

Factors that influence Youth Offending Workers' Assessment of Mental Health Difficulties in Young Offenders.

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ABSTRACT

Introduction. Research has shown that there is a high prevalence of mental health difficulties in young offenders. The Youth Offending Service (YOS) uses a structured assessment tool, ASSET to identify risk factors and inform interventions to address identified risks. Mental health difficulties are one of the known risk factors for offending in young people. Very little is known about the process of mental health assessment and what influences Youth Offending Workers' approach to assessments. The assessment of mental health difficulties has implications for access to mental health services for young people. Therefore, it was felt to be important to understand the assessment process in order to identify how to improve the quality of the assessment. This study explores the factors that influence Youth Offending Worker's assessment of mental health difficulties in young offenders.

Method. Nine Youth Offending Workers from three Youth Offending Teams in South Wales were interviewed using a semi-structured interview schedule. The content of these interviews were analysed using constructivist grounded theory.

Results. Four themes relating to Youth Offending Workers' assessment of mental health difficulties in young offenders were identified: *'Organisational context'*, *'The Youth Offending Worker'*, *'The young person's context'* and *'Reaching a decision'*.

Discussion. The four themes interact with one another and impact on the Youth Offending Workers' assessment of mental health difficulties in young offenders. The findings have a number of clinical and service implications for the Youth Offending Service as well as Clinical Psychology Provision. This includes the need for Youth Offending Workers to; receive more training around mental health difficulties, to have access to clinical supervision and have a better understanding of mental health services. This should help to improve the quality of mental health assessment, ensuring young people's mental health difficulties are identified so that they receive appropriate support to address these difficulties.

1 CHAPTER ONE: INTRODUCTION

1.1 Section one: Introduction

This chapter is divided into five parts. Part one defines the key terms and gives an overview of the prevalence of youth offending, the risk factors associated with youth offending and the financial and social costs associated with youth offending. Part two gives an overview of the structure of the Youth Offending Service (YOS) at a national and local level. Part three focuses on assessment of mental health difficulties within youth offending. This section also provides a theoretical understanding of decision-making in a clinical context. Section four provides a systematic review focusing on the experience of professionals in Criminal Justice Services (Police Officers, Prison Officers and Youth Offending Workers), working with people with mental health difficulties. Finally, section five outlines the rationale and aims for the present study which aims to explore the factors that impact on Youth Offending Workers' assessment of mental health difficulties in young offenders. The literature was identified using key words and databases, which are provided in Appendix 1.

1.2 Definition of key terms

1.2.1 Young offender/youth offending

The UK has three separate criminal justice services, England and Wales, Scotland and Northern Ireland. Each system defines and responds to young offenders differently (McVie, 2011). For the purpose of this study all references to youth offending and/or Youth Offending Services (YOS) will relate to the England and Wales, unless otherwise stated. This is because the research was conducted in South Wales, which is governed by the English and Welsh Criminal Justice Service.

England and Wales have set the age of criminal responsibility at 10 years of age (Great Britain, 1933, 2004). YOS in England and Wales provide a service to all young people aged 10-18 years who have been convicted or cautioned with a criminal offence or who are at significant risk of offending (Crime and Disorder Act, Great Britain, 1998). At the age of 18 years a young person becomes an adult

offender and their management transfers to Probation (Youth Justice Board (YJB), 2012b).

1.2.2 Defining mental health difficulties

The definition of mental health is a widely debated topic with many interpretations and definitions. Defining mental health difficulties in children and young people is even more difficult. There are a number of definitions of mental health, mental health difficulties and mental illness, and these terms are also used interchangeably. For the purpose of this study the term mental health difficulties will be used, other than when citing research where the term used within the research will be used.

One such definition of mental health is provided by the World Health Organization (WHO), who defines mental health as:

“...a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community” (WHO, 2007),

and mental illness as:

“...a broad range of problems, with different symptoms. However, they are generally characterized by some combination of abnormal thoughts, emotions, behaviour and relationships with others” (WHO, N.D).

The Mental Health Act (Department of Health, 2008, P.7.) defines mental illness as *“any disorder or disability of the mind”*. In 2007 Bradley was asked by the UK Government to undertake a review of mental health services for offenders of all ages in the UK. In this report Bradley (2009) uses Nacro’s (2005) (a UK crime reduction charity) definition which defines offenders who have mental health problems as individuals:

“...who may be acutely or chronically mentally ill; those with neurosis, behavioural and/or personality disorders; those with learning difficulties; some who, as a function of alcohol and/or substance misuse, have a mental health problem; and, any who are suspected of falling into one or other of these groups. It also includes those in whom a degree of mental disturbance is recognised, even though that may not be severe enough to bring it within the

criteria laid down by the Mental Health Act 1983, and those offenders who, even though they do not fall easily within this definition – for example, some sex offenders and some abnormally aggressive offenders – may benefit from psychological treatments” (Nacro, 2005, P.1.).

Bradley (2009) identified the difficulty in defining mental health needs in young people and instead chose to look at the definition of good mental health in children as a way of identifying how children with mental health difficulties may present. Bradley utilised the National Health Service (NHS) Health Advisory Service definition of good mental health in children, which is defined as:

“... the capacity to enter into and sustain mutually satisfying and sustaining personal relationships. Continuing progression of psychological development. An ability to play and to learn so that attainments are appropriate for age and intellectual level. A developing sense of right and wrong. A capacity to deal with normal psychological distress and maladaptive behaviour within normal limits for the child’s age and context” (NHS Health Advisory Service, 1995, p.6, in Bradley, 2009).

The definition of good mental health in children and young people will be used by the researcher to define mental health difficulties in children and young people as the absence of one or more of the criterion for good mental health. This definition fits with the researcher’s aim to look at mental health more broadly than the presence of a mental health diagnosis.

1.3 Prevalence of mental health difficulties in young people

It is estimated that, at any one time, around 1.2–1.3 million children (Kim-Cohen, 2003), and one in ten five to sixteen year olds in the UK, will have a diagnosis of a mental health problem (Office of National Statistics (ONS), 2004). Conduct disorders are the most common diagnosis, followed by emotional disorders such as depression and anxiety and then developmental disorders such as ADHD. Of adults experiencing mental illness, half first experience symptoms by the age of 14 years and three quarters by their mid-20s (Kim-Cohen, 2003). Rates of mental health disorders increase in adolescence from 13% for boys and 10% for girls aged 11-15 to 23% in males and females by 20 years of age (Hawton *et al.* 2002). It is reported from hospital records that 13% of 15-16 year olds have self-harmed; however, the figure is likely to be much higher as most young people do not present to Accident

and Emergency after self-harming (Hawton *et al.* 2002). All of the figures stated above are likely to be an underestimation of the level of need around mental health difficulties in young people due to stigma and under reporting (Hawton *et al.* 2002).

1.4 Youth offending in England and Wales

1.4.1 Prevalence of youth offending in England and Wales

Despite a fall in youth offending in England and Wales (Youth Justice Board (YJB), 2014c), there is growing public and political concern about the impact of youth offending (Halsey and White, 2009 and Grimwood & Strickland, 2013).

The latest published statistics showed that in 2012/13, 1,072,068 people were arrested in England and Wales. Of these, 167,995 (15.7%) were young people aged 10-17, of which 27,854 young people (16.6%) were first time offenders (Home Office 2014 and YJB, 2014c).

Of the 167,995 young people who were arrested there were 98,837 proven offences by young people, which represented a fall of 28% from the previous year and an overall fall of 63% since 2002/03. (YJB, 2014c). This fall is thought to be a result of increased spending on prevention services (YJB, 2014a).

1.4.2 Risk factors associated with offending in young people

Research has identified a number of risk factors associated with offending and risk of re-offending by young people. The YJB identifies both static and dynamic factors associated with risk of offending. Static factors “...will remain as they are for the duration of a young person’s order” (YJB, 2010c, p.17). (A young person’s ‘order’ is set by the court and refers to the length of time they require supervision and the specifics relating to their involvement with the Youth Offending Team (YOT)). Examples of static factors include gender, type of offence and the age a young person first came into contact with YOS (YJB, 2005b). Dynamic factors refer to risk factors that the YOT “...can affect change on during the course of an order” (YJB, 2010c, p.17). It is not within the scope of this thesis to explore all of the risk factors associated with youth crime; however, key factors will be presented. For a full review

of the risk factors associated with youth offending see the YJB's report 'Risk and Protective Factors' (YJB, 2005b).

Both static and dynamic risk factors can be categorised under four key areas: family; school; community; and personal/individual factors (YJB, 2005b). There are a number of common risk factors for offenders of all ages, including living in poverty (Farrington, 1992a; 1992b), poor maternal mental health (Basher and Nurse, 2008) and poor education (Kolvin *et al.* 1990; Yoshikawa, 1994; Maguin and Loeber, 1996). There are also a number of factors more specifically associated with young offenders. These include having a close family member who has offended (West 1982; Graham and Bowling 1995); poor parental relationships (Boswell 1995; Margo 2008); unstable living conditions (Liddle 1998); being in care (Social Exclusion Unit, 2001); poor attendance or exclusion from school (Graham and Bowling 1995); lack of engagement in activities outside of education (Margo 2008); socialising with anti-social young people (Goodman and Butler 1986); spending more time with peers than family (Margo 2008); living in a high crime area (Goodman and Butler 1986); mental health difficulties in adolescence (Mrazek and Haggerty, 1994); and aggressive behaviour in childhood (Haapasalo and Tremblay, 1994 and Tremblay *et al.* 1994). It is important to acknowledge that the causal relationship of risk factors is difficult to establish, for example, the risk factor of being in care may be a result of the association between risk factors for being in care and risk factors for offending rather than a direct link between being in care and future offending. This complex relationship is also likely to be present between offending and mental health difficulties in young people.

1.4.3 Mental health as a risk factor for offending in young people

Mental health difficulties are one of the known risk factors for offending in young people (Mrazek and Haggerty, 1994). Difficulties with substance misuse and other hard to treat mental health difficulties are seen as a risk factor for involvement with the criminal justice service for both adults and young people (WHO, 2012).

Bailey, Vermerien and Mitchel (2007) highlight a number of reasons why there may be an association between mental health and offending. For example, many of the

risk factors associated with poor mental health, such as living in poverty, difficulties at school, crime in the neighborhood and social exclusion, are also associated with offending (WHO, 2012 and YJB 2005b). It is also suggested that the stress associated with criminal activity and subsequent involvement with the criminal justice service may increase the risk of developing mental health difficulties (WHO, 2012).

1.4.4 Prevalence of mental health difficulties in Young Offenders

Academic understanding of the prevalence of mental health difficulties in young offenders has been increasing over the last decade. However, research into this area has not been prioritised in the same way as mental health difficulties in adult offenders (Vermeiren, 2003). The research that has been conducted to date shows high prevalence rates of mental health difficulties in young offenders. Prevalence rates have been shown to vary from 50% to 100% (Atkins *et al.* 1999, Teplin *et al.* 2002, Vermeiren *et al.* 2003, Dixon *et al.* 2004 and Leaderman *et al.* 2004). A UK study showed that the prevalence of mental health disorders in young offenders was three times that of the general population of young people (Hagell, 2002). However, the exact prevalence varies widely from study to study. There are a number of reasons for this including differences in how mental health difficulties are defined, the focus of the research and differences in participants e.g. their social background or criminal offence (Bailey *et al.* 2007).

A YJB review of mental health needs in young offenders, both in the community and in prison settings, found the following prevalence rates: 31% of young people presented with a mental health difficulty, 18% had depression, 10% presented with anxiety, 9% reported a recent (within the last month) incident of self-harm, 9% had PTSD, 7% had hyperactivity difficulties and 5% reported psychotic-like experiences (Chitsabesan *et al.* 2006 and YJB 2005a). These rates were ascertained by reviewing the ASSET profiles (core YOT assessment see section 1.11 for detailed explanation) for 301 young offenders and completing the Salford Needs Assessment Schedule for Adolescents (with the same sample of young offenders (YJB 2005a). The percentage of young people within the youth justice system experiencing mental health difficulties was found to be significantly higher than the YJB estimate (Stallard *et al.* 2003). They found that out of 41 young people, 56% presented with a potential

mental health difficulty that required further assessment. These studies were further supported by a study by Anderson *et al.* (2004) in which 50 young offenders were interviewed about their health needs. Out of 50 young people, 22 (44%) were found to have a score indicating a likelihood of mental health difficulties, compared to 10% of the general population of children.

A recent profiling of prolific offenders (25+ offences, in 303 young offenders) in Wales found that 57% had had contact with mental health services, 10% had received a formal mental health diagnosis, 63% were described as coming to terms with a significant past event, 30% were experiencing an emotional or psychological difficulty, 29% had previously self-harmed and 16% had previously attempted suicide (Welsh Government, 2014). The figures for other factors that are known to be associated with mental health difficulties (Rutter *et al.* 1998) were also high, for example, 86% had a chaotic home life, 55% had experienced abuse and 48% had witnessed violence in the home (Welsh Government, 2014). These figures show that there is a high prevalence of mental health difficulties and associated risk factors in prolific young offenders in Wales. The figures thus highlight the importance of being able to identify mental health difficulties and associated risk factors at the earliest opportunity (YJB 2005b).

As well as high rates of mental health difficulties in young offenders, it has also been suggested that there is a high rate of attachment difficulties in people of all ages who go onto offend. A study in the USA found that violent youths and adults were significantly more likely to have an attachment disorder. This group were also more likely to present with co-morbid mental health difficulties (Seifert, 2003 and YJB, nd). Studies have also shown high rates of childhood trauma such as abuse and neglect in young offenders (Boswell, 1996; Fonagy *et al.* 1997). Renn (2010) highlights the potential link between childhood trauma and offending where by the offence may be an 'acting out' of childhood trauma. It has also been shown that trauma affects brain development which may impact on emotional regulation and control increasing the risk of violent offending (Schore, 2003). This may explain the high rates of childhood trauma in young offenders.

If mental health difficulties are not identified and the appropriate support is not offered to young people there are implications for both the young person and society as a whole. Mental health difficulties are known to impact on young people in a number of ways including increasing the risk of having mental health difficulties as an adult (Kim-Cohen *et al.* 2003), social exclusion, poor inter-personal relationships, poor physical health, poor education, employment difficulties and increased stress within the family (WHO, 2003). Also mental health difficulties are a known risk factor for reoffending so not addressing mental health in young offenders increases the likelihood of crime being committed (Mrazek and Haggerty, 1994 and WHO, 2012).

