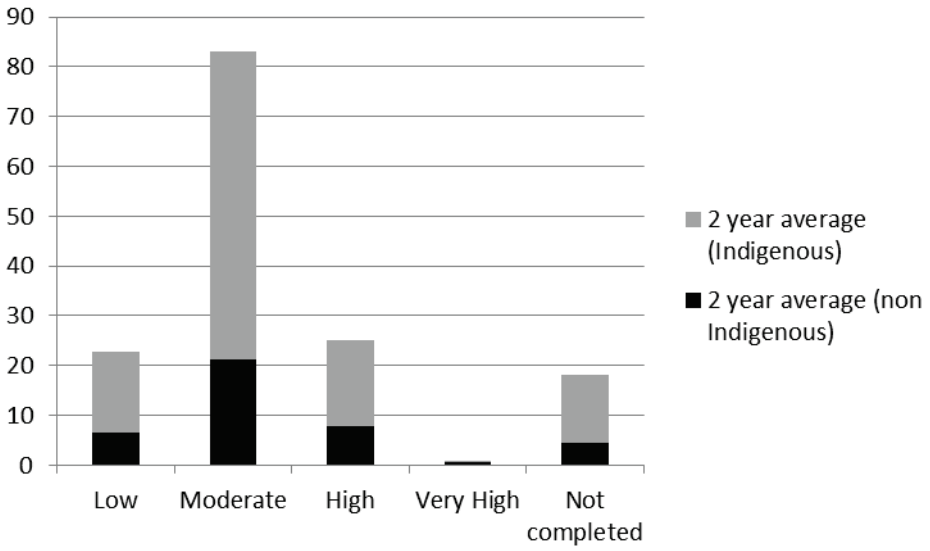
Summary of key data: Townsville Youth Justice Service Centre

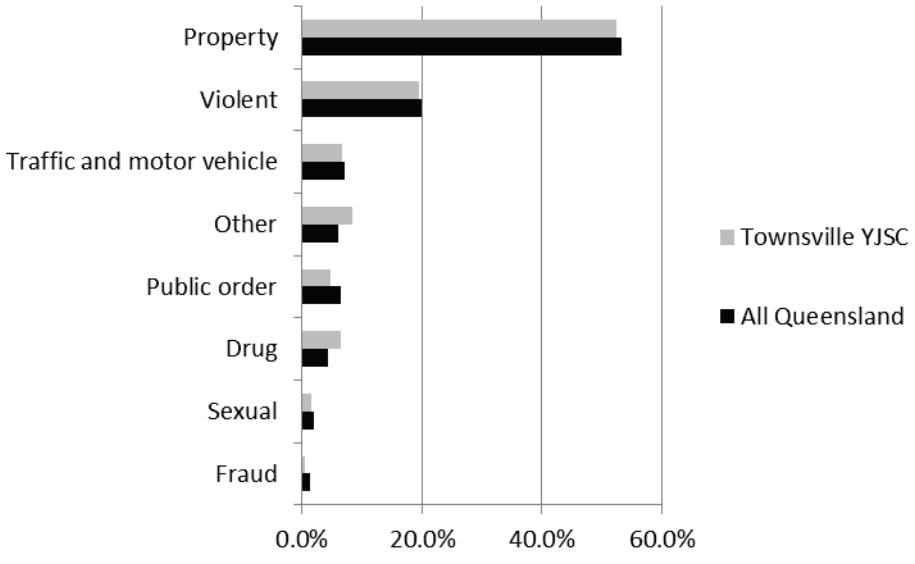
Admissions to orders, Townsville YJSC, 2011-12

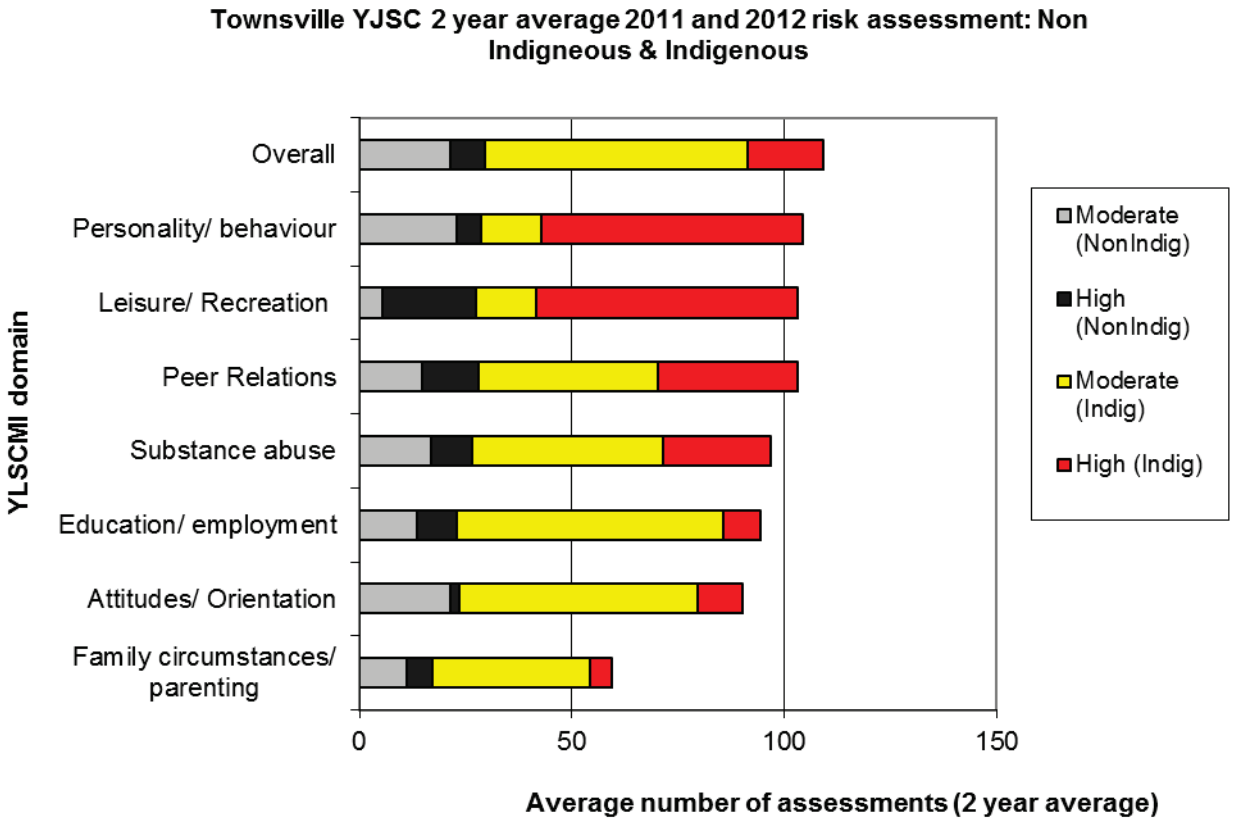
Order type	Number of orders	Proportion of Queensland total	Distinct young people	Average orders per young person	Average orders per young person: all QLD
CSO	53	6.3%	43	1.23	1.21
CRO	16	6.4%	15	1.07	1.07
Detention	25	7.7%	17	1.47	1.45
Probation	125	10.4%	125	1.15	1.23
SRO	12	5.5%	9	1.33	1.32

Overall risk level for Townsville YJSC – 2 year average of 6 month periods



Proportion of the most serious proven offences for distinct young offenders, 1 July 2012 to 31 March 2013: Townsville YJSC and State-wide average





Family

64% of young people assessed in the first three quarters of 2012-13 have one or more issue relating to family and parents (the state-wide average is 72%).[1]

Mental Health

The proportion of risk assessed young offenders assessed with characteristics consistent with the five selected mental health conditions, Quarter 1-Quarter 3 of 2012-13

- One or more identifiable mental health issue:81% (state-wide average 80%)
- Two or more identifiable mental health issue: 52% (state-wide average 60%)
- Conduct disorder: 61% (state-wide average 59%)
- Substance misuse disorder: 49% (state-wide average 62%)

[1] Scoring for the family domain is not sensitive enough for Youth Justice Clients. Conversely the scoring for leisure and recreation is considered too sensitive and is interpreted with caution.

Quality Standards for Youth Inclusion and Support Panels

www.youth-justice-board.gov.uk

Contents

Introduction

Principal aim of a Youth Inclusion and Support Panel

The principal aim of a Youth Inclusion and Support Panel (YISP) is to reduce and prevent the involvement of children and young people aged 8 to 13 years in offending or anti-social behaviour.[1] It seeks to achieve this by using multi-agency planning to help these children and young people to better access mainstream and statutory services.

Core principles

Voluntary engagement

The YISP ensures that any child or young person referred to it only participates after their full, informed consent, and that of their parent or carer has been obtained, and that this is given on an entirely voluntary basis. Participants have the right to withdraw from the YISP at any point without prejudice (i.e. he or she could re-engage at a later, perhaps more appropriate time in their lives).

Targeting

The YISP ensures that it focuses its work on children and young people aged 8 to 13 years who are identified by two or more partner agencies, and/or parents or carers, as being those who are:

- most at risk of involvement in offending and/or anti-social behaviour
- behaving in ways that require a multi-agency response.

Empowerment

The YISP is committed to involving children, young people and families in planning YISP interventions and participating in all aspects of programme delivery. This is shown through policies and standards being in place that foster participation on an equal opportunity basis and that are proportional to age and maturity.

Welfare of children and young people participating in the YISP

The YISP recognises the paramount importance of the needs of the child or young person. It is committed to safeguarding the health and well-being of those engaged in YISP activities at all times, and to steering them away from the dangers of crime.

Assessment

All YISP interventions are based on assessment of the child or young person's needs, in line with the forthcoming Common Assessment Framework Guidance and informed by knowledge of the risk and protective factors associated with involvement in offending and anti-social behaviour. Effective assessment requires the establishment of a strong information-sharing protocol between YISP partner agencies.

[1] This is the core age group: YISPs can however choose to extend the age range above or below these limits.

Measuring impact

The YISP gathers information that demonstrates the impact of its provision on the lives of the children, young people and neighbourhood it serves. It uses this data to set clear and specific objectives that relate to the five key outcomes for children (see below) and demonstrate a reduction on offending and exclusion.

Effective practice

The YISP learns from 'what works' research into targeted prevention, and integrates this effective practice into its development through guidance updates, training and evaluation.

Mainstream services

A focus of every YISP intervention is improved access to mainstream and statutory services.

Key Outcomes for Children and Young People

YISPs should assist youth offending teams (YOTs) in their aim of reducing, year on year, the number of children and young people entering the criminal justice system.

All the interventions they deliver should also make a contribution to the five Key Outcomes outlined in *Every Child Matters: Change for Children*. This will have the greatest impact when programmes also engage with parents or carers, and provide activities and interventions that support and enhance good parenting practice. With this age group, it is also important to recognise that learning and development occur through activities that offer participants play and fun.

The table below gives examples of how YISPs can contribute to the five Key Outcomes.

Key outcome area	Role of the YISP
Be healthy	▪ Provide access to physical activities and promote healthy lifestyles ▪ Provide or access education and support services for prevention and treatment of drug and alcohol misuse ▪ Support parents or carers to ensure that children are healthy ▪ Provide or gain access to individual and group support aimed at improving and maintaining mental health ▪ Promote sexual health through education and ensure access to appropriate services where needed, including awareness of teenage pregnancy ▪ Comply with health and safety legislation and policy

Stay safe	▪ Ensure staff are Criminal Records Bureau checked and that all are child protection trained ▪ Ensure access to Child Protection services ▪ Promote anti-discriminatory behaviour and prevent bullying ▪ Reduce children's experience of and involvement in crime and anti-social behaviour ▪ Ensure YISP is involved in information-sharing processes to prevent children and young people 'slipping through the net' and not receiving the support they need ▪ Ensure children and young people are aware of how to keep themselves safe ▪ Promote positive peer groups ▪ Raise awareness of sexual exploitation and actively prevent it
Enjoy and achieve	▪ Help to ensure all YISP children and young people are in full-time education ▪ Help children and young people make full and constructive use of their leisure time ▪ Provide positive and accessible recreational activities for children
Make a positive contribution	▪ Target, through a multi-agency panel, children and young people at risk of or engaging in anti-social behaviour and/or criminal activity ▪ Prevent or reduce the engagement in anti-social behaviour and/or criminal activity of that targeted group ▪ Focus the YISP interventions on reducing risk factors associated with offending behaviour, and on increasing protective factors ▪ Reduce the experience of bullying and anti-social behaviour among the children and young people involved with the YISP ▪ Provide opportunities for children and young people to contribute to the local community through active citizenship ▪ Promote the engagement of children and young people in law-abiding and positive behaviour ▪ Promote and support personal development and self-confidence through access to constructive and positive activities
Achieve economic well-being	▪ Promote the engagement of children and young people in education ▪ Assist in the preparation of children and young people for further education, training and employment ▪ Support the families of YISP children and young people to improve their socio-economic status

The Quality Standards

The eight Quality Standards that follow allow YISPs and their partners to assess their practices and procedures against clearly defined criteria. The Youth Justice Board encourages programmes to complete and review this self-assessment process on a regular basis.

Scoring

The YISP should assess its fulfilment of the criteria outlined in the Quality Standards using the following rating system.

0	Little or no evidence of the criteria being met.
1	Some evidence that the YISP is working towards meeting the criteria, but not that it is maintaining consistent achievement, or able to prove fulfilment of all the key requirements.
2	Evidence that the YISP is achieving the criteria in most key respects.
3	Consistent and complete achievement of the criteria.

