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New responses to vulnerable children in trouble: improving youth justice

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Introduction

This briefing paper considers emerging opportunities to develop better approaches and services for children and young people in contact with the youth justice system who have complex health needs and vulnerabilities. The paper will firstly examine the parameters used to assess the health and well-being needs of children and young people in trouble with the law, the scale of the challenge and how such needs impact on the risk of offending and on individual capacity to participate in criminal justice system processes. It will then go on to consider the importance of the government's response to *The Bradley Report*¹ and the importance of the government's strategy in *Healthy Children, Safer Communities*² to promote the health and well-being of children and young people in contact with the youth justice system in England, before examining how some of the main changes envisaged by *Healthy Children, Safer Communities* can be implemented.³ Accordingly, the paper will be of particular interest to professionals who work within youth justice and crime prevention systems as they develop a new focus on the health and well-being of children and young people. It will also be of benefit to organisations providing new services as the coalition government's reforms are rolled out.

The provision of a youth criminal justice system for children and young people that is distinct from that provided for adults is congruent with international children's rights agendas and acknowledges that children and young people are particularly vulnerable, requiring special arrangements for safeguarding their well-being. It is also important given that the majority of 'offending careers' actually begin in childhood or adolescence and that the peak age for (known) offending occurs around the period of transition between childhood and adulthood (which, in statutory terms, is around the time of reaching the age of 18). However, whilst it is widely accepted that children and young people who get into trouble with the law are predominantly those who experience or exhibit disadvantages or stresses that correlate with a risk of offending, including family, educational and environmental factors,⁴ until more recently research into the existence of health-related factors was more limited. By way of illustration, the Lord Chief Justice, in his description in 1997 of the typical (young) offender, largely neglected health and mental capacity issues:

"To speak of "the typical offender" is, plainly, to generalise. But research findings confirm what many practitioners from their own experience would assert, that the personal profile of the typical offender can be drawn with considerable accuracy and particularity. He is usually male, and often of low intelligence, and addicted to drugs or alcohol, frequently from an early age. His family history will often include parental conflict and separation; a lack of parental supervision; harsh or erratic discipline; and evidence of emotional, physical or sexual abuse. At school he will have achieved no qualification of any kind, and will probably have been aggressive and troublesome, often leading to his expulsion or to truancy. The background will be one of poverty, poor housing, instability, association with delinquent peers and unemployment."⁵

Lord Bingham's description is essentially that of the 'typical offender' in childhood and adolescence (albeit with social justice language notable by its comparative

absence) and has retained its validity in the intervening years. However, there has been a growing body of research in recent years which has shed more light on factors that closely relate to the health and well-being of vulnerable children and young people at risk of offending. These factors include mental health problems, learning disabilities, learning difficulties, substance use problems and, often, speech, language and communication needs. Indeed, there is a growing research base which indicates that a majority of children and young people in the youth justice system exhibit needs arising from the presence of such risk factors.

The health and well-being needs of children and young people in trouble

Whilst the strategy in *Healthy Children, Safer Communities* builds upon *The Bradley Report* – a review of people with mental health problems and learning disabilities in the criminal justice system – *Healthy Children, Safer Communities* does not focus solely (or even predominantly) on diagnosable mental health problems and learning disabilities, but adopts a much wider view of the health and well-being of children and young people in trouble, taking account of various and complex factors that relate to ‘vulnerability’. Indeed the importance of *Healthy Children, Safer Communities* lies in its vision of more comprehensive provision for the health and well-being needs of children and young people in order to reduce the risk of reoffending. It describes all children and young people in trouble as vulnerable – a development which, potentially, could transform the youth justice system, helping to counter the negative perceptions and attitudes that have prevailed around health in youth justice in recent years.

