HEALTH, EDUCATION AND SUBSTANCE MISUSE SERVICES

THE PROVISION OF HEALTH, EDUCATION AND SUBSTANCE MISUSE WORKERS IN YOUTH OFFENDING TEAMS AND THE HEALTH/EDUCATION NEEDS OF YOUNG PEOPLE SUPERVISED BY YOUTH OFFENDING TEAMS

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EXECUTIVE SUMMARY

INTRODUCTION

This report presents the findings of research, conducted by Nacro on behalf of the Youth Justice Board, to consider the provision of health and education services to young people in the youth justice system. It focuses, in particular, on the roles and responsibilities of health, substance misuse and education workers attached to Youth Offending Teams (Yots), and the extent to which current service provision is adapted to meet the needs of young people supervised by those teams.

The context for the review is the reform of the youth justice system initiated by the Crime and Disorder Act 1998, which required local authorities to create multi-agency Yots from April 2000, to provide a holistic response to the wide range of problems exhibited by young people who offend. Research has confirmed that health-related and educational concerns are both correlated with an increased risk of offending. Accordingly, Yots were required, as part of their minimum statutory membership, to include a person nominated by the health authority and an individual nominated by the local authority's chief officer of education. More recently, the Youth Justice Board has been successful in obtaining funding through the 2000 spending review settlement to allow the appointment of named drug workers in each Yot. This resource is additional to the health contribution, marking a sizeable expansion in specialist staff within the Yot who have a health remit.

THE POLICY BACKGROUND

There is an increasing consensus about the factors which are associated with the risk that young people will become involved in criminal activity. Research has consistently found a significant correlation between young people who experience difficulties of various sorts within the education system and those who demonstrate delinquent behaviour. In particular attainment, absenteeism and exclusion have all been found to be associated with increased levels of offending. There is also clear evidence that the health of children in trouble is inferior to that of the general population. While much of the research has inevitably focused on the relationship between mental ill-heath and substance misuse and youth crime, it is also apparent that poorer health, more broadly conceived, is also correlated with offending behaviour.

The relationship between health, education and youth crime is, however, far from straightforward. In general terms, the factors which predispose children and young people to becoming involved in criminal activity overlap significantly with those that give rise to poor health and educational outcomes. Despite the complexities in what the research tells us, the evidence, nonetheless, points clearly towards a number of conclusions:

- Improving educational opportunities for young people is likely to reduce youth crime.
- Reducing problematic substance misuse will have a positive impact on the rate of offending by young people.

- Promoting mental well-being, and tackling mental health problems, can also be expected to have a beneficial influence on young people's delinquent behaviour.
- Preventing offending, on the other hand, is also likely to correspond with improvements in each of the other areas.

The reciprocal relationship between each of the variables implies that any successful approach to the issue of youth crime will inevitably be holistic – one to which a multi-agency response, in the form of the creation of Yots, is particularly well suited.

Health and education professionals have, then, a full part to play in the prevention of offending and reoffending. A number of legitimate questions arise, however. In particular:

- Should Yot work be characterised by a generic approach, in which all staff undertake all areas of work (with the exception that police officers are precluded by law from acting as appropriate adult), or should discrete specialisms be retained, with a clear demarcation of role? There is, of course, a whole range of possibilities within these two ends of the spectrum.
- Should the primary role of health and education staff be focused on direct service delivery to young people and their families, assessment and onward referral where appropriate, or interface with parent agencies to ensure adequate access to services for young people known to the Yot.
- Depending, in part, on the decisions made regarding the points above, which are the most appropriate backgrounds from which health and education staff might be drawn?

While guidance has generally not been prescriptive, it has contained an implication that effective practice would require health, education and substance misuse staff to retain a clear specialist role: relating to their particular areas of professional expertise; or to their relationship with an external agency. The Youth Justice Board has emphasised the importance of this 'brokerage' role, based on the importance of 'mainstreaming' of service provision in order to ensure that longer term intervention is sustainable and non-stigmatising.

Relatively little is known about how the integration of health and education workers with youth offending services has evolved in practice. The evaluation of the Yot pilots suggested that secondment of these professionals had been more problematic than that from other statutory partners with a history of involvement in the criminal justice system. In addition, relatively low resource input was noted as an issue in the early stages of the Yots' development. In this respect, at least, there has been considerable improvement. As the work of the Yots has become established, the contribution of health and education has risen to over 9%, in each case, of the budget provided by statutory partners. Moreover, the appointment of specific drug workers, on the basis of designated funding, has marked a sizeable expansion in specialist staff within the Yot who have a health remit.

The Youth Justice Board has also set some clear priorities for health and education services, within the youth justice framework, through performance indicators which are relevant to those disciplines. In particular, there is a target that 80% of young people supervised by Yots should be in full-time education, training or employment by the end

of 2003. In addition, time limits have been set for the commencement of assessments by child and adolescent mental health services (CAMHs) of five working days of referral for acute cases and 15 working days for non-acute mental health concerns. Substance misuse workers' priorities will inevitably have to take account of the formula according to which funding was allocated for their deployment. Yots are expected to provide an assessment of the drugs needs of every young person referred to them and to ensure the delivery of appropriate services based upon that assessment.

RESEARCH METHODOLOGY

There were several components to the review, which are outlined briefly below. Further detail on the methods employed are contained in Appendix A.

The first stage of the review was an analysis all Youth Justice Plans currently available, together with other relevant material from individual Yots, in order to provide a broad picture of current arrangements for the provision of health, education and substance misuse services in Yot areas. This was supplemented by a review of the available literature of relevance to health and education service provision to young offenders or people at risk of offending, and of relevance to the health and education needs of such young people.

A principal strand of the evaluation was a self-completion questionnaire survey of health, education and substance misuse workers in every Yot. The purpose of the survey was to determine the role and responsibilities of health, education and substance misuse workers, links with wider services and identification of good practice.

The survey was supplemented by a series of focus groups with health, education and substance misuse workers in a number of regions. Where focus groups were not feasible, telephone interviews were conducted with a small sample of Yot workers in order to ensure adequate geographical spread and coverage across the different groups of workers. The purpose of the focus groups and interviews was to explore in greater detail some of the issues raised during the survey, particularly in terms of working relationships, links with other agencies, roles and responsibilities, issues of effective practice and problematic areas.

FINDINGS FROM THE ANALYSIS OF YOUTH JUSTICE PLANS

The format of Youth Justice Plans has been revised considerably for 2003/04, and they contained limited detail in relation to staff and their backgrounds. It was nonetheless possible to construct a summary of contributions from health and education to the Yot budgets, excluding the designated funding for the appointment of substance misuse staff, which it was not possible to disaggregate. The analysis confirmed a substantial variation in the level of resourcing from education and health within and across regions. For instance, the contribution from education, as a proportion of the Yot budget, ranges from 9.3% in the Eastern region to 2.77% in Wales; the equivalent figures for health are 5.14% in the Eastern region to 2.8% in London. Similarly, at the level of local Yots (excluding the anomalous bracketed figures), education input within the London region varies from over 10% to less than 1%; and health contributions, within Wales, range from over 13% to less than 1%.

Health workers in Yots

A significant number of health workers indicated that there were other health resources available within the Yot. Most frequently, however, this was a reference to substance misuse specialists, and additional resources for other areas of health-related issues were in shorter supply. It seems clear that a majority of health staff are the sole representatives of their agency within the team, and given that many Yots operate over more than one site, it is likely many of them are required to work out of more than one location. Moreover, a third of respondents to the questionnaire reported that they were part-time workers. Indeed, health workers themselves noted that Yots suffer from a particular shortage of mental health professionals.

More than 80% of health representatives were seconded from a parent agency, and for a majority of these workers the secondment is permanent or open ended. Over 40% were seconded by CAMHs, but most of these were not formally members of the service and do not accordingly receive direct clinical supervision through that route.

Integration within the Yot is well advanced. Almost all health workers attend team meetings (despite the relatively high proportion of part-time representation), and a large majority reported that they also attend case discussion meetings. Most had received training when they started work for the Yot, and 84% considered that they were given the same opportunities for training as other Yot staff. Turnover appears to be relatively low and a large majority of respondents had been in post for more than a year.

At the same time, some concerns were expressed over tensions which arose as a consequence of differing expectations on the part of the Yot and parent agencies. Frequently, these centred on different approaches to issues of confidentiality, time-limited work, or the extent to which health staff should be engaged in generic youth justice activities. The lack of facilities for clinical supervision through the Yot structure was also considered problematic.

Most health workers described their role as that of a specialist worker with some generic duties, and an analysis of activities undertaken while working within the Yot confirmed the accuracy of that description. The most frequent form of activity undertaken is assisting with community-based interventions, with about one in four health workers reporting that they carry case responsibility.

In most areas, referral to the health worker was decided on a case-by-case basis, with just over a quarter of respondents indicating that there was a screening process involving specified criteria. On average, around 56% of young people going through the Yot were seen by health workers as having health problems. A further breakdown suggested that relatively high proportions of young people encountered by health workers were thought to have problems with tobacco misuse and family issues. Substance and alcohol misuse and mental ill-health were also considered to affect a considerable proportion of young people.

Nearly all health workers provided interventions themselves, particularly around health education or sexual health education, although group work also featured quite highly. A similar proportion also referred young people to external services where that was required. Particular problems were noted in accessing services for family problems and

mental health issues, which both featured highly in the breakdown of young people's needs. Views of CAMHs varied significantly, with 45% considering the service to be good or very good, and a third to be poor or very poor.

Health specialists, in general, considered health provision for young people in the youth justice system to be adequate (although one in five considered it to be poor or worse). A significant proportion (40%) considered the continuity of provision from custody to the community to be poor or worse.

Education workers in Yots

Education workers were more likely than their health colleagues to have other professionals from the same discipline working within the same Yot. In large part, this is simply a reflection of the relatively larger contribution made by education to the Yots' budgets. Nonetheless, the majority of education staff are probably the sole representatives of their agency within the team and, given that many Yots have more than one work base, many of these professionals are working at more than one site.

Secondment was the most common working arrangement, but a higher proportion of education workers, in comparison to health specialists, were directly employed by the Yot; 11% reported being part-time workers and a worryingly high number indicated that they were in temporary positions. Nonetheless, more than three-quarters had worked in the Yot for more than a year.

In general, education workers appeared to be well integrated into the Yot structure in terms of attendance at team meetings, case planning meetings, and access to training opportunities. A number of respondents were concerned at pressures on them to undertake generic work, but, although it is clear that these pressures were real, education workers appeared to be less resistant than other specialists considered in this review to the prospect of taking on case responsibility and other forms of mainstream Yot work. Indeed, telephone interviews suggested that many education workers considered it an important part of their role.

Accordingly, a lower proportion of education workers characterised their role as a purely specialist one. A breakdown of activities undertaken by education staff appeared to confirm a much higher involvement in generic youth justice work than for health or substance misuse staff. In particular, they were significantly more likely to hold case responsibility and carry out associated tasks such as completing *Asset*. These differences are also reflected in patterns of training received.

As with other specialist workers, the decision to refer a young person appeared to be made on a case-by-case basis, and there was little evidence of any consistent screening process. Nonetheless, one in four education representatives considered that they would see all young people supervised by the Yot who had an educational problem, although the most frequent response suggested that whether or not a young person was seen depended upon the discretion of the Yot worker. More than two-thirds of Yot clients were considered to experience some form of educational difficulty, with the most commonly reported problems relating to non-school attendance, exclusion and poor literacy and numeracy.

Almost three-quarters of education staff provided interventions themselves; these consisted primarily of one-to-one contact. A large majority also referred young people to external agencies, although given the scale of non-school attendance and exclusion, it was perhaps surprising that only a quarter indicated that they made referrals to their parent agency. Difficulties were reported in onward referral as a consequence of a lack of funding for educational programmes for those young people who were hard to place in mainstream school. In general, access to placements was considered problematic.

Overall, less than one in five education workers considered educational provision for young people in the criminal justice system to be good or very good, and almost half considered it to be poor or worse. Continuity of provision from custody to the community was rated slightly more highly, but it should be noted, in this context, that education staff were less likely than other specialists to visit young people in, or have contact with, the secure estate. They were, nevertheless, more likely to hold case responsibility for such children.

Given the centrality of improving educational provision to the delivery of a more holistic service to young people in trouble, it is not clear that the role of the educational specialist should involve undertaking generic youth justice work to the extent that currently appears to prevail in some areas.

Substance misuse workers in Yots

The position of substance misuse workers within the Yot is, in some respects, more straightforward than that of education and health staff because of designated funding for the creation of the posts and a more tightly circumscribed remit. In the first place, there is designated, ringfenced funding to create the post. Given these arrangements, one might reasonably expect that most Yots would include a substance misuse worker.

In fact, 42% of those responding indicated that there were other drug workers within the Yot, 32% of whom were full time. It is accordingly clear that in some cases at least, Yots have access to more than one substance misuse specialist. As might be expected, a larger proportion reported that there were other health workers within the Yot, with 61% indicating that these were full-time posts and a further 17%, part-time. However, this leaves more than 20% of respondents unaware of any additional health staff input into the service, despite the statutory requirement for such representation. In spite of this, substance misuse workers were less likely than health representatives to consider that the Yot ought to have additional health resources available to it. This also translated into a higher regard for provision for young people in the youth justice system as a whole. For the large minority who considered that the Yot should have access to additional services, the availability of mental health provision was most frequently cited.

Direct employment through the Yot was more common than for other staff groups. Nonetheless, secondment was still the most frequent arrangement, although due to the fixed-term nature of the funding, these tended to be of shorter duration. For the same reason, something approaching half the sample reported being in temporary posts. Despite the fact that the substance misuse function within Yots was developed some time after the establishment of Yots, drug workers appeared to be as well integrated into the team structure as other specialists. Attendance at team meetings and case discussions was accordingly high, and 75% considered that they had similar training opportunities to other Yot staff. Access to specialist training was available to almost 90% of drug

workers, who were markedly more likely to have received instruction in motivational interviewing than health or education representatives. The staff turnover appeared to be relatively low with two-thirds of respondents indicating that they had been in post for more than a year.

At the same time, over 10% of drug specialists reported working wholly externally to the Yot. In some cases, indeed, the link appeared quite tenuous and a number of respondents confided that they had for some period been unaware of their supposed role in the youth justice system. Concern was also expressed over the short-term nature of the funding for substance misuse posts, and a number of staff indicated that, in the absence of clarification of extended resourcing, they would be obliged to seek work in another capacity.

Anxieties over pressure to take on generic work figured highly in reported problems, with those carrying out the substance misuse role and drug workers generally resistant to carrying case responsibility. A lower proportion of substance misuse staff than of the other two groups in the review described their role as having any generic component, and the breakdown of activities undertaken since joining the Yot appeared to confirm the accuracy of those descriptions. Almost two-thirds of drug staff reported involvement in assisting with community interventions, over half visited children in a secure setting and a similar proportion contributed to court reports written by others.

Drug workers were more likely than other specialists to see young people referred according to strict criteria, although, in most cases, referral was again on a case-by-case basis. Almost 60% of young people supervised by the Yot were considered by drug workers to have a substance misuse problem, and this figure rose to three-quarters of those seen by this specialist group. Although heroin, crack cocaine or use of volatile substances were estimated to affect less than 50% of young people seen, the extent of that use was, nonetheless, significantly more prevalent than that among the general population.

Only one substance misuse worker indicated that they did not provide interventions to young people themselves. Such interventions took the form, primarily, of education, counselling and group work. Although onward referral to external agencies was universally reported as part of the drug worker function, staff appeared to experience fewer difficulties with locating appropriate resources. Most reported no problem with accessing services outside the Yot for young people who had issues with substance misuse (although 21% did refer to a lack of provision and a further 11% to lengthy waiting times). A higher proportion was concerned at the lack of provision for problematic alcohol consumption, but here too a majority had experienced no difficulties in this area.

These findings might reflect the fact that many of the issues which young people bring to drug specialist workers can be handled within the Yot at Tiers 1 or 2 of service delivery. In this context, it is perhaps significant that caseloads for drug workers were higher than those for other specialist staff.

Substance misuse specialists also had a more positive picture of drug-related provision available to young people in the youth justice system, as a whole, than the other two groups did in relation to their own areas of expertise. Nonetheless, the responses did

suggest that there remained considerable scope for further improvement, and less than half of the sample considered provision to be good or very good. Significantly fewer substance misuse workers were impressed with continuity of provision for those coming out of custody, with less than a quarter reporting it to be good or better. Given that this staff group had the highest level of contact, of the three specialist groups of workers considered in this report, that judgement may take on an added significance.

CONCLUSIONS

Research has consistently found a relationship between youth offending and a range of factors with a health or educational dimension. The presence of staff within Yots who have an educational and health background is, accordingly, a necessary condition of developing effective interventions, as part of a holistic response to youth crime. However, it is not, in itself, sufficient to guarantee that maximum benefit is derived from the involvement of such professionals.

The piloting of Yots suggested that adequate resource input from health and education was likely to prove problematic and, while progress has clearly been made in the intervening period, the current survey suggests that levels of contributions continue to represent a difficulty in some areas. There is wide variation in the allocation of health and education resources within and between regions and, in concrete terms, this differential is inevitably reflected in levels of specialist staffing. The majority of such staff appear to work as the sole representative of their agency within the Yot and, given that many teams operate over split sites, the access to specialist input at any location will be reduced. Moreover, almost a third of the sample of health workers described themselves as part-time, and 10% of substance misuse workers reported working wholly externally to the Yot. In these circumstances, it is clear that there is considerable scope for improving the specialist provision available to young people who offend through an increase in staffing levels in, at least, some areas. Ideally, Yots would benefit from having access to a minimum of one full-time health and education worker on each site.

At the same time, maintaining current levels of services depends on the continued funding of substance misuse specialist posts beyond the current term. If the funding is not renewed, it will place considerable pressure on the existing health contribution to Yots by requiring that health staff address a broader range of risk factors. In the short term, uncertainty over job security for drug workers, many of whom are in temporary posts, has the potential to reduce the pool of substance misuse specialists working in Yots.

Whatever the concerns over levels of staffing, the picture that emerges of specialist integration into Yots is largely positive. In particular, the relatively low staff turnover is indicative of good working relationships within the teams and this is confirmed by staff comments on the issue. At the same time, there were a number of tensions, which became clear during the course of the research, that require resolution:

- Health and substance misuse staff were critical of the lack of clinical supervision.
- The potential for specialist interventions is sometimes underestimated by other Yot staff.
- Agencies have different expectations in respect of issues around confidentiality.

- Health and substance misuse workers (and to a less extent education staff) are uncomfortable with pressure to take on generic work which they consider would undermine their specialist role.

The high level of specialist need among the young people supervised by Yots was recognised by each of the specialist groups of staff and, to a large extent, these confirmed the findings of previous research. In particular, substance misuse, mental ill-health, family difficulties, and problems with literacy and numeracy featured highly.

However, referral to specialist workers generally appears to take place on a relatively ad hoc basis. The introduction of objective screening mechanisms and referral according to clear criteria might improve consistency of service provision.

Most specialist workers provide interventions themselves and, for health and drug workers, these are generally related to their own area of expertise. Access to mental health provision outside the Yot, however, was noted as a considerable problem, which was exacerbated where the health worker was not him or herself a member of CAMHs. Arguably, if distinct substance misuse funding is to remain available to Yots, future health secondments might benefit from being more closely tied to mental health expertise.

There appears to be a variety of models employed to determine the role of specialist workers within the Yots. There is, in particular, some tension between retaining a specialist approach and developing a more generic function for specialist workers. Many specialist staff expressed concerns about experiencing pressure to undertake work of a generic nature. This appeared to be furthest advanced in relation to education workers, who also seem less uncomfortable with taking on case responsibility and undertaking mainstream youth justice work.

The evidence from the current research suggests that this process has the potential to undermine the ability of education representatives to perform what is arguably the most important part of their role: liaison with external agencies to ensure the provision of mainstream services for children who are out of education or training. In addition, there is some doubt as to whether appointments of educational representatives are at a level which would facilitate that brokerage function. This is an issue which would merit further consideration and investigation.

The above reservations notwithstanding, it is important to acknowledge the significant advance that Yots represent over previous arrangements for delivery of health, education and substance misuse services to young people who offend. The rationale for the presence of health and educational specialists at the heart of effective responses to youth crime has become accepted by all the partner agencies, as witnessed by the gradual increase in the relative contributions for those specialist areas. A range of problems that might have gone unnoticed, and in a larger number of cases would have remained untreated, are increasingly identified at an early stage, as the process of assessment has become more sophisticated, and permits the involvement of specialist staff within the Yot.

INTRODUCTION

CONTEXT OF THE RESEARCH

Purpose of the review

This report presents the findings of research, conducted by Nacro on behalf of the Youth Justice Board, to consider the provision of health and education services to young people in the youth justice system. In particular, the Youth Justice Board was concerned that the review should determine the roles and responsibilities of health and education workers attached to Yots, and the extent to which current service provision was adapted to meet the needs of young people supervised by those teams.

Legislative background

The formation of Yots across England and Wales from April 2000 marked a major departure for the way in which youth justice services were delivered. Previously, primary responsibility for dealing with young people who offend resided with local authority social service departments under a general duty to safeguard and promote the welfare of children in need. In most areas, this function was carried out by dedicated youth justice teams staffed by specialist workers. While local arrangements showed considerable variation, the probation service generally provided services to older young people, typically those aged 16 to 17 years.

The Crime and Disorder Act 1998 required local authorities to co-operate with other relevant agencies to establish Yots as the primary vehicle for delivering the new principal aim of the youth justice system – introduced by the same legislation – of preventing offending by children and young people. The teams were conceived as multi-agency bodies which would be able to provide a holistic response to the wide range of problems exhibited by young people who offend. Accordingly, other agencies were obliged to participate in the process and, in particular, to provide resources and staffing to assist in the creation of Yots.

Thus Yots are legally defined by their minimum membership: teams must include a social worker of a local authority social services department; a police officer; a probation officer; and, importantly, from the perspective of the current review, a person nominated by the health authority and an individual nominated by the local authority's chief officer of education.

Policy background

The transformation of the arrangements for delivering youth justice services was heavily influenced by *Misspent Youth*, the Audit Commission's influential report on young people and crime published in 1996. The publication was largely critical of existing provision and its influence was principally derived from the pivotal role it played in bringing together known information on the characteristics of young people most likely to come to the attention of criminal justice agencies. It described a 'cycle of anti-social behaviour' in which youth crime was closely associated with the following:

- inadequate parenting
- aggressive, hyperactive behaviour

- truancy and exclusion
- peer group pressure
- unstable living conditions
- lack of training and employment
- drug and alcohol abuse
- early parenthood.