Quality Standard 1: Neighbourhood selection

Theme	Criterion	Possible indicators/sources of evidence	Rating
Correct location and targeting of YISP	The YISP area remains one of high crime or anti-social behaviour, and the target group comprises those children and young people at high risk of those becoming involved in anti-social behaviour or offending.	▪ Crime statistics demonstrate high levels of youth crime ▪ YISP steering group confirms the need for the panel in this area ▪ Crime and Disorder Reduction Partnerships/Anti-Social Behaviour Strategy specify role of the YISP in preventing youth crime and anti-social behaviour in the area. ▪ Target group reflects national guidance and research evidence on pre-crime prevention work	

Quality Standard 2: Partnerships

Theme	Criterion	Possible indicators/sources of evidence	Rating
Steering group	A YISP steering group is established to hold the programme accountable for its activities, comprising representatives from the key stakeholder agencies and funders. This group may be an established YOT steering group, but should have a dedicated focus on YISP activity.	▪ Steering group terms of reference (or similar) ▪ Steering group meeting minutes (or similar) ▪ YISP Operational Plan (or similar)	
YOT	The YISP and the YOT Fund have a clear understanding of their relationship and responsibilities as the primary agencies responsible for the local prevention of youth crime.	▪ YISP and YOT relationship is described in the Youth Justice Plan ▪ Existence of service-level agreement and terms of reference (or similar) describing the relationship	
Strategic relevance	Understanding of the role and purpose of the YISP is entrenched in the local strategic bodies and partnerships responsible for: ▪ crime and community safety ▪ dealing with youth crime ▪ tackling anti-social behaviour ▪ education ▪ family support and family welfare ▪ children's services ▪ health services.	▪ Local relevant strategic plans and policies reference the YISP ▪ The YISP is a member of, or reports to, relevant strategic planning and policy groups ▪ YISP development has been reported to and/or approved by local elected members ▪ The YISP has been integrated into local Children's Trust and Local Area Agreement arrangements	

Quality Standard 3: Core processes (project management)

Theme	Criterion	Possible indicators/sources of evidence	Rating
Information-sharing	The YISP partners and stakeholders agree how, when and with whom information about the children or young people and their families can be shared, and state the limits of confidentiality. The views and consent of the families must be obtained and included.	▪ Existence of written information-sharing protocols (or similar) ▪ Information-sharing described in panel and/or steering group terms of reference (or similar) ▪ Evidence that multi-agency information has been shared during the verification and assessment process and at panel meetings. ▪ Signed consent forms ▪ The YISP adheres to the *Common Assessment Framework Guidance*	
Data protection	The YISP has a clear policy on accountability for complying with data protection principles in respect of the information it holds.	▪ Written Data Protection Protocol with designated responsibility for Data Protection Act compliance	
Steering group	The YISP partners and stakeholders agree the composition, remit and operations of the steering group.	▪ These issues are described in a written terms of reference (or similar) for the steering group	
Training and development	The YISP understands and responds to the training needs of the panel and the core staff.	▪ Existence of written training plan(s) ▪ Undertaking of staff supervision and appraisal ▪ Audit and provision of training.	
Accessing mainstream services	The YISP partners and stakeholders have a clear understanding of the routes by which mainstream services can be accessed.	▪ Existence of service-level agreements (or similar) between the YISP and mainstream/other service providers.	
Equal opportunities and diversity	The YISP is aware of and responsive to the diverse communities it serves.	▪ Existence of equal opportunities statements/policies/procedures ▪ Ethnicity monitoring of YISP referrals ▪ Translation of marketing and publicity materials into relevant languages ▪ Panel meeting venues have disabled access ▪ Panel meetings are held at times and venues that meet the requirements of service users.	

Programme Action Plans	The YISP has an annual Action Plan, which is regularly reviewed and updated (at least every six months).	▪ Action Plan available ▪ Steering group notes showing regular reviews and updates	
Financial control	The YISP has a balanced budget and has controls in place to ensure regular monitoring takes place.	▪ YISP budget available ▪ Monthly spreadsheets showing cash flow ▪ Written financial policies and procedures	
Agency awareness	The YISP understands and responds to the need to raise and maintain awareness of its objectives and activities among its local stakeholders and partners, including he local community.	▪ Existence of a written marketing plan ▪ YISP attendance at relevant team meetings ▪ YISP 'road-shows' or marketing events	
Service user awareness	The YISP understands and responds to the need to raise and maintain awareness of its objectives and activities among its potential service users.	▪ Service user leaflets (or similar) ▪ Evidence of harnessing partner and stakeholder support in order to engage potential service users ▪ Service user feedback ▪ Young people and their parents or carers are involved in YISP reviews	

Quality Standard 4: Staff and resources

Theme	Criterion	Possible indicators/sources of evidence	Rating
Staff team and resources	The YISP has a dedicated staff team, appropriately configured and resourced to fulfil the key roles set out in the *YISP Management Guidance* and determined by local needs.	▪ Co-ordinator/manager, key worker and administrator roles filled ▪ Evidence of workload mapping/planning	
Child protection	All YISP staff are criminal records bureau checked and meet local Association of Chief Police Officers standards for working with children.	▪ Criminal records bureau certificates ▪ Local child protection training undertaken by staff	
Experience and skills	All YISP staff are appropriately qualified, experienced and/or trained for their respective roles and responsibilities, and have the ability to communicate with children and young people.	▪ Job descriptions and person specifications outline skills required, etc. ▪ Staff qualification and training records ▪ Use of appraisals to determine future training needs	
Panel composition	The YISP includes representatives from the statutory service providers responsible for: ▪ crime and community safety ▪ anti-social behaviour ▪ youth crime ▪ family support and welfare ▪ health services ▪ education.	▪ YISP terms of reference or similar ▪ YISP meeting minutes (or similar) ▪ YISP plan (or similar)	
Resources	YISP members representing mainstream services have the authority to commit the resources of their agency and/or service.	▪ YISP terms of reference (or similar) show panel members with appropriate levels of authority ▪ Existence of written commitment to facilitate access to mainstream services through service level agreements (or similar)	

Quality Standard 5: Core processes (young people and families)

Theme	Criterion	Possible indicators/sources of evidence	Rating
Referral verification	The YISP verifies that only those referrals of children and young people deemed to be at most risk[2] of involvement in offending and anti-social behaviour and as most requiring multi-agency support are considered for targeted work.	■ Existence of threshold criteria ■ Screening mechanisms ■ A written verification procedure ■ Evidence of assessment refusal and/or onward referral	
Referral consent	The YISP secures the written and informed consent of the children or young people and their families to involvement in YISP activities.	■ Existence of signed consent forms ■ Information and advice material for children or young people and their families, translated as relevant	
Assessment	The YISP uses a structured assessment mechanism that identifies the needs, risks and protective factors associated with the child or young person's involvement in offending and anti-social behaviour, and that can also provide a means of demonstrating the impact of the YISP.	■ Use of ONSET or other structured assessment framework, in line with the *Common Assessment Framework Guidance* ■ Ability and means to measure 'distance travelled' by users ■ Staff training in assessment ■ Evidence of data-sharing protocols to ensure assessments are based on multi-agency information	
Engagement of the family	The YISP gives the child or young person and his or her family the opportunity to contribute to the development of the ISP, gains their commitment to its content and achieves high levels of participation in, and completion of, plan.	■ Evidence of the attendance of the child or young person and family at panel meetings ■ Use of family group conferencing or similar models of engagement ■ Children or young people and families are signatories to the ISP ■ Positive service user feedback ■ High levels of participation in, and completion of, plans	
Targeted ISPs	The YISP ensures that the key risks, needs and protective factors identified in assessments are addressed in the ISP.	■ ISPs clearly based on priorities identified through a structured assessment	

[2] YISP Management Guidance suggests that ONSET should indicate the presence of at least four or five risk factors in a child or young person's life in order for him or her to be referred to the YISP.

ISP review	The YISP ensures that all ISPs are reviewed when appropriate (for example, halfway through and at the end of the programme), and that it responds to any problems with completion or service delivery.	▪ Evidence from panel and steering group minutes ▪ Review forms	

Quality Standard 6: Management information

Theme	Criterion	Possible indicators/sources of evidence	Rating
Monitoring and evaluation	The YISP records and analyses its activities and impact, in line with the objectives set out in the YJB's *YISP Management Guidance* and with locally determined targets.	▪ Use of electronic or other management information system ▪ Existence of monitoring reports ▪ Evidence of output/milestone and/or target setting	
Feedback	The YISP strategic stakeholders and partners are aware of the performance and impact of the YISP.	▪ Existence of monitoring reports ▪ Performance and impact of the YISP a standing item on the steering group agenda ▪ Performance and impact of the YISP reported to relevant strategic groups	
Continuous improvement	The YISP continuously develops and improves performance.	▪ Participation in training events, conferences and seminars relating to targeted youth crime prevention ▪ Evidence of actions taken as a result of monitoring reports ▪ YISP Action Plan addresses development of quality provision	

Quality Standard 7: Quality of interventions

Theme	Criterion	Possible indicators/sources of evidence	Rating
Health and safety	All activities are risk assessed, with appropriate measures taken to reduce risks.	▪ Risk assessments are detailed and conform to agency health and safety guidance, and are regularly updated ▪ Parental consent forms include information about specific health or medical issues ▪ Staff trained in health and safety legislation and risk assessment	
Mainstream services	A focus of all YISP interventions is to improve children and young people's access to mainstream and statutory services, in order to bring about improved outcomes for them.	▪ All ISPs outline how access to mainstream services will be improved ▪ All ISP reviews report evidence of improved access to and take up of mainstream services ▪ Existence of service level agreements (or similar) between the YISP and mainstream services, which describe how improved access will be achieved	
Level of participation by young people in design and planning of activities	YISP interventions are developed with full, regular consultation with participants and their families.	▪ Consultation exercises ▪ Interactive material illustrating young people's participation f ▪ Feedback in line with government guidance provided in *Learning to Listen: core principles for the involvement of children and young people* (available from www.everychildmatters.gov.uk)	
Child or young person and family commitment and 'ownership'	The children or young people and their families are partners in tackling the problems that have been identified.	▪ Evidence of child or young person and family contributing and/or being committed to change in YISP activities ▪ Service user feedback	

Community resources	The YISP is active in linking children, young people and families with voluntary sector and community-based groups and services where appropriate.	▪ 'Signposting' and onward referrals at pre-assessment stage ▪ ISPs and reviews show community and voluntary sector service delivery ▪ Community and voluntary sector representatives on the YISP steering group ▪ YISP knowledge of community and voluntary sector resources and services	
Range of interventions/ activities	The YISP has identified a range of activities appropriate to the age, gender and diversity of the core group, and which address the risk and protective factors associated with youth crime prevention.	▪ YISP knowledge of community and voluntary sector resources and services ▪ Activities are in place that enhance community cohesion and consider issues of local diversity ▪ Local Minority Ethnic groups active in YISP delivery ▪ Balance between group and individual interventions evident	
Gap analysis and service development	Gaps in local service provision are identified and the information fed back to the steering group.	▪ Steering group terms of reference (or similar) ▪ Steering group meeting minutes	

Quality Standard 8: Governance

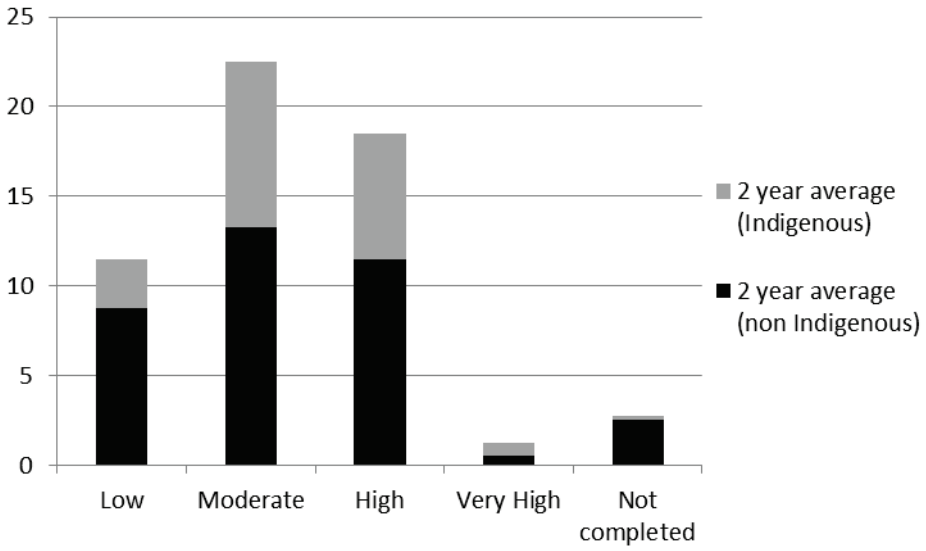
Theme	Criterion	Possible indicators/sources of evidence	Rating
YISP/host organisation relationship	The YISP manager has a clear point of contact and/or a nominated line manager within its host organisation (for example, the YOT) where applicable.	■ Organisation chart showing links and governance between the YOT and the host organisation ■ Existence of clear channels of communication	
Responding to issues	The host organisation responds to issues affecting YISP delivery as they arise.	■ The host organisation reviews Action Plan, and steering group meeting minutes show responses to issues	

Summary of key data: Western Districts Youth Justice Service Centre

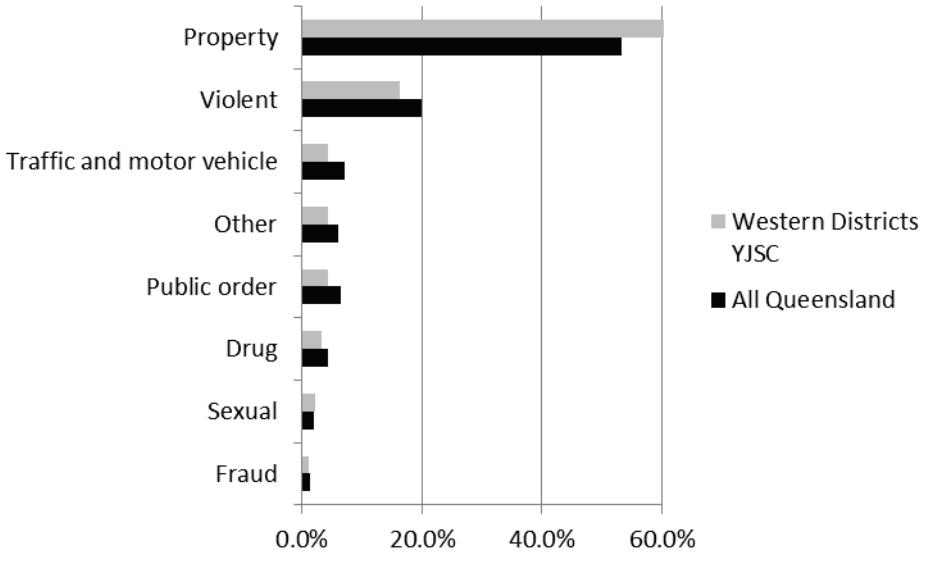
Admissions to orders, Western Districts YJSC, 2011-12