1.4.5 Self-inflicted death in custody

Mental health needs of offenders are identified initially using the ASSET, this information is sent with the young offender if they are sent to prison. Between 1990 and 2011, 31 males between the age of 14 and 17 died in custody in the UK and 29 of these deaths were self-inflicted (Prison Reform Trust and Inquest, 2012). During the same time period, 419 young people aged 18 to 24 years died in custody in the UK, of which 363 (87%) were self-inflicted deaths (Prison Reform Trust and Inquest, 2012). These figures show the importance of young people having an accurate assessment of their mental health needs in order to provide them with appropriate care whilst in custody. Recent reports from coroners' enquires for young people who have died in custody as a result of self-inflicted injury highlight the lack of a detailed mental health assessment at the point of entry to prison as one of the failings that led to self-inflicted deaths in custody (Coles and Shaw, 2012, Lambert Report, 2005, and Prison Reform Trust and Inquest, 2012). The government has recently commissioned an independent review of all self-inflicted deaths in custody of people aged 18-24 (Justice, 2014). The YJB is due to publish a report looking at deaths in custody following a review of all deaths of under 18s since 2000. One of the actions from this report focuses on assessment of young offenders (Justice, 2014).

1.5 Costs associated with youth offending

Offending and re-offending has large financial and societal costs. Being able to identify risk factors such as mental health difficulties and work with the young person

to address these difficulties should help to reduce the costs associated with re-offending.

1.5.1 Financial costs

A longitudinal study carried out between 2000 and 2009 identified the average financial cost associated with each young offender in the UK to be £8,000 per year and the cost of the most prolific 10% of offenders to be £29,000 per offender per year (National Audit Office, 2011). The costs associated with the whole youth offending population in the UK were estimated to be £1 billion a year in 1996 (Audit Commission, 1996). These include costs associated with police time, court proceedings and punishment (National Audit Office, 2011). The Prince's Trust (2010) estimated the cost of crime committed by young people aged 10-17 in 2008 to be £340,688,000 in England and £17,826,000 in Wales. These costs included costs associated with convictions and management of offenders, as well as costs associated with the fear of crime (increased security) and losses from crime (e.g. stolen property). Other reports such as The Independent Commission on Youth Crime and Antisocial Behaviour (2010) have estimated the cost of youth crime in the UK to be £4billion per year, significantly higher than the Prince's Trust's figure. Whilst these costs are estimates, they highlight the potential significant cost associated with criminal activity by young people. There are no reports specifically looking at the cost of youth offending in Wales. However, these reports highlight societal costs both at a taxpayer level and at an individual level due to loss from crime and are likely to be similar in Wales.

1.5.2 Societal costs

Costs to victims of crime committed by adult and young offenders can be separated into tangible and intangible costs. (Dolan *et al.* 2005). Tangible costs are costs that can be measured and are divided into realized costs and anticipatory costs. Realized tangible costs can be either direct or indirect. Direct costs are where financial resources are diverted from other sources in response to the crime, for example, costs associated with medical treatment or police time in collecting statements. Indirect costs refer to losses in earning or output as a result of taking time off work

following a crime. Anticipatory tangible costs relate to the costs associated with attempts to reduce the chance of a crime reoccurring e.g. installing a burglar alarm or buying a rape alarm (Dolan *et al.* 2005).

Intangible costs are harder to measure but can also be broken down into realised and anticipatory costs. Realised intangible costs are associated with the emotional impact of being a victim of crime, and anticipatory intangible costs refer to emotional costs associated with the fear of being a victim of crime (Dolan *et al.* 2005). Many of the intangible costs of crime to victims are hard to define and measure, because many costs associated with being a victim are psychological. The potential impact on the emotional wellbeing of a victim can be far reaching, and a victim of crime may experience feelings of grief, emotional pain and emotional suffering (Dolan *et al.* 2005).

Young offenders themselves are at high risk of being a victim of crime, with over half having been a victim of crime in the same year that they committed their offence (Devitt *et al.* 2009). This exposes the young person to the potential costs associated with being a victim of crime discussed above, and may, in turn, increase the risk factors associated with the young person going on to reoffend (YJB, 2005b).

1.6 Re-offending by young people

1.6.1 Rates of re-offending

Proven re-offending is defined as:

“...any offence committed in a one year follow-up period and receiving a court conviction, caution, reprimand or warning in the one year follow up or a further six months waiting period” (Ministry of Justice, 2012, p.3).

The number of young people reoffending has dropped 49% from 139, 326 young people in 2000 to 70, 504 young people in 2011/12 (YJB, 2014c). This drop in re-offending is cited by the YJB as evidence that the youth offending policy relating to reducing re-offending is working. However, as highlighted in a Youth Justice report in 2014 (YJB, 2014c), this means that the current cohort of young people who re-offend

have significant needs. The YJB, suggest this will make it more difficult to reduce re-offending further (YJB, 2014c).

1.6.2 Re-offending risk factors

Research has identified a number of risk factors associated with reoffending in young people. Risk factors included family, school and community factors such as being in care, poor education, poverty and mental health difficulties (YJB, 2005b).

Research has also shown that the higher the number of risk factors, the more involved a young person is likely to be with the YOS and the more likely they are to reoffend (Wilson and Hinks, 2011). The number of risk factors can thus be used to predict the likelihood of reoffending, with the average number of risk factors associated with reoffending being four (Wilson and Hinks 2011). Due to identified relationship between risk factors and reoffending, it is considered to be important to be able to identify risk factors to target interventions in order to reduce reoffending rates (NACRO 2006, Kemshall 2008a, 2008b and YJB, 2005b, 2010c).

1.7 Section Two: The Youth Justice Service

1.7.1 Legislation

Youth offending in England and Wales is legislated by the UK Government. The Crime and Disorder Act 1998 (Great Britain, 1998), Youth Justice and Criminal Evidence Act (1999) and the Children's Act (Great Britain, 2004) set the agenda for the management and prevention of crime by young people. The main aim of these policies is to reduce the risk of offending by young people. These policies, alongside the green paper, Every Child Matters: Change for Children in the Criminal Justice System (Department for Education and Skills (DfES), 2004), place a requirement on all local authorities to assess the needs of young people who enter the criminal justice system.

1.7.2 Youth Justice Board

The Youth Justice Board (YJB) was established in 1998 through the Crime and Disorder Act (1998). The YJB was formed in response to a government report in

1996 focusing on youth offending in England and Wales (Audit Commission, 1996). This report highlighted major failings in the approach to youth offending. It identified a lack of co-ordination between agencies, which led to poor management of offending behavior in young people due to poor working practice and lengthy delays (Audit Commission, 1996). The report led to the publishing of a white paper in 1997 which outlined the need for a strategy for youth offending work that focused on prevention of offending and re-offending through a partnership between all agencies involved in the YOS (Home Office, 1997). The YJB was thus created to provide a national co-ordination of Youth Offending Services (YOS) in England and Wales.

The YJB is responsible for monitoring the YOS in England and Wales, setting national standards for the provision of services, advising on how to meet the aims of the YOS, promoting and encouraging good practice and safely managing the custody of young people. The YJB is accountable to the Ministry of Justice (YJB, 2014b). There are currently 10 members of the YJB with a range of professional backgrounds; the current interim chair is Angela Sarkis (YJB, nd a).

1.8 Policy

The YJB sets the policy for YOS including policy relating to the assessment of mental health. The following section provides an overview of the relevant policies.

1.8.1 National standards

The National Standards for Youth Justice (YJB, 2010b) set minimum standards required for YOS. These are:

- 1 "Preventing offending;
- 2 Out-of-court disposals;
- 3 Bail and remand management;
- 4 Assessing for interventions and reports;
- 5 Providing reports for courts youth offender panels and civil courts;
- 6 Working with the courts;
- 7 Working with victims of crime;
- 8 Planning and delivering interventions in the community;
- 9 Planning and delivering interventions in custody and resettlement into the community;
- 10 Working with long-term custodial sentences" (YJB, 2010b).

1.8.2 Key elements of effective practice

The YJB provides evidenced-based Effective Practice Guidelines on the core aspects of work of the YOS. Key elements of effective practice have been developed in the following areas: accommodation; assessment; planning interventions and supervision; education, training and employment; engaging young people who offend; mental health; offending behaviour programmes; parenting; restorative justice; substance misuse; and young people who sexually abuse. These guidelines allow local services to create and evaluate a tailored approach to working with young people that sits within the national framework (YJB, 2010b).

1.8.3 Scaled approach

Following a consultation period the YJB introduced the Scaled Approach to Youth Justice in 2010 (YJB, 2010c). This approach focuses on identifying the individual's needs in order to target interventions. This allows a tiered approach to be taken to intervention planning, with the aim of reducing re-offending and the risk of serious harm (YJB, 2010c).

1.9 Youth Offending Teams

The YJB brought about wide changes in Youth Justice, with perhaps the most significant being the introduction of Youth Offending Teams (YOTs) in England and Wales (Home Office, 2009). For the first time there was a statutory duty on local authorities to provide a number of services for young offenders including: appropriate adult service (i.e. the provision of an appropriate adult when a child or young person is in custody, being interviewed by the police or in court); assessment and intervention (including mental health); supervision of offenders in the community; and implementing referral orders for young people (Great Britain, 1998 and Ashford and Chard, 2000). The Crime and Disorder Act (Great Britain, 1998) also placed a duty on the Police, Probation and Health to cooperate with local authorities in the provision of YOS (Ashford and Chard 2000).

YOTs have a primary aim of preventing offending and reoffending (Crime and Disorder Act, 1998). YOTs are expected address the welfare needs of a young person and to enforce the order set down by the court (Crime and Disorder Act, Great Britain, 1998 and YJB, 2008a, 2010b). The act sets out a minimum requirement for staffing within a YOT. This includes at least one of each of the following:

1. *“An officer of a local probation board or an officer of a provider of probation services;*
2. *where the local authority is in Wales, a social worker of the local authority;*
3. *a police officer;*
4. *a person nominated by a Primary Care Trust or a Local Health Board, any part of whose area lies within the local authority’s area;*
5. *where the local authority is in Wales, a person nominated by the chief education officer appointed by the local authority under section 532 of the Education Act 1996”* (Crime and Disorder Act, Great Britain, 1998 Section 39(5)).

A team manager line manages the YOT staff and monitors key performance indicators set by the YJB (Crime and Disorder Act, Great Britain, 1998). The YOT managers are responsible to the Head of Children’s Services within the Local Authority. Each Local Authority is expected to provide a Youth Justice Plan, which outlines how it intends to implement the YOS in its local area (Crime and Disorder Act, Great Britain, 1998).

YOTs are often subdivided into different teams which focus on a specific area of offending. How each YOT provides its service is down to the discretion of the team manager with reference to YOT policy (YJB, 2010c). In the area where the research has been conducted, the teams are divided into Early Intervention and Prevention Teams, Court and Assessment Teams, Community Supervision Teams and Intensive Supervision and Surveillance Programme Teams (ISSP). An example of the role of these teams is given below.

Early Intervention and Prevention Teams work with young people who have been given a Final Warning or a Youth Rehabilitation Order. These orders are given to young people who admit to the police that they are guilty of an offence that is not

considered serious enough to go to court (YJB, 2010d). Prevention teams now also work with young people who are at high risk of behaviour (YJB, 2014a).

Court and Assessment Teams provide an appropriate adult service to young people under the age of 18 who have been detained by the police but do not have the support of an appropriate adult e.g. parent. The team also carries out initial assessments which are presented to court in order to inform the sentence that is given. The team also provides supervision of young people who have been bailed from police custody (Caerphilly County Borough Council, nd).

Community Supervision Teams take on case responsibility for all young people on court orders and ensure that the young person completes the planned intervention by the end of their order. These teams also maintain case responsibility for young people in prison (Caerphilly County Borough Council, nd).

Intensive Supervision and Surveillance Programme Teams (ISSP) provide intensive intervention for repeat offenders and serious offences. They provide close supervision with the aim of addressing the underlying needs of the offender which are thought to have led to the criminal activity (Caerphilly County Borough Council, nd).

1.9.1 The role of a Youth Offending Worker

Youth Offending Workers hold case responsibility for young people and undertake the initial and on-going assessment of all young offenders (Crime and Disorder Act, Great Britain, 1998, YJB, 2010b). Youth Offending Workers come from a range of professional backgrounds.

“There are no minimum entry requirements though many YOT Workers have a degree or equivalent qualification in youth justice, youth work, social work, criminology or other relevant subjects...Most employers would expect experience of work with young people at risk”. (Skills for Justice, nd).

1.10 Youth offending in Wales

1.10.1 Jurisdiction

Law enforcement is not devolved to the Welsh Government, unlike the welfare of young offenders, including housing, health and education (YJB, 2004). Therefore, the Welsh Government does not have jurisdiction over the legal framework but is able to influence and direct services that focus on the young person's needs e.g. housing, health and education.

1.10.2 Policy

The YJB and the Welsh Government produced the All Wales Youth Offending Strategy in 2004 (YJB, 2004). This document sets out the national strategy for reducing offending and reoffending by young people in Wales. A number of key priorities are identified for YOSs in Wales. These priorities include: enabling better identification and support for young people at risk of offending; providing effective community sentences and providing equal provision of services for Welsh children as compared to English. The strategy is due for updating; however, at the time of writing this has not been published (YJB, 2004).

The Welsh Government has also published a white paper focusing on Prevention of Offending by Young People, which is currently out for consultation (Welsh Government, 2014). This white paper focuses on resettlement of prolific offenders (25+ offences) following either a community or custodial sentence.

1.10.3 Structure of services across Wales

There are 18 YOTs in Wales, which are subdivided across four regions. These regional groups provide leadership and aim to ensure consistency across the regions. There is also one secure children's home and one Youth Offending Institution (YOI) (YJB, 2004, Welsh Government, 2012).

As part of the All Wales Youth Offending Strategy (YJB, 2004), a Forensic Adolescent Consultation and Treatment service (FACTS) was created. FACTS provide consultation, training and advice to Child and Adolescent Mental Health Services (CAMHS) and other services working with young offenders and, where appropriate, they work directly with young offenders (NHS Wales, 2012)

1.10.4 Provision in the geographical area

The research was conducted in one of the four youth justice regions in Wales. The region consists of three YOTs and covers five local authorities (with two YOTs covering two local authorities each). The region has a total population of 576,754 (20% of the population of Wales), of which 175,955 are aged between 10 and 18 years (Welsh Government, 2011). In 2012-2013 there were 2825 young people known to the YOS in Wales, with 790 young people (27.9%) open to the YOSs in the research area (YJB 2014c).