In acknowledgement of the breadth of such 'risk factors', the Labour government, elected in 1997, determined that the response to youth crime should reflect a 'joined-up' approach. The most important requirement was that Yots should enjoy 'the right blend of skills and experience' while sharing a common ethos centred on prevention of offending (Home Office, 1997). This was the context in which health and education professionals were, for the first time, to be given a central role in delivering services to young people who come into contact with the youth justice system.

Subsequently, there has been increasing focus on risk, and a growing understanding of the degree of overlap between factors which characterise both children who enter the child welfare systems and those who come to the attention of the criminal justice system (Youth Justice Board, 2001a), and the presence of high levels of family disruption and substance misuse in the lives of young people in trouble with the law (Rutter et al, 1998).

The relationship between education and youth crime

The importance of education to the proper development and socialisation of children and young people is reflected in the title of a well-known study of school effectiveness, *Fifteen thousand hours*. This represents the length of time that a child can expect to spend within a formal educational setting over the duration of compulsory schooling (Rutter et al, 1994). Such a period evidently has enormous potential for influencing behaviour. It is accordingly unsurprising that research has consistently found a significant correlation between young people who experience difficulties of various sorts within the education system and those who demonstrate delinquent behaviour. In particular, attainment, absenteeism and exclusion have all been found to be associated with increased levels of offending.

Attainment

Examination results for the majority of children have shown a gradual year-on-year improvement. The proportion across England who achieve five or more GCSE (or equivalent) passes has risen from 46.3% in 1998 to 51.2% in 2002 (Department for Education and Skills, 2003a). At the same time there is a reducing percentage, 5.6% in 2002, who leave formal education with no academic qualifications. However, this minority is significantly over-represented among those young people who come into contact with the criminal justice system.

Thus an analysis of data from *Asset*, the standardised assessment tool developed for the youth justice system by the Youth Justice Board, indicates that 42% of those referred to Yots were rated as underachieving at school. In addition, 25% were assessed as having special educational needs (Youth Justice Board, 2003a). Among those more troubled children who end up in custody, the scale of the problem is more pronounced. According to the Social Exclusion Unit, almost half of young people in a custodial setting had literacy and numeracy levels below those of the average 11-year-old; while for more than

one in four, those levels were equivalent to, or below, an average 7-year-old (Social Exclusion Unit, 2002).

It might be argued that the relationship between educational attainment and delinquency is explained through a relative inability of those who underachieve to manipulate abstract concepts. Such an inability would then manifest itself in a failure to anticipate the consequences of behaviour – itself an indicator of offending – or to appreciate fully the impact of criminal activity on victims. In reality, however, the relationship is likely to be significantly more complex than suggested by such a linear causal account.

For instance, those resident in poorer neighbourhoods under-perform relative to their more affluent counterparts. Eligibility for free school meals is, to take a concrete example, an indicator of expected level of test scores (Nacro, 1999a). At the same time, low family income, poor housing and large family size are also independently associated with higher levels of offending by children (Youth Justice Board, 2001a).

Achievement is obviously influenced by attachment to school and by the extent to which education is positively valued by the students. Graham and Bowling's path-breaking analysis found an independent correlation between not liking school and self-reported offending (Graham and Bowling, 1995). It seems likely too that attitudes to education are themselves susceptible to family influence. In this context, it may be important that parental attitudes are also commonly regarded as a reliable indicator of delinquent behaviour.

Equally, structural factors, relating to the educational institutions themselves – such as poor standards of teaching, inconsistent enforcement of rules and labelling of less academic children as failures – can have an impact on attachment to school and misbehaviour (Youth Justice Board, 2001a). Indeed, even something as apparently insignificant as the deployment of temporary teachers can influence pupils' attitude to academic work and behaviour while in school (Ofsted, 2002).

It is accordingly hard to dissociate a number of factors from each other and, in all probability, a variety of interrelations will have an impact both on anti-social (or criminal) behaviour and performance within the educational setting. These two elements will in turn exacerbate each other.

Truancy and exclusion

A strong correlation has also been found between truancy, or being excluded from school, and youth crime. At one level, of course, any separation of these factors from those discussed in the previous paragraphs is a relatively artificial one. Lack of attachment to school is likely to find expression in unauthorised absenteeism; conversely, being out of school, whatever the circumstances, will inevitably result in lower attainment than would be anticipated through regular attendance. Nonetheless, the statistics showing a relationship between exclusion and crime are remarkable for their consistency.

Research conducted for the Youth Justice Board by MORI shows that excluded young people are more than three times as likely to admit having committed an offence within the past 12 months. The survey also reveals significant differences in the frequency and seriousness of offending (Youth Justice Board, 2003b). Aggregated data from *Asset* show

how these differences in self-reported delinquent behaviour filter through in terms of the characteristics of those who come into formal contact with the youth justice system. Thus, while only 0.24% of the secondary school-age population were permanently excluded during 2001/02 (Department for Education and Skills, 2003b), 15% of young people supervised by Yots were excluded at the point of referral. More than 40% were regularly truanting (Youth Justice Board, 2003a).

The pattern is more marked for those children whose offending results in confinement within the juvenile secure estate. The Social Exclusion Unit notes that between a quarter and a third of those in custody had no education or training available to them at the point of incarceration (Social Exclusion Unit, 2002). Other studies have found that 48% to 59% of young people in custody had been permanently excluded on at least one occasion (Goldson, 2002; Liddle, 1998).

Permanent school exclusions have been increasing substantially in recent years from a figure of fewer than 4,000 in 1991/92 to a high point of 12,668 in 1996/97. In the following year, the government set a target to reduce exclusions by a third by September 2002. The target was met two years early but, more recently, the earlier trend has reasserted itself. Exclusions rose by almost 15% between 1999/00 and 2001/02.

More than one in six of those excluded are of primary school age. Of particular concern is the disproportionate representation of black children, who are more than eight times as likely to be excluded as the general school population (Department for Education and Skills, 2003b; Owen et al, 2000). There is, too, a clear correlation between school exclusion and social exclusion, more generally conceived, which finds expression in the fact that looked after children are more than 10 times as likely to be permanently excluded (Department for Education and Skills, 2003c).

These figures do not tell the whole story, however, since they do not include exclusions which are not permanent, or unauthorised absences. One study, conducted in the mid 1990s, suggested that fixed term exclusions may be 10 times as common as the permanent variety (Smith,1998). While official data suggest that truancy levels have remained relatively stable in recent years, indicating that 0.7% of school time is lost to unauthorised absence, this is almost certainly a substantial underestimate (Department for Education and Skills, 2002). Many children, for instance, engage in what has been called post-registration truancy: one survey found that 30% of year 10 and 11 pupils had been absent without authorisation over a six-week period and that 10% of 16-year-olds truanted at least once a week (O'Keefe, 1993). The total number of children estimated to be absent from school on any given day has been put as high as 5%, representing 400,000 pupils (Stevens et al. 2002).
To these must be added those who are not on roll at any educational establishment. Although figures are not available, it is sometimes suggested that they are not insignificant, particularly among those children who offend. In one survey of young people on remand, for instance, 36% reported not attending any form of educational provision immediately prior to being locked up; this group was additional to those who said that they were excluded (Goldson, 2002).

It is of course true that not all truants offend. Indeed, many may not even be disaffected; the majority continue to like school and want to stay on beyond the minimum leaving age (O'Keefe, 1993). Nonetheless, this relatively high level of absenteeism is of concern,

since the link between missed schooling and youth crime is well established. For instance, 41% of children under Yot supervision report truanting and a third have previously been subject to fixed term-exclusion (Youth Justice Board, 2003a). Research has also found an almost direct correlation between rates of youth crime in an area and the level of non-school attendance (Social Exclusion Unit, 2002). Estimates by the police in London, suggest that up to 40% of robberies, 25% of burglaries and 20% of thefts are committed by children aged 10 to 16, the majority taking place during school hours (Nacro, 1999).

Once again the issue of causality is a complex one. Permanent exclusion appears, in some cases, to set off a chain of events which serves to loosen ties to a conventional way of life, thereby making offending more likely. On the other hand, the same group of children tend to suffer from pervasive social disadvantage and, as a consequence, delinquency frequently pre-dates the decision to exclude. In such cases, lack of schooling can escalate pre-existing offending careers.

This relationship is not however an automatic one. Research has also shown that almost a third of excluded children had no recorded offences either before or after being excluded. Moreover, for a further 18%, exclusion appears to have been associated with a cessation of offending. Such cases tended to be characterised by the young people being offered individual attention in an alternative educational setting which better met their learning styles and emotional and social needs. Accordingly, removal from mainstream education can, for some young people, be experienced as a positive turning point (Berridge et al, 2001).

The relationship between health and youth crime

Despite the issue receiving considerably greater attention in recent years, the literature on the relationship between health and crime is still relatively limited. That which exists tends to focus on illegal substance misuse and mental health, and there is an increasing consensus about the importance of these issues for the onset of youth offending. While the concentration on drugs and mental well-being is understandable, it is nonetheless helpful to locate them within a broader framework, since it is clear that other health-related issues are factors of some significance.

One survey of a sample of children and young people involved with Yots in the north-west of England, for instance, found that two-thirds who were given health checks were malnourished and half of these were adjudged to be in some sort of medical distress. Many had missed routine health development checks, advice and inoculation cycles, largely as a consequence of missed schooling (Youth Justice Trust, 2001). In a separate study of 192 children appearing before a Manchester court, 19% were found to have significant medical problems (Dolan et al 1999). A recent report on sexual health needs of young people referred to Cambridgeshire and Peterborough Yots, identified a high level of confusion about what services are available, combined with a low take-up of provision (Hanby and Block 2002).

There is clear evidence too that the health of children in custody is inferior to that of the general population. So, while the proportion of all children who smoke is increasing, smokers are over-represented in young offender institutions (YOIs). Detainees are also more likely to have consulted a doctor and to be taking prescribed medication for a physical condition than the average for children of the same age. There is also a marked

contrast between levels of awareness of those in custody about health issues and their physical well-being, with 66% indicating that they were in good or very good health in spite of 40% reporting a long-standing illness (HM Inspectorate of Prisons, 1997). A recent survey of young people remanded to custody found that 28% were suffering physical ill- health for which they were receiving treatment (Goldson, 2002).

It is not, however, at all obvious that there should be any direct causal relationship between delinquency and smoking or physical health issues. It seems more likely that patterns of overall well-being are consistent with what is known about the relation between health and deprivation, on the one hand, and the characteristics of young people who offend on the other (Youth Justice Board 2001a; Nacro 2002a). Such an understanding provides a useful context within which to view the evidence about substance misuse and adverse mental health.

Mental health

The number of young people in the wider population experiencing mental health difficulties has increased significantly since the 1940s. The Mental Health Foundation suggests, for instance, that one in five young people experience psychological problems (Mental Health Foundation, 1999), and an estimated 13% of girls and 10% of boys within the 11 to 15-year-old population suffer from mental disorder (Hagell 2002). But as the incidence of mental ill-health has risen in the general community, so it has become recognised as a predisposing factor to youth crime. Recent research by the Youth Justice Board into what young people in trouble say about themselves might, on the face of it, be thought indicative that a relatively high proportion of them have mental health difficulties. Thus:

- 48% reported that they often felt miserable or sad.
- 24% said they often had difficulties with eating or sleeping.
- 10% had deliberately self harmed.
- Perhaps, most worryingly, 11% had thought about killing themselves.

Significantly, Yot practitioners tended to give lower estimates of the problems than those revealed by the self-reports (Youth Justice Board, 2003c).

What these young people's accounts suggest is confirmed by other research. Estimates from the range of studies investigating the prevalence of mental ill-health among those within the youth justice system (outside of custody), range from 27% to 77%. In one recent study, more than half of those supervised by a Yot were identified as having mental health needs requiring intervention through CAMHs (Stallard et al 2003). A review of the literature concludes that, although there are, inevitably, difficulties of definition – and a considerable overlap with issues of substance misuse – young people in trouble are at least three times as likely to display mental health difficulties as the general youth population (Hagell, 2002).

While prevalence is higher than that found more broadly, the distribution of different types of problem among young people who offend is similar. Most frequent are conduct and oppositional disorders – unsurprising since such disorders are often defined in terms of delinquent behaviour. Anxiety and depression are common. Hyperactivity is particularly associated with anti-social behaviour which persists into adulthood (Rutter

et al, 1998). Post-traumatic stress disorder is also significantly higher among the offending population, particularly those in custody (Hagell, 2002).

Indeed, the custodial youth population appears to suffer from particularly problematic mental ill-health. The Social Exclusion Unit cites a survey of 16 to 20-year-olds in detention which found that two-fifths of sentenced males and a fifth of sentenced females showed symptoms of anxiety, depression or difficulties with concentration. More tellingly, 85% exhibited signs of a personality disorder (Social Exclusion Unit, 2002), a figure which rises to over 90% in another study (Farrant 2001). The relationship between loss and abuse and serious offending, uncovered by Boswell's research on young people sentenced for 'grave crimes', both gives a context for the relatively high level of post-traumatic stress disorder experienced by those in custody, and suggests a link between earlier life history and violent offending. The study found that 91% of the sample had experienced abuse and/or loss. In 35% of cases, there was clear evidence of both (Boswell, 1995).

In any event, such a concentration of young people suffering with mental ill-health (in combination with the damaging experience of custody itself) finds concrete expression in alarming levels of self-harm within the custodial estate. Between January 1998 and January 2002, there were 1,111 reported incidents of young people harming themselves within YOIs. One might reasonably suppose that a substantial number of lesser occurrences go undetected or unrecorded. At the most extreme, young people are driven to take their own lives. Over the same period, 12 boys, aged 16 to 17, committed suicide within custody (Hodgkin, 2002).

The identified risk factors for adverse mental health make familiar reading. Children most at risk include those:

- whose families suffer socio-economic disadvantage or who live in under-resourced neighbourhoods
- whose parents suffer mental health problems themselves
- whose background encompasses experiences of abuse or neglect
- who experience harsh or erratic parenting
- who suffer from a learning disability or learning difficulties – particularly where these give rise to low attainment in reading (Nacro, 1999b).

Once again, then, there is evidence of a significant overlap between factors associated with the onset of mental health difficulties and those associated with offending. Moreover, it can be argued that offending, itself, may generate higher levels of mental health difficulties. Children who exhibit anti-social behaviour at a younger age have an increased rate of emotional problems, anxiety or depression later in life. Risky behaviour, in itself, frequently induces stress. Some mental health symptoms have also been attributed to young people being involved in, or witnessing, violence at a higher level than the general population, in the course of their criminal activity (Hagell, 2002).

The response of the youth justice system can itself contribute to mental ill-health; either through a failure to identify and meet need or by amplifying (or creating) difficulties which are predictive of mental disorder (Hagell 2002). Custody, for instance, can increase the chances of homelessness, loosen bonds between families and reduce the prospects of gainful employment (Nacro, 2003b). There is also evidence that children

placed in the secure accommodation on offending grounds frequently do not receive the mental health services they require (Kroll et al, 2002).

The research then describes a complex pattern in which a constellation of needs is expressed both in terms of offending behaviour and poor outcomes as regards mental health. The relationship is, moreover, mutually reinforcing: mental ill-health increases the risk of offending and vice versa.

Substance misuse and youth crime

Significant media attention has been devoted to the link between the use of illegal drugs and other forms of youth offending. Available information does suggest a clear relationship between the two phenomena. Thus, 12 to 17-year-old boys and girls, who have used drugs in the past year, are at least five times as likely to be 'persistent offenders' as those who have not (Flood-Page et al, 2000). Considered the other way around, almost 90% of young people referred to Yots admit having used illegal drugs. Less than 20% of the sample had used heroin or crack cocaine, but this is nonetheless five times higher than the equivalent figure for use of 'class A' drugs within the general population of the same age. Moreover, those referred to the Yots tend to experiment with illicit substances at an earlier age, their usage tends to be more prolific, and there is a correlation between frequency of offending and the prevalence of substance misuse (Hammersley et al, 2003).

As might be anticipated, drug dependency increases significantly with the seriousness of offending and is alarmingly high for young people who are committed to custody. The Social Exclusion Unit cites a study in which over half of 16 to 20-year-olds reported a dependence on a drug in the year before imprisonment. Of these, one in four sentenced females, and one in seven males, related that dependence to an opiate such as heroin (Social Exclusion Unit, 2002).

Just as young people may experience difficulties with education and not offend, so too drugs use does not automatically lead to criminal behaviour. In the first place, cannabis is by far the most commonly used illegal substance among young people who come into contact with the criminal justice system. It is clear that significant numbers of young people routinely experiment with prohibited substances, cannabis in particular, without becoming involved in offending over and above that involved in the drug-taking itself. Recent surveys, for instance, show that 31% of 15-year-old secondary school children have taken cannabis within the past 12 months (Department of Health, 2003a).

Second, there is also little evidence that cannabis acts as a 'causal gateway' for hard drugs. Indeed, Home Office research suggests that, 'for the sort of reduction in soft drugs that might be achievable in practice, the predicted causal effect on the demand for hard drugs would be negligible'.

The same study concludes that the average onset age of drugs use is above that for youth crime. In effect, delinquency often precedes drugs use rather than vice versa (Pudney, 2002).

Third, it needs to be acknowledged that, while the use of drugs has increased significantly in the recent past, recorded youth crime has fallen – by around 20% during

the 1990s – with the biggest rises being associated with drugs offences themselves (Nacro, 2003a).

At the same time, early onset of substance misuse is often correlated with other factors, which are, in turn, associated with offending behaviour. Truancy, for instance, whose relationship to youth crime was discussed in the previous section of the report, is related to regular smoking and drinking alcohol. Truants are also almost six times as likely to report having taken drugs in the last month (Department of Health, 2003a).

As a consequence, there has been an emergence of an 'holistic' approach to drug use, moving away from an approach by clinicians and criminologists based on personal pathology to one which recognises that 'a wider public health approach which encompasses the full range of tools of social policy is more likely to work than either punitive legislation and isolated arrests on the one hand, or treatment alone on the other' (Young, 2002 page 9). The lack of success of a purely maintenance approach by, for instance, methadone prescription is now well documented (Seddon, 2002), as is the need for wide- ranging interventions, possibly extending over a lengthy period of time, to ensure users successfully cease use (Martin, 2002; Roberts, 2003). As *The Observer* noted

That said, turning an addict into a former addict involves more than helping them off drugs. It can mean a change of scene, new friends, different aspirations, and expectations. For returning a reformed addict to the environment that originally was the cause of their drug problems is hardly a recipe for a stable future. This means that help with housing, benefits, family support, mentoring and employment is also crucial if drug dependent offenders are to remain off drugs and lead a crime free life style. (The Observer, 2001)

The overall picture then has at least four dimensions:

- **a rise in the use of prohibited substances by young people:**
  However, within society as a whole, most of this trend represents temporary or experimental use

- **higher rates of drug use among young people who offend:**
  Given what else is known about children involved in crime, the most plausible explanation may lie in a significant overlap in those factors which are associated with anti-social behaviour and those which increase the risk of the early onset of drug-taking. For example, non-school attendance and poor parenting appear to be associated with both phenomena.

- **young people in contact with the criminal justice system:**
  Those, in particular, whose offending is persistent are more likely to develop problematic drugs use. In part, this may simply reflect earlier onset, which, in itself, is correlated with subsequent escalation. It may also be an outcome of a higher concentration of risk factors among that persistent group

- **problematic drugs use:**
  This can, itself, be a trigger to further offending. Many drugs reduce inhibitions, and perhaps make offending more likely: 58% of young people referred to Yots, for instance, indicated that they sometimes got into fights when under the

influence of a substance. A similar proportion admitted smashing things up under similar circumstances. At the same time, it is difficult for a young person to support an extensive drug habit by legal means. So 42% of those subject to an Intensive Supervision and Surveillance Programme (ISSP) explained their offending, in part, as a mechanism for financing the purchase of drugs or alcohol (Youth Justice Board, 2003c).

Alcohol consumption is not in itself illegal and for that reason has probably attracted less attention than prohibited substance misuse. It is, however, no less problematic. Indeed, in many respects, the relationship with youth crime is similar. Its use is common among the general population, with 24% of secondary school-age children reporting that they had consumed alcohol in the last week (Department of Health, 2003a). The prevalence of alcohol use is, however, again higher within the offending cohort. The Audit Commission established that 50% of a sample of young people on supervision said that they got drunk at least once a week, with a slightly smaller proportion referring to what could be described as problem drinking within their families (Audit Commission, 1996). More recently, 26% of excluded children admitted being drunk at the time of their last offence (Youth Justice Board, 2003b).

The relationship becomes starker when more serious offences are considered. Cookson has analysed the link between intoxication and offending among more than 600 17 to 21-year-olds males sentenced to custody. She concluded that 41% of the sample were under the influence of alcohol at the time of the precipitating offence. Those who had consumed alcohol were much more likely to have received custody for a violent incident as opposed to an acquisitive crime. Levels of consumption were high: the average intake of those who denied being drunk was 11.51 units, in comparison to the 20.6 units of those who accepted that they were intoxicated. The study also found a correlation between reported habitual drinking and the number of previous offences (Cookson, 1992).

One difference between heavy alcohol consumption and other forms of prolonged substance misuse is that it is not generally concentrated among the most disadvantaged sections of the community. Indeed, so far as males are concerned, there are small differences in terms of quantities consumed according to social class. However, according to the Acheson report into inequalities in health, alcohol dependency is linked to socio-economic status, suggesting that the problem goes beyond the chemical impact of the drink itself (Acheson, 1998). In general terms, the factors which predispose children and young people to long term, problematic alcohol consumption will correspond closely to those which give rise to persistent drug abuse.

The role of Yots and Yot staff in relation to health, education and substance misuse

Existing guidance on the role of Yots, and Yot staff, in relation to health, education and substance misuse

The relationship between health, education and youth crime is accordingly far from straightforward. Nonetheless, the evidence points clearly towards a number of conclusions:

- Improving educational opportunities for young people is likely to reduce youth crime.

- Reducing problematic substance misuse will have a positive impact on the rate of offending by young people.
- Promoting mental well-being and tackling mental health problems can also be expected to have a beneficial influence on young people's delinquent behaviour.
- Preventing offending, on the other hand, is also likely to correspond with improvements in each of the other areas.

The reciprocal relationship between each of the variables implies that any successful approach to the issue of youth crime will inevitably be holistic: one to which a multi-agency response is particularly well suited. The creation of Yots was, in some ways, the culmination of a decade of development during which local authorities were increasingly enjoined to adopt partnership-working in the arena of crime prevention. Nonetheless, Yots represented a qualitative shift in the development because of their statutory nature and their breadth of function (Smith, 2000).

The Youth Justice Board was explicit about that the multi-agency nature of the teams would enable them effectively to offer interventions which

tackle the particular factors (personal, family, social, educational or health) that put the young person at risk of offending and which strengthens protective factors. (Youth Justice Board, 1999).