The importance of clear parameters

The health and well-being needs of children and young people, if left unaddressed, can place them at risk of more adverse outcomes in the youth justice system. Many children and young people with a learning disability and/or a learning difficulty will have problems in understanding systems and participating in planning and decision making. In some cases, there will also be a heightened risk of custody, poor presentation in courtrooms, inadequate levels of compliance with bail or community sentence requirements and an associated risk of breach proceedings. The ‘scaled approach’ can further disadvantage some vulnerable children and young people.⁶ In addition, the quality of pre-sentence reports has often been found to be poor in some areas of the country which can deny the courts access to appropriate information on a child or young person’s health prior to decision making.⁷ Furthermore, the right to a fair trial can be compromised where a child or young person’s needs have not been identified. (For a more detailed discussion of mental capacity and fair trial, see Nacro’s briefing, *Mental Capacity and Related Issues in the Youth Court*⁸ and Prison Reform Trust’s publication, *Vulnerable Defendants in the Criminal Courts*.⁹)

Children and young people with speech, language and communication difficulties are also at risk of being unable to fully understand, and therefore comply with, enforceable requirements and programmes of work undertaken by their youth offending team (YOT). Speech, language and communication difficulties are

sometimes associated with (or result from) mental illness, a learning disability or a learning difficulty. As a result of an increase in awareness of such needs over the last few years, some YOTs provide, or have access to, specialist services and therapists. Helpful guidance is also available on the Youth Justice Board's website, along with publications from organisations such as the Royal College of Speech and Language Therapists and The Communication Trust (such as *The Speech, Language and Communication Framework, Every Child Understood* and, for a particular focus on the youth justice system, *Sentence Trouble*).¹⁰ It may be that more than half of children and young people in contact with the youth justice system have speech, language and/or communication needs.¹¹

The Bradley Report noted there were difficulties in defining health problems in the context of youth justice, and practitioners have long tended to avoid using health-related pathways (especially mental health ones) whenever possible. The situation is not helped by the confusion that exists around the definition of many conditions. Some terms have become almost obsolete, some are mainly used only in connection with statute (eg, 'mentally disordered'), some overlap and with others there is a variation in the intended meaning according to whether the discipline is professional or academic. It is imperative, however, that a common language and understanding is developed across relevant agencies and different professions in order to facilitate more effective working between different parties.

Healthy Children, Safer Communities helpfully sets out a number of critical definitions and terms which provide a framework for better joint understanding. It focuses on the term 'well-being' (as opposed to 'welfare' or 'best interests'). This springs from the World Health Organisation's definition of health (a very broad and positive one, and one which *Healthy Children, Safer Communities* adopts) as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. Any discussion about health will therefore encompass drug and alcohol misuse and mental health, as well as physical health more generally.

'Mental health' (again *Healthy Children, Safer Communities* adopts the meaning attributed by the World Health Organisation) is defined as: 'a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community'.

In relation to 'learning disability', *Healthy Children, Safer Communities* adopts the Department of Health's definition, namely:

- a significantly reduced ability to understand complex information or learn new skills (impaired intelligence) with
- a reduced ability to cope independently (impaired social functioning) and
- a condition which started before adulthood (18 years of age) and which has a lasting effect.

In relation to 'learning difficulty' *Healthy Children, Safer Communities* uses the definition contained in the *Education Act 1996* of a child who has significantly greater difficulty in learning than the majority of children of the same age or a disability which

either prevents or hinders him or her from making use of educational facilities of a kind generally provided for children of the same age in schools within the area of the local authority.

According to *Healthy Children, Safer Communities*, all children and young people in contact with the youth justice system are vulnerable and it is important to understand what they mean by this. They define vulnerability in the following way:

‘We use the term in the wider sense in which it is used in the *National Children and Adolescent Mental Health Services Review*¹² and *Targeted Youth Support*,¹³ to include those who experience multiple and complex problems which restrict their life chances and need extra attention to improve their well-being. We use it for children and young people in (or at risk of) contact with the youth justice system. This differs from the narrow sense in which the term is used in the youth justice system – to help determine whether a child can cope in a young offender institution.’