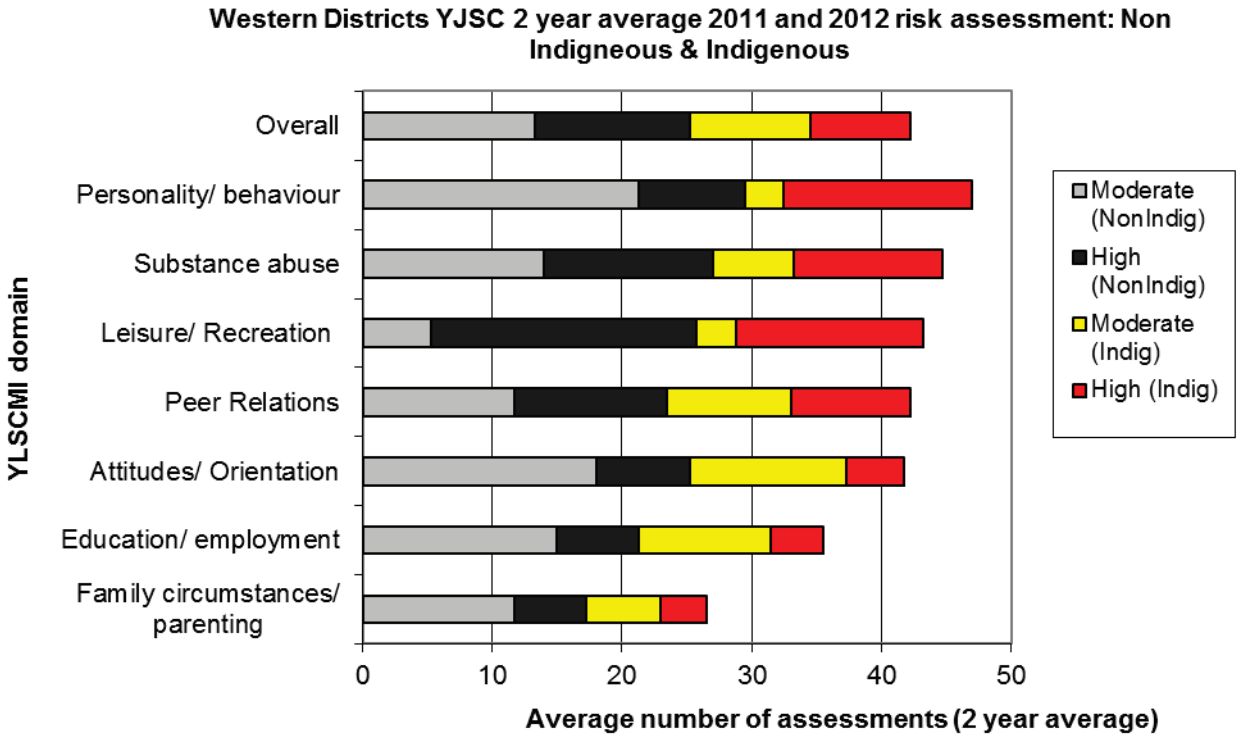
Order type	Number of orders	Proportion of Queensland total	Distinct young people	Average orders per young person	Average orders per young person: all QLD
CSO	17	2.0%	15	1.13	1.21
CRO	5	2.0%	5	1.00	1.07
Detention	10	3.1%	7	1.43	1.45
Probation	33	2.4%	28	1.18	1.23
SRO	9	4.1%	7	1.29	1.32

Overall risk level for Western Districts YJSC – 2 year average of 6 month periods



Proportion of the most serious proven offences for distinct young offenders, 1 July 2012 to 31 March 2013: Western Districts YJSC and State-wide average





Family

83% of young people assessed in the first three quarters of 2012-13 have one or more issue relating to family and parents (the state-wide average is 72%).[1]

Mental Health

The proportion of risk assessed young offenders assessed with characteristics consistent with the five selected mental health conditions, Quarter 1-Quarter 3 of 2012-13

- One or more identifiable mental health issue: 91% (state-wide average 80%)
- Two or more identifiable mental health issue: 81% (state-wide average 60%)
- Conduct disorder: 74% (state-wide average 59%)
- Substance misuse disorder: 76% (state-wide average 62%)

[1] Scoring for the family domain is not sensitive enough for Youth Justice Clients. Conversely the scoring for leisure and recreation is considered too sensitive and is interpreted with caution.

Local Government Leadership

City of Westminster

Repairing broken families and rescuing fractured communities

Lessons from the frontline

Contents

The images used in this publication are illustrative only and do not portray any of the families or individuals mentioned.

Foreword

Tim Loughton MP

Parliamentary Under Secretary of State,
Department for Education

Growing up in a family experiencing very complex health, social, economic and behavioural problems often has a lasting and adverse effect on a child's life chances. Although there are only a small number of these families, the problems pass from generation to generation, for example poor parenting and the effects of domestic violence and abuse. Most local services are not designed to provide the kind of intensive, well coordinated help the families need which means the problems persist. These families are then likely to experience regular crises which make expensive and largely avoidable demands on a wide range of local services.

A new approach is needed to identify the kinds of local service best able to provide the support, incentives and, where appropriate, sanctions, these families need in the most cost-effective way. This approach should be based on examples of successful local practice and must make the most of the voluntary sector and volunteers.

We need to build on successful local projects such as the Westminster Family Recovery Programme. Other areas need to learn from the early successes in reducing child poverty, school exclusion, entrants to the care and criminal justice systems, and long-term unemployment, health or housing problems. On top of this, the projects provide immediate and longer-term reductions in service costs. In the current economic climate, it is only when agencies work together and pool resources that we can achieve vast improvements to services without vast investments.

Intervening early and services working more efficiently with vulnerable families is central to the Government's commitment to unlock social mobility and tackle child poverty. Through earlier intervention we can ensure as many children and young people as possible reach their full potential and have hope and high aspirations for their future.

The Government has asked Graham Allen MP to review early intervention programmes and to look at how the lessons from successful models like the Westminster Family Recovery Programme can be shared across the country.

Congratulations to all involved in this project and long may its success continue.

Introduction

Councillor Daniel Astaire

Cabinet Member for Society, Families and Adult Services, Westminster City Council

Local authorities work best when they are inventive. On those occasions when they look across their own and partner organisations with a determined sense of place and purpose, decisions can be made which materially improve the chances and prosperity of communities.

Westminster City Council's Family Recovery Programme is a prime example of this new way of thinking. At its core, it is an intelligence sharing approach between multiple public agencies dedicated to tackling persistent problem families, which manifest themselves across a wide variety of services. In turn for the support offered, these families adhere to strict 'contracts with consequences', knowing that they could face a raft of measures if they do not co-operate to mend their ways. A twin pronged approach which, as this publication demonstrates, achieves real results.

But a project like Family Recovery does not always sit comfortably with the political times. In an era of austerity and reduced public spending, when budgets are being cut and services redefined, Family Recovery stands out. At a time when in Westminster, we are consulting on tightening the criteria for recipients of adult social care, a key plank of family recovery is the ability to treat parents suffering from low level mental health issues. Outside the programme, these people would not have been eligible to receive state funded care under the current criteria, let alone restricted criteria. What then can be a proper justification for treating those who disrupt society rather than those who may be edging toward vulnerability?

The answer is twofold and is borne out by the findings in this publication. Targeted and specific interventions can create greater savings for the public purse across a range of agencies; our own and independent analysis has confirmed this. It can also tackle and make deep inroads into seemingly impenetrable social blights which have disrupted communities, creating long term unrest and social discomfort. Findings show that the involvement of families recommended to the programme by the police and community safety teams increased feelings of safety and satisfaction amongst local residents.

Localism lies at the very heart of the principles behind Westminster's approach. The problems caused by a small core of misbehaving families will often only affect a relatively small group of people in a neighbourhood. However, low level anti-social behaviour can have an enormous impact on their quality of life. With such a complex myriad of causes and highly localised effects, a top-down approach planned and delivered from Whitehall will never succeed. What works in Westminster

will not necessarily be the right blend of interventions to work for families in Wolverhampton or even Wandsworth. Family Recovery succeeds because it offers local solutions to local problems.

These justifications alone provide confidence that funding Family Recovery is the right thing to do and is politically expedient. These decisions are not easy, but politics is not a straightforward art. We face difficult decisions, involving tough political choices. When, however, these work as Family Recovery clearly does, it gives us a chance to showcase the strength and importance of local government.

In its policy announcements and in setting out its vision for Britain, the new Coalition Government appears to be extremely sympathetic to this approach. The Coalition's Programme for Government committed ministers to investigating new approaches to helping exactly the kind of families that this programme targets and we will be challenging them to put their money where their words are.

Such a non-traditional approach to public services requires a non-traditional funding stream to embed it in public sector culture as more than simply an experiment. Arguably, local government should remain the primary and co-ordinating body in such a project (and is uniquely positioned for this role) but it should not be a primary funder.

Whilst we may argue over the figures and levels of estimated savings and cost avoidance, the principal that a project like family recovery can, over time, deliver savings to the public purse must not be lost in the debate. There is clear evidence of short term cost avoidance leading to long term savings and, at its simplest, the funding of the project should sit where these savings are borne.

Financial support is not, however, given that readily and if this model is to be rolled out across other areas then further innovative thought is required to create a funding model that works for all parties. Thinking outside of the box is just as important with the financing of the project as it is with the project itself. There must be an opportunity for considering forms of social impact bonds or other methods of results based funding. We have enough confidence in the project to pursue this. Furthermore, on the crime agenda, linking the Family Recovery Programme to an Integrated Offender Management scheme could also enlarge the scope and resources available to the Family Recovery Programme. This would involve working closely with partners in the police and probation service. Through Family Recovery, Big Society can also be seen at its best, with communities taking charge of their problems and working together to try to solve them.

This programme delivers. It shows that local government can deliver. Now is the time for the Government to deliver by securing the future of the Family Recovery Programme.

Executive summary

Background to the Family Recovery Programme

Despite its reputation as a lead authority in providing adults' and children's services, Westminster City Council decided in 2008 that a new approach to tackling entrenched social problems was required.

The council calculated that at any one time there were around 40 families in the city responsible for the vast majority of extreme anti-social behaviour and who displayed strong criminal tendencies.

Recognising the interrelation of causes and effects, the 'whole-family' approach embodied by the Family Recovery Programme (FRP) aims to deal with the causes of these problems rather than the symptoms.

With a wide range of expertise, a Team Around the Family (TAF) based entirely in one location is assigned to each family and is candid in setting clear and achievable goals for families with severe problems. A bespoke care plan is instituted for each family to deal with their particular challenges. The families are required to sign a 'contract with consequences' to formalise their involvement with the programme.

An innovative 'Information Desk' collects data from partner organisations and collates the information to offer real-time briefings to members of the TAF. Analysts then monitor the family's continued progress and fast-track them back on to the programme if required.

The FRP has successfully engaged the voluntary sector to deliver some of its services. Not-for-profit organisations currently provide support for preparation for work, debt advice, drug assessments and interventions and in dealing with perpetrators of domestic violence. In future the FRP will involve even more voluntary sector groups.

Supporting families

Involvement in the FRP has been beneficial to a number of families who have engaged with the programme.
The net benefits include:

- the proportion of families who remain unregistered with a local GP has fallen by more than two-thirds following FRP engagement
- studies have shown that mental health services facilitated through FRP have seen greater levels of engagement than conventional methods
- of the families with domestic violence problems, a greater proportion effectively implemented a safety plan following engagement with the FRP
- more tenancies have been secured as a result of FRP engagement, avoiding the upheaval caused by eviction proceedings

- as a result of the FRP, more Westminster families have shown progress in improving conditions, where child protection was a concern at the outset
- more than 80 per cent of children for whom truancy had been an issue have increased their school attendance.

Strengthening communities

In a study of families where crime and disorder was a major concern, the number of offences they were accused of fell by 69 per cent in the 12 months following FRP engagement, while the average number of 'suspected offences' per month fell from nine in the year before intervention to just one and a half afterwards.

A survey of almost 100 of the families' neighbours found that two-thirds were either satisfied or very satisfied with the response of the police and the council.

Most of those surveyed reported lower levels of anti-social behaviour following their neighbours' engagement with FRP.

Savings for taxpayers

Westminster City Council's research suggests that for every £1 spent on FRP, £2.10 in costs is avoided by the public purse in year one. This is supported by a central government-commissioned independent study of the FRP's impact on crime and anti-social behaviour, which estimated that £3 in costs were avoided for every £1 spent on preventing offending through the programme.

Due to the wide range of beneficiaries of this work, only around 42 pence in every £1 of avoided costs directly relates to spending by the local authority, with the remainder being attributed to housing associations, government departments, the NHS and other public agencies.

The targeted and intensive intervention is not inexpensive - at around £19,500 per family. However, early estimates of average cost avoidance per family amount to just over £40,000 in the year during which the family is engaged.

In just one year, some well-engaged families that had previously suffered from complex and entrenched problems turned around their behaviour to such an extent that up to an estimated £136,000 in costs had been avoided.

Extensive longitudinal studies of the pathfinder families are underway to assess the long-term savings resulting from the intervention.

The future of the programme

Political will exists to continue this programme. This political will, however, needs a credible source of funding. Conscious of the current financial climate and choices which are being taken across public services, Westminster is exploring options for linking funding to performance with individual families or sets of families. However, the diffuse nature of beneficiaries from the FRP's work means that an efficient funding source or mechanism does not yet exist.

One option is to widen the funding base so that the organisations that benefit directly from mid to long term cost savings provide investment. This would see more public and quasi-public bodies supporting the programme, including housing associations and the Probation Service.

Origins

A bold and innovative approach required to tackle an entrenched social problem

Research shows that a secure family with strong parental role models is highly influential in a child's wellbeing and development. Unfortunately, many in society lack the emotional support provided by a secure and loving family. In some cases family breakdown leads to a fundamental disconnect with the community and creates far-reaching and deeply entrenched problems that affect the whole of society – poverty, crime, poor mental health and substance misuse. The instinctive reaction to news reports of youth violence, gang activity and anti-social behaviour illustrates how the social exclusion and/or poor behaviour of a relatively small number of residents can blight the lives of whole neighbourhoods and impact on the perception of wider communities.

Until relatively recently, resources and support for these families were in no short supply but funding was ineffectively focused and opportunities missed for better long–term outcomes. Gradually, policy makers have realised that money alone does not represent the best means of addressing the most complex social challenges. A growing body of research conducted by progressive think tanks has illustrated the connection between family breakdown and social decline.

Westminster City Council is widely renowned for delivering excellent adults', children's and family services, but there are families in the city that suffer from the consequences of social exclusion and a toxic combination of housing problems, low school attendance, substance misuse, domestic violence, poor parenting skills and an entrenched dependence on benefits. The cyclical nature of these problems means that victims of state failure are also more likely to suffer from the consequences of the social problems caused by the added strain on community safety resources and additional pressures on educational standards.

In an assessment of the most problematic cases, the council calculated that at any one time, there were around 40 families in the city responsible for the vast majority of extreme anti-social behaviour and who displayed strong criminal tendencies. There were a further 35 families whose children were suffering (or would probably suffer) significant harm likely to require intervention and, in many cases, care proceedings would need to be initiated. Further down

this pyramid of dysfunction, the council predicted that there were around 600 families (approximately one in 30 of all families in Westminster) at significant risk of displaying the symptoms caused by social breakdown. It was estimated that these families were responsible for 80 per cent of children's social care spending in the city, as well as placing disproportionate pressures on local health and policing services.

In 2008, armed with a growing body of evidence illustrating the long-term impacts of social breakdown, Westminster City Council decided that a new approach was required. Whilst many of the services available to at-risk adults and children were performing extremely well, the families in need of the most supervision and support were falling through the inevitable gaps created when the system comprised so many different bodies (including several council departments working to differing and sometimes conflicting centrally driven targets or statutory criteria):

- children's services perform excellently when focused on improving the prospects for children receiving their services, but offered limited support to adult family members
- adults' services in Westminster are also considered excellent but provide few structures for dealing with the problems of parents
- interventions were not tailored to individual needs and many families were being offered too many services that ran concurrently, were poorly phased or were contradictory
- assessments of families were being repeatedly conducted by a range of agencies and council departments without any coordination of information or action, resulting in inefficiency and duplication.