A number of advantages, inherent in bringing all the differing partner agency workers together under one roof, were spelt out:

- the continued recognition of inter-dependency between the various agencies and how their roles complement one another
- the continuation of networking of communication with parent agencies and preservation of identity
- access to appropriate resources
- the bringing of appropriate skills and experience to the equation to meet the needs of young people who offend, their families, victims and the community
- provision of appropriate training for other members of staff within their specialist areas and the sharing of information
- combining a range of different agency perspectives to provide a more holistic assessment of individual young people on which to base effective intervention (Nacro, 2002b).

At the same time, some commentators pointed to potential difficulties. These included:

- differences between confidentiality codes
- communication problems
- children passing from one specialist worker to another
- differing expectations of partner agencies
- lack of clarity over goals, responsibilities, roles (Shell, J. 2001).

In addition, concerns were expressed in relation to:

- a lack of specialist/clinical management and supervision in relation to specialist interventions.

- a potential for over-management
- the absence of professional peers within the team for staff from particular agencies
- difficulties in accessing specialist resources
- identification as part of the youth justice system could lead to inhibition on the young person's part.
- a potential dilution of parent agencies' traditional values and culture
- interventions being time-limited by the constraints of the youth justice system – for instance, by the length of court order – rather than by the needs of the young person (Nacro 2002a).

At the same time, it was recognised that Yots, in spite of the participation of the critical statutory partners, could not hope to address all such issues in isolation. Effective intervention would depend upon a wider integration of the multi-agency team within a broader partnership approach, maximising the impact of the mainstream services of the statutory partner agencies and linking to a range of other social policy initiatives. Accordingly, the precise role of the Yot and specialist staff within it, in terms of addressing issues of health, education and substance misuse, was not given in advance.

A number of legitimate questions arise. These include for instance:

- **whether Yot work should be characterised by a generic approach:**
  This should be one in which all staff undertake all areas of work (with the exception that police officers are precluded by law from acting as appropriate adult), or whether discrete specialisms should be retained with a clear demarcation of role. There is of course a whole range of possibilities within these two ends of the spectrum.

- **the primary role of health and education staff:**
  Should it be focused on direct service delivery to young people and their families, assessment and onward referral where appropriate, or interface with parent agencies to ensure adequate access to services for young people known to the Yot?
- **appropriate background for health and education staff**:
  Depending, in part, on the above decisions, which are the most appropriate backgrounds from which health and education staff might be drawn? Nacro,1999c)?

Inter-departmental guidance issued before the establishment of Yots was not totally prescriptive on these issues. It acknowledged that – with the exception applying to police officers, noted above, all youth justice functions might be undertaken by anyone within the team. It did, however, note a presumption that certain key tasks, such as the preparation of pre-sentence reports and supervising community sentences, would remain the preserve of social workers and probation officers. Some more concrete suggestions were also offered as to the possible roles of health and education staff within Yots.

In particular, 'education staff should expect to:

- help young people accused of offending, and those known to offend, of school age but not at school, back into school, or make other arrangements to meet their

literacy, numeracy or other educational or training needs; many local education authorities already have staff performing this function for young people out of school and it may be appropriate for one or more of these staff to operate as a member of the Yot to assist the team to access relevant local services and other provision

- advise on education issues within the work of Yots and liaise with schools and with other education colleagues, including concerning the provision of information for court reports
- help put young people dealt with by Yots in touch with those able locally to provide careers advice or help with finding employment'

Health staff on the other hand 'should expect to:

- help ensure that both the physical and mental health needs of young offenders which may be relevant to preventing further offending are identified and are addressed through appropriate services
- liaise with any health professionals who are currently providing health care services to the young offender, such as those in primary care settings, including concerning the provision of information for court reports
- provide advice on 'healthy lifestyles', sexual health or drug and alcohol issues as part of work under offending behaviour programmes' (Home Office et al, 1998)

Other commentators, at the time, suggested that there would be merit in Yots distinguishing categories of activity: generic tasks might be carried out by all members of the team; specialist tasks would be reserved for workers from a particular agency; there might be functions which are not the exclusive preserve of any team members, but where particular staff might be expected to take a lead role; and responsibility for liaison with particular agencies outside the Yot might usefully be associated with a particular individual role within the team (Nacro, 1999c).

There was, in other words, a clear implication that effective practice would require health and education workers to focus primarily on retaining a specialist role; that is, undertaking work relating, either to their professional expertise, or to their relationship with an external agency. More concretely, the majority of those specialist staff would be expected to exercise a 'brokerage' function with their parent agency, and other relevant providers, to promote the integration of young people into mainstream services and ensure access to specialist provision where required.

Specialist staff would also have a consultative role within the Yots, to aid colleagues' understanding of issues not within their immediate field of expertise, and to enable them better to deliver a holistic service. Face-to-face work with young people undertaken by specialist staff would accordingly consist primarily in assessment and the provision of advice and information in relation to health and education issues. It might, however, also include certain forms of specialist service delivery – for instance, work on literacy or numeracy, or counselling in relation to substance misuse – where the background of the individual members of staff made that appropriate.

The extent to which specialist staff ought to be direct service providers is constrained by a number of factors. If social exclusion is associated with youth crime, then mainstreaming of services ought to be a priority for an agency tasked with the

prevention of offending. In practical terms, any direct service provision offered by the Yot will not be sustainable once the programme or order leading to intervention has been completed and can at best be a short-term solution. Local education authorities, of course, have a statutory responsibility for provision of appropriate services to children of compulsory school age. For Yots to be involved in service delivery for such children may, accordingly, be counterproductive and reduce pressure of local education authorities to make provision for hard-to-place young people with high-level educational needs. In this context, guidance from the Youth Justice Board, since the establishments of Yots, has increasingly stressed the importance of achieving inclusion in mainstream services and, accordingly, of specialist staff having a sufficient level of seniority within the parent organisation to facilitate that goal (Youth Justice Board, 2003d; Youth Justice Board, 2002b).

Existing knowledge on the role of Yots, and Yot staff, in relation to health, education and substance misuse

Delivery of health and education services, on the model described in the previous section, was always going to be a tall order. The different functions outlined in the guidance implied that an ideal complement of health and education staff would include a range of professional backgrounds, skills bases and levels of seniority. At the same time, resource input from the relevant agencies was likely to be an issue.

It is clear, in any event, that there were some early difficulties. The Home Office evaluation of the nine pilot areas suggested that education and health secondments had been more problematic than recruitment from the other statutory partners. There were questions about whether staff with the right background were being seconded, both in terms of skills and their position within the parent agency. Perhaps of greater concern, a significant proportion of secondments were on a part-time basis, some for as little as one day a week.

The research team considered part-time appointments unsatisfactory and, if less than half-time, unworkable – they were not conducive to specialist staff feeling fully integrated into the work of the Yot, and militated against full-time members of the team establishing effective working relationships with their specialist colleagues. There was, accordingly, a risk that education and health input to the Yot might be marginalised. A survey of Yot staff, undertaken as part of the evaluation, confirmed that access to specialist services was regarded as a significant problem. While difficulties with such access are inevitable, however well-structured and resourced the Yot, it is clear that inappropriate secondments of health and education staff or inadequate resource input from those agencies make their resolution less likely (Holdaway et al, 2001).

Issues relevant to the role of health and education staff within Yots

In order to provide a framework within which to interpret the findings of the current study, it is important to examine some of the priorities which have an impact on the Yots' responsibilities in relation to health and education. Central to the work informed by those priorities, is the concept of assessment. Again, existing information about screening processes currently in use within the youth justice system is scarce, but a brief outline of what is known affords a useful context for considering the outcomes of the present survey.

Some priorities

Given the relationship between non-school attendance and offending, described earlier in the report, it is a priority of some significance that young people within the youth justice system have access to, and are engaged in, appropriate education or training. The Youth Justice Board has recognised the importance of this issue, and has set a target that 80% of young people supervised by Yots should be in full-time education, training or employment by the end of 2003, rising to 90% by December 2004. While responsibility for meeting performance indicators is obviously a team responsibility, and individual supervising officers will largely be accountable for their own cases, there is a clear implication that the work of education staff should be central to enabling Yots to meet the targets.

It is a relatively straightforward exercise to identify a number of potential obstacles. In the first place, as was illustrated earlier in the report, children under Yot supervision are frequently not in education for one reason or another. General truancy rates have remained stable, in spite of government targets to reduce absenteeism by a third. Enforcing attendance among young people who offend is likely to be particularly challenging. Permanent exclusions are rising again after a number of years during which the longer term trend was reversed. Intervening to prevent exclusions by young people known to the Yot will require particularly good working relations with local schools. Education authorities have a responsibility to provide alternative provision for those children who are permanently excluded but, in many cases, the curriculum offered by Pupil Referral Units falls far short of the 25 hours per week required by the Youth Justice Board's measure. A fixed-term exclusion, by contrast, gives rise to no obligation to provide alternative education. The over-representation of children subject to these within the Yot clientele, therefore, presents a further difficulty. Finally, research has shown that the majority of young people serving custodial sentences do not know what, if any, educational or training provision will be available to them on release (Youth Justice Board, 2001b).

In these circumstances, it is not surprising that many areas have some way to go if they are to meet the Youth Justice Board's expectations. During 2002, an average of 65.2% of children on Yots' caseloads were in education, training or employment (Youth Justice Board, 2003e).

From the point of view of education staff, the above considerations point to a number of conclusions. First, effective intervention requires that education staff are able to negotiate effectively with schools, the education authority and other service providers. This will be necessary to:

- ensure the proper exchange of information
- increase the chances of reducing truancy through a rapid and flexible response
- consider alternatives to fixed-term or permanent exclusions
- ensure that adequate alternative provision is offered as required

In practice, the ability of education staff to perform these functions effectively will depend upon the area of expertise of the appointed individuals, and their position and level of seniority within the agency.

Second, it seems likely that the Yot would profit from having access to services to facilitate, supplement or – on a short term basis – to substitute for more mainstream forms of provision. There is anecdotal evidence that some Yots have access to such a resource on a sessional basis, particularly when looked after children are involved, but this is not widespread and the service often provided by, for example, family placement carers with a teaching background often linked to local social services. Many young people who come into contact with the youth justice system might, for instance, benefit from some input on basic skills to maintain them in, or help them to return to, a school environment. In some cases, the ability of Yots to offer schools some form of additional pastoral or teaching support might help to avoid exclusion.

Finally, it will be important that education staff are closely integrated with Connexions staff to ensure a smooth transition from the world of education to training and employment. From this perspective, it is helpful that Connexions shares responsibility with the Yot for ensuring that the target on education, training and employment is met for those over 13 years of age (Connexions and Youth Justice Board, 2001).

For substance misuse workers within the Yot, priorities will be set by the nature of the formula according to which funding was allocated for their deployment. It is intended that the work of such staff should contribute towards the target to reduce repeat offending by drug-using young people who offend by 25% by 2005. As part of this process, Yots are expected to provide for the assessment of drugs needs of every young person referred to them and to ensure the delivery of appropriate services based upon that assessment (Tackling drugs, 2001).

Substance misuse services are structured around a four-tier model, derived initially from that used in Children and Mental Health Services (CAMHs). The model is defined in the following terms:

- Tier 1 (available to all young people) – involves substance misuse education, information and referral to support services
- Tier 2 (for young people who may be vulnerable) – involves providing drug-related prevention and targeted education, advice, and support for children who are identified as being at risk of developing problems with substance misuse
- Tier 3 (for young people who are problem drug users) – involves provision of specialist, but non-medical, drug and other multi-disciplinary services
- Tier 4 (for children with severe problematic drugs use) – involves the provision of specialist medical interventions for young drug misusers who have complex care needs; it may include specialist residential and mental health provision.

Drugs workers ought, then, to be playing a lead role in ensuring that the Yot is able to deliver screening of all young people for whom they are responsible; working towards the position where all staff feel confident in provision of Tier 1 delivery; perhaps providing Tier 2 services themselves; and should have knowledge of, and access to, services at Tier 3 and 4.

Mental health service provision for young people who offend is particularly problematic. In the first instance, identification of mental ill-health is difficult. There is an understandable reluctance to diagnose mental disorder, on the one hand, and the ability to access services which may be dependent on those diagnoses on the other. Young

people themselves are often resistant to any ascription which suggests that they may have mental health difficulties, because of the stigma which frequently attaches to such labels. As a result, screening is difficult, and many Yot practitioners are likely to feel under-skilled in dealing with mental health issues. This might account for the fact alluded to earlier in the report that they frequently underestimate the level of emotional stress experienced by the young people with whom they work.

Where Tier 3 or 4 services are required, involving referral to CAMHs and residential services respectively, there are particular difficulties. Before the establishment of Yots, the Audit Commission noted that three-quarters of managers working within the youth justice field, reported problems with accessing CAMHs, and reported that 10% of trusts could not offer a non-urgent appointment within six months (Audit Commission, 1999). It seems unlikely that matters have improved significantly in the intervening period. A national mapping exercise conducted by the Department of Health during 1992 found that 49.2% of services do not accept referrals for children over 16 years of age, confirming the fears of the Mental Health Foundation that 16 to 18-year-olds tend to suffer by falling between child and adult service provision (Department of Health, 2002; Hagell, 2002). The same exercise revealed that there was a total waiting list of 20,000 children and young people, and 20% of these had waited for more than 26 weeks.

The government has, however, taken steps to improve the situation, and the emerging findings from *National Service Framework for Children* sets a target for all CAMHs to provide a comprehensive service, including health promotion and early intervention by 2006, and to increase services by at least 10% (demonstrated by increased staffing, patient contacts and or investment), according to agreed local priorities [Department of Health, 2003b]).

The Youth Justice Board too has recognised the issue as one of importance, and has set a performance target that all young people assessed as having acute mental health difficulties should commence a formal assessment with CAMHs, for Tier 3 services, within five working days of the latter receiving the referral. The equivalent target for non-acute mental health concerns is 15 working days for Tier 1 – 3 service provision. It should be clear from the foregoing account, that this measure is one which will, of necessity, pose considerable challenges. During 2002, only 65% of cases were processed within the target time (Youth Justice Board, 2003e).

The implications for the role of health staff within Yots are considerable. There is clearly a responsibility to ensure that the team is in a position to provide advice and information on a broad range of health-related issues, including sexual health, substance misuse, alcohol, smoking and other aspects of primary care. Ideally, all staff should feel confident to promote good health, understood in the broadest possible sense, as:

> *a state of complete physical, mental and social well-being and not just the absence of disease or infirmity*. (World Health Organisation, 1946)

In addition, health staff will need to feel comfortable with delivering Tier 1 mental health services. They should be able to assist and provide consultation to colleagues to ensure they are able to work sensitively with young people, where there are concerns about their mental well-being. There should be capacity to conduct mental health assessments in order to ascertain whether higher tier services are required. A good

knowledge of available health provision is essential, as is the ability to access services quickly. To facilitate these arrangements, the Youth Justice Board proposes that where there are CAMHs workers in Yots, these staff should operate as

> *virtual or direct members of local specialist CAMHs, providing an outreach community service to the Yot, while receiving clinical supervision from the CAMHs team.* (Youth Justice Board, 2003d)

Assessment and screening procedures

Reference has been made on a number of occasions to specialist screening or assessment, which inevitably underpins a considerable part of the work of health and education staff, and informs the interventions of the whole team. The Youth Justice Board has developed an individual assessment tool – *Asset* – which is completed for all young people referred to the Yot, and is intended to provide the basis on which all interventions are planned (Youth Justice Board, 2002a). The tool includes brief sections on a number of areas relevant to determining whether specialist educational or health input is required. These include:

- statutory education
- substance use
- physical health
- emotional and mental health.

It is, however, generally recognised that the information elicited is insufficient for specialist assessment, although it may in certain instances be used as a trigger for more in-depth screening.

The Youth Justice Board's effective practice guidance on education, training and employment proposes that *Asset* be used to identify whether there are any barriers to learning. It also suggests that an additional screening process should be utilised to establish any difficulties that the young person might have with literacy and numeracy (Youth Justice Board, 2002b). Yots with seconded educational psychologists or with access to psychological services will be well-placed to conduct such screening. Other teams may find complying with the guidance more problematic since many of the available screening tools are heavily copyrighted.

The Mental Health Foundation notes that the relevant sections in *Asset* do not constitute a proper symptom screen for mental health difficulties, and suggests that many Yot members will not be adequately trained to make proper judgements required by the form (Hagell, 2002). At the time the current research was conducted, the Youth Justice Board was in the process of developing and implementing a mental health screening tool which is triggered by concerns identified through the core *Asset*. Assessment procedures will, accordingly, change significantly in the near future.

The necessity of additional screening in the context of substance misuse is supported by the difference in reported cannabis use by young people recorded by administration of *Asset* (44%) and self-reports elicited through an anonymous questionnaire (98%) in similarly structured groups (Nacro, 2002a).

It is recognised that many drugs services have developed their own assessment tools or have access to one of a number of well-known screening devices and these are currently employed by some staff in some Yots. The tools include the Christo inventory for substance misuse services, the Substance Abuse Subtle Screening Inventory (SASSI) and materials produced by Addaction. The extent of their use has not previously been ascertained, nor the effectiveness of outcomes from planning based upon them. DrugScope has recently produced guidance aimed at professionals working with young people in a range of settings, including youth justice, which provides advice on the first steps in identifying substance-related needs. It acknowledges that it does not provide for a full assessment, but it does suggest ways in which Yot practitioners might contribute to a full screening process which could then be co-ordinated by substance misuse workers within the teams (Home Office, 2003).

THE RESEARCH

AIMS OF THE STUDY

Under the Crime and Disorder Act 1998, health and education authorities are required to provide a health and education worker, as well as health and education resources to Yots. Section 39 (5) of the Act states that a Yot shall include 'a person nominated by a health authority any part of whose area lies within the local authority's area, and a person nominated by the chief education officer appointed by the local authority under section 532 of the Education Act 1996.'

From the information held by the Youth Justice Board, there are approximately 180 health workers, 190 substance misuse workers and 280 education workers attached to Yots from a number of different professional backgrounds. Currently, little is known of the role and responsibilities of health, education and substance misuse workers in Yots. There is however evidence that specialist resources available to Yots are both limited. Moreover, there are wide disparities between various areas – for example, some Yots will have access to a team of workers, while others will not have any direct health input.

The purpose of this review is to identify:

- the variety of health, substance misuse and education workers attached to Yots and their employment arrangements
- the models of assessment and intervention those staff are using to support good practice
- the health/education needs of young people identified through assessments
- Yots' current relationship with wider services and links to key specialist services, for instance CAMHs
- the support and supervision needs of health, substance misuse and education workers, both by the Yot, parent agency and the Youth Justice Board.

METHODOLOGY

There were several components to the review, which are outlined briefly below. Further detail on the methods employed are contained in Appendix A.

The first stage of the review was an analysis of all Youth Justice Plans currently available, together with other relevant material from individual Yots, intended to provide a broad picture of current arrangements for the provision of health, education and substance misuse services in Yot areas. This was supplemented by a review of the available literature of relevance to health and education service provision to young offenders or people at risk of offending, and of relevance to the health and education needs of such young people.

A principal strand of the evaluation was a self-completion questionnaire survey of health, education and substance misuse workers in every Yot. The purpose of the survey was to determine the role and responsibilities of health, education and substance misuse workers, links with wider services and identification of good practice.

The survey was supplemented by a series of focus groups with health, education and substance misuse workers in a number of regions. Where focus groups were not feasible, telephone interviews were conducted with a small sample of Yot workers, in order to ensure adequate geographical spread and coverage across the different groups of workers. The purpose of the focus groups and interviews was to explore some of the issues raised during the survey in greater detail, particularly in terms of working relationships, links with other agencies, roles and responsibilities, issues of effective practice and problematic areas.

FINDINGS FROM ANALYSIS OF YOUTH JUSTICE PLANS

An analysis by the Board of the first year's Youth Justice Plans revealed a relatively low overall resource and staff input, from both education and health authorities, as well as substantial variation in the level of expenditure per head between areas. The percentage share of the total budget from education and health in the first year of the Yots' operation stood at 7% and 6%, respectively, of the total contribution from partner agencies (Youth Justice Board, 2000). Other sources of information also indicated significant potential difficulties in the early stages of the implementation. A survey of Yots in London, for instance, conducted nine months after the teams were established, found that 40% had no health staff working within the team (Nacro, 2001).

There was also considerable variation in the background of staff who were to be seconded; this was particularly marked in relation to health workers, where the potential range of expertise was broader. Health authorities responding to a survey about their intentions, in advance of the formal roll-out of Yots, indicated that a third of secondees were likely to have a background in substance misuse; and a further third be mental health specialists – the remaining secondments would be split between a range of disciplines (Nacro, 2000). Table 1 gives the full breakdown:

Table 1 Appointments of health staff to Yots by area of expertise as at January 2000

Area of expertise/background of staff	Percentage of notified appointments
Mental health	34.5
Substance misuse	33.0
School nursing	17.5
Generic nursing	2.5
Health visitor	2.5
Child health	2.5
Sex therapy	2.5
Child and family guidance	2.5
Behavioural therapy	2.5

It should be emphasised that there have been considerable improvements in the interim period. As the work of the Yots has become established, so the contribution of health and education has risen to over 9%, in each case, of the budget provided by the statutory partner agencies (Youth Justice Board, 2003e). However, these figures are national aggregates. Within them, there remain wide variations in the levels of funding coming from education and health sources for individual Yots.

In what is, perhaps, a more significant development, the Board has been successful in obtaining funding through the 2000 spending review settlement to allow the appointment of named drug workers in each Yot. This resource is additional to the health contribution, marking a sizeable expansion in specialist staff within the Yot who have a health remit. In that context, the relative increases in health contributions – which do not include these monies – appear more significant. This development also provided a

clearer focus for the role of health secondments, since issues of substance misuse can, to a degree, be discounted in considering the appropriate professional background of health secondees. Substance misuse-related work, in other words, is now addressed by a pool of dedicated staff.

A summary of 2003 Yot funding, drawn from the analysis of Youth Justice Plans (all but five plans were available for the analysis), confirms that there are widely differing contributions from education and health agencies to Yot budgets. A breakdown, by region, of resource input by these two agencies as a proportion of total budget is given in Table 2. The figures for the health contribution do not include the designated funding from the Youth Justice Board to appoint substance misuse workers and it has, unfortunately, not been possible to disaggregate this information from the plans.

Figures given in brackets are:

1. so high they may be erroneous
2. may represent a combined education and social services contribution where authorities have 'amalgamated' departments
3. a zero – some plans indicate no resource input from education and social services with a majority funding attributed to the Chief Executive's department.

These apparently anomalous figures have been left out of calculations for the regional and national overall contributions.

