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The Youth Justice Liaison and Diversion pilots

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Why the need for diversion and liaison pilots?

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- ❑ Poor mental health among young people who offend
 - 3 times more likely to have a mental health diagnosis (Hagell 2002)
 - 16-20 year olds: 9/10 diagnosed with a personality disorder in custody (Lader 2000)
 - Custody: neurotic disorders have been identified in aprox 40% of young males and 70% of females under the age of 18 (Lader 2000)
 - High levels of bereavement and trauma



What we know about young people in the YJS

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- 1 in 5 have **learning disabilities** (Harrington and Bailey 2005) and 3/4s have **speech and communication** problems (Bryan et al 2007)
- 2 out of 5 young females and 1 out of 4 boys in custody report **violence at home** (PRT 2008)
- 3/4s in custody have lived with someone other than a parent; 40% had been **homeless** (YJB 2007)
- 84% of 12-18 year olds in custody had 'problematic' drug use; 64%: signs of concurrent mental health difficulties. (Galahad SMS 2007)
- 45% in custody have been **permanently excluded from school** (Bromley Briefing 2008)
- 1 in 3 girls and 1 in 20 boys disclosed **sexual abuse**. **1 in 10 young women** had been **paid for sex**.

Low levels of Yot identification

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- Low rates of identification by Yots (Harrington and Bailey 2005)
- Only 310 out of 1800 young passing through the Yot seen by Yot health practitioner (e.g. from South Tees figures)

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



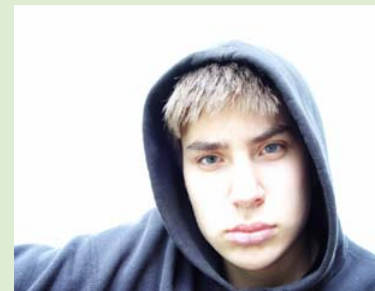
Sainsbury Centre/DH findings

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Service responses

- Low levels of systematic 'point of entry' identification?
- Problems accessing mainstream services: Yots holding complex but sub-threshold cases in silos
- MH services: 'single problem' responses but multiple problems
- No systematic info: PSRs don't address MH/LD/health



Mental health in the YJS: the elephant in the room!

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□ Low stakeholder awareness



Very early intervention

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- ❑ Early recognition of families and children needing support
- ❑ Non stigmatising and assertive outreach approach
- ❑ Needs-led approach focusing on aspirations and including recovery approach
- ❑ Up to 150k per case would be saved from intervening early with children meeting criteria of early onset 'conduct disorder' Friedli, L. & Parsonage, M. 2007.

What should our system be aiming toward?

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- ❑ Children's Centres parenting work
- ❑ Family nurse partnerships
- ❑ Intensive fostering/multidimensional fostering
- ❑ Family intervention programmes
- ❑ Multisystemic therapy
- ❑ Evidence based
- ❑ More effective MH/LD/SLCN assessment and intervention in schools



Early intervention:



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Intervene early (the earlier the better)

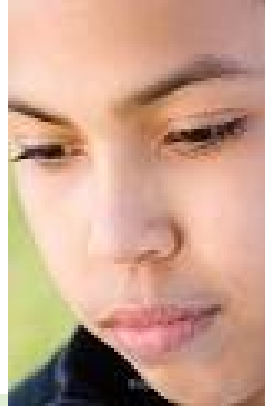
BUT

Early intervention takes time to reap benefits

How do we manage the 'here and now'?

Is there scope for better identification and 'diversion' at the point of entry into the YJS?

What does diversion mean?



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Can include a number of different activities:

- ❑ **Diverting *away from*:** diverting someone out of the CJ system or away from custody
- ❑ **Diverting** someone ***toward*** something (treatment, employment, positive activities etc)
- ❑ Includes a notion of **diverting *within*** a system as well

Evidence base: the adult diversion system

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- ❑ **Tip of the iceberg:** police good at spotting case with the most serious MH problems/miss those with more subtle difficulties = revolving door
- ❑ Identify as early as possible in system
- ❑ Capitalise on all opportunities: police custody/Court/diversion from custody
- ❑ Liaise proactively with police/CPS/courts/Yots/solicitors
- ❑ Diversion has multiple outcomes:
 - reductions in re-offending
 - less harm to victims,
 - cost savings in the criminal justice system (reduction of 2.7 days on remand per case would cover diversion worker) and in health
 - and improvements in mental health



Covering the costs of a YJLD

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£80,000 needed

- ❑ Equivalent to cost of just over 100 weeks of imprisonment.
- ❑ Joint /aligned commissioning (benefits health and YJS outcomes)
- ❑ Doesn't take into account any longer term health cost savings



Creating a youth friendly model



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- ❑ Vulnerable young people don't often reach treatment thresholds for serious mental illness:
 - Clusters of sub threshold difficulties with MH and psychological well-being, speech and language/mixed with other vulnerabilities
- ❑ Early intervention approach: early signs of depression/psychosis
- ❑ Risk factors approach: focus on strengthening protective factors
- ❑ Work with the systems around the young person: family work/school liaison/friendships/leisure (Greenbaum et al 1996)
- ❑ YP need assertive outreach approach, practical/wraparound help and support *into* services

How the model works



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Screening worker backed up by rapid response specialist worker

- ❑ Attend police custody suite/court regularly
- ❑ Screen as many YP pre charge (some bailed pre charge for further assessment via home visit)
- ❑ Refer for full MH assessment where necessary
- ❑ Liaise with CPS/bail support workers/YOT/CAMHS/sentencers/solicitors
- ❑ Advise the court re need for further assessment/packages of care
- ❑ Support young people into 'wraparound' local services
- ❑ Troubleshoot engagement problems/Hold on to cases during waiting periods.

Six pilot sites

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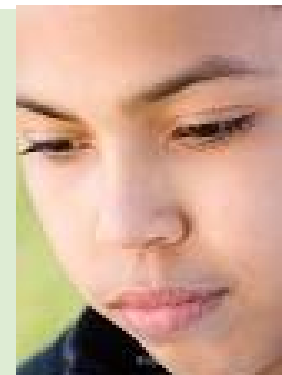
□ Site locations

- Halton and Warrington,
- Peterborough,
- Lewisham,
- Kensington and Chelsea,
- South Tees
- Wolverhampton

□ Operational start date: December 2008 to March 2009

□ Multi agency steering group

□ 2 Year academic evaluation: comparison groups



Findings/challenges so far



- **The challenge of silo busting:** mushrooming services but difficult to pull all the silos into a useful comprehensive map of operational interagency care pathways
- Models need to vary to fit local systems
- **Training:** forensic physician, Police, Appropriate Adult, CPS, solicitors. Sentencers
- **Assessing capacity at point of entry is crucial:** need for sharper focus on capacity pre court
- **The challenge of spanning boundaries:** language, culture, tools
- **No suitable holistic screening tool**



Achievements



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- ❑ Catching cases earlier
- ❑ Catching revolving door cases
- ❑ Workers are a bridge preventing disengagement
- ❑ Halting the 'all or nothing' approach to dealing with mental health: supporting into CAMHS but also into primary mental health care/family interventions/speech and language support

Opportunities



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- **Integrated teams:** cut CAMHS waiting list by 2/3rds (Telford and Wrekin)
 - Cases diverted to range of appropriate lower level support
 - Lower level workers supported through consultation

- **Think Family strategy:** make use of full range of parenting programmes, voluntary sector support, targeted youth support (Importance of Common Assessment Framework)

- **Bradley review:** early intervention (early years/schools)/Yots are central to ID and referral and need consistent expertise/improved training/