Each of the teams has access to their own Community Psychiatry Nurse (CPN)/ Clinical nurse specialists (term used interchangeably), who is seconded from CAMHS within the Local Health Board. The teams also have access to two Clinical Psychologists who work within the Local Health Board CAMHS Tier 3 Forensic Mental Health Service (FMHS) one day a week. The FMHS provides a consultation service for young people presenting with complex and persistent mental health conditions who have contact with YOS. The FMHS meets once a month and includes, two Psychologists, a Consultant Psychiatrist, a Clinical Nurse Specialist from each of the three YOTs, a Nurse Manger, a CPN for Learning Disabilities and a member of Tier 4 FACTs.

1.11 Section three: Assessment of young offenders

ASSET is the main assessment tool used within YOS. It covers the main risk factors associated with youth offending and includes a section on 'emotional mental health needs'. The ASSET is completed at the point the young person comes in to contact with the YOT and is used to inform the court's decision and the intervention and risk

management plan for the young person. If the young person is sent to prison the 'emotional mental health' section of ASSET is used to inform the risk management plan in prison, therefore the accuracy of the assessment is important.

1.11.1 ASSET

The YJB commissioned the University of Oxford to create an assessment tool for the YOS in England and Wales. Alongside this the YJB compiled a panel of experts from YOS, Education, Health, Police, Probation and the Drugs Prevention Advisory Service to ensure that the tool would provide an assessment of a number of risk factors and needs associated with offending. Baker *et al.* (2003) provide an outline of the key requirements set by the YJB for the tool, including identifying key factors, predicting reoffending, identifying young people who present a risk of serious harm to others, identifying young people who are at risk of being harmed and identifying where a more in-depth assessment is required.

Based on these criteria, a standardized assessment tool known as ASSET was created. This tool aims to identify risk and protective factors that are associated with reoffending, which can then be used to develop an intervention plan to reduce the risk of re-offending (YJB, 2011b).

ASSET combines elements from clinical and actuarial assessments. Clinical assessments are subjective in nature and lead to an individualised assessment of the factors influencing the offending behavior (Baker *et al.* 2003). Actuarial assessments use statistical data to predict future behaviour based on the presence or absence of known risk and protective factors (Baker *et al.* 2011). ASSET also includes a self-assessment section as a way of allowing the young person's voice to be heard (YJB, nd f).

ASSET is underpinned by developmental life span theory (Sampson and Laub, 1993) and research focusing on the 'criminal career' paradigm (Blumstein *et al.* 1988 and Graham and Bowling 1995). Developmental life span theory states that adolescents who do not have strong social bonds are more likely to become involved in criminal activity. In order to reduce the risk of reoffending, the young person needs

to experience a turning point or change in their life, for example, getting a job, getting married and maturing (Sampson and Laub, 1993). The ‘criminal career’ paradigm highlights that factors leading to crime can change throughout the course of the ‘criminal career’, for example, the initial reason for committing a crime may not be the same reason for the continuation of criminal activity (Blumstein *et al.* 1998 and Graham and Bowling, 1995). These theories, along with the identified personal and environmental risk factors identified by Rutter *et al.* (1998) for offending, were used to inform the development of the tool.

1.11.2 Structure of ASSET

ASSET is made up of five sections: a core assessment section, a vulnerability section, indicators of risk of serious harm section (YJB, nd e), a young person section and a planning and intervention section (Baker *et al.* 2003). (See table 1.)

Components of ASSET.	Components content aim of assessment
Core Assessment	12 sections assessing risk and protective factors (see figure 1)
Vulnerability	Assessing key vulnerabilities including bullying, relationship difficulties and self-harm and or suicide attempts
Risk of Serious Harm (ROSH)	Assessing risk of serious harm to others
What do you think? (Young person, YJB, nd f)	Aiming to gain young person’s views
Planning and intervention	Covering an intervention plan, risk management plan and a vulnerability management plan

Table 1. An overview of the sections within ASSET.

The core assessment component of ASSET consists of 12 sections which cover 12 identified risk factors for offending by young people, one of which is mental health (Baker, 2003). Figure 1 outlines the 12 factors and highlights the complex relationships between them (see Figure 1).



Figure 1. The 12 sections of the ASSET Core Assessment. (Baker, nd)
(Reproduced with permission from Kerry Baker and Colin Roberts)

ASSET is not meant to be prescriptive but it is meant to guide a conversation that will inform the assessment process (YJB, 2010a). Each of the 12 sections of the core assessment in ASSET is set out as a number of questions with yes/no or don't know responses, and each response is scored 0-4 with:

- “1 =Slight, occasional or only a limited indirect association;
- 2= Moderate but definite association – could be a direct or indirect link. May be related to some offending, but not all. Tends to become offending related when combined with other factors;
- 3 = Quite strongly associated – normally a direct link, relevant to most types/occasions of his/her offending;
- 4= Very strongly associated – will be clearly and directly related to any offending by the young person. Will be a dominant factor in any cluster of offending-related problems”.

(YJB, nd b, p.3, see appendix 2 for examples of scoring)

An ASSET score of two or more for any of the sections is an indicator of a risk of future offending and identifies the need for further support in that area (Baker *et al.* 2005). Youth Offending Workers' have to provide written evidence to support their

responses and justify their decision-making, including evidencing how the factor links to the offending behaviour. (YJB, 2010a).

The YJB has commissioned a new version of ASSET, AssetPlus, which aims to provide an assessment and intervention plan that can *“follow a young person throughout their time in youth justice system”* (YJB 2013a). AssetPlus places greater emphasis on professional judgment and is expected to provide a more focused intervention plan for young people. AssetPlus is due to be launched in 2014/2015. For the purposes of this study all references to ASSET will relate to the current assessment tool unless otherwise stated.

1.11.3 Procedure for assessment

All young people who enter the YOS have a detailed assessment carried out by a Youth Offending Worker (YJB, 2012a). The point at which the assessment is conducted depends on the nature of the crime, the plea the young person makes and the sentencing process. The initial ASSET acts as the pre-sentence report (PSR) which is presented to the court to assist the court in deciding the most appropriate outcome for the young offender (YJB, 2006 and 2010a). Figure 2 outlines the process of assessment and the main pathways within YOS.

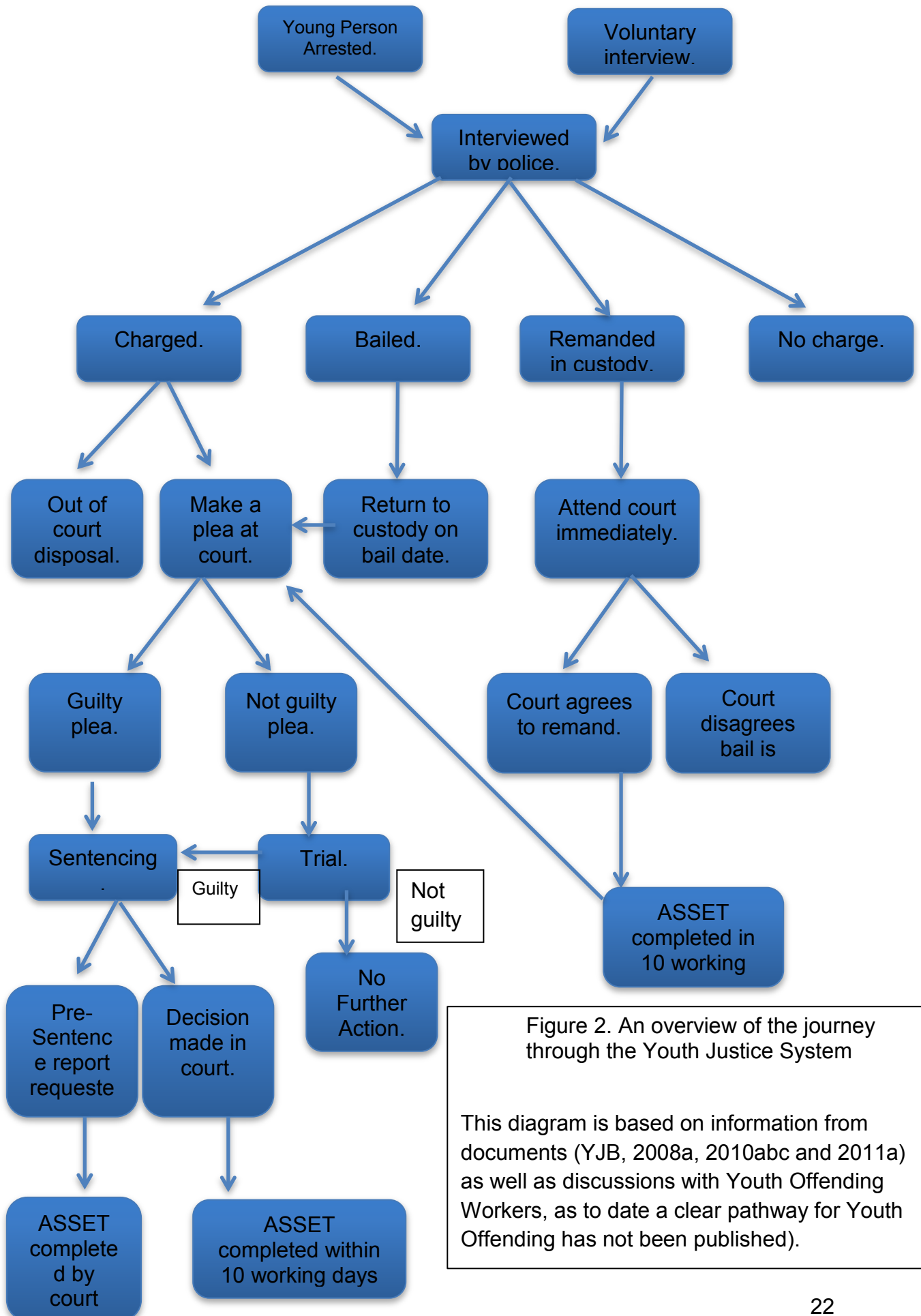


Figure 2. An overview of the journey through the Youth Justice System

This diagram is based on information from documents (YJB, 2008a, 2010abc and 2011a) as well as discussions with Youth Offending Workers, as to date a clear pathway for Youth Offending has not been published).

1.11.4 Evidence base

The validity and inter-rater reliability of ASSET has been measured in three YJB funded studies: Baker *et al.* (2003), Baker *et al.* (2005) and Wilson and Hinks (2011).

Predictive validity

The studies looked at the predictive validity of ASSET, by looking at the extent to which it is able to predict future re-offending.

Baker *et al.* (2003) measured the predictive validity of 3,395 completed ASSET's by comparing reconviction rates at 12 months with the total score from the core ASSET. The study found that the accuracy rate for predicted reconviction based on the ASSET scores was 67%, this rate is considered to be above chance (50% or more Copas, 1992). Baker *et al.* (2003) conclude from the study that ASSET has a high rate of predictive validity and state that predictive validity is similar to that found for assessment tools used with adult offenders (Baker *et al.* 2003; Raynor *et al.* 2000). Baker *et al.* (2005) found a similar rate of predictive validity of 69.4% at 24 months. Ten out of the 12 core factors in ASSET were found to be statistically significant at predicting reoffending. However, both physical and mental health scores were not statistically significant at predicting reoffending (Baker *et al.* 2003).

Wilson and Hinks (2011) found that ASSET provided a high rate of predictive validity for reoffending $t(5124) = 27.5, p < .001$ with an effect size of eta squared = 0.13 for reoffending (n=7,621). Out of the 12 dynamic factors in the ASSET, six were statistically significant. Again both physical and mental health scores were not found to be statistically significant (Wilson and Hink, 2011)

Whilst Baker *et al.* (2003) found ASSET to have a high rate of predictive validity, they present percentages rather than a more robust correlation measure, which is normally used to address predictive validity. Correlations are used as they look at the relationships between a test and the outcome (Shaughnessy, 2000). Baker *et al.* (2005) and Wilson and Hinks (2011) use a correlation to rate the predictive validity of ASSET. Therefore, it is not possible to compare the predictive validity of ASSET

across the studies. It is also important to note that all three studies were funded by the YJB, which may have implications for the impartiality of the results.

Inter-rater reliability

Inter-rater reliability refers to level of consistency in the use of a tool across different raters. Baker *et al.* (2003) looked at the reliability of the ASSET by comparing assessments completed by Youth Offending Workers with Probation backgrounds and Social Services backgrounds, from nine YOTs in England and Wales. Inter-rater reliability was calculated by dividing the young person's static score with their overall score to give a scoring ratio. The mean scoring ratio was compared between professional backgrounds and between YOTs. Baker *et al.* (2003) reported a high level of reliability between workers from a Probation and Social Services backgrounds, both before sentencing (Probation, $p=.561$ and Social Services, $p=.475$) and after sentencing (Probation, $p=.398$ and Social Services, $p=.149$). However, when assessing the reliability of assessments between teams, the study found a low level of reliability for four of the nine teams. This has implications for how widely ASSET data can be used on a national scale to inform policy, as there appears to be inconsistency in the way each team uses ASSET. This also has implications for this study as each of the three teams may have a different approach to ASSET. The approach for measuring inter-rater reliability looked at mean ratio scores rather than comparing the scoring of one case by different professionals, which may have implications for the level of reliability on a case-by-case basis.

Baker *et al.* (2005) used a videoed case study to assess inter-rater reliability for 60 Youth Offending Workers from eight YOTs. Baker *et al.* (2005) used intra-class correlation coefficient (Shrout and Fleiss, 1979) to measure the correlation between ratings. They report statistical significance with a $p<.001$ for all three case studies and conclude that there was consistency across raters. However, they also found that, on occasions, Youth Offending Workers rated the case studies based on perceived needs rather than factors associated with the risk of reoffending. However, there was a low rate of completion (less than half) which has implications for the results in terms of the representativeness of the sample and the reliability of the analysis due to the number of ASSETs completed.

Youth Offending Workers' perspectives of ASSET

Baker *et al.* (2003) reported an analysis of questionnaires completed by 213 Youth Offending Workers from 39 YOTs. Wilson and Hinks (2011) also reported qualitative data from interviews with 102 Youth Offending Workers from 28 YOTs.