Uniting mutual interests: the Family Recovery Programme

Agencies with common objectives should come together to deliver results

Westminster City Council's Family Recovery Programme (FRP) focuses on treating the root causes of social breakdown rather than dealing only with its symptoms. This 'whole-family' approach to intervention recognises the interrelation of the causes and effects of social breakdown, for instance recognising that poor housing and parental drug use are likely to lead to poor health and a lack of educational achievement for children.

With the council as the lead partner, the FRP brings together a number of public services, as well as national and local voluntary groups to share resources, intelligence and expertise and provide a single focus for dealing with the deep-rooted problems suffered by the individual families concerned.
A Team Around the Family (TAF) provides the following expertise:

- adult mental health
- adult substance misuse
- neighbourhood and youth policing
- anti-social behaviour teams
- housing advice
- debt, budgeting and benefits advice
- intensive outreach work focusing on parenting and life skills
- domestic violence (separate specialists in perpetrators and victims)
- education
- child health
- information analysis
- preparation for and access to training, volunteering and work.

The TAF receives referrals from a wide range of statutory and non-statutory organisations. It acts as a single unit, based in one location, and reports directly to a single operational head. TAF members share information from their respective services in a unique way, overcoming agency barriers to provide coherent and consistent action.

The TAF seeks a family's consent prior to intervention – except in cases where crime and children's safeguarding are of critical importance and thus override data protection legislation – in a clear and common-sense way. It sets clear and achievable goals and is candid about the consequences for those individuals who fail to radically improve their behaviour.

Agreement for change

Central to the success of the Family Recovery Programme is the agreement between the TAF and the family involved. Westminster believes that the programme is something best done **with** rather than **to** families. For this reason family members are involved closely in the development of their care plan and are asked to sign a 'contract with consequences'. There is a strict understanding that signing this agreement is a prerequisite to joining the FRP and benefiting from the additional support on offer. Despite conferring no additional statutory powers or legal responsibilities, the contract spells out the possible consequences if families fail to cooperate with the FRP and continue to display negative behaviour. These sanctions include parenting orders, care proceedings, prosecution for non-school attendance, ASBOs and eviction.

For most, this is the first time in their lives that they have been so clearly presented with an outline of their responsibilities by all the agencies involved, and the consequences of not taking ownership of them.

The TAF devises a single care plan, taking into account all the needs and problems of each family member. To open effective communication channels whilst ensuring accountability, the responsibilities of each agency in the TAF is defined, and two lead workers are designated to act as the main points of contact for the family - one lead for the adults and one for the children. The care plan forms the basis of the contract families sign to formalise their involvement in the process. By inviting the family to the meeting where the care plan is formulated, full cooperation with the programme is promoted from the start.

Once the care plan has been established, three-weekly reviews are carried out for the duration of the engagement. The family are themselves included in alternate meetings. These reviews are supplemented by regular updates from information analysts. In the early stages the care plan includes several visits and phone calls to the family every week.

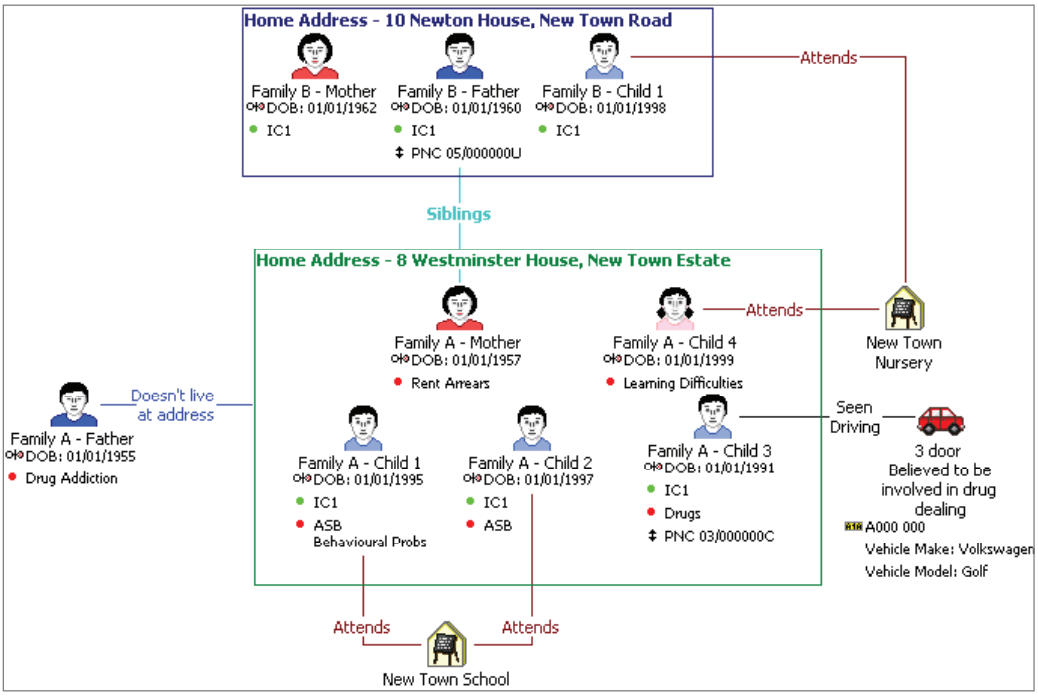
The Information Desk

One of the most difficult obstacles to overcome when designing the structure for the FRP was around collating the vast amounts of existing intelligence on individuals and families held by agencies that would otherwise be unavailable to all FRP partners.

The FRP's Information Desk analysts are an integral part of the project. They actively seek out information held by all the services involved and present it to partners in a simplified format, to ensure the most effective decisions are made when producing care plans. Only with the full picture of a family's problems can the team ensure it delivers the best possible service. Information used to create the care plans includes real time data from the local police, social care case chronologies, existing assessments and details of previous interventions.

The analysts are responsible for assessing outcomes against the aims set out in care plans, and for tracking the progress of families when they formally leave the FRP to ensure they are fast-tracked back in to the system if old issues reoccur.

The way in which information is presented has been important to the work of the Information Desk. An example of the visual method of displaying multi-agency information can be seen below. This method helps illustrate the context for behaviour and has proved popular with the agencies that have used it.



Sample family network chart

Using the I2 Analyst Notebook software (commonly used in law enforcement agencies), the Information Desk produces this visual display of multi agency information. Each family member is displayed in relation to their role within the family whilst the definition of 'family' is fluid and can represent any situation. Key 'attributes' can be added to each icon (family member) for example mental health, previous convictions or rent arrears. The chart is accessible to the Team Around the Family and is updated as new information is available.

Results: supporting families, strengthening communities and savings for taxpayers

A focus on families in need is the decent and cost-efficient thing to do.

In addition to the overwhelming evidence of the harmful consequences of social exclusion and the need to provide stronger support networks to families involved in the programme, Westminster has conducted its own extensive research into the FRP's measurable outcomes to ensure it is providing its residents with value for money. A number of external organisations have also assessed the different elements of the programme and reached similar conclusions about the effectiveness of the FRP.

Tapping into the Big Society

The Family Recovery Programme has successfully engaged the voluntary sector and commissioned a number of not-for-profit organisations to deliver high quality and unique services that could otherwise only be provided at considerable cost to the public purse.

Action for Children provides a range of unique support services for families involved in the FRP. They offer debt and benefits advice and provide training for FRP staff to deal with some less complex financial issues. Action for Children also provides access to work programmes linked to the Westminster Works Programme including individual planning for work readiness, training and volunteering opportunities.

The Domestic Violence Intervention Project (for perpetrators) is one of the few organisations in London equipped to assess perpetrators of domestic violence and offers targeted interventions to ensure offenders take responsibility for and work to change their behaviour.

The Westminster Drug Project (WDP) offers assessments and interventions for parents with a history of drug or alcohol misuse. WDP provides excellent value for money as tested during a recent robust tendering process.

Going forward, the FRP will involve many more voluntary sector groups. We are developing partnerships to help parents into employment and a sports mentoring project to aid those referred with obesity or depression.

Supporting families

One of the clearest symptoms of the social exclusion experienced by many families referred to the FRP is their lack of involvement with their local health network. Given the high prevalence of mental and physical health problems amongst this group, early and successful contact with GPs and primary health is a key goal. This contact both improves the life chances of family members and reduces cost by precluding the need for higher cost intervention later down the line, for instance by avoiding later Accident and Emergency admissions or in-patient treatment for mental health or substance misuse. The TAF gathers health information and sets up a GP registration for a family within 28 days of their initial meeting. Since beginning to collect figures on GP registration amongst FRP families, the proportion of unregistered individuals has fallen from 30 per cent to just nine per cent.

Adult mental health issues often lie at the heart of a family's problems and its eventual referral to the FRP. This, coupled with the council's early findings, points to higher levels of engagement with these mental health services through the FRP than via conventional methods of service engagement.

Parents in families referred to FRP will receive a mental health assessment where the mother or father displays mental health issues affecting their capacity to parent effectively. This review will identify specific needs and provide a gateway to appropriate resources, for instance referral to a GP, counselling services or culturally specific support groups. The TAF's mental health worker will also work with the adult to build self esteem and encourage them to take up employment or training opportunities. Where appropriate the mental health worker will play a key role in the overall decision-making process of the team, sometimes as the FRP lead professional for the adult.

Issues around domestic violence are often linked to the poor mental health and low self esteem of adults within the family. For this reason the mental health worker will regularly work closely with the domestic violence consultant who takes lead responsibility for the victim of abuse, providing intensive support, aiding the victim in making sense of the violence and developing a plan for dealing with potential flashpoints. The domestic violence specialist will also assess the perpetrator of the abuse and make referrals to the Domestic Violence Intervention Project, which has a good record of engaging perpetrators and assisting them in understanding the reasons for and consequences of their actions.

In a sample of ten families with domestic violence problems, 50 per cent effectively implemented a safety plan or increased their understanding of the consequences of their actions as a result of FRP work - a markedly higher proportion than achieve this through more traditional child protection service interventions.

Evaluations of FRP have shown good results in preventing evictions for tenants and helping to secure their tenancies. Feedback from housing officers has been excellent. Overcrowding has also been alleviated for a number of families. Social workers have appreciated having a specific contact in the TAF with in-depth knowledge of local housing, given that there are over 15 large social housing providers in Westminster.

Amongst a sample of ten families who had been through the FRP process and which had Child Protection as the primary reason for referral, only one case was closed with no progress due to the family's disengagement. Six families achieved marked improvements, particularly the adult members. One of the households saw the children removed from a child protection plan and the prospects for the other children had been greatly improved.

Given the clear correlation between poor levels of school attendance and children who display a tendency to exhibit anti-social behaviour, the Family Recovery team prioritises improving families' engagement with educational institutions. School attendance is an issue for around 60 per cent of the households taking part in the FRP. As a result of the intervention, more than 80 per cent of these children have shown increased school attendance.

FRP education workers support children in developing plans for meeting their personal aspirations. They work one-to-one with the child to improve relationships with their school, targeting the predictable issues that arise in a child's education when he or she becomes involved in anti-social or illegal behaviour. Importantly, the FRP education workers also attend school meetings with the parent/s to strengthen the family's relationships with teachers and other staff. Often the FRP team will focus on helping parents to be more positive about their child's abilities and to encourage a willingness to learn rather than communicating negativity about results and outcomes.

Coordination and communication have become key watchwords for FRP education workers in ensuring that everybody involved in the child's school life – the child, family, school and other education professionals – is aware of all developments and is provided with an input in the development of a plan to address any specific problems. This could include school attendance, offending, low level anti-social behaviour or family tensions that all impact upon a child's ability to learn.

Strengthening communities

The Family Recovery Programme has an excellent record in reducing anti-social behaviour amongst its participants and making the communities they live in more satisfied and confident in public services. Communities also often report increased perceptions of safety in their area as a result.

Using a sample of 22 families where crime and disorder was a key concern upon entering the programme, Westminster compared incidents prior to and following at least 12 months of engagement with the FRP. The total number of 'accused offences' fell by 69 per cent in the year after their initial engagement compared with the year leading up to their referral and the average number of 'suspected offences' per month for the whole group fell from nine to an average of 1.5.

A survey of 95 of the families' neighbours revealed good levels of community satisfaction. As the people with the most to gain from improved behaviour, the council takes the opinions of these residents very seriously. It is encouraging that more than two-thirds of neighbours are either satisfied or very satisfied with the response of the police and council. Around half of all those surveyed believed that there had been less anti-social behaviour from their neighbours in the 12 months following the FRP intervention. Only 14 per cent of respondents felt that anti-social behaviour had got slightly or much worse over the period.

These findings have been supported by feedback provided by Westminster's neighbourhood liaison officers, who have reported a calmer atmosphere in areas that were previously blighted by poorly behaved children and families.

Savings for taxpayers

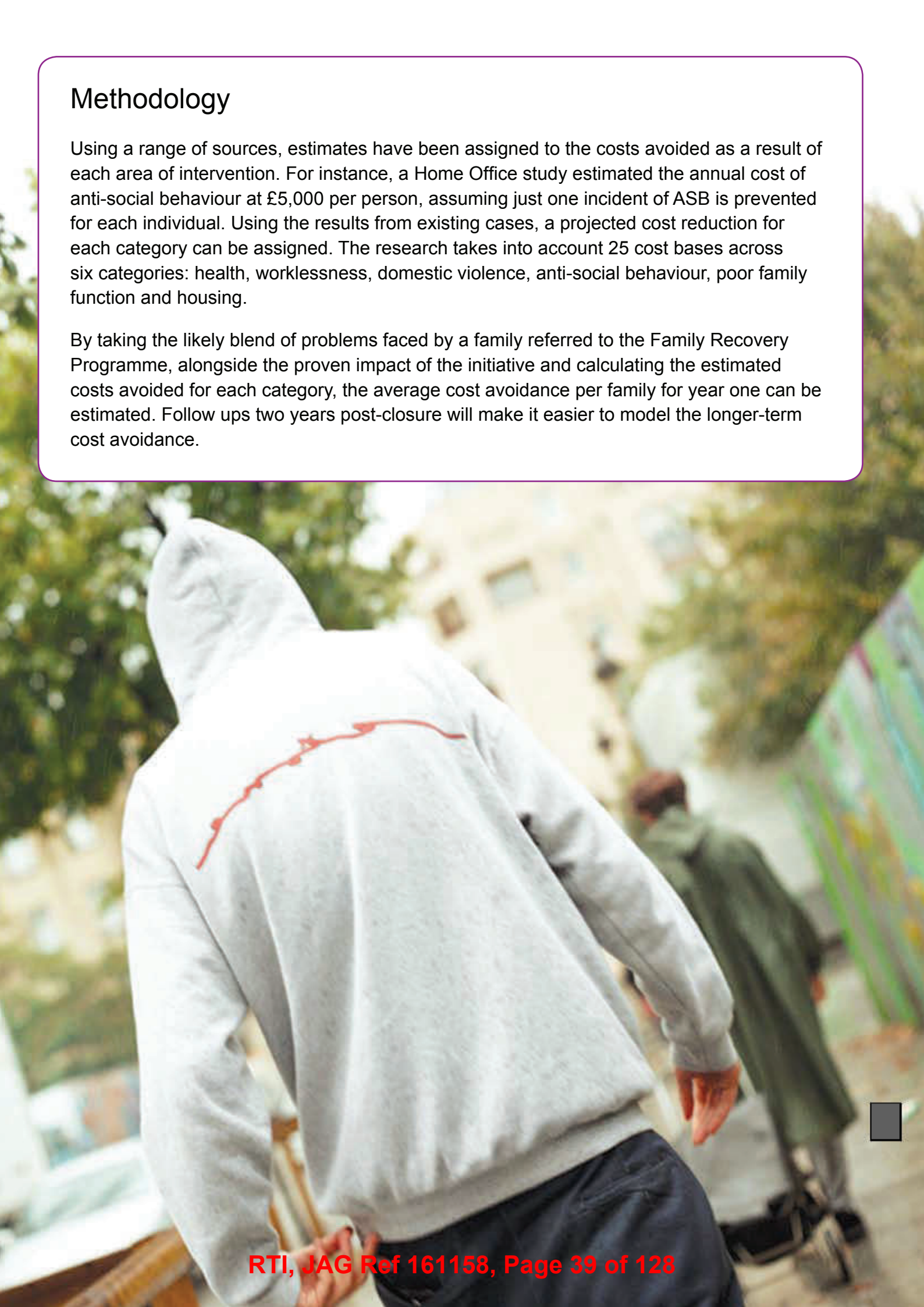
The Family Recovery Programme has delivered significant and hopefully long-lasting change for families, but Westminster takes seriously its responsibility to all residents, not just those with extreme problems or those in their immediate vicinity. For this reason the council has committed itself to demonstrating the financial benefits of the FRP.