Table 2 Regional breakdown of contribution from education and health agencies to Yot budgets 2003/04

Region	Education contribution as% of total funding	Health contribution as% of total funding
London		
Overall regional	5.81	2.8
Highest	10.75 (40.79)	5.22
Lowest	0.75	0.87
South East		
Overall regional	5.36	3.97
Highest	9.68	6.69
Lowest	2.35	0.53 (0)
Eastern		
Overall regional	9.3	5.14
Highest	10.75 (46.73 + 44.3)	9.93
Lowest	2.35 (0)	1.69 (0)
South West		
Overall regional	4.31	3.53
Highest	8.54	6.26
Lowest	2.68 (0)	0.81 (0)
West Midlands		
Overall regional	3.88	3.62
Highest	7.1	5.6
Lowest	2.96 (0)	2.81 (0)
East Midlands		
Overall regional	5.08	4.15
Highest	13.1	6.06
Lowest	2.19 (0)	2.8
Yorkshire		
Overall regional	4.53	3.63
Highest	8.37	7.69
Lowest	1.97 (0)	1.47 (0)
North West		
Overall regional	3.23	3.35
Highest	7.76	6.80
Lowest	1.72 (-2.66!)	1.37 (0)
North East		
Overall regional	3.96	3.61
Highest	6.75	6.91
Lowest	2.33	2.16
Wales		
Overall regional	2.77	4.05
Highest	5.32	13.19
Lowest	1.19 (0)	0.35 (0)
England & Wales		
Overall	**5.2**	**3.63**

A number of points, arising from the information presented in the table, are worth noting:

1. The contribution of health and education authorities, as a proportion of the overall Yots' budgets across England and Wales, appears to be significantly below that cited earlier in this section (over 9% for both agencies). The apparent discrepancy arises because the earlier figures give the contribution as a proportion of the budget provided by the statutory partners – that is excluding the substantial resource input (some £45.5 million) by the Youth Justice Board. The Board's input is included for the purposes of the calculations in the table.
2. The Board's contribution to the funding of Yots includes an element for the appointment of substance misuse workers. As noted above, it has not been possible to disaggregate this from other targeted Board funding and the table, accordingly, understates the level of resources within Yots allocated to health-related work.
3. The table shows a substantial variation in the level of resourcing from education and health within and across regions. For instance, the contribution from education as a proportion of the Yot budget ranges from 9.3% in the Eastern region to 2.77% in Wales; the equivalent figures for health are 5.14% in the Eastern region to 2.8% in London. Similarly at the level of local Yots (excluding the anomalous bracketed figures), education input within the London region varies from over 10% to less than 1%; health contributions, within Wales, range from over 13% to less than 1%.
4. The proportion of funding from a particular agency is obviously relative to that from other sources. A relatively high level of education funding, for instance, might reflect a greater commitment from the education authority in that area or, alternatively, a lower proportional commitment from other agencies.
5. The question arises as to whether there is any link between higher or lower funding levels, and what is determined to be a more or less successful Yot.
6. It is unclear what is meant by the negative education contribution recorded as the lowest in the North West region. It appears the education post in that Yot is vacant, and there is an intention to fill it.
7. Nine Youth Justice Plans recorded a zero contribution for either health or education input. It is unclear whether this reflects a total absence of specialist provision to the Yot in each case. In any event, as noted above, these entries were ignored for the purposes of calculating overall levels of agency contributions.
8. It has not been possible to clarify further the questions which arise from detailed scrutiny of the Youth Justice Plans and these issues may require further investigation.

FINDINGS FROM THE FIELDWORK

The following sections discuss the findings from the survey and focus groups/interviews with health, education and substance misuse workers in Yots. The findings are presented separately for each specialist group of worker, with some common issues discussed in concluding sections.

HEALTH WORKERS IN YOTS

Current arrangements for the design and implementation of health services in Yots

The level of health staffing within a particular Yot might be seen as important for a number of reasons. In the first place, it is an indication of the adequacy of service provision available to the team. Second, where there is more than one health worker post within a single area, there is greater scope for delivery of a broader service that addresses a wider range of health needs, where the individuals concerned have a different area of expertise. Finally, the presence of other staff from the same discipline can assist in the development of a support network for individuals working as a small minority in a field with which they are, in most cases, not familiar.

Health workers were asked if there were any other related resources embedded in their Yot. As might be expected, given the funding stream from the Board to appoint designated substance misuse staff, the great majority – over 91% – made reference to the presence of drug workers, and more than two-thirds of these were full-time posts. Nearly a quarter also reported that there were other full-time health workers in their Yot, with a further 13% of responses indicating that there were other part-time health staff within the team.

Table 3 Are there any other health or drug resources in the Yot?

Health or drugs resources available	%
Yes, other FT health workers	25
Yes, other PT health workers	13
Yes, other FT drug workers	71
Yes, other PT drug workers	21
Other	8
No	9
Base N = 98	

Note: multiple response question, thus percentages add up to more than 100

Systems of liaison with other workers within the same team were generally considered to be good or very good. As shown in Table 4, a small proportion (just under 10%) found the relations 'adequate'.

Table 4 How would you rate systems of liaison with these other professionals?

Rating of systems of liaison	%
Very good	65
Good	24
Adequate	10
Poor	0
Very poor	0
Missing	9
Base N = 89	

This finding does suggest that many health workers are not obliged to practise in isolation from other practitioners from the same discipline. It should not, however, be thought to indicate that the majority of health workers have a second health colleague in the same workplace. In the first place, the function of a substance misuse worker, while it will inevitably overlap with that of the health representative, ought to be distinct. Only 38% of health workers reported additional health resources other than drugs workers. In addition, many Yots operate over more than one site and the presence of a second health worker may simply be a reflection of that fact. Finally, responses inevitably include an element of 'double counting', since two health workers from the same team who both responded to the questionnaire, would inevitably refer to each other. It seems likely, therefore, that the majority of health staff are the sole representatives of their agency within the Yot and that a considerable number may have to operate over a number of locations.

Indeed, more than 70% of health workers felt that other health care professionals should be accessible to them and other Yot staff. The main types of profession cited were mental health, particularly clinical psychologists (a third of those who answered 'Yes' to this question), followed by psychiatrists generally (17%) and other mental health workers (12%).

Table 5 Are there any other health care professionals you feel should be accessible to Yot staff to meet the health needs of young people?

	%
Yes	71
No	21
Missing	8
Base N = 98	

For some, a major concern revealed through the focus groups was access to clinical supervision and appropriate line management. In particular, it was seen to be frequently difficult to obtain psychiatric and psychological supervision at sufficiently high a level. In some cases, health workers felt that they were clinically supervising themselves and considered that management staff within the Yot lacked the expertise to provide the necessary advice:

I find, certainly, from meeting with the deputy manager, I mean it's useful to a certain extent but at the end of the day, she's from a [different] background.'

There was a marked absence in the sort of line management that was available to me at the time. CAMHs said that they weren't in a position to provide clinical supervision … Do we need a personality inventory? Or do we need a mental state assessment? Those are the kind of decisions which you are left very much on your own. And what we do is phone each other.

There is also a perception that protocols between the Yot and the health service were not sufficiently worked out at the start. As a consequence, both health and youth offending services are uncertain where the health worker really fits. The focus groups, for instance, revealed some deep tensions arising from differing expectations of the two services, which can place the individual worker in an invidious position.

I am expected to adhere to those [health] policies. And although I keep saying that I cannot … because of the Yot, then, you know, my health managers are saying you have to adhere to the health policies and procedures. And never the twain should meet.

At the same time, health workers appear to have been relatively well integrated into Yots. Nearly 97% of health workers stated that they attend team meetings in the Yot. The majority (85%) were also likely to attend case discussion meetings. Just under two-thirds of health workers stated that they are involved in preparation of the local Youth Justice Plan. In some instances, however, the relatively low resource input from health had the potential to undermine integration. In one case, the health worker indicated that they were denied access to the same conditions of service as other Yot staff – described as a 'refusal of petty privileges' – on that basis.

Role of health staff (including working arrangements, management, main activities, etc)
More than 81% of health workers were seconded to the Yot, with only 3% being directly employed. Over half (54%) those seconded had permanent or open-ended secondments. Of the remainder, 14% were seconded for between 3 and 5 years, 8% between 1 and 2 years, with a significant number unclear of the arrangements.

Just over 68% were full-time. Nearly 30% considered themselves to be in temporary posts. However, most of these were seconded staff and it seems likely that some of the responses refer to the fact that their position within the Yot is a temporary arrangement rather than an indication of their employment status with the parent agency. The majority (87%) had been in their current post for more than a year. Most (85%) were based wholly in the Yot, with the remainder being partly in the Yot and partly in the partner agency.

Nearly half the health workers responding could be described as generic health professionals (job titles included health officer or worker, health development worker or health co-ordinator). Less than a quarter of respondents had some form of mental health specialism (for example, clinical psychologist, therapist, psychiatrist or mental health practitioner), a finding which is consistent with health staff's concerns, outlined in the previous section, that many Yots have insufficient access to mental health services. An additional 12% described themselves as a 'clinical nurse specialist'.

Table 6 Health workers job type

Job type	%
Generic health professional	49
Mental health professional	23
Clinical nurse specialist	12
Other health worker	15
Missing	1
Base N = 97	

Almost all health workers (91%) reported that they had relevant professional qualifications. However, a much smaller proportion, 28%, had had prior experience in the youth justice system, and this figure is largely explained by the fact that many had worked in a health setting in their previous job.

Of course, job title and previous area of expertise do not, in themselves, give a full account of the role within the Yot. Nearly 59% of health workers considered themselves to be specialist workers, with a further 40% stating that they were specialist with some generic duties.

Health workers expanded on their position within the Yot in the focus groups and, in doing so, highlighted a potential area of tension between their specialist role in relation to the main focus of the work of the Yot. They see themselves principally as professional health workers whose primary concern is the health of the young person. Naturally, they adopt a clinical method of dealing with the young person and this may result in conflict with the Yot's expectations over issues such as medical confidentiality and treatment. For example, health workers might think it appropriate to continue with treatment beyond the bounds of an order if they feel that this is necessary:

What happens when the order finishes and the mothers start ringing you up and saying he's going to kill somebody or he's going to kill himself and you think… I have six on voluntary supervision because nobody else in the world could make contact with them

Considerable frustration was expressed about the lack of understanding from other workers within the team in relation to the dynamics associated with different professional expectations. It is clear that in some areas, there is work to be done to achieve a balance that will allow a degree of flexibility in terms of delivering health services within the Yot and ensuring that longer term intervention is sustainable through accessing resources outside the youth justice system.

There is also considerable diversity across Yots as to the type of work in which health professionals are involved. While, as we have seen, almost all health workers regard themselves as specialists or specialists with some generic duties, the focus groups revealed considerable disquiet about being obliged to carry generic caseloads in at least some areas. Concerns expressed were of three sorts. First, many health staff felt insufficiently trained to undertake generic youth justice work.

The management insist that the health workers within the three different teams carry a generic caseload and I can say without exception that there's not a single officer in that team that agrees that the health workers should carry a caseload. I'm not trained to supervise young people; I don't have any experience

In the odd court situation, I'll say:'Your honour, I'm not trained for this, but I'll answer your questions as best I can,' – but it doesn't do the role appropriately at all. It doesn't do it justice

For others, the extent to which there was pressure for them to move towards a generic approach showed a lack of recognition of their own expertise, which might be put to better use. On occasion, this was linked to the complaint that other members of the Yot, including Yot managers, had a stereotypical view of nurses as 'someone with a bed pan', which is both misleading and outdated.

Although the social workers are seen as generic Yot officers, they can't take on specialist work that you would be expected to do. And that's a constant battle, I think, when you are on your own, you are expected to be there for all groups and things like that.

In addition, it was suggested that generic work had the potential to disrupt health workers' relationship with young people.

And we all find it a bit awkward because we can't do the job that we're trained for. I mean I've gone to a youngster and said to him: 'Look, before I start, I've had a message from the Yot. You must come back with me to the Yot.' That's it. They will walk away and I've lost them when they've agreed to see me. So that's the difficulty of being a case-holder.

From a slightly different perspective:

People are pretty good and motivated when you say: 'Hello. I've come to do a full assessment on you. I'm the psychiatric nurse.' And we've had a Final Warning for shoplifting. You know they get a bit alarmed really. …If I had a kid and they got in trouble, and somebody was visiting the house, I'd be asking a hell of a lot of questions if a teacher or nurse was coming to visit my son or daughter to do an assessment.

Responses to the questionnaires provide a more detailed account of activities undertaken by health workers. While the most prevalent – such as assisting in community-based interventions, contributing to other's court reports, contributing to referral panel reports or assisting in Final Warning programmes – are consistent with a provision of a specialist service, others are indicative of a more generic role. Thus more than a quarter of respondents reported that they act as responsible officers for community interventions, 21% are responsible for the completion of *Asset*, 17% attend the police station, presumably as an appropriate adult, and more than 10% undertake court duty and write pre-sentence reports.

Table 7 Activities undertaken by health workers since joining the Yot

Activities undertaken	%
Attend police station	17
Court duty	11
Assist in *Asset* compilation including part completion	34
Responsibility for completion of all *Asset*	21
Contribute to referral panel reports	52
Write referral panel reports	14
Contribute to others' court reports	55
Write court reports	11
Prepare specialist reports for court	21
Assist in warning programmes	43
Assist in community-based interventions	58
Carry out responsible officer role for community interventions	27
Have contact with secure facilities	55
Visit children in secure facilities	49
Responsible officer for children in secure facilities	13
Provide information for breach proceedings	27
Undertake breach proceedings	12
Base N = 98	

Note: multiple response question, therefore percentages add up to more than 100

At the same time, it should be acknowledged that carrying a caseload is not automatically inconsistent with retaining a specialist role. In the focus groups, some staff indicated that they were happy to act as responsible officers in cases where there was a clear health-related issue.

Training and development of health workers in Yots

Most health workers (56%) stated that they had received training when they started work for the Yot. A large majority (84%) felt that they were given the same training opportunities as other Yot workers, with 89% stating that they also had access to specialist training in their area of expertise. Nearly 18% had received some form of

mental health training. Just under 80% of health workers reported that they also provided training to other members of the Yot.

Translated into concrete terms, health workers had received an average (mean) of 12 days training over the past 12 months. Respondents were asked to list the training that they had received since they started working for the Yot. A majority had received child protection training and computer training. A large proportion had also received Youth Justice Board and *Asset* training (Table 8).

Table 8 What training have you received since you started working for the Yot?

Type of training received	%
Report writing	18
Computer training	71
Management training	6
Child protection training	64
Risk training	29
Inter-agency protocol training	11
Motivational interviewing training	27
Youth Justice Board training	60
Effective practice	16
Court duty skills	15
Cognitive behavioural techniques	30
Assessment/*Asset*	48
Health and safety training	24
Missing	5
Base N = 98	

Just under 59% of health workers felt satisfied with the training provided by their Yot (Table 9). Around one in five, however, considered that they had had insufficient training for Yot work or work around their specialism. At the same time, nearly 93% stated that they felt sufficiently qualified and experienced to do the work the Yot expected them to do. This latter finding is in some tension with expressed views in relation to the adequacy of Yot training and the concerns, articulated in the focus groups, that health workers were insufficiently trained to undertake generic work. It

suggests that, to an extent, relevant experience and qualifications pre-date specialist workers moving into the Yot. This may have implications for the longer term training needs and the maintenance of specialist expertise of the relatively large proportion of the health workforce whose secondments are permanent or long term.

Table 9 Are you satisfied with the training provided by the Yot?

	%
Yes	59
No – insufficient for Yot work	22
No – insufficient for specialty work	18
No – other	15
Base N = 96	

Note: multiple response question, therefore percentages add up to more than 100

Perceptions of relations with CAMHs

Health workers were asked if their Yot had a protocol in place with the local CAMHs service. Around two-thirds stated that this protocol existed.

Table 10 Does the Yot have a protocol in place with the local CAMHs service?

	%
Yes	67
No	28
Missing	5
Base N = 97	

The agreement of such a protocol is a Youth Justice Board requirement. This finding provides some evidence that up to one in four Yots has yet to establish an appropriate agreement. At the same, the fact that a member of staff is unaware of a protocol does not necessarily imply that it does not exist. Indeed, more than 16% of health workers reported that they had no links with the local CAMHs (Table 11), and it may that this group would be less likely to know what agreements are in force between that service and the Yot.

For a larger group, the relationship with CAMHs is much more clearly defined. Nearly 26% indicated they were seconded by, and a formal member of, CAMHs, an arrangement which appears consistent with the model advocated by the Board (Youth Justice Board, 2003d). A further 18% of health workers are seconded from CAMHs but are not formal members and so do not receive direct clinical supervision from that service.

Table 11 What links do you have with the local CAMHs?

Links with CAMHs	%
None	16
Seconded, not formal member	18
Seconded, formal member	26
Other	40
Base N = 95	

Views on the local CAMHs service varied considerably, with similar numbers of respondents reporting that they were very good or very poor. Just over 48% rated the local service as good or very good. Nearly 20% felt that it was adequate and almost a third found it poor or very poor (Table 12).

Table 12 How would you rate the local CAMHs?

Rating of CAMHs service	%
Very good	15
Good	33
Adequate	20
Poor	19
Very poor	12
Don't know/don't use	2
Base N = 95	

In terms of the Youth Justice Board CAMHs targets, more than two-thirds reported that they were able to meet these for acute cases. The proportion was less for non-acute cases (just under 56%). The former figure is slightly higher than that derived from Yot returns to the Youth Justice Board, while the latter is slightly below (Youth Justice Board, 2003e).

Table 13 Are you able to meet the Youth Justice Board CAMHs targets?

%

	Acute	Non-acute
Yes	68	56
No	21	36
Missing	10	8
Base N = 98		

From the focus groups, some concerns were raised in relation to mental health issues. A number of participants considered that the original intention had been for Yots to have access to a generic health worker. Consequently, many of those seconded to Yots do not come from a CAMHs background and yet they are increasingly expected to focus on mental health issues. In this context, some expressed concern that the only performance indicator relating specifically to their work is in relation to access to CAMHs.

You're doing exactly what your job description says. I'm doing what mine says and I assume you're doing what yours says but then you've got this performance measure, which is like at odds with what your job description says you should do.

Some of these workers argued in the groups that they did a great deal of appropriate work that did not involve issues of mental health, for instance dealing with physical health problems or providing the holistic work that used to be the social work role within youth justice. The role of other agencies was said to be so tightly constrained that the relative lack of definition of the health input to Yots allowed a more flexible approach.

I think the Board focused their league table scoring system, which we're being marked against, geared towards criminogenic factors alone, not what can a health adviser or worker do in the Yot in terms of creating a quality service and a quality outcome for that

person and… that has a tendency to gear Yot managers in the same way, because their funding potential's against it.

Other health workers pointed to the difficulty of achieving the targets, which they considered to be, to a large extent, beyond their control. Considerable concern was voiced about lack of provision within CAMHs for some young people, such as those with dual diagnosis or in need of residential rehabilitation. In this context, staff in certain areas cited the fact that CAMHs would not accept referrals for children over the age of 16 years as a significant problem.

We've got 0% because I cannot get CAMHs to see these kids within 5 or 15n days. It's physically impossible. They won't do it. They can't do it…and we were asked to look at the figures and see if a phone call to a primary mental health worker could be the initial assessment. And I was asked at one point to put that on the computers and I said no, because who benefits there? Nobody. It's a lie isn't it?

67% of the cases that come from the Yot currently are post-16, outside school leaving age. So our management structure doesn't reflect the actual needs of the client. And the referral pathways … they are coming into the adult psychiatric services

There are huge gaps and decision- making is often based on what is least harmful to the child…. I've worked on [adult] psychiatric wards and it's no place for a child. It is no place for a 16 year old

In two cases, focus group members complained that CAMHs tended to refer difficult cases back to the Yot because the young people were perceived as dangerous, or failed to turn up for appointments. As a consequence, health workers within Yots felt that they were expected to undertake work with young people which should be located outside of the criminal justice system.

CAMHs say, oh, it's been fantastic, well done, you carry on doing what you're doing. There might be some occasions where I'll kind of insist quite firmly that, because of the significant complex difficulties of the young person, no thank you. I'd like that case to remain open with the consultant to work together jointly.

These two perspectives – that the increasing focus on mental health has the potential to undermine the position of generic health workers and that the CAMHs targets are extremely demanding – coincided in a view voiced by a number of staff in the focus groups. It was suggested that those without a CAMHs background, those who did not have the relevant contacts, inevitably experienced larger difficulties in accessing mental health services.

Another area of concern expressed by health workers in the focus groups was that there is perceived to be no medical expert at the Youth Justice Board who would appreciate their particular difficulties and be able to answer their questions.

Work with young people

Referrals, assessment and workload

The majority of referrals to health workers were on a case-by-case basis. Referrals also came from team leaders. Around a quarter of health respondents stated that young people were referred according to strict criteria.

Table 14 Are young people referred to you by others?

Referral mechanism	%
Yes, on a case-by-case basis	97
Yes, by strict criteria	27
Yes, by team leader(s)	27
No, only those on my caseload	2
No	0
Base N = 98	

Note: multiple response question, therefore percentages add up to more than 100

From the focus groups, it was established that, in many cases, the health worker will see all those who are scored as 2 or more on the health section of *Asset*. In other instances the health worker might see all young people or, instead, may concentrate on certain types of young people, for example, persistent young offenders or those on ISSPs.

Practice is partly dependent on the size of the Yot caseload.

I work in a much more intimate small town-type area [which] gives me the grand opportunity to offer health assessment to all young people coming through the service.

Some workers also take self-referrals directly from young people themselves. In some areas, a health assessment is predicated on consent.

I make it very clear at the beginning of the work that it's not a forceful piece of work. It's about complementing what it is that's going on in their lives. It gives them an opportunity to look at their health and health issues and most do opt on board

In other cases, the health worker will insist that young people keep the appointment, if it is part of their programme of care, but not otherwise. This can cause problems with the remaining members of the Yot.

In the beginning we struggled because they wanted everything to have a statutory component, properly enforced if you don't. I said it's the way we work I'm afraid. Your GP doesn't make you. Your dentist doesn't make you and I can't make you as a member of the NHS.

More than half the respondents stated that they would see all young people with relevant problems if they are sent by other Yot workers. Just under 20% will only see young people with specific problems (Table 15).

Table 15 Would you see all young people going through the Yot who have a known problem with health?

Whether all young people seen	%
Yes	24
Yes, if sent to me by Yot workers	56
No, only those with specific problems	19
Base N = 98	

Health workers appear to have a relatively high caseload: 38% said that they see between 16 and 30 young people per month. Around 12% of health workers stated that they saw more than 30 young people per month. Relatively small proportions only saw up to five young people per month.

Needs of young people

Most young people seen by health workers were registered with GPs (an average of 81%[1]). On average, around 56% of young people[2] going through the Yot were seen by health workers to have health problems.

Respondents were asked to estimate the proportion of young people passing through the Yot with specific problems. While some were reluctant to do this, the majority gave some indication of what they perceived to be the nature and extent of problems. It can be seen (Table 16) that relatively high proportions of young people encountered by health workers were thought to have problems with tobacco misuse and family issues. Substance and alcohol misuse and mental ill-health were also considered to affect a considerable proportion of young people.