Instilling this broader and important definition of vulnerability throughout agencies and systems will not be easy, particularly where young offenders are considered undeserving. If applied across the youth justice system, however, it would help to conclude the much debated issue of whether children and young people in serious trouble should be viewed as ‘children in need’ in the spirit of the *Children Act 1989*. Moreover, given the duties on mainstream services under the *Children Act 2004*, a clear acceptance that such children are in need would support the objective of ensuring that mainstream services have the primary responsibility in the youth justice system for safeguarding (as well as for preventing offending).

One of the fundamental challenges in making a reality of the vision in *Healthy Children, Safer Communities* is ensuring there are effective arrangements in place for inter-agency work. In order for this to happen, it is imperative that there is also a common understanding in place of the definition of the client by age or by stage of human development. *Healthy Children, Safer Communities* adopts international children’s rights standards and thus defines a child as someone under the age of 18. For the purposes of the youth justice system, the age of criminal responsibility forms the entry point, thus the child or young person in the youth justice system is, formally, between 10 and 17 years of age (inclusive). A child is also defined as being a person below the age of 18 by the *Children Act 1989*. However, in the *Children and Young Persons Act 1969* a child is under the age of 14 and a ‘young person’ is a person aged 14 to 17 (and only to 16 years old for certain purposes).

In the police station, the key term used is ‘juvenile’, meaning a person up to the age of 16 (those aged 17 are dealt with as adults in the police station and for the purposes of bail/remand). Furthermore, for those receiving services associated with, or under the provisions of, the *Mental Health Act 1983* (as amended by the *Mental Health Act 2007*) the legislation does not clearly distinguish between individuals by age and makes no specific distinction for children and young people other than in the associated *Codes of Practice* (which require, for example, children under the age of 16 to be in mental health facilities which are separate from those for adults). In addition, the provisions of the *Mental Capacity Act 2005* do not apply to those below the age of 16.

The relationship between the *Mental Health Act 1983*, the *Mental Capacity Act 2005* and the *Children Act 1989* (which, as stated earlier, defines a child as anyone under the age of 18) particularly regarding detention is far from clear. For example, the question of whether to make use of police protective detention under mental health legislation (eg, s136 *Mental Health Act 1983*) or under the *Children Act 1989* is difficult to resolve, with the potential for considerable inconsistency and considerably different outcomes. Similarly, regarding the use of detention, there is a lack of guidance and case law to define the relative merits of firstly, detention or admission to hospital under one of the relevant sections of the *Mental Health Act 1983* or secondly, detention in secure accommodation under s25 *Children Act 1989*.

Practitioners' attempts to avoid stigmatising the child or young person have often resulted in a tendency to favour welfare pathways over mental health pathways. This may indeed be the preferred route when possible but, in some cases, it can store up problems for young people in accessing mental health assessments and services upon reaching the age of 18. For children and young people in trouble with the law, it is often the case that the least favourable criminal route (ie, custodial remands and sentences) represents the line of least resistance and least local cost.

The term 'young adult' is also not clearly defined, and not at all in statute. Normally, this is a person who has reached the age of 18 (some use the term from the age of 16 but this undermines the status of child or young person). The upper age for a young adult is not agreed and is variably considered to be 20 or 21 (as might be the case in a young offender institution) or up to 24 or 25 (as might be the case under legislation relating to leaving care, for example).

The term 'adolescent' is also commonly used in youth work and health services and often linked to the 'child' as in 'child and adolescent psychiatric services' yet the adolescent age range is not well defined, allowing for variations by age and gender in maturation and emotional development periods.

Whilst it is possible to become familiar with the use and meaning of all these different terms, they also serve to illustrate some unhelpful anomalies and tensions which can arise between different pathways and strands of law.