The majority of the savings accruing from the FRP work is attributed to public bodies other than the council. It is estimated that just 42 pence per pound in avoided costs directly benefits the council, with the balance of saving benefiting a wide range of bodies, including Registered Social Landlords (RSLs), the NHS and central government departments such as Work and Pensions, the Home Office and the Ministry of Justice.

Methodology

Using a range of sources, estimates have been assigned to the costs avoided as a result of each area of intervention. For instance, a Home Office study estimated the annual cost of anti-social behaviour at £5,000 per person, assuming just one incident of ASB is prevented for each individual. Using the results from existing cases, a projected cost reduction for each category can be assigned. The research takes into account 25 cost bases across six categories: health, worklessness, domestic violence, anti-social behaviour, poor family function and housing.

By taking the likely blend of problems faced by a family referred to the Family Recovery Programme, alongside the proven impact of the initiative and calculating the estimated costs avoided for each category, the average cost avoidance per family for year one can be estimated. Follow ups two years post-closure will make it easier to model the longer-term cost avoidance.



Although the intensive involvement required by the Family Recovery Programme is not inexpensive, offsetting these costs against the total costs avoided for the public purse helps build a strong case for the targeted intervention provided by the programme: the average cost per family for a year's involvement with the FRP is around £19,500. Early estimates of mean and median cost avoidance per family amount to more than £40,000 and £30,000 respectively in the year during which the family is engaged.

In the council's study of the 50 families to take part in the pilot, the specific avoided costs per family ranged from £300 to £136,000 in the year during which the family was involved in the programme.

A study of 50 families that have been through the FRP estimates that the outlay of £975,000 contributes to avoided costs for public bodies of around £2 million per annum providing a net benefit to the public purse of more than £1 million. Beyond the pilot phase, these up-front costs are likely to diminish as the programme increasingly benefits from economies of scale and estimates suggest that in future 50 families could be supported for a cost of around £650,000.

These predictions should be treated with some degree of caution but an approximate indication of the likely return on investment in FRP to date is £2.10 for every £1 spent. This is based on expert assessments of progress across 25 separate measures, and incorporates official estimates of cost avoidance for each of the factors.

An independent review of the programme has produced even more grounds for optimism. Work carried out by York Consulting on behalf of the Department for Education points to an 'expenditure to cost avoidance' ratio of £1:£3. This research focused solely on crime avoided and reduced levels of anti-social behaviour rather than the more extensive range of indicators assessed in Westminster City Council's own evaluation work.

However, the wide range of beneficiaries for whom costs are avoided and the relatively small proportion of that which is of direct benefit to the council means the case for a unilateral funding structure remains weak. Incentives need to be established for Westminster and other local authorities to continue pursuing innovative policies with a focus on long-term solutions to entrenched problems rather than merely targeting more simple short-term goals.

The long-term costs avoided as a result of such intervention are difficult to estimate, but ongoing longitudinal studies into the families in receipt of FRP support will help us to make these predictions. The first of these studies will be completed in 2011.

Westminster City Council is advancing with proposals for innovative 'payment by results' models to ensure delivery of collective goals for which the chief financial beneficiaries can be found at a national level.

Facts and figures

69% reduction in 'accused offences'

83% reduction in average number of 'suspected offences' per month

67% residents are supportive of the council and police's approach to dealing with those registered with the FRP

48% neighbours reporting reductions in anti-social behaviour since families registered with the FRP

9% proportion of individuals remaining unregistered with a GP (compared with 30% at the start of engagement)

£2.10 the estimated public purse costs avoided by every £1 of expenditure on the FRP

£19,500 average cost per family of involvement in the FRP

£41,000 average estimated cost avoidance for each family involved in the FRP

£650,000 the estimated annual cost of supporting 50 families through the FRP

£2 million estimated costs avoided whilst 50 families are tracked through the FRP

Success stories

Feedback from users should help improve the service for other vulnerable families.

Family A

Referrer
Child Protection Team – Children's Services

Other agencies involved
CP team, YOT, Education Welfare, Connexions

Background and concerns
Five children, one of whom has a child of her own. Mother, four children and grandson all live together.

- mother has history of alcohol misuse and depression
- poor educational attainment
- ASB among children
- teenage pregnancy
- domestic violence.

FRP Care Plan
- address mother's needs
- pre-birth assessment for pregnant child
- benefits check and provision of support
- examine housing needs
- manage children's behaviour
- gather information on children's health
- nursery placement for three year old
- develop mother's parenting skills
- support 15 and 16 year old re-entry into education
- improve school attendance for all children.

Progress and blocks

All aspects of care plan progressed:

- 15 year old daughter is providing good day-to-day care for her baby and is motivated about education
- oldest child supported to move out of family home due to her behaviour posing risks to her younger siblings. She is now living in a hostel and making appropriate use of the resource. She is visiting home and her behaviour has improved
- mother has used parenting advice and support: children are attending school and nursery, have consistent routines, no exposure to domestic violence and mother is seeking employment.

Strengths

- family reacted protectively and appropriately following domestic violence incident
- mother started attending a course with a view to seeking employment
- non-statutory service (FRP) able to engage in meaningful intervention as family sees them differently to statutory services.

Risks

- meaningful engagement with family is inconsistent and their dishonesty around gang activity and 16 year olds presence in their home raises concerns – although stable for past 6 months
- other and 16 year old do not want to testify against 1 year olds father in court in relation to domestic violence incident – potential lack of insight into concerns.

Estimated costs without FRP

These are the estimated costs that the family would have incurred in a year based on their behaviours in the 12 months leading up to the FRP intervention:

Housing

Noise £686
Housing nuisance £1,206

Anti-social behaviour

2x ASBOs £10,700

Education

2x KS4 (age 14-16 risk of PRU) £34,200
2x NEET £5,542

Domestic violence

Domestic violence £23,200

Family function

3x Looked After Children court proceedings and court costs £72,000
2x Cost of care £93,600

Health

Adult mental health £2,740

Cost avoidance with FRP intervention

Intelligence gathered during and immediately after the intervention suggests that the risks of incurring these costs were reduced by the following due to the FRP intervention:

Housing 90%

ASB 75%

Education 75%

Domestic violence 50%

Family function 50%

Health 75%

Total estimated costs avoided in 12 months following FRP intervention:

£136,000

Family B

Referrer
Education Welfare

Other agencies involved
Education Welfare; Education – School; Health; Housing

Background and concerns
Two children aged 14 and 12, plus adult son who is 20 years old all live at home with the mother. The 14 year old has just started having contact with his father. The mother had her first child removed and placed for adoption when mother was 15 years old and in local authority care. Her other three children have been on CP Register throughout their childhood under the category of neglect – last registration ended 2002.

- domestic violence throughout the parents' relationship
- low school attendance (mother attributed to children being unwell due to serious damp conditions in the home)
- various health concerns surrounding the children including obesity
- concerns around mother's mental health.

FRP Care Plan
- core assessment
- full health assessments of children to ascertain whether housing situation is causing children's illness
- offer support to mother to meet children's health needs
- improve school attendance
- emotional support for mother
- review benefits and mother's aspirations.

Progress and blocks
- family has been re-housed
- children's school attendance has vastly improved. 12 year old had one unauthorised absence. 14 year old's attendance increased to approximately 80 per cent - supported by FRP education worker, education welfare officer and school, plus FRP health visitor, FRP intensive outreach worker and school nurse
- mother and children have acknowledged they are over-weight and the mother has made changes in the diet she provides for the children and is encouraging them to be more active
- the family has agreed to a referral for family therapy - without this intervention it is likely that the mother would have been successfully prosecuted by the education department.

Strengths

- multi-agency working has enhanced understanding of the family's issues and facilitated those needs in a targeted and timely way
- improved housing, education, children's health and mother's emotional well-being
- staged intervention with both adult and children's lead workers has improved outcomes for the family as a whole.

Risks

- engagement and changes made need to be sustained
- contact between children and their father due to historical domestic violence.

Estimated costs without FRP

These are the estimated costs that the family would have incurred in a year based on their behaviours in the 12 months leading up to the FRP intervention:

Housing

Post eviction accommodation provision £18,840
Arrears £360
Eviction £12,994
Possession action £3,748

Education

NEET £2,771
Education welfare and court proceedings £3,369

Family Function

2x Children in Need £600

Health

Chronic health issue/disability £1,793
Adult mental health £2,740

Cost avoidance with FRP intervention

Intelligence gathered during and immediately after the intervention suggests that the risks of incurring these costs were reduced by the following due to the FRP intervention:

Housing 75%

Education 90%

Family function 90%

Health 25%

Total estimated costs avoided in 12 months following FRP intervention:

£34,200

Family C

Referrer
Children's Services

Other agencies involved
Children's Services; Marlborough Family Service & Talking Without Fear; Education-School, School Nurse

Background and concerns:
Single mother with 4 children including a daughter of 18 years old who has a baby born in April 2009, all living in same household. Contact arrangements are in place for the father. The family has been known to Social Services since 1994.

- parents separated after serious incident of domestic violence and mother obtained non-molestation order.
- children have poor attendance and attainment at school
- poor engagement with family therapist
- debts and rent arrears
- mother's low mood
- ineffective parenting.

FRP Care Plan
- individualised benefits/debt advice
- support and advice regarding housing and overcrowding
- address experience of domestic violence with mother and provide support around impact
- explore and put in place family therapy
- work with father around contact with children and other practical issues
- father to be offered risk assessment by domestic violence intervention project worker for perpetrators attached to FRP
- father to be meaningfully engaged with substance misuse services
- health visitor to check baby's progress & development and support around positive parenting, health and nutrition.

Progress and blocks

- mother engaged with parenting support services and there was an improvement in the children's attendance at school. Mother and children are engaged with talking without fear project and therapeutic services
- issues of debt and rent arrears addressed by mother with assistance from FRP benefits advisor
- father attending a residential detoxification programme, prior to FRP involvement. Also participated in the risk assessment for perpetrators and agreed to attend the 32 week programme at the Domestic Violence Intervention Project (DVIP)
- Children having positive contact with father, and both parents wanting to resume relationship
- eldest daughter and baby moved out of family home, easing the overcrowding. However mother's 15 year old niece moved in due to problems at her home. The benefit was counteracted by this arrangement
- father was approaching end of residential placement and talking about returning home. Advised by professionals that he needed to complete DVIP programme and move to second phase of treatment regarding his alcohol programme. Mother also started to disengage with FRP workers and social worker
- father relapsed and presented as angry and violent to family. Mother able to protect children using guidance provided to the family. Children supported during these periods and father was returned to rehabilitation facility
- without this intervention and given the level of violence it was highly likely that the youngest children would have been taken into care.

Strengths

- a multi-agency, targeted approach has improved the complex and longstanding issues for this family
- good partnership working between agencies ensured effective communication creating a sense of cohesion and safety for the family
- consistency in approach by multiple agencies meant the Team Around the Family was able to continue with the care plan despite father's relapse and periodic non-engagement from the family.

Risks

- father's progress is good but he may yet relapse with potentially negative consequences on overall family progress
- longstanding domestic violence and entrenched behaviours are difficult to change – an intensive approach over time is necessary.