[1] Taking the mean of all responses as a measure.
[2] See previous footnote.

Table 16 Roughly what proportion of the young people you have worked with have had problems with:

%

Problems encountered	Proportion of young people					
	None	1-25%	26-50%	51-75%	76%+	Missing
Substance misuse	2	14	13	41	20	9
Alcohol misuse	2	16	16	38	18	9
Tobacco misuse	2	6	8	38	38	8
Mental health problems	2	21	22	31	14	9
Physical disabilities	28	57	3	0	0	12
Sexual health problems	7	41	26	13	2	11
ADHD*	3	52	24	12	1	8
Asthma	7	66	11	2	0	13
Epilepsy	31	56	1	0	0	12
Dental problems	12	46	17	7	1	16
Optical problems	15	62	5	2	0	15
Other physical health problems	4	69	11	2	1	12
On long-term script	7	71	7	0	1	13
Family problems	1	3	12	38	37	9
Bereavement	3	41	27	19	2	8
Attempted suicide or self-harm	3	45	22	14	2	13
Base N = 98						

* attention deficit hyperactivity disorder

Access to information

Another potential area of difficulty for a multi-agency agency is the question of whether sufficient information is shared for the team to conduct its work efficiently. From the perspective of health workers, there are two sides to the question: first, whether they are able to access relevant information about the young people referred to them; second, whether their position as a seconded member of staff places constraints upon the information which they are able to share with their Yot colleagues.

In terms of the first dimension, nearly all health workers (99%) reported having access to Yot case records. The response in terms of specific information relevant to their particular area of specialism was, as might be expected, lower, but nonetheless still higher than one might anticipate. Thus, just under 70% of health workers reported having access to young people's health records. Moreover, access to health records also varied according to whether health workers were seconded or directly employed by the Yot. Table 17 suggests, perhaps counter-intuitively, that directly employed staff were more likely to have access to health records than those seconded from a health setting[3].

[3] It should be noted that the number here is very low. Caution should be exercised in interpreting this statistic.

Table 17 Access to health records according to secondment/direct employment by the Yot.

%

Whether access to health records	Nature of employment		
	Directly Employed	Seconded	Other
Yes	100	68	71
No	0	32	29
Base Ns =	*4*	*75*	*14*

In terms of the second element of information-sharing, the focus groups elicited some concerns about the Yots' expectation that information obtained by health workers will automatically be shared. Some noted tensions with the confidentiality policies of their parent agencies; others complained of a lack of guidance. In many cases, the concerns were linked to issues of professional culture similar to those discussed earlier, which make some health workers wary of interventions based on compulsion.

Bear in mind these kids aren't coming to us to seek advice, we're going to them to offer advice. You know you want to safeguard their future possibilities. I wouldn't like to think that I was generating information that could stop a kid from things at a later date. Nobody's given me any guidance. … You know if it meant preventing crime… but if not, then it's private.

The client says 'I don't want anybody to know'. Then it is about assessing whether they are competent or not… So we wouldn't just do it. That's the point I'm trying to make here…It is about consent and confidentiality, and information-sharing is based on the parent's consent.

What's happened is there is a service agreement [on confidentiality] with all the partners within the crime and disorder partnership… But is it not worth the paper its written on because it is incredibly woolly. Very, very woolly. And an awful lot of it is up to the discretion of whoever is sharing the information. And knowing the CAMHs service as I know it, and I have made enquiries with the CAMHs service. I know they wouldn't back it, no way.

Some staff were explicit that they would not pass on information elicited in the course of their work with young people to other members of the Yot, and that they take considerable care, as a matter of professional ethics, that information they have been given is not included in Yot databases or files. Nonetheless, they did recognise that if the young person admits to a specific crime, confidentiality is a grey area. Some health workers reported that they routinely explain that fact to a young person before any interview begins.

Assessment and interventions

Although a relatively large proportion of health workers reported that they completed *Asset* or contributed to its compilation as part of their work (see Table 7), very few appeared to rely on it alone for the purposes of their own health assessments. Indeed, twice as many indicated that they preferred to exercise professional discretion. Over 80% reported using a separate assessment tool or *Asset* in association with measure of assessment (Table 18).

Table 18 What tools would you use in assessing young people?

Assessment tools	%
No tools – professional discretion	13
Asset	6
Other	35
Asset plus other	45
Base N = 97	

Assessment is an area of some contention for health workers. Focus groups show that they will often fill in their own assessment form, frequently either that of an agency from which they are seconded or which they have developed themselves.

It would look at every aspect of their life from sexual health, immunisation, GP, dentist, optician – every single thing that would affect their every day life.

I talk about things like testicular self-examination for lads, making them aware of appropriate hygiene and the benefits to that and the pitfalls it you don't. I talk about breast examination with the females; I talk about their development and growth in terms of their sexual needs. Of the harm that could become of smoking cigarettes; look at what they're doing if they take cannabis. How are you taking it? What are you taking…. and lots and lots of opportunity for them to think about what it is they're doing.

Health workers in groups were not confident that *Asset* necessarily identified all the problem areas:

Say cannabis – within our Yot I think it's got a low score; there's not that many kids using cannabis on the Asset, but I would say 98% of the kids that I see tell me that they're using cannabis.'

Following assessment, most health workers offer a range of interventions themselves. Indeed, no health respondents to the questionnaire indicated that they did not provide any form of intervention. The most frequent forms of direct service provision were health education or sexual health education. Two-thirds of those surveyed also offered group work and anger management (Table 19).

Table 19 Do you provide interventions yourself?

Interventions provided by health workers	%
Yes, therapy	51
Yes, counselling	60
Yes, health education	84
Yes, sexual health education	79
Yes, group work	68
Yes, anger management	68
Yes, other	53
No	0
Base N = 97	

Note: multiple response question, therefore percentages add up to more than 100

In most cases, however, health workers' intervention was not specifically linked to any particular area of the Yot's work. Where staff did indicate they had a particular remit

associated with a particular function, it was more likely to be with those young people subject to detention and training orders (DTOs) or ISSPs: that is, those whose offending is more serious or persistent (Table 20).

Table 20 Do you have a specific remit for:

	%
Remand and bail	12
Fostering	6
Other local authority accommodation provision	7
Restorative justice approaches	8
ISSPs	19
DTOs	17
None of these	59
Missing	15
Base N = 98	

Note: multiple response question, therefore percentages add up to more than 100

Referrals to other agencies

Despite the fact that all health workers provide direct interventions themselves, all but 2% also make referrals to other agencies. Health workers were most likely to refer young people to any agencies available and also for those workers who were seconded, to their seconding agency or to agencies specified by the Yot (Table 21). Most (90%) expected feedback from other agencies, although 51% found that they did not receive it as frequently as they would have liked, and a further 7% indicated that they did not receive it at all.

Table 21 Do you refer young people to other agencies?

	%
Yes – to any agencies available	95
Yes – to my seconding agency	27
Yes, to agency specified by Yot	17
No	2
Base N = 97	

Note: multiple response question, therefore percentages add up to more than 100

Respondents were asked about whether they encountered difficulty in accessing resources, outside the Yot, for the same range of problems identified in Table 16, and to indicate what form those difficulties took. The greatest obstacles to onward referral were noted in relation to mental health difficulties and family problems, both of which were regarded as factors affecting a substantial of those with whom the Yot works. In both cases, the primary difficulties reported related to lack of provision and waiting times (Table 22).

Table 22 In which areas would you find it difficult to find assistance outside the Yot for young people and why?

%

Problems encountered	Reason for difficulty in finding assistance							
	Lack of provision in area	*Waiting times*	*Level of demand*	*Budgetary restraints*	*Yot or other agencies' policies*	*Poor relations with relevant agencies*	*No difficulties experienced*	*No response*
Substance misuse	15	9	7	2	4	2	65	9
Alcohol misuse	17	4	8	1	3	2	65	7
Tobacco smoking	25	0	6	0	0	2	57	11
Mental health problems	32	56	26	7	11	8	26	4
ADHD	21	39	18	2	9	4	31	13
Family problems	34	28	22	4	8	4	27	12
Bereavement	36	12	6	2	0	2	42	12
Have attempted suicide or self-harm	28	33	19	1	7	5	40	7

Base n = 98

Capacity and provision in specific areas were also a significant concern for health workers in the focus groups – notably in the case of crisis beds and provision for mental health cases aged 16 to 18. Dual diagnosis management was said to be "a nightmare", both because of the difficulty of deciding "is it psych or is it drugs?", and the shortage of appropriate services. The lack of residential assessment appeared to be particularly marked in Wales.

Inevitably, the ability to refer young people to agencies outside the Yot will lead to health workers attempting to hold on to young people who might be better served by specialist provision. Ensuring access to such resources appears to remain a major challenge for the youth justice system as a whole and Yot health workers in particular.

Health provision for young people in the criminal justice system generally

As a result of their experience within the youth justice system, in conjunction with their background and previous experience, health workers are quite well placed to give an assessment of the standard of health care provision for those who come to the attention of the criminal justice system. Less than a third of health practitioners rated such provision as being good or very good. The most common response was that health provision was adequate (Table 23). In large part, what might be characterised as a lack of endorsement, is likely to reflect the earlier noted difficulties in accessing resources for the most common health problems experienced by young people supervised by the Yots.

Table 23 How would you rate health care provision for young people passing through the criminal justice system?

Rating of health care provision	%
Very good	3
Good	27
Adequate	42
Poor	19
Very poor	3
Missing	6
Base N = 98	

Health workers' opinion of continuity of service provided to young people coming out of custody was markedly less positive. More than two-thirds of practitioners (72%) were aware of information-sharing protocols between their Yot and the secure estate but it seems likely that in most cases these would not go beyond the exchange of documentation required by national standards.

Very few respondents rated current provision as 'very good', with 27% finding continuity of provision 'good' and 40% saying that it was poor or very poor (Table 24).

Table 24 How would you rate current continuity of provision from custody to community for young people?

Rating of continuity of provision	%
Very good	2
Good	24
Adequate	26
Poor	33
Very poor	7
Missing	8
Base N = 98	

Health workers who had a more positive view of the current system tended to be those involved in sentence planning or visiting young people while they were in custody. Typical comments in the questionnaire included:

The involvement of Yot workers in planning meetings during custody provides continuity.

Young people are visited in custody regularly to prepare them for release. Every effort is made to put in place appropriate … interventions to support them on release.

Conversely, those who had a low regard for the continuity of provision tended to relate it to the lack of communication between the secure estate and those responsible for the community element of the custodial experience. Comments from those who rated provision as poor included, for example, the following:

Have attempted to set up communication systems for young people due for release from our main custodial unit. No improvement, systems not utilised by custodial unit.

Often not aware of a young person with a need until discharged, i.e.: high risk of self harm or a pregnant young woman who is discharged with no follow up appointment. Have set up protocols with Yot staff to address this.

While the creation of Yots has undoubtedly resulted in a better targeting of health-related services to young people who come into contact with the youth justice system, it appears that, from the perspective of most health workers, there remains significant scope for further improvement.

EDUCATION WORKERS IN YOTS

Current arrangements for the design and implementation of education services in Yots

As with other specialist staffing to the Yot, the levels of educational staff input available within a single team is of some significance in ensuring adequacy of provision and in developing the breadth of service that might expected of education professionals. More than a third of respondents indicated that there were other full-time education workers in their Yot, with a further 18% stating that there were other part-time workers (Table 25). In addition, 30% also referred to the presence of other professionals within the Yot with some form of education remit, primarily Connexions personal advisers.

Table 25 Are there any other education resources embedded in the Yot?

Education resources available	%
Yes, other full-time education workers	36
Yes, other part-time education workers	18
Yes, others[1]	30
No	30
Base N = 142	

[1] Primarily Connexions staff. Note: multiple response question, so responses add up to more than 100.

The majority of staff rated liaison with those other professionals good or very good, with only 4% considering them to be poor (Table 26).

Table 26 How would you rate the systems of liaison with these other professionals?

Rating of liaison systems	%
Very good	44
Good	34
Adequate	12
Poor	4
Very poor	0
Missing	7
Base N = 101	

A number of points arise from these findings. In the first place, the level of educational representation within the Yots appears to be higher than that of health staff (excluding Connexions staff and substance misuse workers) by some margin. Thus 54% of respondents in the former sample indicated that there were other education workers within their team (full- or part-time) compared with 38% of health workers who reported other staff from the same discipline within the Yot (Table 3). This might be thought an expected outcome of the lower contribution of health to Yot budgets across England and Wales.

At the same time, for reasons outlined in the earlier discussion of health staff, it seems probable that a significant proportion of education workers are the sole representatives of their agency and that, in some cases at least, they will be expected to work across more than one site. Moreover, where there is more than one educational professional within the team, liaison is not as highly rated by educational workers as it is by those from a health background.

At the same time, integration within the Yot appears to be good. Nearly all education workers stated that they attend team meetings – important, given that over 15% of such staff are part-time – and more than 90% attend case discussion meetings.

In terms of planning at a broader level, just over two-thirds of education representatives reported being involved in the preparation of the Youth Justice Plan. However, at the level of inter-agency strategic planning, involvement was lower with 44%, indicating that they did not contribute to the process (Table 27). To a certain extent, involvement in strategic planning is likely to depend upon level of seniority within the parent agency. The fact that only half of education representatives appear to engage in inter-agency planning might be thought a cause for concern, given the importance attached to the brokerage role of the

education function within the Yot, and that effective, long-term provision depends on the ability of education staff to access mainstream education resources for Yot clients.

Table 27 Do you contribute to local inter-agency strategic planning?

	%
Yes	50
No	44
Missing	7
Base N = 147	

Role of education staff (including working arrangements, management, main activities etc)
Nearly 70% of education representatives were seconded to the Yot, with a further 22% being directly employed by the team. While health workers tended to have open-ended or permanent secondments, the largest group of education staff (46%) had fixed-term contracts for between three and five years. Almost equal proportions (16% and 15% respectively) were either on permanent contracts or seconded for a shorter period of between one and two years. Just over three-quarters of respondents had been in post more than a year.

A significant majority (84%) were full-time, a much higher proportion than their colleagues from health. At the same time, education workers were also more likely to indicate that they were in temporary positions (43%). While some of this might be explained by seconded staff responding on the basis that their secondment to the Yot – as opposed to their substantive post with the local authority – was temporary, it does not account for the whole picture: 31% of those directly employed by the Yot and 61% of those who described their employment arrangements as 'other' also indicated that their position was temporary. Given the statutory nature of the function within the Yot, the relatively high levels of education posts which are not considered permanent, may be an issue for concern and would merit further investigation. At the same time, a large majority (88%) were based wholly in the Yot.

Half the education sample could be described as generic education workers (e.g. education officer, education adviser, education specialist) with their job title giving little further indication of how the education role within the Yot is carried out in practice. Just over 18% described themselves as education welfare officers and a further 7% as education social worker. These two titles are likely to reflect differences in terminology between local education authorities rather than any significant divergence of function. Other job titles included teacher (7%) and Connexions worker (2%). Of the 'other' category, some were youth workers, some generic Yot workers and some, perhaps rather unexpectedly had health responsibilities.

Table 28 Education workers job type

Job type	%
Education worker	50
Education welfare officer	20
Education social worker	8
Teacher	7
Connexions worker	2
Other	14
Base N = 145	

More than three-quarters of education staff had relevant professional qualifications and more than a third (36%) had some experience in the youth justice system before taking up their current position.

When asked to describe their role within the Yot, less than half of education workers reported that they were specialists. Most thought of themselves as having a mixed function, with 56% indicating that they were specialist workers with some generic duties. However, almost 5% suggested that they were generic Yot workers. Overall, the responses suggest that education staff are much more likely than other specialist workers to be engaged in non-specialist youth justice work.

To the extent that the picture is an accurate one, it suggests that the vision of education representatives within Yots as concentrating primarily on reintegrating young people into mainstream provision may not have been realised across the board. Education workers were under-represented in the focus groups. [4] Nonetheless, the issue of case responsibility was raised as a difficulty by education staff in one of the discussions. It was argued that holding cases affected relations of trust with young people. As long as education workers were able to retain a specialist identity, they could work well with young people. Becoming a case-holder could interfere with that relationship, as young people come to perceive education staff as 'the enemy' and are less amenable to positive intervention.

We can't do the job we've trained for because we have to do case holding.

The questionnaire asked education workers to indicate which area of work within the Yot was most problematic. A significant number of the free-text responses made reference to the tensions associated with undertaking generic work. For instance, one respondent suggested that the biggest problem was:

Resisting demands to complete a variety of generic duties – this would be at the expense of my role as education worker.

Others did not object specifically to undertaking generic tasks per se, but felt that they had received insufficient training to do so, or were concerned at the lack of parity in terms of pay and conditions in comparison to other staff undertaking generic duties.

[4] In part, because the research was conducted over the summer period and the holiday arrangements for significant numbers of education workers appear to conform to the academic year.

Lack of training in writing reports, court work and the requirements to supervise court orders without previous training. Lack of resources to work with young people and inequality felt when other colleagues doing similar work earn higher salaries.

Overall, however, education workers appear to have expressed less concern about carrying a generic caseload than other specialist Yot workers. Indeed, one participant in a focus group from a relatively small Yot was clear that it was an essential part of the role. Of five education workers who took part in telephone interviews, only one thought that they should not carry a generic caseload.

An analysis of the tasks undertaken by education workers provides a further insight into the extent to which they undertake work which is of a generic nature (Table 29). The most frequent responses are those which might be thought consistent with carrying out a specialist function. Thus, more than 60% of education workers stated that they had contributed to others' court reports, and over half had contributed to referral panel reports and assisted in community-based interventions since joining the Yot. On the other hand, activities which are more closely aligned with generic work were also commonly reported. More than a third of education workers had acted as responsible officer for community interventions and had had responsibility for completion of *Asset* (one would, of course, expect a certain degree of coterminosity between these two activities). In addition, over 20% had attended the police station as appropriate adult, written court reports and referral panel reports, or had been responsible for undertaking breach proceedings. On each of these indicators, education staff are much more likely to be involved in generic Yot work than either health or substance misuse workers.

By contrast, education workers were less likely than other specialist staff to have visited young people in the secure estate or to have had contact with secure facilities, despite having a larger role in acting as a responsible officer for children in such placements. Yet the reintegration of young people into education, training and employment when they leave custodial institutions is recognised as a prerequisite of a successful return to the community.

Table 29 Activities undertaken by education workers since joining the Yot

Activities undertaken	%
Attend police station	22
Court duty	13
Assist in *Asset* compilation including part completion	49
Responsibility for completion of all *Asset*	35
Contribute to referral panel reports	53
Write referral panel reports	28
Contribute to others' court reports	62
Write court reports	21
Prepare specialist reports for court	12
Assist in warning programmes	44
Assist in community-based interventions	58
Carry out responsible officer role for community interventions	35
Have contact with secure facilities	49
Visit children in secure facilities	44
Responsible officer for children in secure facilities	15
Provide information for breach proceedings	38
Undertake breach proceedings	22
Base N = 144	

Note: multiple response question, therefore percentages add up to more than 100

Training and development of education workers in Yots

Around 66% of education workers stated that they had received training when they started working for the Yot, higher than that given to health and drugs staff. Education workers were also more likely than the other two groups to perceive that they had the same training opportunities as other Yot staff, with 94% stating that this was the case. A high proportion (82%) felt that they were given the opportunity for specialist training in their area of expertise but this was, nonetheless, lower than that afforded to health and drugs workers.

On average, education workers had received 9 days training in the past 12 months. This relatively low figure may relate to the fact that a lower proportion of education representatives, than staff in the other two groups, had been given access to specialist training. Indeed, training opportunities for education workers appear, in part, to be related to the extent to which they undertake generic tasks. Thus, those who described their role as a specialist one were less likely to have received training when they joined the Yot than generic workers or those who indicated that they undertook generic tasks. Conversely, the relatively low proportion of specialist education workers appears to be reflected in the reduced opportunities for specialist training and, consequently, the reduced number of training days within the past year.

Similar considerations might help to account for the fact that education workers appeared more satisfied than the other groups with the training they had received from the Yot (Table 30), in spite of the fact that they had received less input in the recent past. Since education professionals are more likely to be engaged in generic work, training outside of their specialist field will take on a greater relevance. So the higher levels of training afforded to education workers when they joined the Yot is reflected in a lower proportion of such workers considering that they have been insufficiently trained for Yot work. Education workers were significantly less likely than colleagues from other professions to provide training to other members of the Yot with less than half (44%) reporting that they did so. This may be a further reflection of the fact that they are more embedded in generic work. Alternatively, other team members might consider that they are less in need of improving their knowledge and understanding of education-related issues than of mental health or substance misuse.

Table 30 Are you satisfied with the training provided by the Yot?

	%
Yes	67
No – insufficient for Yot work	16
No – insufficient for specialty work	18
No – other	9
Base N = 142	

Note: multiple response question, therefore percentages add up to more than 100

Despite some concerns over training provided by the Yot, 90% of education workers felt that they were sufficiently qualified to do the work required by the Yot. This again suggests that experience obtained before working within the team is important in equipping specialist staff to undertake the tasks required of them within the youth justice system.

A breakdown of training received, also gives an indication of the extent to which education staff are expected to engage in mainstream Yot work. As with other specialists, a majority

of education workers had received child protection training and computer training (Table 31). However, education specialists were much more likely to have received assessment/*Asset* training. A higher proportion of education staff had also been given training in court work and effective practice. At the same time, just over a fifth of educational workers had undertaken training on inter-agency protocols, suggesting that, for a significant minority, the inter-agency interface is regarded as a significant part of the function.

Table 31 What training have you received since you started working for the Yot?

Training received	%
Report writing	22
Computer training	73
Management training	5
Child Protection training	58
Risk training	32
Inter-agency protocol training	21
Motivational Interviewing training	22
Youth Justice Board training	56
Effective practice	38
Court duty skills	18
Cognitive behavioural techniques	35
Assessment/*Asset*	58
Health and Safety training	24
Missing	8
Base N = 135	

Note: multiple response question, therefore percentages add up to more than 100

Work with young people

Referrals, assessment and workload

As with health staff, the majority of referrals to education workers were on a case-by-case basis (Table 32), with a large proportion also coming via team leaders. Around a quarter of respondents stated that young people were referred according to strict criteria.

Table 32 Are young people referred to you by others?

Referral mechanism	%
Yes, on a case-by-case basis	92
Yes, by strict criteria	23
Yes, by team leader(s)	41
No, only those on my caseload	3
No	1
Base N = 143	

Note: multiple response question, therefore percentages add up to more than 100

While a quarter of respondents indicated that they would see all young people with a known educational problem, almost half said that they would only do so where a referral was made by someone else in the team (Table 33). Just under 20% will only see young people with specific problems. Such a pattern would not appear to be consistent with the use of an objective consistent screening process and a coherent framework for further assessment suggested by the Board's Key Indicators of Quality in *Key Elements of Effective Practice – Education, Training and Employment* (Youth Justice Board, 2002b).