The scale of the challenge

A number of recent research reports and studies have focused on the health and well-being needs of children and young people in contact with the youth justice system. *Healthy Children, Safer Communities* outlined 'the scale of the challenge' in this area citing that:

- over three quarters have serious difficulties with literacy and numeracy (in custody)¹⁴
- over a third has a diagnosed mental health disorder (in custody)¹⁵
- over a quarter has a learning disability (in custody and in the community).¹⁶

Other findings also confirm the emerging picture of the extent of related problems and needs:

- Of those young people who are not in education, employment or training, 38% have complex needs (including special educational needs) that must be met before they are able to progress on to education, employment or training.¹⁷
- From August 2008 to July 2009, 39% of young people entering custody were performing at below level 1 in literacy and 64% were performing at below level 1 in numeracy.¹⁸
- Another study found two thirds of young people in the criminal justice system left school with no qualifications or not knowing what qualifications they had. By way of comparison, just 6% of all school leavers in 2003 had no graded GCSEs.¹⁹
- Of children in custody, research showed 85% had signs of personality disorder and 10% had signs of a psychotic illness.²⁰
- Girls in custody have higher levels of mental health problems, with 86% of 17-year-old girls having some level of psychiatric disturbance.²¹
- Twenty-nine children have died in custody since 1990, most by self-inflicted death and one by restraint.²²
- Of school-age children in custody, over a quarter have the literacy and numeracy levels of an average seven year old.²³
- Young women under 18 are twice as likely to self-harm as adult women (in custody). In 2007, 89% of under 18s harmed themselves.²⁴
- The number of children assessed (under remand legislation) as vulnerable in custody was 1,148 in 2007.²⁵
- Of children in the youth justice system (not just those in custody) one study found that one in five had a learning disability.²⁶
- Of children in the youth justice system, a study found that three quarters had speech and communication problems.²⁷

Despite the surge in research on the health and well-being needs of children in the youth justice system, there remain gaps. In particular, more research would be beneficial in relation to certain groups which are over-represented in the youth justice system (such as looked after children and black and minority ethnic groups) and the extent of their vulnerability and the nature of the problems they experience.

Turning over a new leaf for children in trouble?

The vision for youth justice set out in *Healthy Children, Safer Communities* provides an opportunity to develop a system that views children and young people in trouble as children first and offenders second. It has children's human rights at its heart and re-engages mainstream services in youth justice services, providing for children's needs in order to reduce offending. This section describes how *Healthy Children, Safer Communities* came about, the main sets of principles which underpin it and how best to harness mainstream services to implement its vision.

The Bradley Report – setting children apart

There has been a surge of interest and policy development aimed at ensuring that more vulnerable children and young people in the youth justice system and their

needs are dealt with in a more appropriate way. One of the main catalysts for the subsequent emergence of *Healthy Children, Safer Communities* was the publication, in April 2009, of *The Bradley Report*.²⁸ This review of people with mental health problems or learning disabilities in the criminal justice system set out recommendations aimed at improving and increasing the diversion of offenders from prison and providing court diversion and liaison services which are effectively supported. In fact, *The Bradley Report* addressed issues, and made recommendations, that spanned the entire offender pathway: from early intervention, antisocial behaviour orders, arrest, diversion and prosecution to trial, remand, community sentences, custody and resettlement. Lord Bradley's recommendations or, at the very least, his direction of travel were generally accepted by the then Labour government, and the Department of Health's strategic delivery plan was detailed in *Supporting Health, Improving Justice: The national delivery plan of the Health and Criminal Justice Programme Board*.²⁹

Initially, Lord Bradley had intended to include children and young people in the remit of his report. However, apart from a few specific issues and recommendations, it emerged with a strong focus on the adult system. Lord Bradley explained that he had not been able to include children as a key element in the overall population in contact with the criminal justice system citing the following reason: 'As the review progressed, it became clear to me that there are some key differences that set the population of children and young people apart, and this built a strong case for not including them as part of my review.'

Nevertheless, in recommending a separately commissioned review, Lord Bradley stressed that diversion of children and young people is 'probably the area that provides the best opportunity for diversion in its broadest sense' by influencing young people away from 'an adulthood of crime'. He noted the distinct differences between the adult and youth justice systems and the difficulties of defining, or even identifying, some health problems in the case of children and young people, stating: 'Mental health needs in children often do not manifest clearly as mental illness but in ways that are less readily defined.'