Estimated costs without FRP

These are the estimated costs that the family would have incurred in a year based on their behaviours in the 12 months leading up to the FRP intervention:

Housing

2x Arrears £720

Education

NEET £2,771
Education welfare £5,638

Domestic violence

Domestic violence £23,200

Family function

2x Cost of Care £93,600

Health

Adult mental health £2,740
Substance misuse (risk of rehab) £17,400

Cost avoidance with FRP intervention

Intelligence gathered during and immediately after the intervention suggests that the risks of incurring these costs were reduced by the following due to the FRP intervention:

Housing 90%

Education 75%

Domestic violence 75%

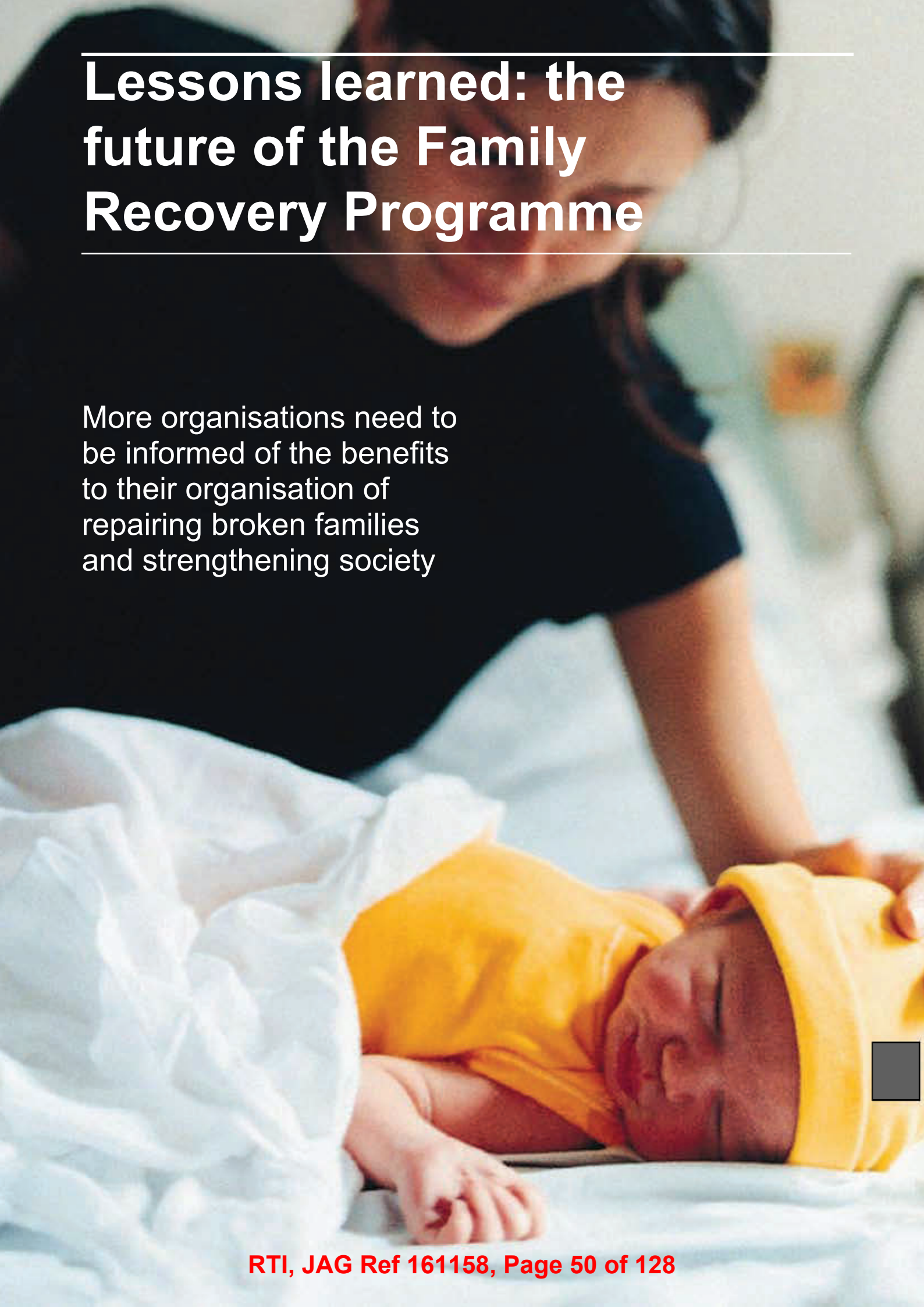
Family function 90%

Health 50%

Total estimated costs avoided in 12 months following FRP intervention:

£118,700

Lessons learned: the future of the Family Recovery Programme



More organisations need to be informed of the benefits to their organisation of repairing broken families and strengthening society

Westminster City Council is extremely proud of the Family Recovery Programme and its results. However, given the uncertain economic climate and the diffuse and often unquantifiable nature of the programme's benefits, we recognise the need to demonstrate its positive economic impact.

The current Department for Education pathfinder funding for FRP ends in March 2011. In a tight fiscal environment and with relatively little of the avoided costs benefiting the local authority, the incentives and justification for further investment by Westminster taxpayers alone are understandably weak.

In the knowledge that Westminster residents receive great benefit from the programme, the council is exploring options to secure the FRP. One option is to widen the funding base so that the organisations that benefit directly from mid to long term cost savings provide investment. This would see more public and quasi-public bodies support the programme, including RSLs and the Probation Service. By bringing more organisations together under the FRP umbrella and increasing their commitment, information sharing between the FRP practitioners and information-holders would also increase.

Another option is to link funding to performance. Using a 'payment by results' model could see clawbacks by funding partners if FRP failed to achieve its cost-avoidance aims for particular bodies.

Proposals for this kind of 'payment by results' models of funding could also ensure higher levels of accountability in achieving positive social outcomes. Currently the diffuse nature of beneficiaries necessitates an overarching view of the FRP's work at central government level before initiating a joined-up approach to a full funding structure. There is also potential to link the programme to an innovative new payment by results scheme for Integrated Offender Management.

As we enter a new financial era where resources are tight, grant funding tied to results is likely to become not just desirable but necessary to drive efficiency, sustain quality and encourage innovation in public services. Traditional funding mechanisms and reporting procedures will inevitably undervalue holistic approaches required to tackle the deep-rooted societal problems that the FRP was designed to address. The current system of local expenditure of centrally raised block grants with results assessed against strict targets handed down by a single Whitehall department does little to encourage the required innovation.

Appendix one: FAQs

Who can make a referral to the FRP?

Referrals are welcomed at any time from statutory and non-statutory agencies. Most referrals to date have been from the children's, adults', child health and crime and anti-social behaviour services. As the project expands, we hope to receive referrals from GPs, voluntary sector partners and other government agencies such as the Probation Service and DWP.

What is the caseload capacity of FRP?

Teams take on 80 cases over a period of 12 months. In its first year the programme concentrated its work in the North and North West of the city, where social exclusion is most prevalent. By September 2009 the service was rolled out city-wide.

Is participation in the FRP voluntary?

Families consent to information being shared between agencies to create their Family Recovery Care Plan at the TAF meeting. They also sign a 'Contract with Consequences', which outlines all the possible repercussions of non-cooperation. 95 per cent of families who have been referred to the FRP have consented to working with the team and have also signed the contract.

How much does the FRP cost?

The funding of the FRP reflects the partnership ethos of the programme.

Breakdown of costs for 2010/11 are as follows:

- Westminster City Council: £400,000 plus housing officer at no cost
- DCSF – Think Family Pathfinder: £300,000
- Westminster PCT: £240,000
- DCSF – Anti social behaviour and youth crime Family Intervention Programme grants: £ 274,000
- Metropolitan Police: providing two police officers at no cost
- European Social Fund - £11,000 for employability work.

How does FRP differ from Family Intervention Projects (FIPs)?

Every local authority now has funding to develop a FIP aimed at families who are engaged in crime and anti-social behaviour.

The aims of the Family Recovery Programme are much wider than FIPs. Whilst a large proportion of those families referred to the FRP have been identified by community protection services, the programme works with families with a wide range of other problems including those associated with poor parenting, low educational attainment and mental health issues. The FRP works with families who are at risk of losing their liberty, their home and/or their children.

How long does the FRP work with a family before statutory care proceedings are put in place?

The FRP currently has several cases where it works closely to support the work done by children's social workers, particularly cases at high level children in need and child protection levels. FRP work will provide evidence upon which children's social care can base decisions about any statutory action around child protection or initiation of legal proceedings. FRP is not responsible for the timing of these decisions but has the responsibility and expertise to indicate and/or refer to statutory agencies when concerns about the welfare of children are raised.

How is the programme being evaluated?

As a recipient of DCSF Think Family funding, the programme will be part of a national evaluation. In addition, the council is monitoring 19 separate performance indicators based on outcomes both for families and for the wider community. The council has also commissioned academic research through the University of East Anglia on the effectiveness of the methods of intervention.

The benefits of early, sustained intervention of this kind are widely accepted but the consequent savings to the public purse have never been clearly articulated. Westminster City Council has, therefore, devised a robust cost avoidance analysis of the overall project.

Appendix two: timeline

The Family Recovery Programme works best when action is swift and effectively coordinated

Day 1

FRP referral is received, the case is screened and a decision about whether to accept the case is made.

Week 1

Within the first week:

- a family visit is completed to obtain consent
- the Information Desk starts a search for data across different agencies.

Week 2

Within the first fortnight:

- the first Team Around the Family (TAF) meeting is held to bring together all relevant agencies including: social services, schools, police and adult mental health workers as well as specialists on family therapy, housing, domestic violence and benefits.
- the care plan is written with input from the family
- a small TAF is established and lead professionals are appointed for adults and children
- the family agrees to the care plan.

Months 1-6

- family seen several times per week by lead workers with support form TAF members
- a schedule of 3 weekly reviews is put in place involving the family to review progress on plans and risks.

Month 6-12

- intensity gradually reduces and contacts with community services are established with the family
- subject to the family's progress, the case is closed and handed over to lower tier services.

Year 2

For a period of up to two years:

- the family is monitored and fast-tracked back into the Programme if necessary.

Appendix three: costs avoided

The research conducted by Westminster City Council into the costs avoided as a result of FRP action is predicated on the published national costs of 25 individual indicators linked to social breakdown. Where this was not available, the council used local unit costs to estimate the total cost avoidance. However, improvements will not always be absolute. For that reason, expert opinions were sought to assess the percentage improvement for each family in relation to each of the measures included in the table below.

Risk	Cost	Source
Rent arrears	£360	Westminster's own administration costs
Noise	£686	DfE Negative Outcomes Costing Tool - Noise including staff time and prosecution and informal intervention
Housing nuisance	£1,206	Westminster's own costs - 40 hours housing officer time
Possession action	£3,748	DfE Negative Outcomes Costing Tool - possession action
Eviction (legal action to LA)	£12,994	DfE Negative Outcomes Costing Tool- nuisance behaviour legal action to local authority
Post eviction accommodation provision	£18,840	Westminster's own costs based on 6 months temporary accommodation
Youth Offending Team (YOT) intervention	£4,391	Westminster's own costs per order/intervention
Career criminal	£8,571	Impact Assessment of Youth Crime Action Plan, July 2008, Home Office, DCSF, MoJ: £300k over a lifetime divided by 35 years
Cost of ASBO	£5,350	DfE Negative Outcomes Costing Tool
Young prolific offender	£24,000	Westminster's own costs – average cost of young prolific offenders in a year prior to joining FRP using costing data from Home Office and other sources
Graffiti	£6,462	DfE Negative Outcomes Costing Tool - Graffiti (low)

KS3 (age 11-13 risk of Pupil Referral Unit)	£39,100	Westminster's own costs
KS4 (age 14-16 risk of Pupil Referral Unit)	£17,100	Westminster's own costs
NEET	£2,771	Estimate cost of being 'Not in Education, Employment or Training' at age 16-18, DCSF, Research Report RR346, 2002: £97k over a lifetime divided by 35 years
Education welfare officer (EWO) (no court)	£2,819	Westminster's own costs based on average cost per educational welfare case
EWO and court	£3,369	Westminster's own costs based on average cost per educational welfare case plus £550 magistrates court fees (from DfE Negative Outcomes Costing Tool)
Domestic violence	£23,200	DfE Negative Outcomes Costing Tool
Child in Need (CIN)	£300	Westminster's own costs of Child Protection staff time, average Section 17 contribution
Parenting Order	£781	DfE Negative Outcomes Costing Tool - Parenting Order. Only families with YOT involvement are at risk of parenting orders
Child Protection Plan	£5,000	Westminster's own costs of child protection staff time, average Section 17 contribution
Looked After Child court proceedings and court costs	£24,000	Westminster's own costs of child protection staff time, average Section 17 contribution. Used where individuals incur legal costs but do not go into foster care
Cost of care	£46,800	Westminster's own costs - 1 year foster care at £900 per week
Chronic health issue/ disability	£1,793	Costs from DfE - 10 x £20 per GP visit, 2 x £116 per outpatient visit, 4 x £32 prescription visit, 2 x inpatient £443 per day. £110/visit, 1 x emergency ambulance x £237/journey
Adult mental health	£2,740	CNWL Mental Health Trust cost of IAPT counselling
Substance misuse (risk of rehabilitation)	£17,400	Westminster's own costs including NHS detox contribution

Local Government Leadership
Local Government House
Smith Square
London SW1P 3HZ

Telephone 020 7187 7388
Facsimile 020 7187 7383
Email info@localleadership.gov.uk

www.local.gov.uk

City of Westminster

Westminster City Council
City Hall
64 Victoria Street
London SW1E 6QP

Telephone 020 7641 2168
Fascimile 020 7641 3156
Email nbishopp@westminster.gov.uk

www.westminster.gov.uk

Local Government Group

The Local Government Group is made up of six organisations which support, promote and improve local government.

Local Government Association
Local Government Improvement and Development
Local Government Employers
Local Government Regulation
Local Government Leadership
Local Partnerships

Printed on 100 per cent recycled paper using vegetable based ink.

For a copy in Braille, Welsh, larger print or audio, please contact us on 020 7664 3000.
We consider requests on an individual basis.

L10-619

WHERE'S THE JUSTICE?: YOUNG PEOPLE, MENTAL HEALTH, AND THE LAW

Roger Hearn

THIS PAPER IS BASED ON THE INTERIM FINDINGS OF "THE YOUNG PEOPLE, Mental Health and Criminal Justice System Project" (YPMHCJS), a one-year study currently being conducted in Victoria.

The primary focus of this paper is on young people with mental health problems who have been unable to access services that adequately meet their needs. In order to highlight current service gaps, it has been useful to look specifically at a particular group in society that has always had trouble getting services—young people who have broken the law. This paper therefore has a particular focus on young people with mental health problems who have had some sort of contact with the criminal justice system. First, however, it will be necessary to look at existing mental health services for all young people. The gaps in services that result in some of these people being caught up in the criminal justice system will then be examined.

The conclusions raised provide us with a useful critique of the deficiencies in our existing mental health services. Some of these are related to a lack of resources. Young people are seen as a low priority when it comes to the provision of services. The process of deinstitutionalisation has meant fewer inpatient services and a greater reliance on community based support services. For young people, however, these services have not been forthcoming.

The location of existing mental health services is usually within institutionalised settings and based on a medical model. The institutionalised nature of psychiatric services has often resulted in an inflexible response to some young people, and a series of gate-keeping measures that can prevent access. Those affected by this include the homeless, young people from lower socioeconomic areas, and substance abusers. Many psychiatric services also have a narrow, medicalised view of mental health. While some young people have significant mental health problems, they are often not able to access adolescent psychiatric services because they are deemed not to have a "diagnosed illness".

The existing gaps in services for young people can have three major implications. First, young people can be caught up within the adult psychiatric system, a system that is ill-equipped to deal with their needs. Second, young people without access to adequate services are driven increasingly to a crisis point that can result in suicide. Finally, many of these young people, denied support through the mental health system, can find themselves in contact with the criminal justice system. This system is not equipped to deal adequately with these young people. The ignorance of mental health problems prevalent in the general community is reflected in all levels of the criminal justice system. Current legal process does not provide a context for young people's mental health problems to be explored adequately. This can result in young people with mental health problems being caught up in the criminal justice system. This places further barriers to young people accessing appropriate mental health services.

Services for Young People With Mental Health Problems

Mental health services traditionally have been offered in specialist, state-run psychiatric facilities. With the moves towards deinstitutionalisation, however, there has been a reduction in inpatient public adolescent psychiatric services. Whilst deinstitutionalisation has led to fewer places in psychiatric units, this process has not been followed up adequately with community based support services.