Table 33 Would you see all young people going through the Yot who have a known problem with education?

Whether all young people seen	%
Yes	25
Yes, if sent to me by Yot workers	49
No, only those with specific problems	16
No response	10
Base N = 147	

Caseloads are similar to those of health staff. Around 41% of education workers saw between 16 and 30 young people on average per month. Around 12% stated that they saw more than 30 young people per month. Relatively small proportions only saw up to five young people per month.

Needs of young people (and gaps in services)

More than two-thirds of young people, on average, were perceived by education respondents to have education-related problems, with the most common difficulties pertaining to unauthorised absences from education or poor literacy and numeracy (table 34). A significant proportion of young people referred to the Yot were also reported as having previous fixed-term exclusion.

Table 34 Roughly what proportion of the young people you have worked with in the Yot have had problems with any of the following?

%

Problems encountered	Proportion of young people					
	None	1-25%	26-50%	51-75%	76%+	Missing
Permanently excluded	1	55	17	12	5	10
Fixed-term exclusion	1	46	29	12	1	12
Previous permanent exclusion	1	42	27	14	5	12
Previous fixed-term exclusion	1	16	29	25	16	13
On unauthorised absence	2	12	20	25	29	11
Literacy/numeracy problems	1	14	20	33	22	10
Have special educational needs statement	0	50	39	8	2	12
School age but no education provision	8	57	18	4	3	10
Over school age but no education provision	8	31	24	12	7	18
Base N = 147						

Perhaps surprisingly, particularly in the light of reported difficulties in accessing various forms of provision (described in more detail in 'Assessment and interventions', page 53), a lack of education provision was not one of the most commonly cited problems.

Access to information

Again, almost all respondents (99%) stated that they had access to Yot case records. Education workers were also asked if they had access to young people's education records and 84% stated that they did.

Whether education workers were able to obtain relevant case information depended to an extent on whether they were seconded or employed directly by the Yot (Table 35). A higher proportion of the former indicated that they had access to education records – presumably because such records are more likely to reside with schools/the parent agency. A number of those participating in telephone interviews highlighted exchange of information as one area where practice has made substantial progress. In particular, the ability of Yots to access information rapidly from schools was said to have improved significantly.

Table 35 Access to education records according to secondment/direct employment by the Yot

%

Whether access to education records	Nature of employment		
	Directly employed	Seconded	Other
Yes	77	84	82
No	23	16	18
Base N[s] =	*26*	*90*	*11*

Assessment and interventions

Education workers reported being more much likely to use *Asset* as the sole means of assessment than either health workers or drugs staff, with more than a third indicating that they did so (Table 36). This relatively greater reliance may be related to greater involvement of education professionals in generic work, with the associated requirement to complete *Asset* at the beginning and end of intervention. In addition, as we have seen, education representatives are also more likely than other specialist workers to have received *Asset* training (Table 31). At the same time, education specialists were also more prone to relying on professional discretion than workers from other backgrounds and, in interviews, a number of staff criticised *Asset* for not covering basic skills and for failing to record data of an educational psychological nature.

Table 36 What tools would you use in assessing young people?

Assessment tools used	%
No tools – professional discretion	20
Asset	35
Other	17
Asset plus other	5
Base N = 137	

Over 73% of education workers stated that they provided interventions themselves, primarily on a one-to one- basis. Focus group discussions suggested that, in some cases, staff considered that the services they were asked to deliver – for example, anger management – were inappropriate given their professional background and beyond their expertise and knowledge base.

As with other specialist workers, interventions provided by education staff were most commonly not linked to a particular area of the Yot's work (Table 37). However, despite the fact that they are less likely to liaise with the secure estate or to visit young people in secure establishments (Table 29), education representatives appeared to be more involved in the delivery of DTOs than health or substance misuse staff. At the same time, they were much less likely to have a role in relation to remand and bail.

Table 37 Do you have a specific role for

	%
Remand and bail	5
Fostering	4
Other local authority accommodation provision	6
Restorative justice approaches	14
Intensive Supervision and Surveillance Programme	19
Detention and Training Orders	25
None of these	44
Missing	11
Base N = 147	

Note: multiple response question, therefore percentages add up to more than 100

Referrals to other agencies

The vast majority of education workers (97%) reported that they referred young people to agencies outside the Yot. However, it may be a matter of concern, given the expectation that a primary focus of the role is to reintegrate young people back into mainstream educational provision, that only a quarter of respondents refer to their seconding agency. Even when responses from seconded workers alone are considered, the proportion making such referrals remains below a third.

Table 38 Do you refer young people to other agencies?

	%
Yes – to any agencies available	85
Yes – to my seconding agency	25
Yes – to agency specified by Yot	22
No	3
Base N = 144	

Note: multiple response question, therefore percentages add up to more than 100

Nearly all (97%) expected feedback from other agencies, but 58% stated that they did not receive feedback as frequently as they felt they should, and a further 6% indicated that they received none at all.

Participants in the telephone interviews confirmed that they experience difficulty in accessing provision outside the Yot, with some referring to a shortage of funding for educational programmes for young people who are hard to place in mainstream school. The situation may be exacerbated by stereotypical attitudes towards young people in contact with the criminal justice system. Schools can be difficult to convince that such young people might want to learn. When no school placement is available, the education department might then attempt to "save money on our kids because they just don't feel they'll achieve anything."

Moreover, when education workers were asked the area of work that was most problematic for them in their role, the most frequent response concerned provision of services outside the Yot and access to placements. A number contrasted their experiences with the expectations of the Youth Justice Board. For instance:

Not having places in schools for young people or alternative providers which I can access as I do not have any budget. Yet the Board expect 25 hours education per person. This is just not realistic until the local education authority has enough provision for all.

The mismatch between the expectations laid down by the Board (90% in full- time education, training or employment) and the reality of young people being excluded, or the wait for children with statements [of educational special needs] in special school. As education officers within the Yot, we have no power to speed up or influence this process… Many of our cases receive no education for weeks or months, and I feel powerless to affect this process.

As was the case for health workers, education workers also found it problematic to find assistance outside the Yot for young people with mental health problems.

Education provision for young people in the criminal justice system generally

In spite of the increased focus upon the importance of education and training in preventing and reducing offending with the creation of Yots, education representatives within the teams have a relatively negative view of provision for young people who pass through the criminal justice system. Only 17% rated it to be good or very good, and less than a third considered it adequate (Table 39). One respondent did however acknowledge that there was wide disparity from one area to another.

There is wide variation in the educational provision in Yots, so this is a subjective response relating to the geographical area within which I work.

This rather pessimistic assessment is less favourable by some margin than health and drugs workers' views of facilities available to young people within their own area of expertise.

Table 39 How would you rate education provision for young people passing through the criminal justice system?

Rating of provision	%
Very good	1
Good	16
Adequate	31
Poor	38
Very poor	6
Missing	8
Base N = 147	

In this generally negative context, it might be argued that the relatively large proportion of time which education workers within the Yot appear to spend on generic work might be put to better use in ensuring that young people have access to appropriate provision outside the youth justice system. A good many education staff clearly recognise the importance of such an approach, and one of the commonly noted difficulties in the role was precisely around liaison with the local education authority. The following problems, for instance, were articulated:

Pushing the boundary of expectation of provision for school-age young offenders: it is unconsciously accepted that there are holes in the education safety net. Yot and educational establishment perspectives on this often conflict, and this interface has to be managed. It is easy to harbour feelings of failure on both sides. It is, however, very interesting work, as the Yot serves as a 'disclosing agent' for the number of young people drifting or plummeting out of the state education system.

Negotiations with headteachers, deputy headteachers, head of year in schools to help maintain young people in school … networking with other agencies.

To a degree, there is a tension between this view of what the education worker should be engaged in, and the fact that many educational representatives appear content that generic Yot work should be regarded as a central part of their function.

Perhaps surprisingly, education workers are, more likely than the other two specialist groups, to perceive current continuity of provision from custody to community as 'adequate' (Table 40). Nonetheless, it remains true that almost a third rated that continuity as poor or very poor.

Table 40 How would you rate current continuity of provision from custody to community for young people?

Rating of provision	% of education workers
Very good	3
Good	15
Adequate	42
Poor	26
Very poor	4
Missing	10
Base N = 147	

Comments from those who rated the system as good indicated that they had some qualifications about the extent to which it was effective. For example, one worker stated that:

Provision is there – some better than others – it breaks down when a young person is not committed and unco-operative.

Many more who found the system poor had responded with comments. Lack of provision for children with emotional and behavioural difficulties was cited as a problem, as was catering for young people with chaotic lifestyles who may not regard education as a priority. It was felt that many agencies do not understand the needs of young people passing through the secure estate. One respondent commented that:

[Young people] we work with are often those with educational problems which the education system can't provide for (funding, resources, time, lack of willingness). Until the education system is changed our young people will continue to fail on what is a 'conveyor-belt' system.

SUBSTANCE MISUSE WORKERS

Current arrangements for the design and implementation of substance misuse services in Yots

The position of substance misuse workers within the Yot is, in some respects, more straightforward than that of education and health staff. In the first place, there is designated ringfenced funding to create the posts. In addition, while there may be scope for debate as to the extent to which staff should be delivering direct services, the remit is, nonetheless, more tightly circumscribed than that associated with health, more broadly understood, and education. Given the arrangements for funding, one might reasonably expect that most Yots would include a substance misuse worker.

In fact, 42% of those responding indicated that there were other drug workers within the Yot, and 32% of these were full-time (Table 41). Although there are difficulties in interpreting this information, as a consequence of double-counting and teams working over more than one site (see earlier discussion in 'Current arrangements for the design and

implementation of health services in Yots', page 39), the figures do suggest that, in some cases at least, Yots have access to more than one substance misuse specialist. As might be expected, a larger proportion reported that there were other health workers within the Yot, with 61% indicating that these were full-time posts, and a further 17%, part-time. However, this leaves more than 20% of respondents indicating that there was no additional health staff input into the service, despite the statutory requirement for such representation.

Table 41 Are there any other health or drug resources in the Yot?

Health or drug resources available	%
Yes, other full-time health workers	61
Yes, other part-time health workers	17
Yes, other full-time drug workers	32
Yes, other part-time drug workers	11
Other	5
No	8
Base N = 102	

Note: multiple response question, thus percentages add up to more than 100.

As with the other specialist groups, there appeared to be few problems of communication between the various health staff (where there were other such staff within the teams). Almost 90% of respondents found that systems of liaison with other professionals were good or very good, while 12% felt that they were adequate (Table 42). Only one respondent considered such systems to be poor.

Table 42 How would you rate systems of liaison with these other professionals?

Rating of systems of liaison	%
Very good	58
Good	29
Adequate	12
Poor	1
Very poor	0
Base N = 90	

A higher proportion of substance misuse staff than specialist health workers considered the health resources available to the Yot to be at an adequate level, with just over half indicating that they did not think that there was a requirement for any additional health care professionals. A significant minority disagreed, however. Where respondents made a specific reference to the type of additional resource input that ought to be available, the most common reference was to mental health or CAMHs provision.

Table 43 Are there any other health care professionals you feel should be accessible to Yot staff to meet the drugs needs of young people?

	%
Yes	48
No	52
Base N = 100	

The focus groups revealed some concerns among substance misuse workers about gaining access to appropriate and consistent supervision, in particular where they were obliged to operate over more than one site and therefore work to a number of managers. This can be a particular problem when major crises occur and can leave the individual worker feeling vulnerable.

In some cases, this was linked to a perception that other staff within the Yot might not fully appreciate the role of the substance misuse worker or recognise the extent of his or her expertise. Thus, workers complained that it was difficult to get colleagues to take their "knowledge as trustable", and that other Yot staff were inclined to tell the drug specialist what the young person's requirements were, rather than relying on his or her "professional diagnosis of what they need and what will benefit them." In some instances, this was linked to the fact that other members of the team underestimated the potential for substance misuse interventions.

The Yot worker doesn't necessarily know what we can do as drugs and health professionals around cannabis and alcohol use. They kind of give us referrals because they have to, but they are not sure what we have to do. So they are kind of saying: 'Well you know it is only just a little bit of alcohol', but actually there is a lot of work we can do there because of our holistic approach to it. It opens up the reasons why people are drinking and smoking cannabis, and that is where the real work is.

In others, it was related to the specialist knowledge base of supervisors:

Lack of supervision from management – when it does happen, they lack specialist knowledge to explore substance misuse issues.

Nonetheless, most substance misuse workers, like their specialist colleagues from health and education, were clearly fairly well integrated into the Yot. Nearly all (96%) stated that they attended team meetings and a significant proportion (84% – slightly lower proportion that the other two specialist groups) case discussion meetings. The focus groups confirmed a general impression that substance misuse specialists had been welcomed into the teams (albeit if the full extent of what they might contribute was not always recognised). The fact that there were other specialist workers already within the teams made it easier to fit into the multi-agency structure.

I feel welcomed and accepted into the team and I feel like I am a member of [it].

I do feel that I am part of the team, as there are lots of specialists.

Fewer substance misuse workers than workers in the other groups reported being involved with preparation of the Yot's Youth Justice Plan (38% stated that they had some involvement). Although the information is not available from the current research, it may be that this is an indication of drugs workers being appointed to lower grade posts than their colleagues from health and education. The status of different specialist workers within the team might also be related to the expectations of the type of work from each group.

Role of substance misuse staff (including working arrangements, management, main activities, etc)

Given the background to the inclusion of substance misuse specialists within Yots, it would be reasonable to expect that a higher proportion of such staff would be directly employed than in the case of those specialists where there is a statutory requirement for representation. The results of the survey bear that assumption out, and 32% of drug workers reported being directly employed by the Yot. The most frequent employment arrangement however was still secondment, with 41% of respondents falling into that category. As with other specialists, the majority (84%) worked full-time and two-thirds had been in post for more than a year.

There are, however, other significant differences between the employment arrangements for substance misuse staff and other specialists. Secondments, for instance, tended to be for a shorter period than for the other two groups: 37% were contracted for a period of between one and two years, with just 20% subject to permanent or open-ended appointment to the Yot. Nearly 45% of those responding stated that they were in temporary posts, and this was particularly so for those who were employed directly by the Yot, where the proportion of temporary workers rose to 69%. In addition, far fewer substance misuse staff than in the other two groups worked solely in the Yot. More than a quarter were based partly in a partner agency, and 11% worked wholly externally to the Yot, compared with almost none of the education and health staff. In some cases, the link between the Yot and that agency appears to be relatively tenuous: in the focus groups a number of drug workers confided that they had been in post some time before they appreciated that they had any input into the Yot whatsoever.

That's what my job description said. It didn't even mention the Yot.

I didn't know either! I'd never heard of the Yot. I just thought it was something bobbing on the sea

Most of the differences in employment arrangements appear to relate to variation in the funding mechanisms for this specialism. In particular, funding for drug work is not statutory, it was obtained some time after Yots were established and is committed only for a three-year period. The latter factor has clearly caused a degree of anxiety for those staff whose appointment is temporary, and job security may become an increasing issue while uncertainty as to future funding remains. One worker indicated that it was the most difficult thing about their role:

The most problematic area for me has been the last couple of months with the uncertainty of the positions that are being funded after 2004 and having to decide to take other positions … Job security has a major impact on workers. We have put a lot of effort into the post to make them [sic] a success, with a positive pro-active attitude. We are now beginning to feel that we will have to look for permanent employment when jobs come up.

A further consequence of the funding arrangements is that there was considerably less variation in the job titles of the roles in which drug professionals worked. A full 86% might be considered as specific substance misuse workers (job titles included drug and alcohol worker, substance abuse worker and, in some cases, either drug worker or alcohol worker). However, a few respondents (5%) indicated that they were general health workers, and this

may raise the prospect that, in a small number of cases, the funding for drug input is being diverted to accommodate an absence of provision from the health authority.

More than 82% of substance misuse workers stated that they had relevant qualifications and 47% had had prior experience in the youth justice system: the latter being a significantly higher proportion than that for health or education workers.

If job title does not necessarily give a complete account of the roles of particular members of the Yot, for substance misuse workers, there appears to be a greater correlation than for other specialists. In particular, staff with a drug remit are significantly less likely to undertake generic youth justice work. Thus nearly 68% of this group described themselves as specialist workers. The proportion who considered themselves to be specialist workers undertaking some generic duties (a further 28%) was considerably lower than the equivalent proportions for health and education representatives.

Nonetheless where there was an expectation, on the part of the Yot, that generic work should be undertaken, it had the potential to lead to tensions, some of which were apparent in the focus groups.

I am a drugs worker – if I wanted to be a Yot one, I'd have trained as one.

I mean at the moment, I'm basically sticking to my guns and I've dug my heels in and said no I'm not writing PSRs [pre-sentence reports] because I've been in courts where the judge is saying I'm not trained to do a PSR. That's not my job, but I'm not doing nothing like my job description at all and that's what I've been talking about in supervision recently.

Not all substance misuse staff object to generic work however, provided that there is a rationale for carrying a particular case which relates to their specialist skills. For instance, if a young person has overdosed, then it may be appropriate to allocate the case to a drug specialist.

I've got no gripe with those. It's where I've got bog-standard criminal cases and the criminal work that I've got that I'm not happy with.

Some workers were ambivalent, recognising that there were advantages for them in being required to carry a specialist caseload, although it might not represent the best use of resources.

I enjoy parts of it, its more strings to my bow in a sense. But, you know, at the end of the day when I leave the Yot, I'll do drugs work, I won't be into criminal justice. That's my love, that's what I can do.

In concrete terms, a breakdown on tasks undertaken by substance misuse staff since joining the Yot gives an indication of the relative balance of generic and specialist work. Drug workers were considerably less likely than health or education professionals to be involved in activities which might be thought indicative of a generic role (Table 44). These included attending the police station, undertaking court duty, completing *Asset*, writing court or referral panel reports, acting as responsible officer or undertaking breach proceedings. Nonetheless, almost a quarter did report having been a responsible officer for community

interventions. The most common activity, by some margin, was contributing to community-based interventions, and nearly two-thirds of substance misuse workers stated that they had done so. More than half had visited children in secure facilities, had contact with secure facilities, or contributed to court reports written by others.

Table 44 Activities undertaken since joining the Yot

Activities undertaken	%
Attend police station	10
Court duty	7
Assist in *Asset* compilation including part completion	23
Responsibility for completion of all *Asset*	16
Contribute to referral panel reports	44
Write referral panel reports	21
Contribute to others' court reports	53
Write court reports	15
Prepare specialist reports for court	14
Assist in warning programmes	36
Assist in community-based interventions	64
Carry out responsible officer role for community interventions	23
Have contact with secure facilities	52
Visit children in secure facilities	54
Responsible officer for children in secure facilities	10
Provide information for breach proceedings	44
Undertake breach proceedings	12
Base N = 103	

Note: multiple response question, therefore percentages add up to more than 100

Training and development of substance misuse workers in Yots

Nearly two-thirds of drugs workers (62%) had been given training when they started working for the Yot, a similar proportion to that of other two groups of specialist staff. Access to specialist training was regarded as good, with 88% indicating that opportunities for such training had been made available to them. This is reflected in the fact that the

average number of days training for drugs workers in the past 12 months – 11 days – is similar to that recorded by health representatives and above that received by education staff.

A slightly lower percentage of substance misuse workers than health and education staff (75%) perceived that their training opportunities were the same as other Yot workers. Perhaps as a consequence, substance misuse workers appeared to be least satisfied of all the three groups with the training they had received from the Yot (Table 45).

Table 45 Are you satisfied with the training provided by the Yot?

	%
Yes	62
No – insufficient for Yot work	20
No – insufficient for specialty work	14
No – other	12
Base N = 100	

Note: multiple response question, therefore percentages add up to more than 100

Despite these concerns, nearly all the respondents in this group (96%) felt that they were sufficiently qualified and experienced to do the work required by the Yot. A relatively high proportion, nearly 73% of substance misuse workers, stated that they provided training to other members of the team.

The profile of training received is, in some respects, similar to that for other staff groups. Thus, a majority of substance misuse workers had received child protection training and computer training (Table 46). However, this sample were much more likely to have undertaken training in motivational interviewing training (52%), presumably because this type of intervention is regarded as particularly relevant to substance misuse work. Conversely, drug workers were least likely of the three groups to receive Youth Justice Board training, perhaps reflecting the fact that they appear more detached from the Yot than the other two groups, and that most of them will have come into post at a later stage of the Yot's development.

In general, training which might be considered applicable to generic youth justice work, was less prevalent among substance misuse staff. A lower proportion for instance had engaged in report writing or *Asset* training. Nonetheless, some staff were wary that such training might be a precursor to taking on a larger generic caseload.

I keep hearing these little things on the grapevine and it kind of scares me in a sense. I actually came into this job to be a youth offending drugs worker. I did not come in to be a Yot worker… And there's this sneaky little thing of sending us on any Yot training going, you know you can go because you are part of the team. Yeah. For my own personal development that's fine. But in a sense now I get to understand the reason why we've been steered this way is because whoever is actually at the top feels we … would be holding caseloads … Are they going to be upping our salaries to what the Yots are on?

Table 46 What training have you received since you started working for the Yot?

Training received	%
Report writing	14
Computer training	61
Management training	3
Child protection training	59
Risk training	24
Inter-agency protocol training	15
Motivational interviewing training	52
Youth Justice Board training	45
Effective practice	29
Court duty skills	10
Cognitive behavioural techniques	36
Assessment/*Asset*	42
Health and safety training	30
Missing	10
Base N = 93	

Note: multiple response question, therefore percentages add up to more than 100

Work with young people

Referrals and workload

Substance misuse workers were more likely than respondents from the other two groups to state that they would see all young people with a problem relevant to their own specialism (Table 47), with almost a third indicating that all young people with a known substance misuse issue would be seen. A further 49% stated that they would see all young people with relevant problems, if they were referred by other Yot workers.

Table 47 Would you see all young people going through the Yot who have a known problem with drugs?

Whether all young people seen	%
Yes	32
Yes, if sent to me by Yot workers	49
No, only those with specific problems	19
Base N = 102	

Note: multiple response question, therefore percentages add up to more than 100

It may be that the higher proportion of specialist intervention, which these findings imply, is a reflection of fact that drug workers appear to retain a more specialist focus. Moreover, substance misuse might be seen as a narrower and more defined area for intervention in comparison to problems with health and education, understood at their broadest.

It may also reflect the fact that referrals to drug specialists are more likely to be guided by strict criteria. Although the majority of referrals (as with other specialisms) tended to be made on a case-by-case basis, a third of respondents indicated that referrals were governed by laid down criteria (Table 48). Nonetheless, there was also some concern that Yot workers did not always refer young people who would benefit from a substance misuse service.