This difficulty is now widely accepted, although a remedy is not. The often overlapping definitions of 'mental disorder', 'mental health', 'learning disability' and 'learning difficulty' are not easy to negotiate. Moreover, it is issues of capacity and maturity that are of particular relevance to children and young people in a formal criminal justice system, which are hampered by a low age of criminal responsibility and the absence of the sort of protection that had, until 2000, been provided by the doctrine of *doli incapax*.³⁰

Healthy Children, Safer Communities

The recommendation for a separate commissioned review was not followed. However, the government promised and delivered *Healthy Children, Safer Communities* as a separate strategy for children and young people. It was widely welcomed and sets out policies and approaches that are more child friendly than those presently in place.³¹ Importantly, although it does deal with mental health problems and other specific vulnerabilities, it is sufficiently broad in context for the main principles of the strategy to apply to all children and young people in trouble.

Indeed, it provides a blueprint that could, if properly and fully implemented, transform the youth justice system, making it more effective in reducing offending and mitigating the harmful effects of criminalisation on children and young people. It could also significantly reduce overall costs so long as reductions in the expensive use of custody are achieved as envisaged.

A strong set of principles underpins *Healthy Children, Safer Communities*. In particular, it puts the *United Nations Convention on the Rights of the Child* at its core, supported by the *Children Act 1989*, the *Children Act 2004* and the *Human Rights Act 1998*. This makes the strategy unique in the context of youth justice and, if it were implemented, it would begin to satisfy the recommendations made by the United Nations Committee on the Rights of the Child in its periodic reports on children's rights in the UK, the most recent one being in 2008.³² Based on the key principles, *Healthy Children, Safer Communities* describes services for all children in contact with the youth justice system that:

- treat these young people as children who are entitled to the services that are available to their peers in the community
- recognise that these children will often require enhanced support and tailored responses in order to achieve equivalence with their peers and increase their chances of achieving good outcomes
- are based on early and holistic assessment of their individual needs
- take full account of their individual vulnerabilities, related to their age, gender, ethnic/cultural background, previous life experiences, current situation and any disability
- properly address problems arising from experiences of discrimination, harassment and bullying based on their sexual orientation, religion/belief, ethnicity or disability or arising for any other reason
- ensure proper attention is paid to safeguarding young people at risk of, or experiencing, significant harm through abuse or neglect
- establish for each child a trusted relationship with at least one key adult
- make full use of the range of agencies and organisations providing local services, to ensure due attention is given to needs that are linked to social relationships, self-care, education and learning, and skills development
- encourage the engagement of young people and their families by involving them in designing and evaluating the services that are on offer, the way they are delivered, and their accessibility and relevance, and
- are available long term, where necessary, and help support young people as they negotiate key transitions between childhood and adulthood and between different services and placements.

The strategy in *Healthy Children, Safer Communities* presents seven key objectives:

- Intervene early to address emerging health and well-being needs and prevent offending.
- Ensure children throughout the youth justice system pathway access universal, targeted and specialist services that are used by all children.
- Underpin interventions with holistic assessments.

- Acknowledge the importance of supportive family relationships and a strong sense of belonging in the community.
- Achieve a co-ordinated approach to improving health and well-being.
- Provide services that make a difference.
- Ensure high-quality provision and improved outcomes for children, young people, families and communities.

The key to applying these principles and achieving the objectives is engaging mainstream services.

Harnessing mainstream services

Although *The Bradley Report* did not focus on children and young people, it did contain three recommendations, primarily to do with awareness training for professionals concerning the identification of mental health-related problems at an early stage. *Healthy Children, Safer Communities* takes this theme further, particularly in the context of ensuring early intervention and diversion, and then goes on to link early intervention and diversion to the harnessing of mainstream children's services – including health and welfare services. Its vision is of holistic screening and assessment at an early stage, leading to services which are within the *Every Child Matters* framework. This would see, where necessary, a multi-agency team around the child (and family) co-ordinated by a suitable lead professional who has a key and lasting relationship with the child or young person. As well as delivering the statutory aim of the youth justice system to prevent reoffending, *Healthy Children, Safer Communities* states there should also be a strong focus on safeguarding and meeting the needs of the vulnerable.