It should be noted that the community, when well resourced, is the most appropriate place to provide services for young people suffering from a range of mental health problems. Few young people require specialist psychiatric services with inpatient care. However, mental health budgets in the State of Victoria continue to reflect an emphasis on inpatient care. Currently, around 80 per cent of funding is still geared toward the large state-run institutions. Only 2.6 per cent of the mental health budget goes to the community managed support services, with only a few of these services offering any programs for young people. This means that support services for young people often are not available, or are inadequately resourced. Moves toward deinstitutionalisation are to be applauded, but only when the process is accompanied with a genuine shift in resource allocation.

Young people with mental health problems and psychiatric services: the gate-keeping strategies

Some young people are at an extreme disadvantage when it comes to locating mental health services that meet their needs. Many of Victoria's decreasing public adolescent psychiatric facilities appear to be inaccessible to young people who are homeless, who come from lower socioeconomic backgrounds, who are from broken families, or for a range of other reasons. This is disturbing, given that research has suggested that the young people who are traditionally excluded from services have a higher incidence of mental health problems (Elliot et al. 1989).

Socioeconomic factors and mental health service provision were highlighted in "The National Youth Survey", a longitudinal study of American youth. The study found that lower class young people have a higher identifiable incidence of mental health problems than middle-class young people. However, it found that the middle-class youth utilised mental health services more often than lower class youth (Elliot et al. 1989). These findings were supported by a Western Australian study (Cook 1988), which discussed improvements in child and adolescent psychiatric services, but highlighted young people who were socially disadvantaged as not utilising these services.

Institutional settings—a major deterrent for young people

The traditional setting of the majority of the State's adolescent psychiatric services is medical and institutional. Many of the institutions are large, or they are placed within general hospitals. As a consequence this places restrictions on some young people, who can find it difficult to access services so located. The medicalised nature of many of the adolescent psychiatric services provides a major deterrent for some young people. These include formalised admission procedures and lengthy waiting periods. Many adolescent psychiatric units consulted in the study had waiting periods of two to three months. Homeless young people who may have difficulty when it comes to making appointments in the long term, or who are put off by formalities, are at a particular disadvantage.

Finally, access to the larger hospital-based services seems to be geared more to adults, either parents or service providers. This is based on the location of the services and the procedures for entry. It would take a very motivated young person to access these services without the support of a well informed adult.

The family in treatment

Adolescent psychiatric services have traditionally required that a patient's family is involved in therapy. Although said to be changing, this still appeared to be the preference of most of the adolescent psychiatric services consulted during the study. This is based on the assumption that treatment is only really effective when the family is involved. This reliance on family poses a number of problems that can prohibit access to services for some young people. A commitment from a family to be involved in treatment implies a time and money component. For people from low income groups these costs could be a significant prohibitive factor.

Another problem with a reliance on families in treatment occurs if you do not have a family, or if your family is just not interested in being involved. A young person may also have good reasons for not wanting his or her family to take part in treatment. For example, homeless young people forced to leave the family home because of physical or sexual assault may have grave concerns about involving an abusive parent in treatment. Such a requirement restricts the choice of service available to young people. It could also be argued that for many young people the family has ceased to be the most

significant influencing factor in their lives once a certain age has been reached. Often a young person's peer group has a far greater impact upon him or her.

The secure and stable home environment

The requirement by most of the adolescent services that a young person have secure housing before treatment is offered is another measure that can keep some young people away from services. The importance of secure housing cannot be under-estimated when it comes to a person's mental health. Generally, it would be desirable for a young person to have a stable home before treatment commences. However, sometimes this is not possible. For some young people a mental health problem might need to be addressed before they are able to access a housing service; for example, in cases where a person has extremely challenging behaviours. Overall, this factor has the tendency to encourage Community Services Victoria (CSV) and psychiatric services to avoid taking responsibility, placing the young people concerned in a "Catch 22" situation. This effectively excludes them from any service.

The issue of guardianship

For the adolescent services which are (reluctantly) prepared to admit young people where there is no family involvement, the issue of guardianship is another prohibitive factor. There is a requirement that a young person has a guardian who can take responsibility where necessary. CSV has the power to take on this role, particularly in cases where there are protective issues involved, but is often reluctant to do so.

Some organisations consulted during the YPMHCJS study discussed CSV's reluctance to deal with protective issues after a young person had turned fifteen years of age. The reluctance was amplified when a young person had been caught breaking the law. Current Victorian legislation means that seventeen-year-olds are not eligible to have guardianship vested by any department. For young people who do not have the active involvement of a parent, this can pose significant problems. There is a reluctance by adolescent services to admit people on an involuntary basis (which is what is required if a parent is unwilling or unavailable to provide consent), hence there is a tendency for this group of young people to be denied services at these facilities.

Mental health services for young people awaiting legal proceedings

Another major concern identified during this study was the reluctance by adolescent psychiatric units to accept young people awaiting legal proceedings. As will be discussed later, this can result in some young people being unnecessarily detained within the criminal justice system. What was particularly disturbing was that this practice can also extend to young people who have been victims of crime (for example, survivors of incest). This was on the basis that a young person may be removed from the family environment if CSV were to become involved. It was also felt that allegations needed to be addressed in court before treatment could be offered.

Inexcusably long waiting periods for psychiatric services also had the effect of streaming some young people with mental health problems into the criminal justice system. In one instance, a fifteen-year-old male was involved in a serious shooting. He was identified as having a serious mental health problem and being a potential danger to both himself and the community. The magistrate deferred sentencing for three months until he had sought psychiatric assistance. However, when he was referred to the local psychiatric unit he was placed on a three-month waiting list.

To exclude young people in these situations goes against the United Nations Charter on the Rights of the Child, of which Australia is a signatory. It also contradicts the Victorian Government's social justice strategy in relation to providing equal access to services.

Other deterrents to adolescent psychiatric services

Other barriers also exist for young people with "dual disabilities". Young people who have an intellectual disability coupled with a mental health problem, are often excluded from services at adolescent psychiatric services. The situation is often worse for young people with borderline intellectual disabilities. These young people can find themselves trapped between two systems and receive help from neither.

Age can be another barrier to access. Many adolescent services do not see young people in the seventeen to eighteen-year-old bracket.

Similar problems also exist for young people who are substance abusers and who have a mental health problem. Given the close link between substance abuse and crime, this service gap increases the likelihood that a young person's needs in this area are met inappropriately through the criminal justice system. The nature of the state's adolescent psychiatric units usually means that they are unable to provide a service for young people exhibiting aggressive behaviours. As will be described later, this can result in young people entering the adult psychiatric system.

A fifteen-year-old male who, at the time of contact, was being discharged from an adult psychiatric facility was deemed unsuitable for an adolescent psychiatric service because he was "too young". The young person was on probation and facing other charges. He had no stable home environment to return to. It is easy to see how this young person could find himself within the juvenile justice system. He was suffering from a severe mental health problem that had in the past contributed to his offending behaviour. Without support and a home, it was unlikely that he would last long before coming to the attention of police.

Personality disorders

During the study, a number of youth supervision units reported that in some cases the label "personality disorder" was being placed on their clients. This often had disastrous results for the labelled young person. In one case, a young person had previously been hospitalised in an adult psychiatric unit and assessed as "schizophrenic". After a stint of law-breaking he was given a sentence in a youth training centre. A referral was made to the psychiatric

unit he had previously attended. However, the young person was now assessed as a "sociopath" by this unit and therefore was not seen as suitable for treatment. Whilst it is not possible to determine the appropriateness of these assessments, it seems possible that a person's mental illness could be cast as a personality disorder as soon as that person offends.

The Garry David case has also begun a debate that has seen a further withdrawal by mental health professionals from "treating" people with personality disorders. No longer defined as "mad" by the 1986 Victorian Mental Health Act, the response of psychiatrists to people with the sometimes dubious title of "personality disorders", has been to refuse treatment. These people are now seen to fit into the domain of the criminal justice system. The Victorian Law Reform Commission's (1990) report on this subject discussed the importance of not refusing hospitalisation to a person suffering a personality disorder, where other criteria are met.

Private mental health services

It is disturbing to note that more inpatient services are provided for young people in the private sector than in the public sector. This has a number of implications relating to the services received by young people. Private services exclude young homeless people and most families on low incomes because of the financial outlays required. For example, the average cost per day for Pathways, a Melbourne clinic, is over $500. It seems possible that the provision of private psychiatric services could result in different outcomes for the children of higher income earners who are caught "acting out". They may have a greater chance of being "treated" in a private facility rather than "punished" in the criminal justice system.

These deficiencies in service provision can have three major consequences, a young person will end up in an inappropriate adult psychiatric system; within the criminal justice system; or finally they may take their own lives.

The Adult Psychiatric System as a Catchment Area

A significant number of young people is ineligible for adolescent psychiatric services because of the gate-keeping measures highlighted earlier. For these young people the long-term prognosis appears bleak. In an address to the Federal Human Rights Commission Inquiry into Mental Illness, Professor David Leonard (1991) outlined the dangers for adolescents placed into adult services. These included assault by chronic patients, and the development of inappropriate behaviours including self-mutilation or violence. Treatment in such a setting could actually do more harm than good. Post traumatic stress syndrome is the name given to a condition that follows a "harmful" stay in a psychiatric hospital. The recent audit of Victoria's psychiatric services painted an even grimmer picture of the abuse faced by residents in the State's psychiatric hospitals (Health Department of Victoria 1992).

Young People and Suicide

One implication of not having a range of mental health services for young people experiencing mental health problems is that they might take their own lives. This might result from a severe mental illness. However, during the study, many youth services talked of the frustration of trying to refer a young person who was suicidal, but not seen as "mentally ill", to psychiatric services. In a number of cases young people were refused services only to attempt a suicide soon afterwards. The Australian Bureau of Statistics figures show the rate of suicide for young people aged between fifteen and nineteen, has increased 100 per cent since 1965. Suicide is second to motor car accidents as the most common form of death for young people. The suicide rate for fifteen to nineteen-year-old urban males increased by almost 100 per cent between the periods 1968 and 1988. The increase for rural youth was 500 per cent in the same period (Dudley 1992, p. 83).

The Criminal Justice System as a Catchment Area

Kosky et al. (1990) found that young people in an Adelaide youth training centre had emotional and behavioural disorders at a comparable level to young people attending adolescent psychiatric services. They found that most of the young people remanded in custody came from a "chaotic social background and were without education and family support" (Kosky et al. 1990, p. 24). Studies in the USA showed distinctions on the basis of race. Lewis et al. (1980), in a comparison between adolescents in a State psychiatric hospital and a correctional facility, found that both groups had essentially the same characteristics with regard to psychotic symptoms and offending behaviours. The study found that white adolescents were more likely to be hospitalised in the psychiatric hospital, while black adolescents were more likely to be incarcerated in the correctional facility. It would be interesting to compare these results with the situation for Aboriginal people, given their over-representation in the criminal justice system.

Some factors responsible for apprehension

Acting out resulting from a "psychotic episode" Young people who are experiencing episodes of a serious mental illness may commit offences that are entirely related to their illness. As Anne Deveson (1989, p. 169) recalls in her account of her son Jonathan's schizophrenia:

> their crimes are usually petty ones—failing to pay a bus fare, petty theft, vagrancy—the kind of crimes that Jonathan kept committing. A young man picks up a brick and smashes the plate glass window of a retail store because he sees a dinosaur jumping out at him. A young woman is repeatedly arrested for walking out of restaurants without paying because she believes she does not need to pay. She says she is the reincarnation of Jesus Christ.

Depression, aggression and crime During the YPMHCJS study, some young people linked their criminal activity with factors such as depression or substance abuse. Studies have identified young people as more likely than the general community to suffer from depression (Howard 1987). These studies also link depression with substance abuse. Depressed young people would actively seek exciting activities that were often illegal or dangerous. These activities could often be exacerbated by substance abuse. Depression can also lead to young people, especially young males, displaying aggression towards others. Young people also cited boredom as a contributing factor in substance abuse and crime.

Homelessness Young people with mental health problems make up an increasing number of the homeless population, both in Australia and overseas (for an Australian example, *see* Herrman et al. 1990).

The report by the Human Rights and Equal Opportunity Commission (HREOC) (1989) *Our Homeless Children*, found that young homeless people had a greater likelihood of being involved in the criminal justice system. This was related to the greater visibility of homeless people and hence their increased likelihood of being detected by police. Young homeless people are also forced into crime because they lack an adequate income, or because of a need for shelter, which might result in an apprehension for trespass. For a variety of reasons, these problems are exacerbated for homeless young people with mental health problems (who have a higher rate of apprehension and detention).

The HREOC report (1989) also found that young offenders, after being placed in correctional institutions, were generally at a higher risk of homelessness because of the lack of special programs on release. It also appeared to be the case for young people leaving wardship. This displays quite clearly how the state, through neglect, can aggravate a young person's mental health problems, by releasing them into homelessness. It also stamps an inevitability on a young person re-offending because of his or her lack of secure housing.

The Police as the first Point of Contact

In attempting to determine why some young people with mental health problems might be inappropriately streamed into the criminal justice system, it is useful to look at police involvement with this group.

As already discussed, mental illness can increase the risk of arrest, particularly if a person has the added disadvantage of being homeless. Several studies have displayed the difficulties faced by police in determining the incidence of mental illness when dealing with the public (*see*, for example, Teplin 1984). By not being able to identify when someone has a serious mental illness, police may have a tendency only to act on an offending behaviour.

The YPMHCJS Project is currently undertaking research to determine the level of understanding of mental illness by police in Victoria. Early

indications suggest a major need for training about mental illness. Training would need to promote skills that enable a greater understanding and awareness. However, there is also a significant need for police to have a clearly defined set of procedures in relation to dealing with this group. Where these are not available, a lack of uniformity in police responses can result. Often, however, no amount of training for police will provide alternatives to detention. At present, because of the service gap in generic youth housing and specialised mental health services, very few options exist. In particular, young people with extreme behavioural or emotional problems, but not suffering from a "diagnosable" mental illness, provide police with few alternatives. Dr David Wells, the Chief Police Surgeon, consulted during the YPMHCJS project, described attempts by police to access psychiatric services as a "nightmare", particularly adolescent services. He viewed many of the existing services as "inflexible" when it came to admitting people.

During the YPMHCJS study, police described the hours spent driving from hospital to hospital, trying to find a place for someone in an acute condition. This also included travelling to country areas when city hospitals could not be accessed. The trauma in these instances could only exacerbate existing conditions.

The Children's Court

Magistrates appear to have the same difficulty as police in dealing with this group of young people, particularly those with extreme behavioural problems. The high number of young people with mental health problems in correctional facilities suggests that magistrates have, in the past, lacked specific skills in identifying mental health problems and/or lacked suitable options regarding alternatives to incarceration within a youth training facility or prison. The lack of alternative options for magistrates was raised during the YPMHCJS study and reflected the concerns raised in other studies (for example, the Social Development Committee, 1991). In particular, young people who were described as "seriously disturbed" and who could pose a risk to society, posed significant problems.