Wilson and Hinks (2011) reported that Youth Offending Workers felt that ASSET provided a useful checklist, helped them focus their thinking and ensured they took a holistic view of the young person. However, they also felt that ASSET could be subjective, as individual workers may weigh up the information differently and thus score differently. They also suggested that some questions were not relevant and that there were some gaps in the assessment (Wilson and Hinks, 2011). Baker *et al.* (2003) reported similar findings with Youth Offending Workers describing the subjective nature of ASSET. However, Baker *et al.* (2003) conclude that the high inter-rater reliability for ASSET suggests this is less of a problem in practice.

Nearly half of the Youth Offending Workers reported finding it difficult to discuss emotional and mental health difficulties with young people, due to a perceived lack of skills (Wilson and Hinks, 2011). Baker *et al.* (2003) found a similar response, with participants stating that they had to make decisions about mental health difficulties without being qualified to do so. Wilson and Hinks (2011) also found that the young person's level of engagement and the Youth Offending Worker's training and skills made the assessment of emotional and mental health easier.

Baker *et al.* (2003 & 2005) conclude that the findings of their studies should be shared with Youth Offending Workers and used to support ASSET training for Youth Offending Workers.

1.11.5 Training of Youth Offending Workers

Training for Youth Offending workers is organised at a local level and is the responsibility of the YOT manager. There is no formalized ASSET training, but managers are expected to ensure that Youth Offending Workers have the necessary skills to carry out ASSET (Baker *et al.* 2003). The Key Elements of Effective Practice for Assessment, Planning, Interventions and Supervision document (YJB, 2008a)

offers Youth Offending Workers specific advice on how to communicate with young people and parents/carers during the assessment and identifies potential training needs of YOT Workers in relation to assessment. Guidance on using ASSET is also available (YJB, nd d, 2003, 2008a and 2011b).

The training needs of Youth Offending Workers were highlighted as an area for concern in study by Roberts *et al.* (2001). This study involved sending questionnaires on the use of ASSET to 350 Youth Offending Workers from 39 YOTs in England and Wales, 213 Youth Offending Workers responded. The study found that 20% of participants had not received any formal training on ASSET, and the majority of respondents (figures not published) expressed the need for further training (Roberts *et al.* 2001). However, this study was conducted shortly after ASSET was implemented, and it is suggested by Baker *et al.* (2003) that the level and amount of training may have improved since. However, the demand for training from Youth Offending Workers has remained high, which suggests that there is still a training need (Baker *et al.* 2003).

1.12 Screening for mental health difficulties

1.12.1 What is screening?

The YJB use an example of screening (used interchangeably with assessment) in a health context to explain the rationale for screening young offenders. They state that screening is used to identify a “*common or severe treatable illness within a given population*” with the aim of preventing or treating the illness (YJB, 2003, p.5). The YJB have identified eight mental health problems to target in the screening/assessment of young offenders using ASSET: depression, self-harm, anxiety, post-traumatic stress disorder, drug misuse, alcohol misuse, attention deficit hyperactivity disorder and psychotic disorders (YJB, 2003).

1.12.2 Policy relating to screening for mental health difficulties

The Welsh Government’s strategy paper, Together for Mental Health (Welsh Government, 2012), identifies mental health problems in young offenders as a key

area for development. This document states that if screening within the YOT identifies mental health difficulties, the young person should be able to access generic services including tier 1-4 CAMHS services (Welsh Government, 2012). In the All Wales Youth Offending Strategy (YJB, 2004), the Welsh Government and the YJB set out clear referral timescales following the identification of mental health difficulties in young offenders. If acute mental health difficulties are identified, a CAMHS assessment should commence within five working days, and all non-acute mental health concerns should be referred to the appropriate CAMHS tier (1-4), and assessment should commence within 15 working days. There is no clear guidance within the strategy for how acute and non-acute are defined or assessed (YJB, 2004). These recommendations and targets highlight the importance of accurate assessments to ensure that the young person is able to gain access to appropriate services and to ensure that services do not become overwhelmed. The YJB's Key Elements of Effective Practice- Mental health document (2008b) outlines the approach that the YOT should be taking in regarding to assessment, identification and intervention.

1.12.3 Structure of mental health screening

Assessment of mental health difficulties is one of the twelve sections of the core ASSET (see Figure 3). As stated above, an ASSET score of two or more is used to indicate the need for further assessment of mental health difficulties by a mental health professional. In the case of teams involved in this research study, they all had access to a Community Psychiatric Nurse (CPN) seconded from CAMHS to work within the YOT. (See appendix 2 for 'Emotional and Mental Health' section of ASSET).

To supplement the emotional mental health section of the Core ASSET, the University of Manchester and Salford NHS Trust were commissioned by the YJB to develop Child and Adolescent Mental Health Screening Tools. These are known as the Mental Health Screening Questionnaire Interview for Adolescents (SQIFA) and Mental Health Screening Interview for Adolescents (SIFA). Youth Justice Staff complete the SQIFA (YJB, 2003) for any young person scoring two or more on the mental health section of the ASSET. If a young person scores a three or a four on

the SQIFA they will then be referred to the CPN within the YOT who completes the SIFA (YJB, 2003) (see figure 3 for the assessment process, see appendix 3 for a copy of the SQIFA).

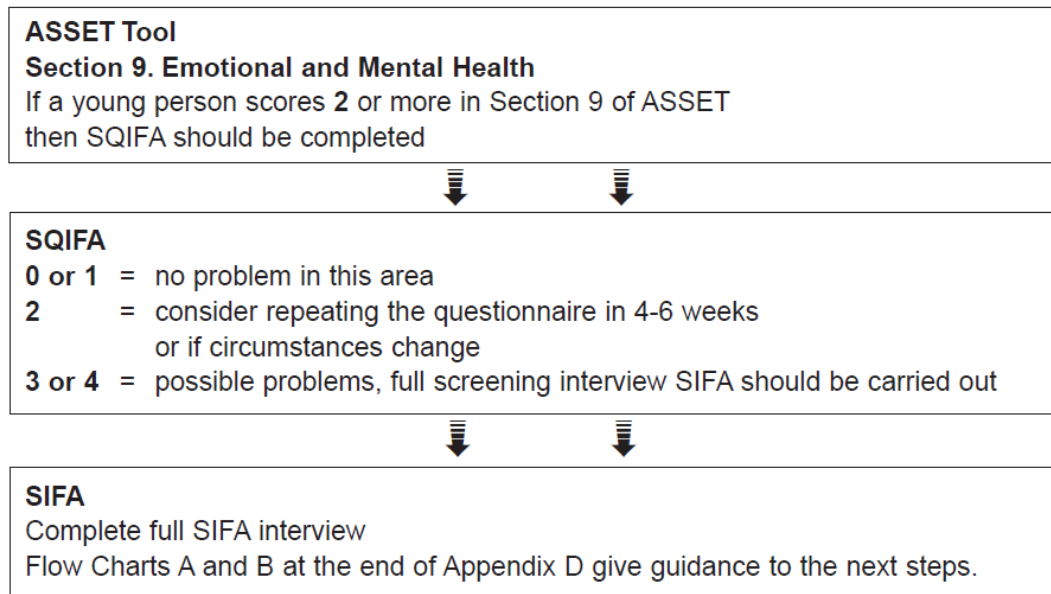


Figure 3. An overview of the mental health screening process in Youth Offending (YJB, 2003). Reproduced with permission of the Youth Justice Board. Copyright Youth Justice Board 2003.

Interestingly, ASSET does not categorise abuse and neglect under ‘emotional and mental health’ problems, instead placing it under the ‘family and relationship’ section (YJB 2011b). This is surprising considering the wide body of evidence linking the experience of abuse and trauma with mental health difficulties (For example Norman *et al.* 2012 and Schneider *et al.* 2007,) (YJB, 2011b).

1.13 Psychological theories of decision-making

One potential factor that may influence Youth Offending Workers’ Assessment of mental health difficulties relates to decision-making. This section will discuss theory relating to decision-making and link this to the process of assessment in the YOT.

Assessment by its very nature requires the assessor to make judgments and decisions based on the information that is found (Baker *et al.* 2011). The process of

making judgments and decisions are seen as two separate processes. Judgments involve integrating information in order to form an understanding of a situation, whereas decision-making requires the individual to make a decision on what to do next based on the judgments that they have made (Goldstein and Hogarth, 1997). It has been suggested that it is important to understand how decision-making heuristics impact on clinical decision-making in order to reduce bias in the decision-making process (Murray and Thomson, 2010).

1.13.1 Decision-making in Youth Offending

Within Youth Offending, YOT Workers are expected to come to a judgment and make a number of decisions based on their assessment. The area that often has had the most focus is the assessment of risk to others (Kemshall and Pritchard, 1997 and YJB 2010c). However, the Youth Offending Workers are also expected to come to a judgment and make decisions relating to the young person's welfare and to address the young person's needs including mental health difficulties (Baker *et al.* 2011 and YJB 2008a and 2010abc). Youth Offending Workers make use of a structured assessment procedure to support their judgments and make decisions based on actuarial and clinical processes (Kemshall *et al.* 2007). Actuarial approaches to decision-making make use of statistical information, while clinical processes locate the understanding of the young person within their context (Baker *et al.* 2011).

1.13.2 Cognitive factors affecting decision making

Decision-making in youth offending requires the worker to collate information, analyse this information and come to a judgment and decision based on the assessment. It is well evidenced that humans struggle to process large amounts of information in order to make decisions (Klein *et al.* 1993). In order to overcome this, cognitive heuristics (cognitive techniques that can be used to support decision-making) are employed often unconsciously, and heuristics help to reduce the cognitive effort related to decision-making (Tversky & Kahneman, 1974). Despite the benefit of using heuristics to inform decision-making, their use can lead to errors in judgments and decisions, as not all decisions fit within a rational model (Gigerenzer *et al.* 2011). There are a large number of heuristics that can impact on decision-

making; however, Baker *et al.* (2011) have identified two main ones that they suggest have significant influence on decision-making in the context of Youth Offending. These are the confirmatory bias (Mahoney, 1977) and the anchoring and adjustment bias (Tversky and Kahneman, 1974).

The confirmatory bias refers to the process of holding onto information that confirms the assessor's initial hypotheses or beliefs, even when information that questions that decision comes to light (Mahoney, 1977 and Strachan and Tallant, 1997). This makes it difficult to change assessments based on new information coming to light (Baker *et al.* 2011). Ditto *et al.* (1998) suggest that the confirmatory bias occurs in decision-making due to the amount of cognitive effort required to process information that is not preferred information, compared to the effort required to process information that fits with the individual's pre-existing hypotheses. It is therefore suggested that in time-pressured environments such as those found within YOTs, the use of heuristics are one way of reducing the effort associated with decision-making (Murray and Thomson, 2010). Baker *et al.* (2011) use the example of a Youth Offending Worker being unable to notice signs of motivation in a young person whom they have labelled as unmotivated to highlight the confirmatory bias.

The anchoring and adjustment heuristic describes the tendency to estimate an outcome based on an initial value (the anchor) and adjust understanding based on this anchor in order to reach a final judgment. Murray and Thomson (2010) provide an example of how the anchoring and adjustment bias might influence decision-making about risk. They suggest that clinicians will use previous risk assessments to form an anchor based on the outcome of the previous assessment. For example, when a person has been previously assessed as low risk, the clinician will use this information to inform their decision about the current risk. The practitioner may thus place less weight on new information which suggests that the young person is a high risk if this does not fit with the anchor that the person is low risk. The effect of the anchoring and adjustment heuristic is that the professional may not take into account new information and therefore may not adjust the risk assessment accordingly (Borum *et al.* 1993). An individual's professional experience can also act as an anchor for making judgments (Cioffi, 1997). For example, the experience of working with a young person who has made a serious suicide attempt may result in the

professional anchoring high risk and then being unable to adjust decision-making based on new information for that young person. Therefore, the anchoring and adjustment heuristic may have implications for assessment and decision-making in Youth Offending (Baker *et al.* 2011).

1.13.3 Clinical decision making models

Decision-making in all contexts can be seen in terms of a continuum, with simple decisions at one end relying on intuition, and complex decisions at the other end using more analytical processes (See figure 4). Baker *et al.* (2011) suggest that Youth Offending Workers make decisions at both ends of the continuum, and therefore clinical decision-making requires the use of both rational and intuitive processes (Schwalbe, 2004).

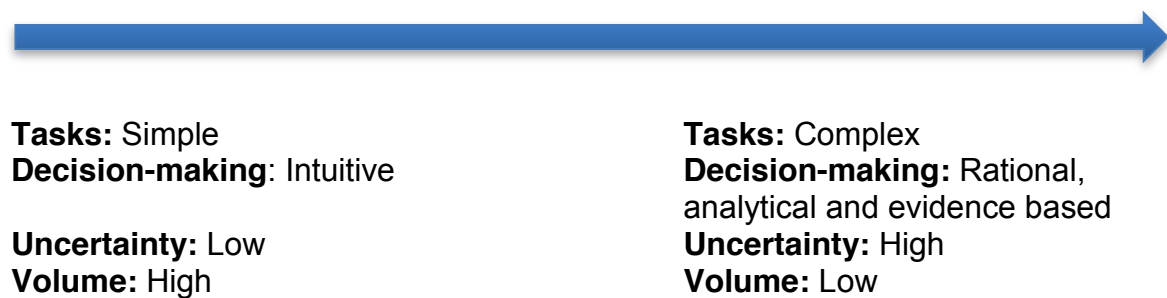


Figure 4. Continuum of decision-making (Baker *et al.* 2011 and NHS Education Scotland, nd)

Decision-making in a clinical context requires the practitioner to make hypotheses based on the information available to them. This requires the practitioner to make judgments and requires the organisation to allow the practitioner to have discretion over the judgments that they make in the context of accountability. Accountability refers to the ability of the practitioner to evidence why they have come to a particular decision (Baker *et al.* 2011). Combining both discretion and accountability through the use of intuitive and rational decision-making allows both the needs of the organisation and the young person to be met (Baker *et al.* 2011). As discussed above, Youth Offending Workers have to pay attention to both the young person's needs and the risk posed to the public in the context of punishment and retribution (Scottish Government, nd and YJB, 2010abc). Needing to be risk and welfare

focused has the potential to add a level of complexity to decision-making as these two needs may be in conflict (Eadie and Canton, 2002). These decision are perhaps most similar to decision-making by Social Workers in the context of child protection decisions.

