a view to rolling out across the country from 2015.

'J' is a 13-year-old boy. He was referred by the police to a point of arrest health liaison and diversion project for an alleged offence of shoplifting. The health worker visited J and his family at home, completing an initial screen for problems requiring fuller assessment.

J lived at home with his mother and younger brother; his father had recently separated from the family following a history of domestic violence. J's mother described increasing problems managing her son's behaviour on her own. J struggled with schooling and was now a regular non-attender. J and his mother disclosed long-term problems with behaviour, staying focused and expressing emotions. During discussions, J also talked of problems with cannabis use, alcohol and anger (talking of being scared about what would happen if he really 'lost it'). He said that cannabis stopped his mind racing and helped him relax and calm down.

This assessment led to a referral to local Child and Adolescent Mental Health Services for suspected attention deficit hyperactivity disorder (ADHD). He was successfully diagnosed and a package of support was put in place involving medication, support from the school special educational needs team and parenting support for his mother. While awaiting assessment, J was also linked up with substance misuse support locally to explore his cannabis use (children with ADHD have a higher risk of reliance on substances). He was also referred to youth offending prevention workers to address offending risks.

Case study

A promising approach to supporting young people with Asperger syndrome at HMP Young Offenders Institution Feltham – Barnet, Enfield and Haringey NHS Trust

Young people need effective communication skills to cope in custodial establishments, to complete rehabilitation programmes and to gain and maintain employment. Stable employment can help prevent re-offending and effective communication skills are highly valued by employers.

The speech and language therapist at HMP Young Offenders Institution Feltham works directly with young people with speech, language and communication needs. The therapist also works with prison staff to raise awareness of speech and communication needs and how behaviour can often mask underlying needs.

'S' was referred to the speech and language therapist. He appeared to be isolating himself from others on the unit. He was also prone to violent outbursts and staff generally struggled to manage his behaviour. An initial speech, language and communication assessment identified some deficits in social communication and recommended a more detailed assessment. This identified a diagnosis of Asperger syndrome.

The speech and language therapist and the psychologist within HMP Young Offenders Institution Feltham worked jointly with the young man to address both speech, language and communication needs and emotional/behavioural needs. They also provided support to the wider staff team. During this work the young man was able to improve his understanding of his behaviour and why he felt the way he did. As a result, he became easier to manage and was able to develop more appropriate coping strategies. There were no further episodes of violence and destructive behaviour in custody and as a result the young man was considered for early release.

At the release meeting, in recognition of this progress, he was initially offered a reduced period on Home Detention Curfew (or 'tag'). However, to his credit, he was able to recognise that he needed an additional period of monitoring to help him embed and maintain a more socially acceptable and productive routine and avoid going back to his old ways. He therefore argued, in front of a group of professionals, for an extended period of curfew to support his progress.

children through the youth justice system is not only detrimental to children's wellbeing but also increases their chance of future re-offending.[68] **Reducing the numbers of children and young people entering the youth justice system is now a key public health outcome.** For this reason, Youth Offending Team triage and health liaison and diversion screening initiatives are often located at the gateway to the youth justice system, working with the police and courts to assess early risk/needs and diverting young people towards resources best placed to prevent further offending. Many police forces also aim to resolve youth crime and reduce risks through talking to the victim and the young person and brokering a solution to make recompense for their crime (known as Youth Restorative Disposals/Community Resolution). **This type of restorative justice/mediation, if well implemented, has a good record of reducing crime.**

A number of other interventions (often working closely with the family and strengthening support systems around the young person) have been identified as effective in reducing youth offending.[60,63] These include the following:

Multidimensional treatment foster care: young people with high safeguarding needs or conduct problems are placed with intensively trained foster parents, providing a structured environment and promoting social and emotional skills. Programme staff work closely with foster parents, teachers, Youth Offending Team workers and employers to ensure consistency of approach and reinforcement of pro-social values. The Legal Aid, Sentencing and Punishment of Offenders Act 2012 provides an important opportunity to commission and make more use of options such as multidimensional treatment foster care which have a better record of success than standard custodial remands.

Functional family therapy: teenage behavioural problems are addressed through a collaborative, problem-solving approach, working weekly with the family and child to build communication, negotiation and other skills over three to six months.

Multisystemic therapy: professional therapists (supervised by clinical psychologists or psychiatrists) have small caseloads and provide an outreach service to families with 24/7 availability for four to six months. Plans are developed collaboratively with the child and family and interventions are pragmatic and tailored to address specific needs, often including work with school staff, peers, neighbours and community organisations. Multisystemic therapy also has a promising record of supporting improvements in progress in drug and alcohol misuse.

Aggression replacement therapy: this targets adolescents with entrenched patterns of aggression using cognitive behavioural and social skills approaches. **It is highly cost-effective with proven reductions in crime, anger and aggression.** However, most violence prevention programmes are designed for and tested with young males; evidence suggests that young females need more gender-sensitive and specific responses acknowledging the importance of experiences of victimisation, positive relationships and improved self-esteem as an exit from crime and violence.