Observations conducted during the study have shown major difficulties for young people to receive a fair court hearing. Young people had limited opportunities to speak with duty lawyers. Often young people stated that they were encouraged to plead guilty to charges they did not commit, in order to get a lighter sentence. It seems unlikely that young people's mental health problems would receive much attention in a system that allows little examination of the young person's life situation.

After the Institutions—Young People in the Community

Young people face a gamut of problems when they re-enter the community after a stay in a youth training centre or a psychiatric facility. These include a lack of housing, vocational and financial options. Being labelled "young offender" or "mentally disordered" excludes these young people from a range of opportunities and services available in the community. Any additional

problem or disability the young person might have places further restrictions on the community resources that are available to this group. An amazing array of official and unofficial restrictions can face a young person trying to gain access to services. These include restrictions for substance abusers, people with psychiatric problems, behavioural problems, and dual disabilities. Age is also a restriction. All too often these restrictions force the young person back in contact with the criminal justice system. The increased pressure of living in unsupported and unstable environments can also exacerbate mental health problems.

Strategies to Deal With Mental Health Problems

Society has a number of choices in the way it deals with mental health problems. Problems can be responded to when a crisis point is reached, in a residual or "band-aid" manner. Alternatively, a problem can be viewed in a more comprehensive manner that takes into account the variety of contributing factors related to mental health problems.

Structural factors can contribute to less than optimum levels of mental health for society as a whole. For example, unemployment is a situation that can contribute to or result in mental health problems. However, given the current high levels of unemployment, there is little that young people can do on an individual level to address this. The issue of homelessness is another crucial variable that can have a detrimental effect on mental health. Power imbalances based on gender also have a negative impact for some. Structural factors therefore need to be placed foremost on the policy agenda regarding how our community deals with mental health problems.

The variety of systems that interact with children and young people need to be examined and healthy outcomes encouraged; for example, relevant educational opportunities and family support needs to be available. Where intervention is necessary, different systems (like mental health and welfare systems) need to be able to interact in a positive and beneficial manner. It is also necessary to improve the relationship between the various systems to ensure that young people receive the most appropriate services. High risk areas, low income areas, for example, need to be highlighted. Finally, individuals need mental health services that are relevant to their life situation, not just for the best possible outcomes for psychiatric services. Services need to be accessible to individuals, alone or with their families or with relevant peers.

Financial cost cannot be used as a justification for a shortfall in services. The cost of keeping a young person in a youth training centre is high. Some of these young offenders go on to serve time in adult prisons. Therefore, the long-term expense that can result from not providing services that prevent people with mental health problems from entering the criminal justice system, or by not addressing young offenders' health needs once they are within the system, can be astronomical. Most importantly, the human costs can be devastating.

References

Cook, H. 1988, "Disturbed children and adolescents—whose responsibility", *The Bulletin of The National Clearinghouse For Youth Studies*, vol. 7, no. 4, November.

Deveson, A. 1989, *Tell me I'm here*, Penguin Books, Ringwood, Victoria.

Dudley, M., Howard, J., Kelk, N. & Walters, B. 1992, "Youth suicide in New South Wales: urban-rural trends", *The Medical Journal of Australia*, vol. 156, January, pp. 83-8.

Elliot, D., Huizinga, D. & Menard, S. 1989, *Multiple Problem Youth: Delinquency, Substance Use, and Mental Health Problems*, Springer-Verlag, New York.

Health Department of Victoria 1992, *Audit of Standards of Treatment and Care in Psychiatric Hospitals in the State of Victoria*, Victorian Government Printer, Melbourne.

Herrman, H., McGorry, P., Bennet, P. & Singh, B. 1990, "Age and severe mental disorder in homeless and disaffiliated people in inner Melbourne", *The Medical Journal of Australia*, vol. 153, August.

Hirst, C. 1989, *Forced Exit: A Profile of the Youth and Homeless in Inner Urban Melbourne*, Crossroads Youth Project, Community Services Victoria and Salvation Army, Melbourne.

Howard, J. 1987, " 'Life's a bitch and then you die'—depression, delinquency and suicide", in paper presented at the conference on Youth Suicide, *The Australian Experience*, New South Wales.

Human Rights and Equal Opportunity Commission 1989, *Our Homeless Children*, Australian Government Publishing Service, Canberra.

Kosky, R., Sawyer, M. & Gowland, J. 1990, "Adolescents in custody: hidden psychological morbidity?", *The Medical Journal of Australia*, vol. 153, July.

Law Reform Commission of Victoria 1990, *The Concept of Mental Illness in the Mental Health Act 1986*, no. 31, April, Melbourne.

Leonard, D. 1991, "Submission to the Human Rights and Equal Opportunity Commission Inquiry Into Mental Illness", April.

Lewis, D., Shanok, S., Cohen, R., Kligfield, M. & Frisone, G. 1980, "Race bias in the diagnosis and disposition of violent adolescents", *American Journal of Psychiatry*, vol. 137, no. 10, October.

Social Development Committee 1991, Inquiry into Mental Disturbance and Community Safety, *Young People at Risk*, First report, Victorian Government Printers, Melbourne.

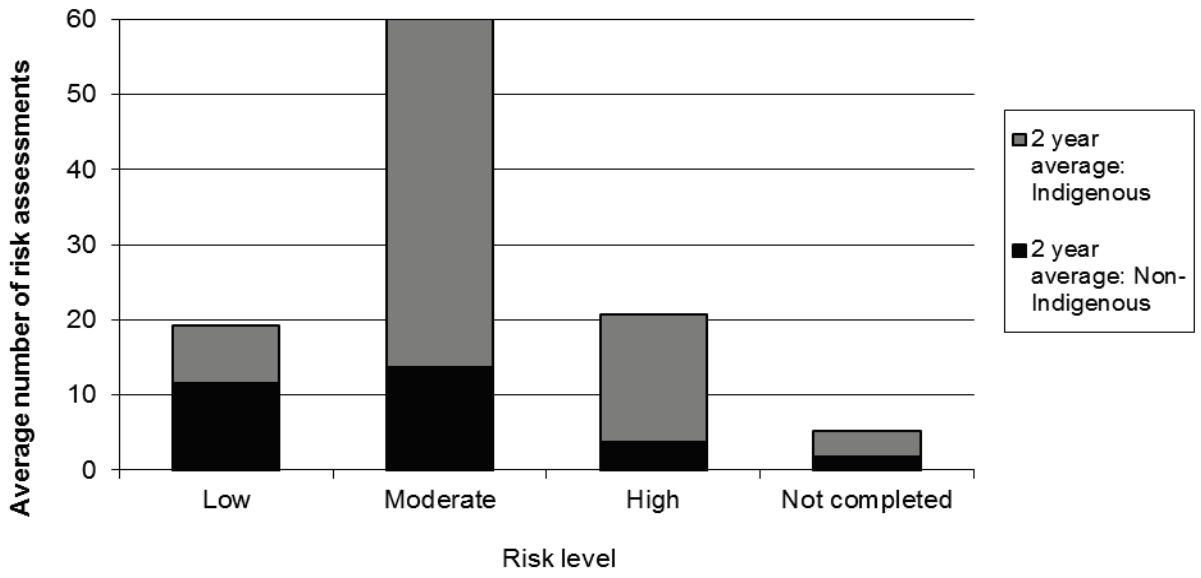
Teplin, L. 1984, "Criminalising mental disorder, the comparative arrest rate of the mentally disordered", *American Psychologist*, vol. 39, no. 7.

Summary of key data: Rockhampton Youth Justice Service Centre

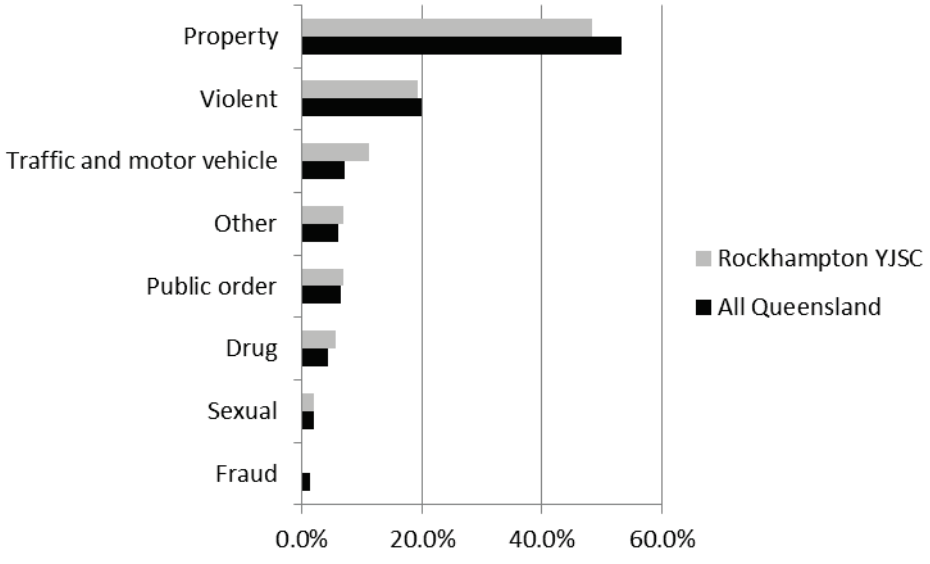
Admissions to orders, Rockhampton 2011-12

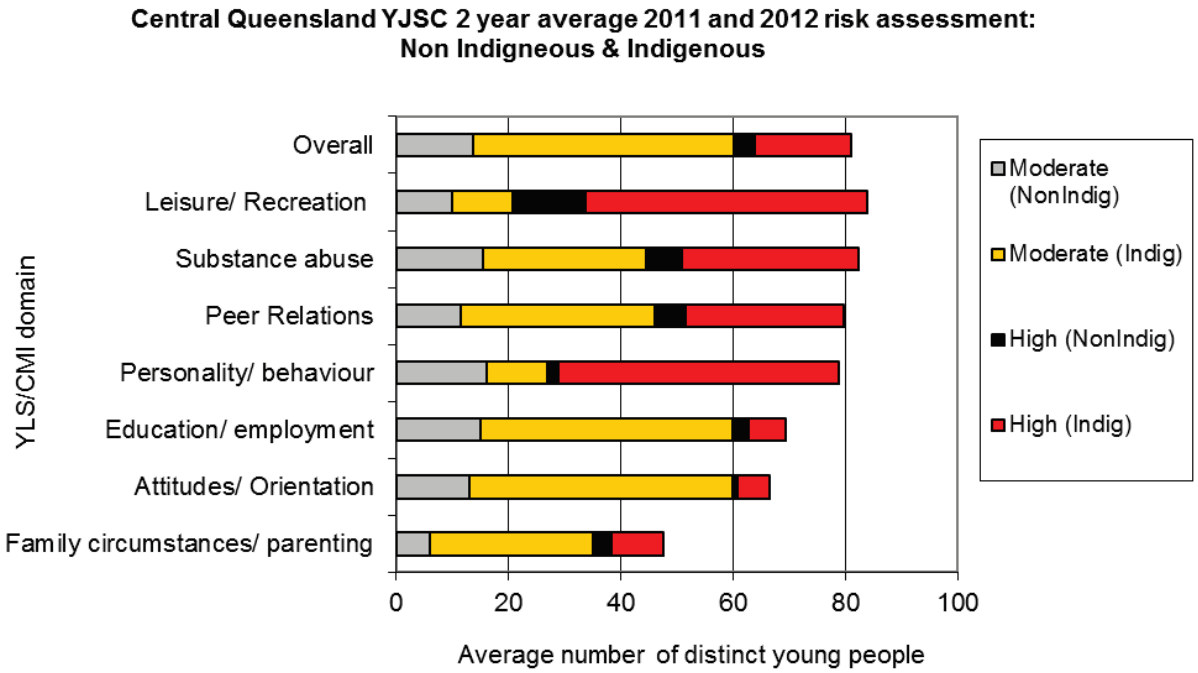
Order type	Number of orders	Proportion of Queensland total	Distinct young people	Average orders per young person	Average orders per young person: all QLD
CSO	54	6.43%	40	1.35	1.21
CRO	21	8.4%	18	1.17	1.07
Detention	37	11.5%	19	1.95	1.45
Probation	96	6.9%	70	1.37	1.23
SRO	34	15.7%	17	2.00	1.32

Overall risk level (2 year average of 6 month periods): Rockhampon YJSC



Proportion of the most serious proven offences for distinct young offenders, 1 July 2012 to 31 March 2013: Rockhampton YJSC and State-wide average





Family

80% of young people assessed in the first three quarters of 2012-13 have one or more issue relating to family and parents (the state-wide average is 72%).[1]

Mental Health

The proportion of risk assessed young offenders assessed with characteristics consistent with the five selected mental health conditions, Quarter 1-Quarter 3 of 2012-13

- One or more identifiable mental health issue: 85% (state-wide average 80%)
- Two or more identifiable mental health issue: 67% (state-wide average 60%)
- Conduct disorder: 71% (state-wide average 59%)
- Substance misuse disorder: 69% (state-wide average 62%)

[1] Scoring for the family domain is not sensitive enough for Youth Justice Clients. Conversely the scoring for leisure and recreation is considered too sensitive and is interpreted with caution.

YLS/CMI indicators of mental health concerns

Mood Disorder/psychosis: one or more

- personality behaviour: has inflated self esteem (Mood disorder, Psychotic Disorder)
- youth depressed (Mood disorder)
- youth suicide attempts (Mood disorder)
- youth diagnosis of psychosis (Psychotic Disorder)

ADHD

- personality behaviour: has short attention span (ADHD)

Substance Misuse Disorder: one or more

- chronic substance misuse (Substance Misuse Disorder)
- chronic alcohol misuse (Substance Misuse Disorder)
- substance misuse interferes with life (Substance Misuse Disorder)
- substance misuse linked to offences

ODD – 2 or more

- personality behaviour: has poor frustration tolerance (Oppositional Defiance Disorder)
- personality behaviour: has tantrums (Oppositional Defiance Disorder, PTSD)
- personality behaviour: verbally aggressive and impudent (Conduct Disorder Oppositional Defiance Disorder)
- engages in denial (Conduct Disorder)

Conduct disorder: 3 or more

- personality behaviour: has inadequate guilt feelings (Conduct Disorder)
- three or more prior convictions (Conduct Disorder)
- three or more current convictions (Conduct Disorder)
- education: history of truancy (Conduct Disorder)
- personality behaviour: physically aggressive (Conduct Disorder)
- personality behaviour: verbally aggressive and impudent (Conduct Disorder Oppositional Defiance Disorder)
- personality behaviour: verbally aggressive
- orientation: antisocial pro-criminal attitudes (Conduct Disorder)
- orientation: defies authority (Conduct Disorder, Oppositional Defiance Disorder)
- orientation: is callous and has little concern for others (Conduct Disorder)
- engages in denial (Conduct Disorder)
- History of sexual and physical assault (Conduct Disorder)
- assault on authority figures (Conduct Disorder)
- history of weapons use (Conduct Disorder)
- history of setting fires (Conduct Disorder)
- History of escapes (Conduct Disorder)
- Third party threat (Conduct Disorder)