Research focusing on child protection decision-making has shown that although Social Workers are good at collating information to help inform decisions, they then struggle to analyze this information (Dorsey *et al.* 2008). Decision-making in the context of child protection has been found to be only slightly more reliable than guessing (Dorsey *et al.* 2008). These findings have led to a drive towards the use of Structured Professional Judgment for child protection decisions which utilize assessment and decision-making tools alongside professional judgments in order to improve the reliability and accuracy of decision-making. At present the evidence base for the use of such tools is relatively small due to a lack of significant research. Guidance has, however, been given on the criteria that such tools should meet in order support decision making adequately. These include a need for balance between the use of tools and professional judgment, coverage of a wide range of areas relating to the topic that is being assessed, and suggestions for how tools can be incorporated into existing practice (Barlow *et al.* 2012).

1.14 Section Four: Systematic Review- Introduction

A systematic review of the literature was conducted to provide an in-depth overview of the research. The initial systematic review question was in line with the research question: **Factors that influence Youth Offending Workers' assessment of mental health difficulties in Young Offenders.** This review returned one paper; whilst this paper was relevant, it was felt that a wider systematic review was needed in order to further understand the topic being researched. Therefore, the systematic review question was widened to include key professionals that work with offenders across the age span, including Police Officers, Youth Offending Workers, Probation and custody staff (who will be referred to as Criminal Justice staff). Therefore, the systematic review question was **Criminal Justice Staff's experiences of assessing mental health difficulties in offenders.** The review aimed to provide a structured, critical overview of research.

This chapter provides an overview of the search process, a descriptive account of the included studies, a critique of the studies focusing on quality, an overview of the themes found in the research and the implications for future research.

1.15 Method

1.15.1 Search strategy

Relevant studies were found by searching the following electronic bibliographic databases between the 14/02/14 and 18/02/14: Applied Social Sciences Index and Abstracts (ASSIA), British Nursing Index, Cochrane Library, Education Resources Information Centre (ERIC), PsychArticles, PsychINFO, Pubmed, Social Care Online, Scopus and Sociological Abstracts.

1.15.2 Search terms

Searches were carried out using the following search terms: **'mental health' AND assessment OR Screening and Police OR Custody OR 'Youth Offending' OR Probation.**

1.15.3 Inclusion and Exclusion Criteria

The following inclusion and exclusion criteria were adopted:

1.15.4 Inclusion criteria:

- Articles from both peer and non-peer reviewed journals to capture all published articles across a range of journals;
- Qualitative or quantitative research studies;
- Offenders with mental health difficulties;
- Assessment/ screening for mental health difficulties in offenders;
- Professionals' experiences;
- Offending in adults and young people.

1.15.5 Exclusion criteria:

- Unpublished studies / abstract only;
- Not published in English;
- Validation of an assessment tool;
- Mental Health Act (1983) assessments;
- Young people's experiences or the experiences of parents or carers;
- Provision of mental health services for offenders;
- Prevalence rates;
- Evaluation of staff training packages.

1.15.6 Search process

The search resulted in 1,232 titles, which were reviewed using the exclusion and inclusion criteria stated above (see Appendix 5, for the outcomes of the searches). Following abstract reviews it was possible to exclude 1,217 studies which focused on prevalence rates of mental health, provision of mental health services for offenders or were duplicates. This resulted in 15 papers being considered for review. From the 15 papers, 11 further articles were identified from the reference lists of the articles being reviewed, and one paper was found in the grey literature (informally written material including reports). Therefore, 27 papers were reviewed in detail against the inclusion and exclusion criteria. Following this review, a further 20 were excluded. Figure 1 provides a diagrammatic representation of the search process. Seven studies were thus included in the systematic review.

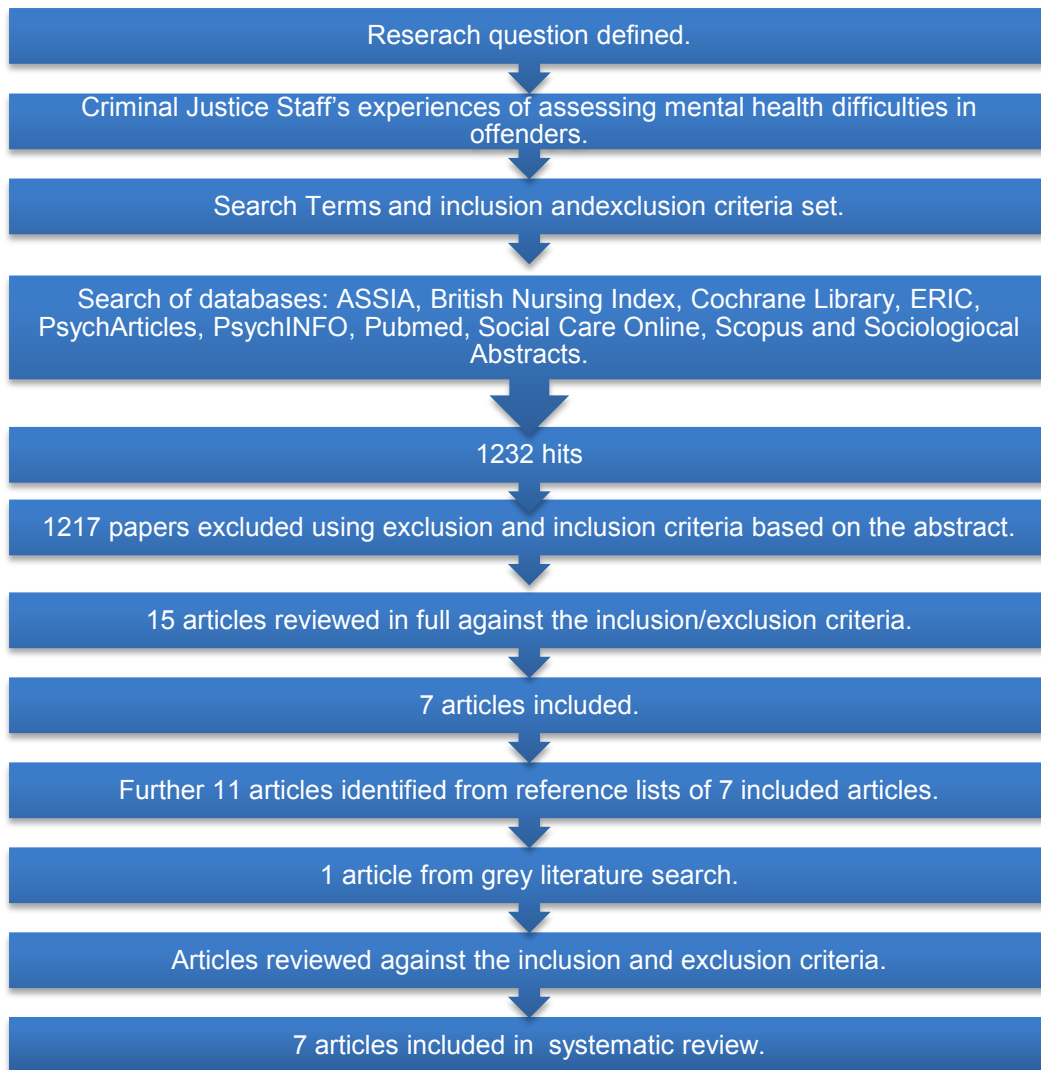


Figure 1. An overview of the systematic review process.

1.16 Results

1.16.1 Summary of included studies

Seven studies were included in the systematic review. Teplin and Pruett (1992) and Knowles *et al.*'s. (2012) studies aimed to understand professionals' experiences of identifying mental health difficulties in offenders. Menzies (1987), Green, (1997) Kropp *et al.* (1999), Callahan, (2004) and Eno Loudon and Skeem, (2012) all aimed to understand the decision-making process for the identification of mental health difficulties in offenders.

Table 2 provides a description of the design, participants, method, results and the discussions from each included studies is provided. A narrative account is also given to highlight the design, method and participants.

1.16.2 Design and method

Of the seven studies, two studies used a qualitative methodology (Teplin and Pruett, 1992 and Knowles *et al.* 2012), two studies used surveys (Kropp *et al.* 1999 and Callahan, 2004), one study used a quantitative methodology (Eno Louden and Skeem, 2012) and two studies used a mixed methodology (Menzies, 1987 and Green, 1997).

Teplin and Pruett (1992) used observations and subsequent content analysis of Police Officers' interactions with members of the public that the researching team later assessed from their observations as having mental health difficulties. Knowles *et al.* (2012) used a semi-structured interview to gain an understanding of Youth Offending Workers' attitudes to screening for self-harm in young people. Kropp (1989), and Callahan (2004) used a questionnaire to ask participants about themselves as professionals and complete a risk assessment for a vignette of a male adult offender who either presented with or without mental health difficulties. Eno Louden and Skeem (2012) used an experimental methodology where participants completed a risk assessment and management plan based on a vignette case study of an adult offender. Menzies (1987) analysed police records to assess decision-making by police officers in how to respond to adults with mental health difficulties. Green (1997) used quantitative content analysis of Police Officers' arrest documents and semi-structured interviews with Police Officers about their experiences of encounters with members of the public with mental health difficulties.

A number of methods of analysis were used, including interpretative phenomenological analysis (IPA) (Knowles *et al.* 2012) and statistical methods, including ANOVA (Eno Louden and Skeem 2012), t tests (Menzies, 1987 and Kropp *et al.* 1989) and logistical regression (Callahan, 2004 and Green, 1997). Both Teplin and Pruett (1992) and Green (for the qualitative part of the study) did not clearly state the method of analysis used.

1.16.3 Sample

The participants were selected either via opportunistic sampling in the work place (Knowles *et al.* 2012, Eno Louden and Skeem, Callahan 2004, Teplin and Pruett, 1992, Kropp *et al.* 1989) or through a recommendation from a manager (Green, 1997). Menzies' (1987) study used police records for all offenders who were referred by the police to the Brief Assessment Unit in the opening year of the unit (1978) and did not include any participants. The sample sizes for the studies using an interview or focus group ranged from 8-12 with a mean of 10, and the studies using survey data ranged from 78 to 1,877 respondents with a mean of 536 respondents. Participants included Police Officers (Green, 1997, Teplin and Pruett, 1992), Youth Offending Workers (Knowles *et al.* 2012), Probation Officers (Eno Louden and Skeem, 2012) and Prison Officers (Callahan, 2004 and Kropp, 1989). Four out of the seven studies were conducted in the USA (Kropp *et al.* 1989, Teplin and Pruett, 1992, Callahan 2004 and Eno Louden and Skeem, 2012); one was conducted in the UK (Knowles *et al.* 2012); one in Canada (Menzies, 1987) and one in Hawaii (Green, 1997).

Table 2. Description of Studies included in the systematic review

Author, date	Aim	Method (design, data collection and analysis)	Participants	Results	Discussion
Quantitative-experimental					
Eno Louden, J.E. & Skeem, J.L. (2012) (USA)	To understand what effect offender mental health difficulties have on Probation Officers' risk assessments.	Experimental methodology. Participants were randomly allocated a case vignette either representing no diagnostic disorder, schizophrenia, major depression or bi-polar disorder, with either the presence or absence of substance misuse. Participants were asked to complete a risk assessment and intervention plan. They also completed a questionnaire about their background. Results were analysed using a 4 x 2 ANOVA.	234 Probation Officers recruited from two Probation offices in the USA. 51.3% of participants were White, 30.8% were Hispanic, 7.3% were African American and 10.6% were from other ethnicities. 55.6% were female and 54.4% were male. They ranged from 26-63 years with a mean age of 40.9 years.	Mental health difficulties were associated with assessment of increased risk reoffending and violence. Risk was highest for bi-polar disorder 72.8% chance of reoffending and 53.5% chance of being violent as compared to 49.3% and 39% for no mental health difficulties which was a significant difference $p=0.001$) and schizophrenia (53.5% and 55.2% as compared to 49.3% and 39% for no mental health difficulties which was a significant difference $p=0.001$). The presence of mental health difficulties was associated with more restrictive interventions, with enforced treatment being recommended for people with a diagnosis of schizophrenia. Substance misuse increased assessment of risk, but not significantly when mental health disorders were also present. This was thought to be a result of a ceiling effect.	Eno Louden and Skeen (2012) suggest that Probation Officers perceive mental health difficulties as a sign of high risk. Forced mental health treatment and close supervision was felt to be required because of the risk of violence especially for people with a diagnosis of schizophrenia. The authors point out that this is in contrast to research which suggests that having a diagnosis of schizophrenia does not increase the risk of violence. It is thus suggested that training needs to focus on mental health diagnosis in informing risk assessment. The researchers also suggest that risk management tools should be revised to reduce the emphasis on mental health as a risk factor for violence. Relevance to this study: Suggests that criminal justice staffs' risk assessments may be negatively influenced by the presence of mental health difficulties.
Quantitative- survey based.					
Kropp, R.P. <i>et al.</i> (1989)	To evaluate the perceptions of	Quantitative survey. This included demographic	78 out of 85 potential participants took part	Significant differences in the perceptions were reported.	Offenders with mental health disorders were seen as different from offenders

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(Canada)	Prison Officers towards mental health difficulties in adult prisoners. To inform the training of Prison Officers and support staff.	information and ratings of perceptions of 4 different groups: mentally disordered offender, other offenders, mentally ill patients and most people. Descriptive statistical analysis.	in the study. Prison Officers were recruited from one jail in Canada. 67 participants were male and 11 were female.	Mentally disordered offenders were seen as less predictable, less rational and more mysterious. They were also seen as significantly more dangerous than mentally ill patients. 95% of participants wanted more training, 90% of participants felt that mentally disordered offenders increased the stress of the job and 89% felt mentally disordered offenders should be managed separately.	without mental health disorders and mentally ill patients. Staff reported that patients with mental health disorders are more dangerous and challenging than prisoners without mental health difficulties. However, mentally ill patients were seen more positively than offenders with mental health disorders. It was suggested by the authors that this was a result of Prison Officers viewing prisoners as “bad” and patients as “mad”. They highlight the need for training around understanding and working with offenders with mental health disorders. Relevance to this study: Suggests that criminal justice staffs’ risk assessments may be negatively influenced by the presence of mental health difficulties.
Callahan, L. (2004) (USA)	To understand Prison Officers’ views about mental health difficulties, it’s causes and the management of mentally ill offenders.	Quantitative study using a survey focusing on Prison Officer’s role and understanding of mental health difficulties, naming of mental health difficulties and cause of mental health difficulties. Presented with a case vignette of an offender either with or without the presence of mental health difficulties. Statistical analysis using chi-squared.	1877 Prison Officers completed the questionnaire. 79.7% were male and 10.3% were female, 73% were white, 18.3% were black and 8.7% were from other ethnicities. 15% stated that they had mental health problems. The age of participants was not presented.	Prison Officers were able to correctly identify schizophrenia and depression. However, they were also likely to identify mental health difficulties in vignettes with no reported mental health difficulties. All of the results analysed found a significant relationship between the officers’ understanding of the offenders and the presence or absence of mental health difficulties. Officers felt that schizophrenia was the most serious disorder. The presence of violence increased the perception of seriousness of the mental health difficulties. Officers were most likely to attribute the cause of the prisoners’ difficulties to “mental	The authors conclude that Prison Officers’ views parallel views found amongst the general public. Officers tended to apply multi-causal factors for the presence of mental health difficulties. The nature of the disorder and the presence of violence were used to decide if the offender could make their own treatment decisions. The authors highlight the need for better training of Prison Officers. Relevance to this study: Suggests that criminal justice staff may incorrectly identify the presence of mental health difficulties in offenders, in the absence of evidence. The identification of mental health difficulties may restrict the level of autonomy and the control offenders have over their treatment.