ADHD in Youth Offending Teams: many children remain unidentified with ADHD in Youth Offending Teams or receive a medication-only approach to help manage their needs; these children often require a multidisciplinary approach backed by National Institute for Health and Care Excellence (NICE) guidance to sustain progress.[69] For those still in education, closer working is required between Youth Offending Teams and special educational needs support teams to improve children's outcomes.

Plans are currently in progress to transform regimes in custodial settings for children and young people by placing greater emphasis on strengthening educational attainment.[70] Many children and young people entering custody have high levels of learning disability and speech, language or communication difficulties. In addition, many have very poor records of school engagement and attainment in schools; for example, in a 2011 Inspectorate of Prisons/Youth Justice Board survey, 86% of young men and 82% of young women surveyed said they had been excluded from school[71], and 42% of young men surveyed said they were 14 years or younger when they were last in education.[71] Under-attainment is often the result of entrenched unidentified health and social care needs with **poor mental health and emotional wellbeing being particularly associated with poor achievement in school**. There is currently no robust evidence that increasing educational attainment in secure settings will lead to decreases in offending. Furthermore, focusing solely on education, using a mainstream school approach, is unlikely to be sufficient to support progress in these children and young people. A special educational needs approach, based upon theoretical models used in residential schools for those with emotional and behavioural difficulties, is more likely to promote sustainable progress. Any changes to regimes should be carefully monitored and evaluated using high-quality research methods to ensure that findings not only support community safety concerns but also the broader life chances and safeguarding needs of a vulnerable group of children and young people with long-standing unmet needs.

Service models

Priority should be placed on developing and resourcing more robust pathways to a range of engaging specialist services. Children and young people in the youth justice system often have sizeable and multiple health needs but poor records of engaging with largely clinic-based community health services. **Traditional service models are not designed to meet their multiplicity of need; nor are funding streams which create gaps during critical transition points during the teenage years.** Youth Offending Teams could provide an opportunity to improve outcomes for a concentration of young people with high health and social inequalities who impose a significant burden on a range of budgets over time. Earlier intervention and closer links with an array of local health and social services and smarter commissioning are required to ensure that service models and funding streams better match the pronounced needs of these young people.

Young people with mild-to-moderate needs may not meet the threshold for support from specialist services. Therefore, effective interventions need to be able to be delivered by non-specialist services (but with support available via training and consultancy from local networks of specialist practitioners). Engaging voluntary sector services offering wraparound support can provide important support to help young people make progress towards healthy adult lives, but these must be evidence based.

Case study

Multisystemic therapy – the Brandon Centre, London

Multisystemic therapy is an intensive home-based, goal-oriented and time-limited therapy (usually delivered over three to five months) shown to reduce offending, antisocial behaviour and the chances of being placed in care. Multisystemic therapy empowers caregivers to regain control and promote sustainable behaviour change in a young person, reducing reliance on formal systems. Therapy is closely supervised, ensuring that it is delivered in a way which maximises the likelihood of promised results.

'C' was 15 and lived with his mother, and siblings. His parents were separated. His father had been in an alcohol rehabilitation unit and his mother suffered from depression and anxiety. C was attending the Child and Adolescent Mental Health Service for cannabis-triggered anxiety and psychosis, as well as the Youth Offending Team, following a number of offences. He was also involved with a gang. He was excluded from school and was sporadically attending a pupil referral unit where his behaviour was poor. A referral was successfully made to the Brandon Centre multisystemic therapy team in London to help C address mounting difficulties.

The therapist engaged C's mother, setting treatment goals based on C's behaviour. They identified multiple risk factors fuelling his behaviour but also many untapped strengths within the family. The therapist held a professionals' meeting to secure whole-system alignment and to set goals for treatment. The therapist worked with C's mother to help her improve her supervision of his behaviour, introducing a contract of rewards and boundaries.

Negative peer influences were identified and addressed through liaison with parents and through the help of the neighbourhood police who acted quickly to find C at key addresses when he absconded. The therapist worked closely with staff in the pupil referral unit to implement and review a plan supporting behavioural improvements. C was also eventually found an alternative placement in a college where he could foster more positive peer contacts. His uncle also found him work in a local gym. He earned a 'wage' that was held in a bank account he could only access when he had completed a month of clean drug tests. Although initially resistant, he slowly began to engage with the system of rewards offered for clean drug tests and began to reflect on his drug use. By the end of treatment he had eight weeks of clean tests.

The therapist noted that C's mother found it a struggle to remain warm in her relationship with her son, particularly when he misbehaved. This fuelled his negative behaviour. Through role play and observation, the therapist helped his mother to develop more positive communication skills and strategies and also completed a six-week cognitive behavioural therapy programme with her to help her depression. The therapist worked with both parents together, to enable C's father to remain supportive to his mother.

After five months C was no longer using drugs or involved in a gang. He had not committed an offence for four months and was engaging in college with no unauthorised absences. He was also no longer having hallucinations and had bonded with pro-social peers. His relationship with his mother, father and uncle had also improved.