Achieving consistent, good quality, holistic assessment is currently hampered by the confusing use of a plethora of different assessment tools and approaches. It is not only professionals of different disciplines and in different settings who must deal with the inconsistency of assessment tools. Children and young people may also experience a considerable number of assessment processes in succession. They may encounter:

- the Common Assessment Framework
- ASSET (which focuses on factors relating to the risk of offending)
- ONSET (used mainly in relation to the early prevention of offending)
- various custodial screening and assessment tools
- specialised mental health assessment tools (some not covering assessment for a learning disability, conduct disorder or speech, language and communication needs)
- specialist tools used by child and adolescent mental health services (CAMHS)
- tools used in education, social care and substance misuse.

It can be seen, therefore, that in youth justice, assessment tends to focus on offending-related factors. Consequently, physical health problems are sometimes overlooked and mental health problems and learning disabilities often underestimated.

At present, ASSET is under review and it is hoped that youth justice tools may become more closely aligned with the Common Assessment Framework as a result. Meanwhile, the Centre for Mental Health is piloting youth liaison and diversion teams aimed at identifying best practice in screening and assessment at an early stage, so that the information can then inform decision making at the point of arrest, at the point of prosecution and during court proceedings.

With regard to mainstream services taking a prominent role in meeting the needs of children and young people in trouble, *Healthy Children, Safer Communities* makes clear that the key task for the lead professional is to provide for any continuing need, including during the period of transition to adulthood where necessary. It also makes clear the role of the YOT in relation to the rest of the team around the child: 'The lead professional role will not normally be undertaken by a YOT worker and, where it is, it will be with the support of mainstream services.'

The change in approach that this signals marks a potentially significant shift from the currently unhelpful separation of responses to children who offend from responses to other children in need. This separation results partly from the existence of different strands of law (criminal justice, welfare/safeguarding and health in particular).

Nevertheless, the difficulty for young offenders of gaining access to mainstream services constitutes a barrier to this change in approach. The provision of health (and other specialist) workers in YOTs was intended to assist in securing access to services from parent agencies and other agencies. But there is inconsistency in the models employed by YOTs, with some working collaboratively across different disciplines, whilst others have no health or CAMHS secondees in place at all. Prison Reform Trust's report, *Seen and Heard*, provides evidence and recommendations regarding the role of health workers in YOTs (as well as presenting critical evidence about the quality of screening and assessments for vulnerable children and young people).³³

Another barrier to this change is that, in times of budgetary restraint, mainstream services tend to adjust their service thresholds, limiting services to those most in need. In many cases children and young people experience multiple problems and disadvantages (as *Healthy Children, Safer Communities* indeed recognises) any one of which taken on its own may not be sufficient to reach a service threshold. Yet it is the totality of problems and needs taken together which represent an overwhelming and disabling whole. Working together, under an *Every Child Matters* framework, local authority children's services, health services, housing, education and youth work agencies must overcome the barrier of 'silos' and service thresholds in order to support vulnerable children, young people and their families properly (as well as developing specialist services such as family intervention projects). Their duties to work together to promote children's well-being are enshrined in statute under the *Children Act 1984*.

On the face of it, the statutory basis underpinning YOTs is not in harmony with the idea of harnessing mainstream services in youth justice: the clear and singular statutory aim of the youth justice system is to prevent offending, as provided for by s37 of the *Crime and Disorder Act 1998*: 'It shall be the principal aim of the youth justice

system to prevent offending by children and young persons. In addition to any other duty to which they are subject, it shall be the duty of all persons and bodies carrying out functions in relation to the youth justice system to have regard to that aim.’ This aim has been strongly adhered to in youth justice and powerfully promoted by the Youth Justice Board throughout its history – arguably to the neglect of giving other duties sufficient attention. *Healthy Children, Safer Communities* redresses the balance between what might be perceived as competing duties and principles. As already mentioned, it bases its vision on a children’s human rights framework and the *Every Child Matters* agenda. Thus, on the one hand it seeks to make the statutory aim more of a corporate duty with one of its two main themes being ‘Harnessing mainstream services to reduce offending and reoffending’. On the other hand, it seeks to balance the aim of preventing offending with duties to promote health and well-being in the youth justice system by ‘ensuring children throughout the youth justice system pathway access universal, targeted and specialist services that are used by all children’.