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				<p>illness” in vignettes describing symptoms of schizophrenia and least likely to be “mental illness” for the vignettes with no mental health disorder. However, 58.1% of officers attributed difficulties in the vignette with no symptoms to mental health difficulties, increasing to 80.4% when violence was also present. Officers had a range of explanations for the cause of “mental illness” including chemical imbalances, genetic factors and stressful life events.</p>	
Author, date	Aim	Method (design, data collection and analysis)	Participants	Results	Discussion
Qualitative					
<p>Knowles, S.E. <i>et al.</i> (2012) (UK)</p>	<p>To understand staff attitudes towards screening for self-harm in young offenders.</p>	<p>Qualitative design using semi-structured interviews focusing on screening for self-harm. Interpretive phenomenological analysis was used to analyse data.</p>	<p>Opportunistic sampling of Youth Offending Staff from one YOT in England. Eight YOT workers were interviewed (reached theoretical saturation). All had experience of mental health assessments with young people.</p>	<p>Identified two dimensions on which staff attitudes varied: “active/passive and “positive/negative”. The “active/passive” dimension related self-harm, with active representing confidence in working with self-harm and viewing it as an important aspect of the role. The “positive/negative” related to screening and the effectiveness of mental health support with positive representing perceived benefits and effectiveness.</p>	<p>The authors conclude that the Health Beliefs Model may be applicable to this professional context and not just to a health context. They highlighted the need for overcoming barriers to self-harm screening at an individual (perceived competency) and organisational (availability of services) level. It was suggested that their two dimensional model could be used to inform training of youth offending staff.</p> <p>Relevance to this study: Youth offending staff assessment of mental health difficulties may be affected by their confidence about assessment, their beliefs about the benefits of assessing for mental health difficulties and their views on access to mental health support.</p>

Author, date	Aim	Method (design, data collection and analysis)	Participants	Results	Discussion
Mixed methodology.					
Menzies, R.J. (1987) (Canada)	To understand how police officers reach decisions regarding members of the public arrested and sent to an assessment unit who also presented with mental health difficulties. To make recommendations on how the police respond to people with mental health difficulties.	Mixed methodology, quantitative and qualitative analysis (chi-squared and t-tests) of arrest reports.	592 adults referred to a forensic assessment unit following arrest due to concerns about their mental health. Medical records, police records and summary for each patient containing social demographic and medical information, and information about the clinical decisions were obtained for 525 of the 592 cases.	The police assessed 57% as mentally ill, 38.1% were deemed to require psychiatric assessment, over 10% were assessed as a risk to self and 30.6% as a risk to others. Three measures were significantly linked to an increase in assessed risk level: previous violence; a violent offence; and considered to be mentally ill. There was a statistically significant relationship between Police Officers' risk assessment and subsequent forensic professional rating of risk. Police Officers used four different approaches for reporting and supporting decision-making: focussing on the crime; reproducing "moral panic"; highlighting breakdown of official routines; and implanting a message about punishment.	The author highlighted the influence of police assessment on subsequent assessment of risk of violence by forensic clinicians. They also suggest that Police Officers are adept at reporting information so that it is taken seriously by forensic clinicians. The researcher also suggests that Police Officers have become more comfortable labelling offenders as mentally ill with the development of forensic units as the unit allow for both the mental health needs and the judicial requirements to be met. Relevance to this study: Criminal justice staff may report their assessments in a certain way in order to obtain access to specific services for offenders. Initial assessments undertaken by criminal justice staff may influence subsequent forensic and/or psychological assessment.
Teplin, L.A. & Pruett, N.S. (1992) (USA)	To understand how police officers decide which individual should be hospitalised, arrested or dealt with informally. To highlight the complexity of decision-making around 'mentally disordered citizens'.	Observational study of all police interaction with the public using an incident coding form and a narrative account. Mental health disorders were assessed through the completion of a symptom checklist by an independent observer. Data was	283 police officers were randomly selected from 2 districts within a US city over a 14-month period in 1980-1981. This resulted in 1,396 police-citizen encounters involving 2,555 adults.	The police were most likely to use informal measures to resolve issues. Of 2,555 citizens observed, 85 were considered to be mentally ill. Mentally ill citizens were significantly more likely to be arrested (46.7%) than non-mentally ill citizens (27.9%) (Chi Square=13.66 p<.001). Of the 85 people considered to be mentally ill, 10 were hospitalised. Police officers did not tend to consider hospitalization as an	The authors suggest that changes in services such as deinstitutionalization have led to the rise of the "street corner psychiatrist". Police have discretion to decide if someone is "bad", "mad" or "eccentric" and have adopted an informal code to assist their decision-making. The authors suggest that the code is based more on social-psychological and structural/organisation factors than psychiatric symptomology. The level of involvement and decision-making about mental health by the police highlights the need for further training.

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		<p>statistically analysed using Fisher's Exact test to determine the relationship between the presence and absence of mental health difficulties and the response of the police officer.</p> <p>Qualitative data was not analysed.</p>		<p>option due to stringent hospital admission criteria. Mentally ill people were arrested when their behaviour was considered to be too deviant or too dangerous to be admitted to hospital or too serious (defined by a number of socio-psychological variables). Informal dispositions (non-arrest) were used most commonly for individuals described as "neighbourhood characters", "troublemakers" and quiet "crazies.</p>	<p>Relevance to this study: Criminal justice staff may have increased responsibility for making assessment and decisions regarding mental health difficulties in offenders. Criminal justice staff may adopt informal strategies to support their decision-making.</p>
<p>Green, T.M. (1997) (Hawaii)</p>	<p>To understand how police officers decide whether to arrest a person or refer them to mental health services.</p>	<p><u>Part 1.</u> Quantitative analysis of incident coding forms filled in by police officers when they encountered an adult with mental health difficulties. Forms were analysed using logical regression.</p> <p><u>Part 2.</u> Structured and semi-structured interviews with police officers. The method of analysis of data is not stated.</p>	<p><u>Part 1.</u> Incident coding sheets were collected for one month in 1994 from the Hawaiian police force. 148 forms were analysed.</p> <p><u>Part 2.</u> 11 police officers from 5 out of the 8 districts in the Hawaiian police force were interviewed. All of the participants were male with an average age of 32.4 years and an average of 5.5 years of police experience.</p>	<p><u>Part 1.</u> Officers' involvement with the mentally ill individuals resulted in arrest (14.95), informal sanction (warnings etc.) (52%) or no action (20.3%).</p> <p><u>Part 2.</u> Officers felt they could tell if someone was mentally ill by the presence of certain attributes e.g. homeless rather than asking questions. None of the officers had received any formal mental health training. The officers felt that their time was wasted because of the long wait for a medical response when dealing with mentally ill people.</p>	<p>The authors concluded that a large amount of police involvement with the mentally ill is informal and not documented. This was thought to result from pressure from the police department and the medical department to resolve situations quickly. Police officers assess mental health difficulties through the presence of certain attributes. Police officers were not clear how to decide if a person with mental health problems should be taken to custody or hospital. They also felt that the hospital system should be more willing to admit patients with mental illness against their will in order for them to receive treatment. The authors highlight the need for officers receive more training focussing on recognising and assessing mental health difficulties.</p> <p>Relevance to this study: Criminal justice staff assessment and decision-making around mental health difficulties in offenders may be reliant on gut instinct due to a lack of training. Not all police involvement may be accurately documented.</p>

1.16.4 Quality of the research

A quality framework was used to assess the credibility of the findings presented in the studies. The Support Unit for Research Evidence (SURE) frameworks for qualitative (SURE 2013b), intervention/ experimental (Sure 2013a) and cross sectional/correlational studies (SURE, 2012) were chosen as they incorporate a number of quality checklists including Health Evidence Bulletins Wales (HEBW, Weightman, 2004), National Institute of Clinical Evidence (NICE) Public Health Methods Manual (NICE, 2012) and versions of the Critical Appraisal Skills checklists (CASP, 2010).

A narrative description of the quality of the research is presented below. The quality review is also presented in table 3 (qualitative framework SURE, 2013b), table 4 (intervention/experimental framework, SURE, 2013a) and table 5 (Cross sectional/correlational studies framework, SURE, 2012).

As each of the tools has a different format and number of criterion, the scoring guidance from the SURE quality framework, cross sectional/correlational studies (Cardiff University, 2012) was used. A quality framework should allow the reader to compare the quality across different study methodologies. The scoring guidance uses ++ to represent good, + to represent mixed, - to represent poor, *nr* to represent not reported and *na* to represent not applicable. (see SURE, 2012 for scoring guidance).

1.16.5 Narrative of the quality of the research

Research Aims, Methodology & Design

All of the studies provided a clear aim for the research. The chosen methodologies for each of the studies were considered to be appropriate to meet the aims of the study. The qualitative studies (Teplin and Pruett, 1992, Knowles *et al.* 2012, Menzies, 1987 and Green, 1997) all aimed to understand professionals' experiences of identifying mental health difficulties in an offending population. The survey based studies (Kropp *et al.* 1999, Callahan, 2004, Menzies, 1987 and Green, 1997) and the quantitative study (Eno Louden and Skeem, 2012) all aimed to understand the

decision-making process when identifying mental health difficulties in an offending population. Green (1997) was the only author to present a rationale for why the particular methodology used had been chosen (Qualitative).

Recruitment & data collection

How participants were recruited was explained in all seven studies; however the level of detail varied. Callahan (2004), Knowles *et al.* (2012) and Eno Loudon and Skeen (2012) were the only studies which provided a detailed description of the recruitment process and the participants. Opportunistic sampling methods were used in all but one study which relied on managers to select participants. None of the studies fully address the potential for bias or the influence of power in the recruitment process.

Reflexivity

None of the studies discussed the relationship between the researcher and the participants and the potential impact this may have had on the results.

Ethical issues

None of the studies reported obtaining ethical approval for the study or discussed issues around confidentiality, consent and anonymity of the data.

Data analysis

Data analysis was discussed in all of the studies except for the qualitative section of Menzies (1987) and Teplin and Pruett's (2003) studies. Triangulation of the data was not discussed in the qualitative studies (Menzies, 1987, Teplin and Pruett. 1992, Green, 1997 and Knowles *et al.* 2012). All of the qualitative studies contained direct quotes from participants: however, none of them described how the quotes were selected. Only one of the qualitative studies clearly identified how themes were developed during analysis (Knowles *et al.* 2012).

In terms of the quantitative studies, Eno Loudon and Skeem (2012) used appropriate statistical methods in their analysis, and reported the effect size and confidence interval for their data. Krop *et al.* (1989), Menzies (1987), Green (1997) and Callahan (2004) did not report power calculations for their sample; however, the analytical

methods used were appropriate for the data and the precision of association between the data was given.

Findings and value of the research

All of the studies presented clear findings based on their research and linked these findings to theory and practice. The studies also highlighted how the findings could inform future practice. Out of the seven studies only three provided a detailed overview of the limitations (Callahan, 2004, Eno Louden, 2012 and Knowles *et al.* 2012). Identified limitations included not obtaining young people's views (Knowles *et al.* 2012), the generalisability of the study (Callahan, 2004, Eno louden and Skeem, 2012 and Knowles *et al.* 2012) and the impact of professional background (Knowles *et al.* 2012).

As can be seen from the quality review, none of the studies meet all of the criteria consistent with a high quality study. Therefore, the narrative synthesis of the findings from these research studies, which is presented below, needs to be interpreted with this in mind.

Table 3. Questions to assist with the critical appraisal of qualitative studies_(SURE, 2013b).

Quality Rating	Teplin, L.A. & Pruet, N.S., (1992)			Knowles, S.E. et al. (2012)			Menzies, R.J., (1987) (qualitative section)			Green, T.M. (1997) (qualitative section)		
	++/+	na/nr	-	++/+	na/nr	-	++/+	na/nr	-	++/+	na/nr	-
1. Does the study address a clearly focused question/hypothesis?	++			++			++			++		
	+			++			++			++		
Setting?												
Perspective?												
Intervention or Phenomena		na			na						na	
Comparator/control (if any)?												
Evaluation/Exploration?	+			+			+			+		
2. Is the choice of qualitative method appropriate?			-			-			-	+		
Do the authors discuss how they decided which method to use?	++			++			++			++		
Is it an exploration of behaviour/reasoning/ beliefs?	+			++			++			+		
3. Is the sampling strategy clearly described and justified?	+			++			++			++		
Is it clear how participants were selected?	+			++			+			+		
Do the authors explain why they selected these particular participants?			-	+			++			+		
Is detailed information provided about participant characteristics and about those who chose not to participate?	++			++			++			+		
4. Is the method of data collection well described?	++			++			++			+		
Was the setting appropriate for data collection?	++			++			++			+		
Is it clear what methods were used to collect data? Type of method (e.g., focus groups, interviews, open questionnaire etc.) and tools (e.g. notes, audio, audio visual recording).	++			+			++					-
Is there sufficient detail of the methods used (e.g. how any topics/questions were generated and whether they were piloted; if observation was used, whether the context described and were observations made in a variety of circumstances?		nr			nr			nr			nr	
Were the methods modified during the study? If YES, is this explained?	++				++			++		++		
Is there triangulation of data (i.e. more than one source of data collection)?		nr		++				nr			nr	
Do the authors report achieving data saturation?			-			-			-			-

5. Is the relationship between the researcher(s) and participants explored?			-			-			-			-
Did the researcher report critically examining/reflecting on their role and any relationship with participants particularly in relation to formulating research questions and collecting data?			-			-			-			-
Were any potential power relationships involved (i.e. relationships that could influence in the way in which participants respond)?			-			-			-			-
6. Are ethical issues explicitly discussed?			-			-			-			-
Is there sufficient information on how the research was explained to participants?		nr			nr			nr			nr	
Was ethical approval sought?			-			-			-			-
Are there any potential confidentiality issues in relation to data collection?			-	+		-			-			-
7. Is the data analysis/interpretation process described and justified?			-	+		-			-			-
Is it clear how the themes and concepts were identified in the data?		nr			nr			nr			nr	
Was the analysis performed by more than one researcher?		nr		+				+				-
Are negative/discrepant results taken into account?	++			++				++			+	
8. Are the findings credible?	++			+	nr			+			+	
Are there sufficient data to support the findings?	+			++				++			++	
Are sequences from the original data presented (e.g. quotations) and were these fairly selected?	++			++				++			++	
Are the data rich (i.e. are the participants' voices foregrounded)?	++			++				+			++	
Are the explanations for the results plausible and coherent?			-	++						-		-
Are the results of the study compared with those from other studies?		nr			nr			nr			nr	
9. Is any sponsorship/conflict of interest reported?			-	++						-		-
10. Finally...consider:	++			++				++			na	
Did the authors identify any limitations?												
Are the conclusions the same in the abstract and the full text?												