Table 48 Are young people referred to you by others?

Referral mechanism	%
Yes, on a case by case basis	86
Yes, by strict criteria	33
Yes, by team leader(s)	24
No, only those on my caseload	0
No	0
Base N = 103	

Note: multiple response question, therefore percentages add up to more than 100

Substance misuse workers also appeared to have the highest caseload on average of the three groups of specialist staff, with 43% of respondents seeing between 16 and 30 young people per month. Around 18% reported that they saw more than 30 young people per month, suggesting that a large share of drug specialists' workload is taken up by face-to-face delivery. This finding is consistent with the fact that substance misuse staff are more likely than other specialists to be involved in community-based interventions.

Needs of young people

Just over 58% of young people known to the Yot were, on average[5], regarded by substance misuse workers as having substance related problems.

Almost half of drug workers considered that over three-quarters of the young people with whom they had worked had had some form of problem with substance abuse. Although this, in itself, is hardly surprising, it suggests that in some cases, drug workers are dealing with young people without any such problems. This might reflect involvement of staff in elements of Tier 1 service delivery, such as provision of information or substance misuse

[5] Taking the mean number

education. Alternatively, it might offer a further indication that a proportion of substance misuse specialist resources are allocated to generic work.

Tobacco intake, which featured highly as an issue for health workers, was again regarded as one of the more problematic issues by substance misuse staff (Table 49). Although heroin, crack and volatile substances were seen as affecting less than 50% of young people seen by these workers, the extent of use which the table suggests is significantly above that in the general population.

Table 49 What proportion of the young people you have worked with have you had problems with:

%

Problems encountered	Proportion of young people					
	None	1-25%	26-50%	51-75%	76%+	Missing
Substance misuse	0	6	18	19	45	13
Alcohol misuse	0	11	18	32	28	12
Heroin dependency	15	61	9	2	2	12
Cocaine/crack dependency	19	59	8	0	0	14
Misuse of volatile substances	18	56	7	2	0	18
Misuse of prescription drugs	31	50	3	1	1	15
Use of tobacco	2	8	3	16	58	14
Drug or alcohol-related phys health problems	5	55	20	3	1	16
Drug or alcohol-related mental health problems	2	59	17	6	2	15
Other problems with substance misuse		5	18	20	46	11
Base N = 103						

Access to information

As with other specialist workers, substance misuse specialists appear to experience little difficulty with accessing information held by the Yot on the young people with whom they worked, even though some of these staff, as we have previously noted, work from a different location. The great majority, 95%, stated that they had access to Yot case records for young people. On the other hand, drug workers experienced far greater difficulty in obtaining health records, with less than a quarter indicating that they were able to do so. Access was better for drug workers who were seconded, presumably because in some cases records were held by their parent agency (Table 50). Nonetheless, in comparison with health workers, the flow of communication appears somewhat problematic.

Table 50 Access to health records according to secondment / direct employment by the Yot

%

Whether access to health records	Nature of employment		
	Directly employed	Seconded	Other
Yes	17	31	19
No	83	69	81
Base Ns =	*29*	*39*	*26*

On the other side of the equation, some major concerns were expressed in the focus groups about expectations placed on substance misuse workers to share what they clearly regarded as sensitive information with other staff in the Yot. Many drug workers regard a high level of confidentiality as a prerequisite for developing relationships of trust with young people, that they consider necessary for successful intervention. The following comments were typical in this context:

Because there's a lot more, they won't tell. They'll tell me things that they wouldn't tell somebody else, which can again cause problems, because obviously you're part of a team and you need to sort of share information…. There is some information, it's not relevant. I don't need to share it with the supervising officers. But it's just a personal thing of trust with that young person.

In some cases, such information would extend to information about offending behaviour.

If it's something that's relevant, then I will share it. If it's just something that isn't, then there isn't any need to do that, and that agreement, everybody is happy with that and the team's quite comfortable with the way I work … [If I say to a young person] but what do you do to be able to get hold of, you know, all these drugs and stuff? Well, you know I rob … and I get this and I sell here and I sell there. I mean that's the information I don't need to share because obviously everybody knows, if they use their brain, that this client isn't getting the money from pocket money.

While this drug worker's team appear comfortable with such an approach, that is clearly not a universal experience. The most frequent response from this group of staff to the question about the most problematic area of work for them involved issues of confidentiality. It should be noted too in this regard that the responses which typically emanated from substance misuse staff are not inconsistent with recent Home Office guidance on working with children who use drugs which argues that:

If a child is to be encouraged to approach a service for help, it is essential that they are able to do this knowing that their confidence will not be passed on without their knowledge or consent.

Confidentiality should not be breached, for example, to report a crime where it is in the best interests of the child to ensure needs are met to stop further crimes being committed.
(Home Office, 2003)

Assessments and interventions

Less than a quarter of substance misuse staff reported that they had contributed to, or taken responsibility for, completion of *Asset* (Table 44). Nonetheless, this specialist group reported being more likely than other health workers to rely solely on it as for assessment purposes. On the other hand, the Christo inventory was used almost as much as *Asset* and most respondents made reference to other forms of assessment. Some staff complained that *Asset* was not sufficient for their purposes. One worker contrasted *Asset* with their parent agency's assessment in the following terms:

[It] is so in depth. It covers all aspects of a young person's life. It is not like the Asset where it is just a tick box. We really go into depth with them and actually promote conversation about that. We are not dealing with the drug using habit. It is the person first.

Reliance on professional discretion was higher than that indicated by other health workers, but lower than that of staff from an educational background (table 51).

Table 51 What tools would you use in assessing young people?

Assessment tools used	%
No tools – professional discretion	15
Asset	25
Christo inventory (drugs only)	24
Other	55
Asset plus other	31
Base N = 100	

Note: multiple response question, thus percentages add up to more than 100

Substance misuse workers also expressed concern about the number of forms which they had to fill in, particularly if they were seconded on a temporary basis. These might include all the Yot paperwork with additional requirements for their parent agency. This, they felt, was something which should have been addressed in service-level agreements and was symptomatic of a lack of understanding of the expectations of funders, as well as service provision. Concerns about confidentiality, discussed in the previous section, also had an impact on the willingness of drug workers to use *Asset*.

As with other specialists, nearly all substance misuse workers provided some form of intervention, with only a single respondent indicating that they did not do so (Table 52). As might be anticipated, over half of drug workers offered education, counselling and group work. In one focus group, substance misuse staff referred to a variety of other forms of intervention which they provided, including drama workshops, music-based work and a motor project.

Table 52 Do you provide interventions yourself?

Interventions provided by drugs workers	%
Yes – therapy	27
Yes – counselling	66
Yes – education	89
Yes – group work	73
Yes – other	49
No	1
Base N = 102	

Note: multiple response question, thus percentages add up to more than 100

In most cases, as with other specialists, drugs worker intervention was not closely associated with a particular area of the Yot's work (Table 53). Nonetheless, a slightly higher proportion of substance misuse than other workers had a specific role in the delivery of ISSPs and DTOs, which may reflect the higher concentration of problematic drug use among young people whose offending is serious or persistent. It is also consistent with the fact that drug staff reported being more likely than others to visit children in secure facilities.

Table 53 Do you have a specific remit for:-

	%
Remand and bail	19
Fostering	4
Other local authority accommodation provision	8
Restorative justice approaches	16
Intensive Supervision and Surveillance Programme	25
Detention and Training Orders	21
None of these	57
Missing	12
Base N = 103	

Note: multiple response question, therefore percentages add up to more than 100

Referrals to other agencies

In addition to provision of direct services, referral to outside agencies is a significant part of the substance misuse workers' role, and all but one respondent reported doing so. This group of staff was less likely than the other two to refer to their seconding agency, but this presumably reflects the relatively low proportion of secondments for this specialism. As a consequence, almost all indicated that they would refer to any appropriate agency available (Table 54). The large majority (86%) expected feedback from other agencies, although more than half (55%) did not receive it as frequently as they would have liked.

Table 54 Do you refer young people to other agencies?

	%
Yes – to any agencies available	93.0
Yes – to my seconding agency	8.0
Yes – to agency specified by Yot	11.0
No	1.0
Base N = 103	

Note: multiple response question, therefore percentages add up to more than 100

Most substance misuse workers did not report any difficulty with accessing services outside the Yot for young people who had substance misuse problems (although 21% did refer to a lack of provision and a further 11% to lengthy waiting times). A higher proportion was concerned at the lack of provision for problematic alcohol consumption, but here too a majority had experienced no difficulties in this area. Again, waiting times for young people with mental health problems created difficulties for substance misuse workers attempting to find services outside the Yot.

Substance misuse provision for young people in the criminal justice system generally

Substance misuse workers appear to have a higher regard for provision relevant to their specialism available to young people within the youth justice system than do health or education workers, with 45% of the former group rating such provision as good or very good (Table 55). This perhaps reflects the recent policy focus on drugs interventions, resulting in increasing resources being targeted at young substance misusers. At the same time, the views of drugs workers may also be influenced by the relative ease, in comparison with health and education workers, with which they report being able to access resources for their client group.

Table 55 How would you rate drugs provision for young people passing through the criminal justice system?

Rating of provision	%
Very good	7
Good	38
Adequate	29
Poor	24
Very poor	3
Base N = 99	

Significantly fewer substance misuse workers than in the other two groups were impressed with the continuity of provision between the secure estate and return to the community. Less than a quarter rated it as good or very good, and almost 40% considered it to be poor or very poor (table 56). Given that substance misuse staff have the highest level of contact with young people in custody, of the three specialisms considered in this report, that judgement may take on an added significance.

Table 56 How would you rate current continuity of provision from custody to community for young people?

Rating of provision	%
Very good	4
Good	20
Adequate	28
Poor	31
Very poor	8
Missing	9
Base N = 103	

Those who found the continuity good or very good, moreover, tended to qualify their comments. For example, some felt that although the system largely worked, there should be more drugs workers based in young offender institutions and that drugs experts in the Yots should be more involved in assessment of need:

The facilities are there – but they need to be used appropriately – appropriate levels of intervention, e.g: I do not feel that every young person should have to be seen by a specialist drugs worker. Yot workers should use their relationship with them to assess the need and determine the appropriate level of intervention.'

Those who were more negative about the system cited accommodation for drug/substance users as a particular problem. This, along with integrated support for drug users leaving the secure estate, made it very difficult for such young people to make a successful transition to the community:

Especially in terms of access to housing, support into work/education that is specifically geared to their needs. There is a lack of activities/provision to enable drug users to build new life, meet new people, develop skills, etc, away from drugs.'

CONCLUSIONS AND IMPLICATIONS FOR FUTURE POLICY AND PRACTICE

The creation of Yots, as a multi-agency response to youth crime, is distinguished by its commitment to a holistic approach in dealing with the risk factors associated with the onset of offending behaviour. The deployment of an array of professionals with the necessary range and breadth of skills is key to the endeavour. Research clearly demonstrates the importance of education and health – including issues around substance misuse – in helping to explain the differential risks that young people will become involved in delinquent activity. The input of resources from agencies with expertise in those areas is, accordingly, an integral part of what has been termed the "new youth justice" (Goldson, 2000).

However, while the presence of staff within Yots who have an educational and health background is a necessary condition of developing effective interventions, it is not in itself sufficient to guarantee that maximum benefit is derived from the involvement of such professionals. The area is a relatively new and untested one. The optimum level of resource input, over and above the statutory minimum, is not obvious and will inevitably be determined, in part, by competing priorities for the contributing agencies. It is an issue on which, to date, there has been little guidance.

The question of the most appropriate role of such staff within the team – for instance, the extent to which they should be involved in direct service delivery or focus their efforts on specialist assessment and onward referral, with the brokerage function which that implies – is one with a variety of possible answers. Other decisions depend, in part, on the resolution to that question: they include, for example, the most suitable background discipline from which specialist staff should be drawn, the preferred status within their parent organisation and whether a multi-agency approach should imply evolution towards all members of youth offending services carrying a generic caseload.

Guidance published in advance of the establishment of Yots made some tentative, but non-prescriptive, suggestions about how these issues might be approached. So far, however, relatively little information has been available on the range of models adopted in practice. The current review provides a picture of how Yots have responded to the challenge of incorporating disciplines not traditionally centrally involved in delivery of services to young people in trouble, and offers a baseline description of developing practice of health, education and substance misuse workers within that arena. A number of themes emerge from the research which may have implications for future policy and practice as it relates to the deployment of specialist resources within Yots, and these are summarised in the following sections of the report.

LEVELS OF STAFFING AND RESOURCE INPUT

The piloting of Yots suggested that resource input from health and education was likely to prove more problematic than that from other agencies, most of whom had previously experienced a closer relationship with the youth justice system. Available information for the first year of national roll-out of Yots confirmed that staffing, and contributions to the overall teams' budgets were, in some cases, at levels which would make it difficult to

achieve the vision of an integrated, holistic service capable of addressing the broad range of need exhibited by young people most at risk of offending.

Progress has clearly been made since that early stage. The proportion of the overall budget, provided by the statutory partners, contributed by health and education authorities has risen. More significantly, perhaps, the establishment of a discrete, centrally funded, substance misuse function has increased substantially the total health input into the teams over and above the rise in health contributions. The same process has, moreover, facilitated some clarification of the most appropriate role of health representatives within the Yot, since there is no longer an expectation that addressing drugs and alcohol misuse, among the range of other relevant health-related issues, should be the responsibility of those staff.

Yet the current survey suggests that resource input remains a difficulty in some areas. There is a wide variation in the level of resourcing, as a proportion of the total Yot budget both within and between regions: the contribution from health and education, for instance, ranges from less than 1% to over 13% (Table 2).

In concrete terms, such differentials are inevitably reflected in the levels of specialist staff within individual Yots. The findings from the current project suggest, as might be expected because of the funding arrangements for those posts, that most teams had access to at least one substance misuse worker. More than 10% of those staff, however, worked wholly externally to the Yot and, in some cases, had not, initially at least, appreciated that their role was primarily within the youth justice system.

The situation in relation to education and health representation is less clear, with 54% and 38% of respondents, respectively, indicating that there were other staff (full-time or part-time) from their own specialisms within the team. Making allowance for double counting, however, it seems likely that a high proportion – probably a majority in both cases – of health and education staff are working as the sole representatives of their agency within the local youth justice system. Moreover, taking into account that the majority of Yots operate over split sites, it is probable that most health and education professionals are required to work over more than one location. Over 30% of health workers described themselves as part-time, suggesting that even at workplaces with a designated health specialist, that provision is frequently not comprehensive. Nine Youth Justice Plans recorded a zero contribution from either health or education, presumably indicating that, in those areas, there are no specialist staff in post.

Inevitably, the relatively low levels of staffing which these findings imply lead to a stretching of resources. A majority of health and substance misuse workers, for instance, considered that additional professional staff ought to be available to the Yot to meet the health care and drugs needs of the young people with whom they worked.

Furthermore, the fixed-term nature of funding for drug workers has the potential to exacerbate such difficulties. In the first place, if that funding is not renewed, it seems clear that the current level of resourcing from health authorities is insufficient to make up for the short fall in substance misuse expertise available to the Yots, which would inevitably arise. In the more immediate future, a number of staff referred to the impact of short-term funding on their readiness to remain in post without clarification over future job security. Almost half of drug workers reported being in temporary positions, and this proportion

rose to almost 70% of those who were directly employed by the Yot, as opposed to those seconded from another agency.

To maintain current levels of service provision, it will, accordingly, be important that a decision about future funding arrangements for substance misuse workers is made relatively quickly. In the longer term, a comprehensive holistic provision would be enhanced by Yots having a minimum of one health and one education worker – preferably full-time – on each operational site. On the basis of the current findings, that development would appear to require additional resourcing from parent agencies in some areas.

INTEGRATION OF SPECIALIST STAFF WITHIN YOTS

Whatever the concerns over levels of staffing, the picture that emerges of those specialists working within Yots is that they are well integrated into teams' structures. A majority of health (81%) and education workers (70%) are seconded. Drug workers are more likely to be directly employed by the Yot, but the most frequent arrangement for this staff group too was secondment. Yet there is a high degree of staff continuity, and for each of the three groups considered, a large majority had been in post for more than a year, rising, in the case of health workers, to 81%. The relatively low staff turnover – particularly given that most workers have the option of returning to a parent agency – might be thought to suggest that positive working relationships between workers from different specialisms have developed within the teams.

A number of other indicators also suggest relatively high levels of integration. Well over 90% of those responding reported that they attend team meetings – particularly significant, given that that almost one in five works part-time. In addition, a large majority (more than 80%) stated that they regularly attend case discussions. Access to training also reflects a certain assimilation into the work of the Yot, and over three-quarters of each specialist group considered that they were given the same training opportunities as other members of the Yot. At the same time, their specialist status within the team appears to be recognised and most respondents acknowledged that specialist training was also made available to them. Although some reservations were expressed about the adequacy of training provided for the work expected of them, by around one in five specialists, almost all respondents considered that they were adequately qualified and experienced to undertake their role.

Access to Yot case records was almost universally available to specialist staff, again suggesting a high degree of integration, although the flow of information with parent and other external agencies was more problematic.

Inevitably, this positive picture needs to be balanced against a number of expressed concerns. Health and substance misuse workers, in particular, were critical of supervisory arrangements and suggested that, in many cases, no provision was made for clinical supervision and that line managers within the Yot did not have the level of knowledge or expertise to compensate for that absence. Where staff are seconded, this is a matter which might be resolved with the parent agency. For direct employees – primarily substance misuse workers – this is not an option, and Yot managers may wish to consider how else clinical supervision might be provided.

Some respondents also alluded to tensions between the expectations of their parent agency and those of the Yot. On occasion, these tensions revolved around the extent to which

specialist staff should function as generic youth justice workers, an issue addressed in greater detail in due course. There was also a feeling among some staff that the potential for work on issues of health and substance misuse was not always fully appreciated by others within the team, and the benefit which the presence of specialist workers might bring to the youth offending service was not always maximised.

However, health and drug workers, in particular, also raised significant concerns about differences, according to professional background, arising from policies and practices in relation to confidentiality. Some staff took the view that a guarantee of confidentiality was essential to developing a level of trust with young people necessary to engage them in order to address problems of, for instance, mental ill-health or substance misuse. Such concerns were also related to issues around compulsion, and a number of specialist staff were clearly uncomfortable with health-related services being seen as part of a court order. By the same token, difficulties were sometimes associated with the Yots' expectation that intervention ought to be time-limited by the nature and duration of a youth justice programme.

Resolution of some of these tensions may be simply a matter of time. For instance, as other Yot workers develop a greater sense of the range of services and the extent of the expertise that specialist staff can bring to the team they are more likely to make greater use of them. In this context, it is encouraging that a little under half the education workers and a significantly higher proportion of drugs and health workers provide training to other team members. Other tensions may be an inevitable result of combining professionals from a range of backgrounds with associated differences in perspectives, cultures and approaches to engaging with young people presenting difficulties. Greater transparency of the partner agencies as to what they expect from their employees will go some way towards preventing individual members of staff becoming the focus of such tensions. It seems likely that addressing issues such as confidentiality, compulsion and case closure in protocols with parent agencies has some potential for reducing subsequent misunderstandings.

REFERRAL PROCESSES, ASSESSMENT AND THE SPECIALIST NEEDS OF YOUNG PEOPLE

The high level of need among young people was recognised by each of the specialist groups of staff. Over half of those known to the Yot were considered to have problems with health or substance misuse, and two-thirds have difficulties of an educational nature. Given the nature of previous research outlined in the section of this report on the policy background (page 5), the issues most frequently cited as problematic are those that might have been anticipated:

- substance misuse
- alcohol misuse
- smoking
- mental ill health
- family difficulties
- problems with literacy and numeracy
- exclusion and absenteeism
- significant levels of concern were also noted in relation to:
- self-harm or attempted suicide
- sexual health problems
- children with special educational needs
- lack of provision for those of school age

In addition, while use of heroin, cocaine or 'crack' were associated with fewer young people, the incidence was well above that in the general population.

The mechanics of referral of young people to specialist staff appeared to vary, but the majority of professionals reported that the decision would be taken on a case-by-case basis, implying that there is significant scope for making the arrangements more systematic. Around a quarter of health and education representatives indicated that whether or not they saw young people was determined by strict criteria but, for substance misuse workers, this proportion rose to a third. Partly as a consequence, drug workers appeared to be more confident than the other two specialist groups that they saw all young people with relevant problems. This difference might also go some way to explain why substance misuse specialists had a higher caseload (though no doubt this also reflects the extent to which specialist staff are expected to focus upon direct service delivery as opposed to other functions – an issue discussed in more detail in due course).

In terms of their own assessments, a surprisingly high proportion of each group relied on professional discretion as opposed to an assessment tool (20% in the case of health and education workers and 15% of drug specialists). Conversely, the reliance on *Asset* as a sole tool for assessment was lower than might have been anticipated, given its role as the primary assessment mechanism for the youth justice system. A number of staff in each category were critical of *Asset* because they considered that it did not provide sufficiently detailed information for their needs. The imminent introduction by the Youth Justice Board of a systematic screening mechanism for mental health needs will no doubt have a considerable impact upon the assessment practice of health workers. A variety of screening tools specific to substance misuse already exist, and there may be merit in Yots adopting one of these where they are not currently in use. There is currently no universally available screening mechanism to assess educational needs, and this may be an issue which the Youth Justice Board may wish to consider in due course. A broader application of objective specialist assessments might go some way to improving consistency of referral to health, education and drug staff, and to reduce the case-by-case approach to such referral which currently appears to predominate.

Almost all health workers and substance misuse workers offer a variety of forms of intervention to young people with whom the Yot works, primarily in the form of educative provision – although group work also featured highly. The proportion of education staff involved in direct service delivery was lower, at just under three-quarters and, in this case, the most frequent form of intervention offered was on a one-to-one basis.

Specialist staff almost universally reported that they also referred young people to agencies outside the Yot, although, for education representatives, the fact that less than a third of seconded workers made referrals to their seconding agency might be thought relatively low. Each group indicated that there were some difficulties with finding appropriate provision.

Significant obstacles were reported in accessing services for mental ill-health and family problems, both of which factors were noted as affecting a substantial proportion of those with whom the Yot works. In this context, it is significant that less than half of health workers rated their local CAMHs as being good or very good, and 12% considered the service very poor. In particular, the fact that the majority of health workers (over 75%) were from a non-mental health background was thought to make access to CAMHs more

problematic. It is arguable that if separate substance misuse funding is to remain available to the Yots, there may be merit in future health secondments being more closely tied to staff with a mental health expertise.

Educational staff too reported significant difficulties in reintegrating young people into mainstream educational provision or in obtaining funding for those who require specialist placements. Conversely, while one in five drug workers reported a lack of provision for young people with substance misuse problems, and a slightly higher percentage for alcohol misuse, more than half experienced no such difficulties. This may be a reflection of the fact that many of the drug-related issues, which young people exhibit, can be treated within the Yot, by those specialist staff at Tiers 1 and 2 of service provision. That would, in addition, go some way to accounting for the fact that this group of workers appeared to carry a higher caseload than health and education colleagues.