C's mother said:

'Thank you for all your hard work with us, no one has fought so hard to help us […] you've helped me to be a calmer, more understanding mother and I'll always be grateful.'

Conclusion

Children and young people in the youth justice system can accumulate severe and multiple risks across their life course. By the time they enter the youth justice system, their life chances are compromised, they significantly impact on the wellbeing of their communities, risk factors are embedded and attempts to mobilise and build compensatory protective factors are more complex and costly. There is a need for integrated commitment, funding mechanisms, and action from all sectors to identify and intervene at the earliest possible point with these children to change costly and damaging life trajectories. There is also a need for service models and approaches which reach out to children and families in their communities, which are evidence based and which recognise and respond better to multiplicity and longevity of need.

What we still need to find out

There is still a lot we do not understand about why certain children and young people end up in the youth justice system and the complex interplay of risk and protective factors that affect their life trajectories. We particularly need better quality longitudinal information to help crystallise the protective factors which can reduce the chances of children and young people entering the youth justice system. Measuring behaviour change resulting from health and social interventions is critical to evaluating their usefulness. There is currently a dearth of high-quality evaluations of interventions for children and young people in the youth justice system. Evaluations need to be independent, with robust and sensitive outcome measures, and with both short and long-term follow-ups comparing intervention outcomes with those receiving standard support.

Specifically, we need the following:

- **Up-to-date and robust representative prevalence data on the health and social care needs of children and young people at all stages of the youth justice system.** A previous national prevalence study was narrow in focus (i.e. psychiatric morbidity and custody) and there is an urgent need to capture the significant changes in the youth justice system population over recent years.
- Continued investment in high-quality UK research concerning what interventions work for children and young

people in the youth justice system and at what point in their lives these are most effective. For example:

- **There is a particular need to improve the quality of research available on gender-specific and black and minority ethnic-specific protective factors and interventions; most research into prevalence and interventions has so far been focused on white British males.**
- We know that many young men in custody show signs of acquired and traumatic brain injury. However, there is a lack of clarity concerning effective interventions to improve prospects. We also have poor information concerning the prevalence of this condition among young people on community Youth Offending Team caseloads or among young women and black and minority ethnic young people.
- The same is true for children and young people with speech and language difficulties, mild-to-moderate learning disabilities and attachment disorders. We are increasingly aware that relatively large proportions of the youth justice population face these challenges; however, there is less high-quality research pinpointing what works to support improvements, reduce offending and improve broader life chances.
- We need to continue to develop a higher quality evidence base for what works for children with substance misuse, conduct difficulties and multiple needs.
- We also need more research focused on how effective interventions such as multisystemic therapy, multidimensional treatment foster care and functional family therapy can be more systematically and effectively integrated into standard Youth Offending Team practice.
- We need continuing analysis of both the effectiveness and cost-effectiveness of interventions in the youth justice system with follow-up of the long-term outcomes of interventions.
- We are developing a better awareness of neuroscientific changes taking place in the adolescent brain, but we also need a better understanding of the extent to which these changes provide a critical opportunity for intervention during a young person's development.

- Children and young people should only enter custody for grave offences and as a last resort. There is currently a lack of high-quality evidence driving the design of custodial regimes for those who must enter secure units. There is an urgent need for high-quality international research investigating which regimes (e.g. size of unit, theoretical approach underpinning the regime, adaptations to better support black and minority ethnic-specific and gender-specific needs and experiences, and units closely linked to local communities vs geographically distant units) have the best chance of improving outcomes for this vulnerable group.

Key messages for policy

- Good evidence exists that high-quality programmes focused on strengthening support systems around children and young people (particularly parenting) in combination with developing children and young people's internal resilience have the best chance of improving multiple outcomes.
- Behavioural problems in children and young people often mask underlying unmet needs (e.g. maltreatment, trauma, bereavement, skills deficits and learning disabilities).
- Children and young people in contact with the youth justice system are more likely to have multiple health problems, yet many of their needs go unrecognised and unmet, thus undermining their life chances and placing a significant burden on the public purse.
- While the numbers of children and young people entering the youth justice system are falling, the health and social needs of those in the youth justice system are increasingly complex.
- Children and young people face a stepping-stone pattern of risk where early risks lead to antisocial behaviour during childhood and increased likelihood of convictions as a teenager.
- Early multi-agency, multi-sector action to strengthen protective factors is key to breaking this pattern.
- Life course action plans are required for children and young people with behavioural problems, integrating early multi-sector action and co-ordinated funding but also recognising that it is never too late to intervene.
- Youth offending prevention activity and Youth Offending Teams provide an important moment to assess need and support resilience with effective evidence-based interventions.
- A priority should be placed on developing and resourcing more robust pathways to engaging a range of specialist services with the capacity to strengthen the assets of these young people.
- Children and young people in the youth justice system need outreaching, engaging and youth-shaped models of support to maximise the chances of supporting change.
- Custody should be used as a last resort and high-quality research is required to establish an evidence base as to the size and type of regime best placed to support the high needs of these vulnerable children and young people and improve community safety.

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