Table 4. Questions to assist with the critical appraisal of intervention/experimental and controlled observational studies (SURE, 2013a)

	Eno Louden, J.E. & Skeem, J.L. (2012)		
Quality Rating	++/+	na/nr	-
1. Does the study address a clearly focused question/hypothesis	++		
Population/problem?	++		
Intervention?		na	
Comparator/control?		na	
Can you identify the primary outcome?	++		
2. Was the population randomised? If YES, were appropriate methods used? E.g.: random number tables, opaque envelopes Note: The following methods are not appropriate: alternating participants coin toss, birth dates, record numbers, days of the week	++		
3. Was allocation to intervention or comparator groups concealed?	+		
Is it possible for those allocating to know which group they are allocating people to? As above, methods such as alternating participants coin toss, birth dates, record numbers, days of the week will not allow appropriate allocation concealment		nr	
4. Were participants/investigators blinded to group allocation? If NO, was assessment of outcomes blinded?	++		
5. Were interventions (and comparisons) well described and appropriate?	++		
Aside from the intervention, were the groups treated equally?	++		
Was exposure to intervention and comparison adequate?	++		
Was contamination acceptably low?		na	
6. Was ethical approval sought and received? Do the authors report this?		nr	
7. Was a trial protocol published?			–
Was a protocol published in a journal or clinical trial registry before participants were recruited?			–
If a protocol is available, are the outcomes reported in the paper listed in the protocol?			–
8. Were the groups similar at the start of the trial?		nr	
Are baseline characteristics provided and discussed (e.g. age, sex, social class, life style etc.)?	+		
Are any statistically significant differences adjusted for?		nr	
Are any differences >10%?		nr	
9. Was the sample size sufficient?		nr	

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Were there enough participants?		nr	
Was there a power calculation? If YES, for which outcome?		nr	
Were there sufficient participants?		nr	
10. Were participants properly accounted for?	+		
Was follow-up \geq 80%?		na	
Were patients analysed in the groups to which they were randomised?	++		
Was an Intention to Treat analysis conducted?		na	
Was the follow-up period long enough?		na	
11. Data analysis: Are you confident with the authors' choice and use of statistical methods?	++		
Were estimates of effect size given?	++		
Were the analytical methods appropriate?	++		
Was the precision of intervention effects (confidence intervals) given?			-
Were they meaningful?		nr	
12. Results: Were outcome measures reliable (e.g. objective or subjective measures)?	++		
Were all outcome measurements complete?	++		
Were all important outcomes assessed?	++		
Are the authors' conclusions adequately supported by the results?	++		
13. Is any sponsorship/conflict of interest reported?		nr	
14. Finally...consider: Did the authors identify any limitations?	++		
Are the conclusions the same in the abstract and the full text?	++		

Table 5. SURE quality framework cross sectional correlation studies. Modified checklist for correlation or cross sectional studies. (NICE, 2012a and SURE 2012).

Quality framework criteria		Kropp, R.P. <i>et al.</i> (1989)	Callahan, L. (2004)	Menzies, R.J. (1987) (Survey section)	Green, T.M. (1997) (Survey section)
1	1.1 Is the source population or source area well described?	+	++	+	++
	1.2 Is the eligible population or area representative of the source population or area?	++	++	++	++
	1.3 Do the selected participants or areas represent the eligible population or area?	++	++	++	++
2 Method	2.1 Selection of exposure (and comparison) group. How was selection bias minimised?	Na	na	na	na
	2.2 Was the selection of explanatory variables based on sound theoretical basis?	++	++	+	+
	2.3 Was the contamination acceptably low?	Na	na	na	na
	2.4 How well were likely confounding factors identified and controlled?	Na	na	na	na
	2.5 Were rigorous processes used to develop the questions (e.g. were the questions piloted / validated?)	++	+	++	++
	2.6 Is the setting applicable to the UK?	+	+	+	+
3. Out come	3.1 Were the outcome measures and procedures reliable?	++	++	++	++
	3.2 Were the outcome measurements complete?	++	++	++	++
	3.3 Were all important outcomes assessed?	++	++	++	++
Time	3.4 Was there a similar follow-up time in exposure & comparison groups?	Na	na	na	na
	3.5 Was follow-up time meaningful?	Na	na	na	na
4. Analyses	4.1 Was the study sufficiently powered to detect an effect if one exists?	Nr	nr	nr	nr
	4.2 Were multiple explanatory variables considered in the analyses?	++	++	++	++
	4.3 Were the analytical methods appropriate?	++	++	++	++
	4.4 Was the precision of association given or calculable? Is association meaningful?	++	++	++	++
	5.1 Are the study results internally valid (i.e. unbiased)?	++	++	++	++
	5.2 Are the results generalizable to the source population (i.e. externally valid)?	++	++	++	++

1.16.6 Narrative synthesis of key themes

This section reviews the main themes discussed in the included studies with reference to the systematic review question, namely, Criminal Justice Staff's experiences of assessing mental health difficulties in offenders.

1.16.7 Criminal justice involvement with mental health difficulties

All of the studies highlighted a high level of involvement of the criminal justice system with offenders with mental health difficulties. Police Officers dealing with people with mental health difficulties reported spending the majority of their time "*trying to fix a situation*" rather than dealing with a criminal offence (Green, 1997). Arrest was considered to be the last resort when the person was violent or excessively disruptive (Green, 1997). Teplin and Pruett's (1992) study found that whilst the police favoured informal disposal, "mentally ill citizens" were significantly more likely to be arrested than "*non-ill*" citizens. Like Green (1996) and Menzies (1987), Teplin and Pruett (1992) found that hospitalisation was used for the minority of "*mentally ill offenders*". It was concluded that this was a result of the stringent criteria set by hospitals for admission and the co-occurrence of violence and mental health difficulties, which often meant hospitals would not admit the offender.

1.16.8 Risk and violence associated with mental health difficulties

Menzies' (1987) study showed a significant association between police identification of mental health difficulties in offenders and assessed risk of violence. Furthermore, the research found that subsequent assessment of risk by forensic health professionals was significantly associated with the initial assessment by the police (Mahoney, 1977 & Strachan and Tallant, 1997). The similarities in assessments may mean that the police are accurate in their assessments or it may suggest that confirmatory bias (discussed in section 1.13) is influencing the forensic professionals' assessment (Baker *et al.* 2011). However, this hypothesis is not reported by Menzies (1987). The study also highlighted the weight placed by police on mental health difficulties and their assessment of violence and risk when recommending bail conditions for offenders (Menzies, 1987). Menzies (1987) found

that the police used their reports to highlight their assessment of the dangerousness of the offender in order to inform the degree of punishment.

Eno Louden and Skeem (2012) found that the assessed presence of a mental health disorder significantly increased police officers' perception of risk and the likelihood of a violent incident, and that this was highest for a diagnosis of schizophrenia and bipolar disorder. Substance abuse alone increased the level of perceived risk of violence; however, there was no significant increase when substance abuse and mental disorder were combined. The authors suggest that this was a result of a ceiling effect on risk in the presence of mental disorder.

Callahan (2004) found that a history of violence increased police officers' perception of the seriousness of the mental health difficulties. Also, a history of violence, the presence of mental illness, race (non-whites), gender (male) and beliefs about the cause of mental health difficulties (chemical imbalance, stress and or genetic) significantly increased police officers' perception of the offender being at risk of self-harming.

Kropp *et al.* (1989) found that prisoners with mental health difficulties were perceived the least favourably when compared to prisoners and mentally ill patients. Prisoners with mental health difficulties were seen as less predictable, less rational and less understandable than prisoners without a mental disorder. However, prisoners were seen as more manipulative than prisoners with mental health difficulties. Prisoners with mental health difficulties were considered to be more dangerous than mentally ill patients.

1.16.9 Staff perceptions of screening

Knowles *et al.* (2012) identified two dimensions for staff attitudes towards screening for self-harm in young offenders. These were positive/negative and active/passive. Positive/negative referred to workers' perceptions of the benefit of screening, either perceiving benefits for screening (positive) or perceiving a lack of benefits for screening (negative). On the active-passive dimension, an active response was associated with confidence in working with self-harm and perceiving it to be an

important part of their role, whereas a passive response was associated with a lack of confidence and a perception that it was someone else’s role. Knowles *et al.* (2012) proposed four profiles for workers’ attitudes towards working with young offenders who self-harmed: a “*reliant profile*,” characterised by seeing the importance of screening but relying on using a screening tool and deferring responsibility for working with self-harm to others; a “*dismissive profile*,” characterised by reliance on personal skills to ensure the effective use of a screening tool and expressed confidence in working with self-harm; an “*integrated profile*,” characterised by a reliance of personal skills rather than a screening tool and expressed confidence in these skills combined with a perceived relevance of the need to screen for self-harm; a “*conflicted profile*,” characterised by beliefs about the limitations of the mental health system and an inability to overcome these limitations alongside a reliance on external support and screening tools but not finding these helpful and feeling that self-harm conflicts with the need to focus on the offence (see Figure 5).

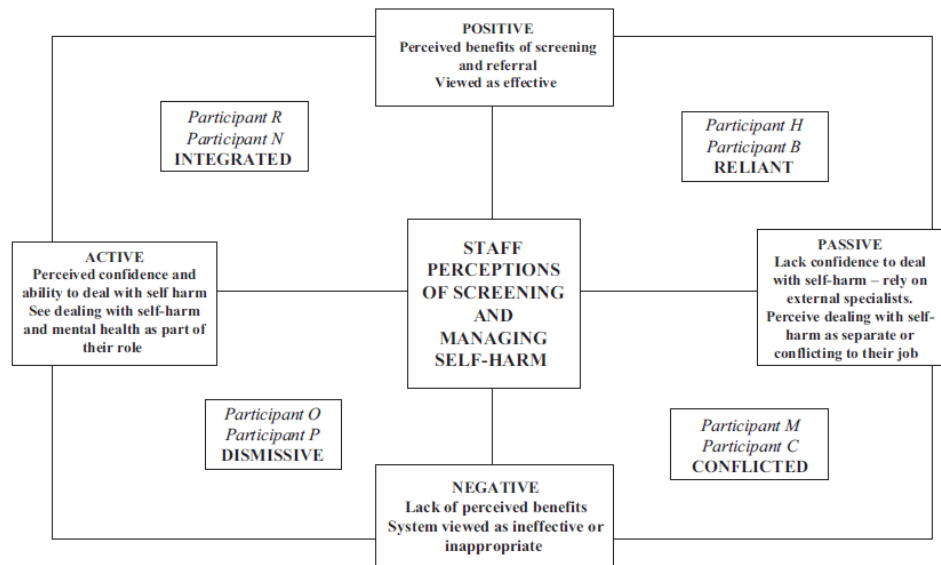


Figure 5. Overview of the themes (Knowles *et al.* 2012, p4).

1.16.10 Factors affecting screening for mental health difficulties

Knowles *et al.* (2012) suggest that perceived role and confidence in working with mental health difficulties influences attitudes to screening for mental health difficulties in young offenders. They highlight the need for integration of

organisational factors such as the role of Youth Offending Workers and personal factors such as perceived competency in order to understand staff attitudes and support them in their work.

1.16.11 Decision-making

Green's study highlighted the use of 'gut feeling' by Police Officers' who felt they were able to "*tell if someone was seriously mentally ill*" (Green, 1997, p481). The study highlighted a lack of formal training in screening and identification of mental health difficulties, with police officers acquiring knowledge through on-the-job experience. Menzies (1987) also concluded that Police Officers had little training in recognising mental health difficulties and had to rely on their own understanding of mental health to inform their judgments and decisions.

Eno Loudon and Skeem (2012) found that the presence of mental health difficulties in an offender had a significant impact on Police Officers' decision-making in relation to risk management. Officers were likely to recommend enforced mental health treatment in a secure environment and increased level of contact for offenders living in the community with a diagnosis of schizophrenia.

Callahan's (2004) study found that Prison Officers were able to identify different types of mental health disorders. Prison Officers rated the seriousness of prisoners' difficulties by the presence of a disorder, with a diagnosis of schizophrenia being considered the most serious. The presence of violence also increased Police Officers' perception of seriousness in the context of mental health difficulties. Police Officers were found to apply multiple levels of causation for mental health difficulties and a diagnosis of schizophrenia was considered to occur as a result of a chemical imbalance.

Teplin and Pruett (1992) identified three categories of mental health difficulties that the police tended to deal with in an informal way: "*neighbourhood characters*", "troublemakers" and "quiet crazies". "*Neighbourhood characters*" refer to people in the community whose behavior or appearance distinguishes them from the rest of the population; their behaviour is predictable and therefore the police and community

tolerate their behaviour. “*Troublemakers*” are known to the police and are dealt with informally as their behaviour on arrest is considered too difficult to handle. “*Quiet crazies*” are considered to be more “*disordered than disorderly*” and do not pose a significant problem to the police or community and are therefore dealt with informally. Arrest was often used when Police Officers felt the individual should be hospitalised but they were not admitted, especially when the behavior is considered deviant and the police feel that the behaviour is likely to continue. Teplin and Pruett (1992) suggest that police decisions about intervention with people with mental health difficulties are based on social, psychological and contextual factors rather than psychiatric symptomology. Police intervention tended to focus on informal measures rather than specific mental health interventions (Teplin and Pruett, 1992).