These different experiences of ability to access appropriate external resources, also seems to translate into divergent ratings of the specialist provision available to young people within the youth justice system. Thus, while all staff considered that there was significant scope for improvement, 45% of substance misuse workers considered that drug provision was good or very good. By contrast, only 26% and 17% of health and education workers thought the provision for health care and education, respectively, for children with whom the Yot works, was good or very good. It seems likely that these differences in perspective of the relevant specialist staff reflect, in part, the extent to which they experience difficulties in accessing services external to the team. The level of resources, within the Yot, relative to the need which young people present, might also impact upon these ratings.

Both health and substance misuse workers rated services to ensure continuity of provision on transfer from custody to the community markedly less positively: about 40% of both groups considered such provision to be poor or very poor. Education workers by contrast gave a higher rating on this measure than to the youth justice system as a whole. This was in some respects an unexpected finding, given the rather negative assessment of educational provision within custodial institutions of previous research (Youth Justice Board, 2001b; HMIP, 2001). It may accordingly be significant in this context that education staff were less likely than the other two groups to have visited young people in, or to have had contact with, the secure estate.

In many respects the issues highlighted in this section are resource related – both internal to the Yot and externally. Recent developments, described in the policy background section (page 5) of the report – particularly as regards CAMHs and substance misuse provision – ought to have a positive impact as additional services come on stream. However, the role and function of specialist staff within the Yots might also a bearing the ability of the team to overcome obstacles to locating appropriate external provision. It is to that issue that we now turn.

THE ROLE OF SPECIALIST STAFF WITHIN THE YOT

There appears to be a variety of models employed to determine the role of specialist staff within the Yot. In addition, there appear to be subtle distinctions between the particular specialisms. Job title provides some indication of the type of work that staff might be engaged in. Almost half of health workers might be considered generic health professionals, and as previously noted, a minority had a background in mental health. Education staff too

have job titles which categorise them predominantly as generic education professionals, although more than a quarter are educational welfare officers/ education social workers, and 7% are teachers. Drugs workers by contrast have a much narrower range of job titles, with almost 90% falling into the category of substance misuse specialist. The difference seems likely to reside in the funding arrangements for these particular posts and the, arguably, more defined nature of the specialism.
A more revealing finding derives from asking the three groups to define their role within the Yot. 68% of drug workers and a slightly lower proportion of health representatives considered themselves to be specialists. Less than half of education workers classified themselves in those terms, and the majority considered they were specialists with some generic functions. A further five% of education representatives reported that they were generic youth justice staff. On the face of it, these findings suggest that education professionals are more likely than other specialists to be involved in generic Yot duties. Moreover, there appears to be a marked difference in the attitude of the various staff groups to taking on such work.

There is clearly significant pressure on many specialist staff to become involved in mainstream youth justice work. Health and drug workers were, in the main, resistant to taking on a generic caseload – unless there was rationale for so doing in a particular case. Indeed, this was one of the central concerns arising out of the focus groups. Their objections were based on a number of considerations. They felt insufficiently knowledgeable and had not received adequate training. It undervalued their own expertise and undermined the provision of a specialist service. Finally, a number of staff considered that it had the potential to affect adversely their relationship with the young people referred to them. While some education workers expressed reservations about pressures from the Yot to undertake generic work, they did not as a group appear to have the same concerns as the other specialists. Indeed, nearly all of the small number participating in telephone interviews considered generic work to be an important part of their role.

The analysis of activities undertaken by the three groups of staff confirms that education representatives are indeed more likely to be involved in mainstream youth justice tasks. On a range of indicators – attending police stations, undertaking court duty, taking responsibility for completing *Asset*, writing referral panel reports, writing court reports, being a responsible officer and undertaking breach proceedings – education staff were more likely to be engaged in generic activities than health and drug workers. The breakdown of training received since starting work in the Yot, is also consistent with this general pattern. Educational staff were more likely to have attended training on the use of *Asset*, effective practice, court work and report writing. The majority of drug workers by contrast had undertaken training in the use of motivational interviewing, a technique generally regarded as having a direct relevance to their specialism. Moreover, those education workers who considered themselves to be specialists were less likely to have received training when they first joined the Yot than those who saw the role as involving an element of generic work, suggesting perhaps that training was in some degree dependent on education workers being prepared to undertake non-specialist activities.

Differences between the three groups of staff are to be expected, given the nature of the concerns which their presence within the Yot is designed to address. For example, a significant proportion of health related issues or problems with substance misuse require interventions at Tiers 1 or 2 and, in these circumstances, it seems appropriate for this work

to be undertaken by specialist staff within the Yot, without recourse to an external agency. Most educational problems – with the possible exception of additional input to combat problems associated with low levels of literacy or numeracy – are, by definition, not of this sort. They are more likely to concentrate around the issues of lack of appropriate placement or non-attendance. Addressing these, implies the centrality for education specialists of negotiating with educational providers external to the Yot to encourage reintegration into mainstream provision, rather than specialist intervention within the youth justice system. That, in turn, may require that educational workers, in the Yot, have a certain level of managerial status within their parent agency and are able to broker access to resources. It is not clear that current arrangements are always consistent with such a model.

It is difficult to generalise, and the sample of education workers who participated in the telephone interview included those with practitioner, operational and strategic responsibilities. Nonetheless, the evidence from the current research, given the extent of caseloads and the activities which education staff typically undertake, suggests that many appointments are not at a level which would allow successful negotiation with external providers. Tellingly, one participant in the telephone interviews, quoted earlier in the report, indicated that Yot education officers have no power to influence schools or the education authority. From the opposite perspective, it may be also be significant that less than half of education specialists, for instance, reported being involved in strategic inter-agency planning at a local level.

Of course, the same issue will arise for other specialists where provision is sought outside of the Yot, but to the extent that a higher proportion of health and drug problems can be addressed internally, the difficulty may arise less frequently. The function might be, in other words, less central to the operation of the specialism within the Yot. This is not of course to suggest that obtaining external services for health and substance misuse can be ignored. Yots would clearly benefit from having access to health and education staff with sufficient seniority to ensure that referrals are given the appropriate priority. This however would be additional to the Tier 1 and 2 services which can effectively be delivered in-house.

If it is right that there is less potential for education representatives to undertake specialist casework with young people within the Yot, and, if it is also reasonable to assume that many such staff have been appointed at practitioner level, there will inevitably be pressure for education staff to carry a workload similar to others within the team. That might go some way to explaining the fact that such staff are more involved in generic youth justice activities.

Finally, to the extent that any of the specialist groups is not best placed to negotiate provision with their parent agencies and other specialist providers, the promise of a completely holistic response, deriving from a multi-agency approach, will fail to realise its full potential.

ACKNOWLEDGING SUCCESS

The above reservations notwithstanding, it is important to acknowledge the significant advance that Yots represent over previous arrangements for delivery of health, education and substance misuse services to young people who offend. The rationale for the presence of health and educational specialists at the heart of effective responses to youth crime has become accepted by all the partner agencies, as witnessed by the gradual increase in the

relative contributions for those specialist areas. A range of problems that might have gone unnoticed, and in a larger number of cases would have remained untreated, are increasingly identified at any early stage as the process of assessment has become more sophisticated and permits the involvement of specialist staff within the Yot.

In this context, the focus groups and questionnaires were bound to highlight some of the successes of integrating a range of specialist professionals within the multi-agency bodies tasked with addressing the range of disadvantage and need, which young people in the criminal justice system typically display. In general, these successes fall into one of three broad categories.

First, many staff spoke of the importance of their role in raising awareness among other professionals within the team and other agencies with whom the Yot has regular contact. As one drug worker put it:

I have raised the awareness of the problem of drug use locally, which the local drug project was unaware of. They were not seeing the heroin users and primarily saw the cannabis users, and were unaware of the problems heroin users present to the criminal justice system.

A similar example from education:

Raising the awareness of educational issues affecting young people and adding to their social exclusion – this has included dyslexia awareness training and the introduction of a screening tool; also awareness of basic skills and low literacy training for all Yot staff.

Secondly, a number of staff described the benefits which can accrue to the young people with whom they work.

Engagement with young people, allowing intervention to be constructive and supportive – young people are now referring back to the drug worker for advise on how to reduce their substances. That has to be a sign that the posts are working.

Providing structures and support that isn't time limited to young people who are often chaotic. Providing 'real' information and education to minimise harm. Providing a non-punishing relationship for the young person.

Finally, specialist staff provided evidence of how their presence within the Yot could make a difference in terms of accessing external resources which might not otherwise have been available.

I have been successful in securing placements for seriously disengaged young people and supported them back into education after a considerable period of absence.

Building up relationships within schools – creatively looking at options for young people and getting young people with very bad records on paper into provision where they are achieving and succeeding.

In a way, maximising the potential of the presence of health and educational representation in Yots involves meeting precisely that challenge: creating a framework which can increase

substantially the proportion of young people 'who have very bad records on paper' but who are able to access provision where they are achieving and succeeding.

APPENDIX A: METHODOLOGICAL ISSUES, RESPONSE RATES AND CHARACTERISTICS OF THE SURVEY SAMPLE

YOUTH JUSTICE PLANS

In the original tender, it was anticipated that part of the work would be a search of the Youth Justice Plans as a source of information. In particular these were to be:

- numbers of health and education workers within Yots
- professional backgrounds and employment arrangements
- services provided
- financial contributions from different agencies,
- specific links between Yots and other local health/education-related services

The tender was based on experience in previous years of the format of Youth Justice Plans and the use that had been made of them in previous research. Unfortunately the format of the Plans has changed, particularly the level of detail in relation to staff and their backgrounds. This was largely in response to comments from Yots and those tasked with the compilation of them.

Accordingly the questionnaire was structured to provide the information no longer available from the Plans.

One interesting aspect to emerge from the financial information supplied by the Youth Justice Board is the wide range of percentage contributions across the Yots, summarised in Table 2. It is incomplete, because of the inability to disaggregate the contribution from the Youth Justice Board to individual Yot budgets which is relevant to this study, as opposed to contributions for ISSP for example.

Survey of health, education and substance misuse workers

Initially, a total of 334 questionnaires were emailed or posted during June 2003 to named health and substance misuse workers and Yot managers on behalf of education workers, as the Youth Justice Board did not possess a list of workers in the last category (177 health, 191 drugs and 156 Yot managers). We asked workers to copy questionnaires to colleagues where it was known that they had not received a questionnaire. In the case of Yot managers, we asked them to forward the questionnaires to all education workers in their Yots. Each questionnaire had a unique identity number to ensure that there was no duplication, and also for information for a reminder that was sent out some 3 weeks later. The table below shows the total number sent adjusted to take into account additional questionnaires received from workers in each group[6]. The response rate also takes into

[6] Note that responses on questionnaires returned with duplicate IDs were checked to ensure that these were additional rather than duplicate questionnaires. In the case of education workers, although we asked the people we mailed to notify us of numbers sent out, in many cases this information was not received and therefore it is difficult to estimate the response rate for this group. If the original Youth Justice Board estimate of 280 were taken as the total number of education workers, this would give a response rate of 53%, similar to that for the other two groups.

account Yots which sent a response to state that they currently had no education/health/substance misuse workers (five each for health and substance misuse and four for education). The totals mailed suggest slightly larger numbers of workers in the health and drugs categories than originally anticipated.

Table 57 Response rates to the survey

	Total sent	Total returned	*Response rate (%)*[1]
Health	183	98	*55*
Education	203	147	*74*
Substance misuse	201	103	*53*
All	**587**	**348**	***61***

[1]Taking into account Yots which stated they had no worker in post: these are excluded in the calculation

Although the questionnaires for health and substance misuse workers were mailed directly to these workers, it is interesting to note that the highest number of Yots from which responses were received was for education (93 Yots had at least one worker returning a questionnaire for this group, compared with 78 for health and 75 for substance misuse workers). A number of emails to substance misuse workers were returned, with questionnaires subsequently being posted out: This may go some way towards explaining the relatively low response for this group. We also had comments from some workers in this group that they did not feel that the questionnaire related to them, as they did not see themselves as part of the Yot.

The regional distribution of respondents is shown in Table 60 below.

Table 58 Regional distribution of respondents

Yot region	Type of worker		
	Health	Education	Drugs
East Midlands	5	5	9
Eastern	8	4	8
London	9	12	6
North West	14	17	17
North East	6	8	7
South East	11	14	13
South West	10	9	9
Wales	6	10	10
West Midlands	8	7	8
Yorkshire	20	12	14
Not known	1	3	2
Base n=	*98*	*147*	*103*

Note: percentages are rounded to the nearest whole number

With information lacking on the numbers of education workers mailed, it is not possible to calculate response rates on a regional level for all groups of workers. Table 61 below shows the regional response rates for health and substance misuse workers. It can be seen that responses from substance misuse workers were lowest for London, the South West and the West Midlands; and those from health workers for London and the West Midlands.

Table 59 Regional response rates for health and substance misuse workers

Yot region	Health		Drugs	
	Nos mailed	% response	Nos mailed	% response
East Midlands	7	*71*	12	*75*
Eastern	11	*73*	16	*50*
London	23	*39*	24	*25*
North West	27	*52*	33	*52*
North East	12	*50*	12	*58*
South East	25	*44*	28	*46*
South West	19	*53*	23	*39*
Wales	11	*55*	16	*63*
West Midlands	20	*40*	20	*40*
Yorkshire	28	*71*	17	*82*
All regions	**183**	***54***	**201**	***51***

Note: Excludes responses where regional unknown

In the case of education workers, it is possible to look at responses according to Yots in each region. The highest number of Yots from which responses emanated (in terms of at least one education worker from a Yot sending a response) came from the East and West Midlands, the North West and the South East, with the lowest number of Yots responding again being the London ones.

Characteristics of respondents to survey

The majority of respondents in each group were women, particularly in the health worker group.

Table 60 Gender of respondents

%

	Type of worker		
	Health	Education	Drugs
Male	15	31	34
Female	85	69	66
Base N =	*98*	*147*	*103*

A high proportion of each group was white, although the proportion of respondents from minority ethnic groups was greater for the drugs workers than for other groups. In Great Britain overall, the minority ethnic population in 2001 was 8%, with the proportion for England being 9%[7].

[7] Census 2001, National Statistics

Table 61 Ethnicity of respondents

%

	Type of worker		
	Health	Education	Drugs
White	94	93	89
Black	4	5	4
Asian	0	1	4
Mixed/Other	2	1	3
Base N =	98	143	3

Age varied according to type of worker. The profile of the drugs/substance misuse workers was younger than that for health or education. Health had the greatest proportion of workers aged 35 and above, whereas more than 50% of substance misuse workers were aged below 35.

Table 62 Age of respondents

%

Age band	Type of worker		
	Health	Education	Drugs
18-24	0.0	1.0	5.0
25-34	20.0	25.0	49.0
35-44	54.0	28.0	34.0
45-54	23.0	34.0	10.0
55+	4.0	13.0	2.0
Base N =	*98*	*143*	*100*

Note: percentages are rounded to the nearest whole number.

Focus groups and interviews with health, education and substance misuse workers

Four focus groups were held. The first and largest was with health workers from different Yots in the North East. These had already formed their own forum and one of the members of this kindly arranged a meeting of workers. The second focus group was made up of four substance misuse workers and a Connexions worker who worked with them in the Midlands. The third focus group took place in South Wales and was made up of three substance misuse workers, two health workers, one education worker and a probation officer from two Yots. Strenuous efforts were made to contact London Yots for a focus group there: 33 workers were contacted, five agreed to come and in the end two substance misuse workers eventually arrived. Efforts were made to arrange focus groups in other areas, including the South West, South East and West Yorkshire, particularly of education workers, but, because the majority of these appear to adhere to the school vacation schedule, this proved unsuccessful. The focus groups were thus supplemented by a small number of telephone interviews with workers in Yots in these areas.

APPENDIX B: TABLES NOT INCLUDED IN THE MAIN REPORT

Area of responsibility

Area of responsibility		Type of worker	
	Health	Education	Drugs
	1	5	4
Specialist worker	59	39	68
Specialist but some generic duties	40	56	28
Base n =	*96*	*142*	*102*

Attend team meetings?

		Type of worker	
	Health	Education	Drugs
Yes	97	99	96
No	3	1	4
Base n =	*97*	*142*	*103*

Attend case discussion meetings?

		Type of worker	
	Health	Education	Drugs
Yes	85	89	84
No	15	11	16
Base n =	*95*	*141*	*102*

Involved in preparation of Youth Justice or other plans?

		Type of worker	
	Health	Education	Drugs
Yes	64	67	38
No	36	33	62
Base n =	*97*	*143*	*101*

Were you given training when you started at the Yot?

		Type of worker	
	Health	Education	Drugs
Yes	56	66	62
No	44	34	38
Base n =	*97*	*143*	*101*

Are you given the same training opportunities as other workers?

		Type of worker	
	Health	Education	Drugs
Yes	84	94	75
No	16	6	18
(No response)			7
Base n =	*96*	*144*	*103*

Do you have access to specialist training opportunities?

		Type of worker	
	Health	Education	Drugs
Yes	89	82	88
No	11	18	6
(No response)			6
Base n =	*97*	*142*	*103*

Number of days training in last 12 months

Worker type	Mean	n	Std. Devn.	Missing n
Health	12.2	*93*	13.1	*5*
Education	8.6	*128*	6.6	*19*
Drugs	11.4	*94*	10.9	*9*
All	10.5	*315*	10.3	*33*

Do you provide training to other members of the Yot?

		Type of worker	
	Health	Education	Drugs
Yes	79	44	73
No	21	56	27
Base n =	*97*	*140*	*102*

Do you feel sufficiently qualified to do the work the Yot asks you to do?

		Type of worker	
	Health	Education	Drugs
Yes	93	90	96
No	7	10	4
Base n =	*96*	*143*	*102*

Do you see all or some parents?

		Type of worker	
	Health	Education	Drugs
All parents	3	16	4
Some parents	66	66	75
(No response)	31	18	21
Base n =	*98*	*147*	*103*

If you see all or some parents, do you see them:

		Type of worker	
	Health	Education	Drugs
Whenever possible	54	47	28
Occasionally	22	27	41
Rarely	5	7	6
(No response)	18	20	25
Base n =	*98*	*147*	*103*

Do you have access to Yot case records?

		Type of worker	
	Health	Education	Drugs
Yes	99	99	95
No	1	1	5
Base n =	*98*	*142*	*102*

Do you have access to [health/education] records?

		Type of worker	
	Health (health records)	Education (education records)	Drugs (health records)
Yes	66	84	22
No	31	16	77
Sometimes	3	1	1
Base n =	*95*	*141*	*100*

Do you expect feedback from outside agencies re referrals?

		Type of worker	
	Health	Education	Drugs
Yes	90	95	86
No	10	5	8
(No response)			6
Base n =	*98*	*143*	*103*

Do you receive feedback from outside agencies?

		Type of worker	
	Health	Education	Drugs
Yes, almost always	36	29	40
Yes, not as frequently as I should	51	58	55
No	7	6	5
(No response)	6	7	
Base n =	*98*	*147*	*99*

Does the Yot have [are you aware of] information-sharing protocols with the secure estate?

		Type of worker	
	Health	Education	Drugs
Yes	58	65	51
No	23	14	17
(No response)	18	20	32
Base n =	*98*	*147*	*103*

In what areas would you find it difficult to get assistance for young people and for what reasons?

			Type of worker	
		Health	Education	Drugs
Substance misuse	Lack of provision for this in area	15	7	21
	Waiting times	9	7	11
	Level of demand	7	9	5
	Budgetary restraints	2	3	9
	YOT or other agencies' policies	4	4	3
	Poor relations with relevant agencies	2	1	3
	No difficulties experienced	65	67	63
	(No response)	9	15	8
	Base n =	*98*	*144*	*101*

			Type of worker	
		Health	Education	Drugs
Alcohol misuse	Lack of provision for this in area	17	8	29
	Waiting times	4	4	9
	Level of demand	8	7	6
	Budgetary restraints	1	1	6
	Yot or other agencies' policies	3	3	1
	Poor relations with relevant agencies	2	1	3
	No difficulties experienced	65	65	53
	(No response)	7	18	11
	Base n =	*98*	*147*	*103*

			Type of worker	
		Health	Education	Drugs
Tobacco smoking	Lack of provision for this in area	25	5	18
	Waiting times	0	1	1
	Level of demand	6	3	6
	Budgetary restraints	0	1	1
	YOT or other agencies' policies	0	1	2
	Poor relations with relevant agencies	2	1	1
	No difficulties experienced	57	69	59
	(No response)	11	20	18
	Base n =	*98*	*147*	*103*

			Type of worker	
		Health	Education	Drugs
Mental health problems	Lack of provision for this in area	32	16	20
	Waiting times	56	30	40
	Level of demand	26	17	14
	Budgetary restraints	7	4	3
	YOT or other agencies' policies	11	5	2
	Poor relations with relevant agencies	8	5	7
	No difficulties experienced	26	36	36
	(No response)	4	16	11
	Base n =	*98*	*147*	*103*

			Type of worker	
		Health	Education	Drugs
ADHD	Lack of provision for this in area	21	14	15
	Waiting times	39	23	13
	Level of demand	18	6	4
	Budgetary restraints	2	3	2
	YOT or other agencies' policies	9	5	0
	Poor relations with relevant agencies	4	2	2
	No difficulties experienced	31	35	49
	(No response)	13	22	23
	Base n =	*98*	*147*	*103*

			Type of worker	
		Health	Education	Drugs
Family problems	Lack of provision for this in area	34	19	26
	Waiting times	28	19	11
	Level of demand	22	18	7
	Budgetary restraints	4	8	5
	YOT or other agencies' policies	8	3	3
	Poor relations with relevant agencies	4	4	1
	No difficulties experienced	27	40	43
	(No response)	12	19	20
	Base n =	*98*	*147*	*103*

			Type of worker	
		Health	Education	Drugs
Bereavement	Lack of provision for this in area	36	16	28
	Waiting times	12	8	7
	Level of demand	6	8	2
	Budgetary restraints	2	0	2
	YOT or other agencies' policies	0	1	0
	Poor relations with relevant agencies	2	2	4
	No difficulties experienced	42	50	49
	(No response)	12	22	17
	Base n =	*98*	*147*	*103*

			Type of worker	
		Health	Education	Drugs
Have attempted suicide or self-harm	Lack of provision for this in area	28	14	18
	Waiting times	33	15	12
	Level of demand	19	8	8
	Budgetary restraints	1	1	2
	YOT or other agencies' policies	7	2	0
	Poor relations with relevant agencies	5	1	3
	No difficulties experienced	40	48	52
	(No response)	7	25	17
	Base n =	*98*	*147*	*103*

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