A further barrier to the implementation of the strategy in *Healthy Children, Safer Communities* is the stigma that children, young people and their families fear they will encounter if they acknowledge they have a ‘mental health’ issue or learning difficulty. Along with that comes sometimes an unwillingness to access services which are hard to engage with (or vice versa). A key way of overcoming such barriers is ensuring the active participation of service users in designing and delivering services, with determined action to make those services attractive to children and young people. As noted by the Standing Committee for Youth Justice, increasing the participation of service users in order to help make services more attractive is a matter which could have been given greater attention in *Healthy Children, Safer Communities*.³⁴

Finally, it should be noted that, although welcome and full of potential, *Healthy Children, Safer Communities* has received some criticism on the grounds that it holds with the emphasis on ‘intervention’ that has been a feature of the youth justice, antisocial behaviour and prevention systems since the reforms heralded by the *Crime and Disorder Act 1998*. This is not to suggest that there should not be intervention, but rather that informality is also an important notion along with the principle of only intervening when necessary and to the minimum degree that is appropriate. This principle is inherent in the *United Nations Convention on the Rights of the Child* and related guidance, rules and treaties, and is also one of the primary principles in the *Children Act 1989* (namely, that a court should make an order only if that is better for the child than making no order).

Implementing change in a new political landscape

At the time of writing, the (new) government has continued to indicate some commitment to the approaches set out in *The Bradley Report* and *Healthy Children, Safer Communities*. The Green Paper, *Breaking the Cycle*,³⁵ includes commitments to support the Department of Health’s agenda to divert those with mental illness and drug dependency away from custody and to develop liaison and diversion services:

‘Lord Bradley’s report on improving mental health outcomes for offenders proposed rolling out a national liaison and diversion service by 2014. We believe this is the right approach and is in line with the reforms set out in the Department of Health’s White Paper *Equity and Excellence*.³⁶ This includes an aim to improve access to services particularly for those with long-term conditions, including mental health problems. The Department of Health, Ministry of Justice and Home Office, working with the National Health Service which has funding and commissioning responsibility, will identify a number of pilot projects that will help shape best practice, quantify the benefits and develop appropriate quality standards. This will include young people. We will aim to complete this work by 2012 and subject to an assessment of the success of the projects, roll out a national implementation programme.’

The Green Paper indicates further progress in line with *Healthy Children, Safer Communities*, including increasing the diversion of children and young people to mental health and other services:

‘The police, working in partnership with other local agencies, will have more freedom to determine the most appropriate response, depending on the severity of the offence and the circumstances of the young offender. This could involve reparation or interventions such as a referral to mental health provision to tackle offending behaviour.’

The payment-by-results agenda of the coalition government, together with the ‘incentivising’ of local authorities to work effectively and invest in services related to youth justice might result in a shift towards mainstreaming youth justice services. In particular, the prospect of local authorities bearing the cost of custody and detention could be a driver for implementation of much of the vision contained in *Healthy Children, Safer Communities* – which would be likely to reduce the use of custody overall. On the other hand, perhaps the most significant risk to implementation of *Healthy Children, Safer Communities* will be a drift into ‘justice by geography’ as each area is given increased flexibility and freedom in commissioning services based on results rather than processes.

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- 2 Department of Health, Department for Children, Schools and Families, Ministry of Justice and the Home Office (2009) *Healthy Children, Safer Communities* available at www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_109772.pdf (accessed 21 December 2010)
- 3 Health is a devolved responsibility in Wales.
- 4 For an introduction to risk factors (and protective factors) and related issues, see Kemshall H (2008) 'Risk factors' in: Goldson B (ed) *Dictionary of Youth Justice* Cullompton: Willan Publishing.
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