1.16.12 Criminal justice staff views of mental health services

Green’s (1996) study showed that police officers felt that the system for dealing with offenders with mental health difficulties did not work. They felt hospitals took too long to assess and often refused admission even though Police Officers felt that the custody suite was not the appropriate environment. This finding is supported by Menzies’ (1987) study, which found that hospitals were reluctant to admit mentally ill offenders who presented a risk to staff and/or patients.

1.16.13 Study recommendations

Kropp *et al.*’s. (1989) study reported that 74 of the 78 Prison Officers who responded wanted more training in working with offenders with mental health difficulties and 67 did not feel that the training they had received had adequately prepared them for their role. All of the studies concluded that there is a need for further training for criminal justice staff in order for them to understand and work with mental health difficulties in offenders and be aware of the implications of their difficulties for management of risk. Teplin and Pruett (1992) suggest that police officers also need more training and understanding of potential mental health resources (e.g. hospital and community support) in order to inform their work. Knowles *et al.* (2012) highlight the importance of integrating organisational and personal factors within training programmes, as both factors impact on professional attitudes.

1.16.14 Implications for future research

All of the studies highlight issues of competence and a need for further training for criminal justice staff working with offenders with mental health difficulties. The studies also highlight a lack of research in this area. Of the seven studies only one was conducted within the UK. This was also the only study to look at mental health difficulties in young offenders but focused specifically on self-harm rather than a wider range of mental health difficulties. There is thus a need for further research in the UK focusing on the factors that influence Criminal Justice Staff screening of mental health difficulties in young offenders.

Due to the quality of the studies reported in this systematic review (tables 3, 4 and 5), the findings need to be treated with caution. None of the studies met the full standards for quality based on the criteria used within this review. The main areas where studies fell below the expected quality level were in triangulation of the data for qualitative studies (Menzies, 1987, Teplin and Pruett, 1992, Green, 1997 and Knowles *et al.* 2012), providing an overview of the limitations of the study (Menzies, 1987, Kropp *et al.* 1989, Teplin and Pruett, 1992 and Green, 1997), lack of detail regarding recruitment of participants (Menzies, 1987, Kropp *et al.* 1989, Teplin and Pruett, 1992 and Green, 1997) and reflexivity. Therefore, any future research needs to take account of these limitations and address the concerns around quality presented within this review.

1.17 Section five: Rationale and aims of the research

This study aims to understand the factors that influence Youth Offending Workers' assessment of mental health difficulties in young offenders and help to address the lack of research in this area. It was felt important to understand more about the assessment process in order to see if changes were needed to improve the assessment of mental health difficulties. It was hoped that highlighting any potential changes to the assessment process would provide evidence to improve the quality of mental health assessment and thus increase the identification and support of mental health difficulties in young offenders, reducing the risk of reoffending and reducing the risks associated with having a mental health difficulty.

This study aims to take a psychological approach to understanding the factors that influence Youth Offending Workers assessment of mental health difficulties. More specifically the study aims to:

1. Gain a better understanding of the views of Youth Offending Workers on the process of assessment and identification of mental health difficulties in Young Offenders;
2. Gain an understanding of the factors that influence Youth Offending Workers' assessment of mental health difficulties in young offenders;
3. Explore the extent to which Youth Offending Workers feel equipped to carry out assessments of mental health difficulties in Young Offenders;
4. Identify training needs for Youth Offending Workers in the assessment of identifying mental health difficulties in young offenders;

CHAPTER 2. METHODOLOGY

2 Overview of the chapter

This chapter considers the design and procedure for the study, the aim of which is to explore the factors that influence Youth Offending Workers' assessment of mental health difficulties in young offenders. A qualitative methodology was adopted using constructivist grounded theory to analyse semi-structured interviews carried out with Youth Offending Workers. Participants were recruited from three YOTs in South Wales. This chapter will explore the rationale for using constructivist grounded theory, as well as providing information on the researcher's theoretical and professional stance and the implications this may have for the research. The research procedure will be outlined, including information on recruitment, ethical and governance procedures, data collection and data analysis.

2.1 Qualitative methodology

2.1.1 Philosophy

Qualitative methodologies take a non-statistical approach to the analysis of information. They are informed by inductive processes, which aim to identify patterns in data from individual cases to form conceptual categories and create meaning from the data. Unlike statistical approaches to research, qualitative methodologies do not aim to identify a cause and effect relationship (Willig, 2008). Rather, they aim to provide a description through the creation of explanation and meaning derived from human experiences (Parahoo, 2006).

Research methodologies are underpinned by epistemology, which focuses on the nature of knowledge and explores how we can know and what we can know. Epistemology can be seen as a continuum from relativism to positivism (Willig, 2008). Qualitative methodologies are underpinned by relativism, which acknowledges the subjective nature of the construction of knowledge and recognises the impact of the individual, culture and society on the interpretation of knowledge (Burr, 2003). Therefore, knowledge derived from relativist research provides one

possible account of the data; other researchers may construct different accounts of the data. Knowledge and experience is mediated by history, society and culture, and therefore, knowledge is a result of co-construction; in the case of research, between the researcher, the participant and society (Mills *et al.* 2006ab and Charmaz, 2000). This is in contrast to quantitative approaches, which are underpinned by positivism, which states that objective and unbiased knowledge exists and, therefore, it is possible to form truths (Polkinghorne, 1983).

Qualitative methodologies encompass a broad range of approaches all of which aim to focus on people's perceptions and experiences, capturing difference and highlighting the rich nature of human experience (Ashworth, 2003). They allow social, historical and cultural factors to be considered more fully than is possible when taking a quantitative approach. This focus may explain the increased use of qualitative research methods in psychology and other disciplines of late (Smith, 2003).

Qualitative methodologies enable theories to be developed through the analysis of verbal data. These approaches allow conclusions and hypotheses to be drawn from smaller numbers of participants than would be traditionally found in a quantitative approach. This has the advantage of enabling research to be conducted in areas where it may not be possible to obtain a large sample or where the focus of the research is more related to gaining understanding and meaning rather than cause and effect (Willig, 2008).

2.1.2 Rationale

A qualitative approach was adopted for this study, as it has been proposed by Fossey *et al.* (2002) that such approaches lend themselves to research where there is a small evidence and theory base. Although there is a large amount of research focusing on the mental health difficulties in young offenders (including Chitsabesan *et al.* 2006, Anderson *et al.* 2004) (see chapter 1 for a review of the literature) and the assessment of young offenders (including Stallard *et al.* 2003, Baker *et al.* 2002, 2003 and 2005) (see chapter 1), studies have tended to be quantitative studies reporting prevalence rates and the validity of assessment tools. It has only been

possible to find one paper focusing on mental health assessment and screening in this population. The paper looked at self-harming behaviour in young offenders (Knowles *et al.* 2012). This study aims to expand on these findings by focusing on the process of assessment and screening of mental health difficulties in young offenders by Youth Offending Workers.

Qualitative approaches also lend themselves to studies where the topic of research is broader than a specific cause and effect, hypotheses-based research question (Orona, 1997). This study aims to investigate the factors and influences on Youth Offending Workers' assessment of mental health difficulties in young offenders. The study does not aim to test a hypothesis based on existing theory. A qualitative approach will thus allow for in-depth exploration of Youth Offending Workers' experiences in order to gain insight into factors and influences that impact on their work.

Qualitative approaches involve the use of semi-structured interviews. This approach can help to reduce the risk of the data being influenced by the researchers' understanding, ideas and philosophy by allowing the interview to direct or influence the direction of the conversation (Charmaz, 2000 and Willig, 2008). Based on the factors discussed above, the researcher decided that a qualitative approach was best suited to addressing the aims of this study.

2.2 Constructivist grounded theory

2.2.1 Overview

Constructivism does not accept the existence of one reality or truth, instead it proposes that realities are socially constructed and may therefore vary from person to person (Mills *et al.* 2006ab). This results in multiple realities, which are influenced by the individual and their context (Charmaz, 2000).

Constructivism highlights the interrelationship between the researcher and their subjects. Meaning is co-constructed between these two people and therefore the researcher becomes part of the research (Pidegon and Henwood, 1997).

Constructivist approaches require the researcher to acknowledge and state their beliefs and values in order for their influence on the research to be evaluated by both the researcher and the audience (Stratton, 1997). A constructivist approach to grounded theory highlights the fact that the researcher is providing an account of the experience and meaning of the participants which will be influenced by their own beliefs and values (Mills *et al.* 2006ab).

Constructivist grounded theory is defined by Charmaz (2006) as

“A [qualitative] method...that focuses on creating conceptual frameworks or theories through inductive analysis from data. Hence, analytic categories are directly ‘grounded’ in data... it involves the researcher in data analysis while collecting data - we use data analysis to inform and shape further data collection. Thus, distinction between data collection & analysis [in] traditional research is intentionally blurred in grounded theory studies”. (p.187)

A constructivist approach to grounded theory is said to be different from an objectivist approach (Glaser & Strauss, 1967), in which the researcher assumes the position of neutrality. When taking an objectivist approach the researcher analyses the participants’ responses with the assumption that their own beliefs and values will not influence this process (Charmaz, 2006). Constructivist grounded theory instead recognises the influence that the researcher’s own beliefs and values will have on the process of interpretation and meaning-making. The research aims to co-construct an understanding that arises through the creation of a shared reality. This approach takes account of the participants’ experiences and connections between meanings are created to provide one (of many) possible overarching interpretations (Charmaz, 2006).

2.2.2 Rationale

A constructivist grounded theory approach has been adopted as it assumes that individuals’ interpretations and associated attributed meanings impact on behaviour. As mental health assessment in young offenders is a relatively under-researched area, the creation of theory was felt to be more clinically relevant than testing hypotheses deduced from the existing evidence base (Glaser & Strauss, 1967). Research to date has focused on reliability and validity of assessment tools rather

than the experience of the assessor and the young person. Utilising a constructivist approach recognises the mutual construction of a theory between the researcher and the participant (Charmaz, 2000). Using constructivist grounded theory will therefore allow the Youth Offending Worker's experience to be explored.

The aim of this research has been to reach an interpretive understanding of the meanings presented by the participants in order to provide a theoretical interpretation of the process of the assessment of mental health difficulties in young offenders. Developing a theory around the assessment of mental health difficulties in young offenders may help to inform Youth Offending Workers' assessments. It may also influence CAMHS' approach to supporting Youth Offending Workers in assessing, identifying and supporting young people with mental health difficulties.

2.2.3 Quality

Elliott *et al.* (1999) criteria for qualitative research were used to guide the research process and ensure the quality of the data and interpretation. Elliott *et al.* (1999) have developed seven standards for qualitative research in order to ensure the validity of qualitative research, improve the quality of analysis and further develop the approach. The seven standards will be outlined and the researcher's attempt to follow the criteria will be highlighted.

1. Owing one's perspective

Researchers should make their theoretical orientation, expectations, beliefs and values clear to the reader. This includes ideas and beliefs that are already held as well as ideas and beliefs that arise throughout the course of the research. This allows the reader to understand how the researcher's beliefs and orientation may have impacted on the interpretation of the data. The researchers and gatekeeper's positions are discussed below in section 2.2.5. The researcher also kept a reflective log throughout the process, which allowed developing changes in the researcher's orientation to be identified. (See appendix 4 for an extract of the reflective log).

2. Situating the sample.

Participants should be described in as much detail as needed to allow the reader to be aware of who was involved in the study and how the results might generalise to other contexts. Relevant anonymised demographic data is provided in section 2.5.4.

3. Grounding in examples.

Examples of the data should be provided to highlight the analytic process and the subsequent understanding derived from it. Grounding the theory in examples allows the reader to evaluate the fit between the data and the understanding, as well as allowing them to explore possible alternative ways of understanding. This approach can be seen throughout the results section in Chapter 3 and appendix 15, which provides an example of a coded transcript.

4. Providing credibility checks.

Elliott *et al.* (1999) propose a number of ways the credibility of the data can be checked. For the purpose of this research, the academic and clinical supervisors, as well as a fellow trainee, reviewed the themes that arose from a number of the transcripts to highlight any discrepancies. The idea of presenting and discussing the findings with the clinical nurse specialists in YOTs was considered as another way of providing credibility checks. However, it was not possible to obtain research and design approval from the Local Health Board in the timescale of the project. This is, therefore, a limitation of the study and will be discussed further in chapter four.

5. Coherence.

Coherence refers to the formation of a narrative that explains the structure of the topic being researched. In this case, a narrative about the factors affecting Young Offending Workers' assessment of mental health difficulties is given that links coherently to the data collected. A narrative and diagrammatic account of the data is provided in the results and in the discussion sections in chapter three and four. Any nuances within the data are clearly highlighted.

6. Accomplishing general vs. specific research tasks.

This refers to the researcher stating the aim of the research and can take two forms; a general overview of the topic area based on a range of situations/examples/

participants or a specific focus on an instance or a single case. The approach taken to the research task has implications for the generalisability of the data. A general approach can be more widely generalised, whereas a specific case cannot be generalised (Elliott *et al.* 1999).

This study aims to provide a general understanding of the phenomenon which can then be extrapolated within the context in which the research has been carried out. In the case of this research it will only be possible to extrapolate the results to the work YOTs in the research study. However, it may be possible to use the research findings to inform the thinking of other YOTs across the UK, but it will not be possible to extrapolate the findings directly to these teams, as data was only collected within a small geographic area of South Wales. The limitations of any extrapolation of the data will be clearly highlighted in the discussion in chapter four.

7. Resonating with readers.

The data should be presented in a way that reflects the subject matter, has resonance for the reader and adds to or clarifies the reader's understanding of the subject matter. The researcher intended to provide an account of Youth Offending Workers' assessment of mental health difficulties based on their accounts. Throughout the writing up of the research the chapters were read by the academic and clinical supervisors to ensure that the research resonated clinicians working within and externally to youth offending.

2.2.4 Personal and professional reflexivity

Qualitative approaches (Willig, 2008), and, especially, constructivist grounded theory, place great emphasis on the researcher being able to take a position of reflexivity (Charmaz, 1995). Reflexivity refers to the researcher's ability to reflect and process how their beliefs and values may have impacted on the process of the research. Within constructivist grounded theory reflexivity is placed at the centre of research (Willig, 2008). The researcher is required to state their position, including any relevant beliefs or values, allowing the reader to understand the potential impact that the researcher may have had on the research (Elliott *et al.* 1999 and Charmaz, 2006).

Ahern's (1999) 'top tips for reflective bracketing' were also used to help ensure the reflexivity of the researcher throughout the project. Ahern (1999) suggests focusing on reflectivity in three core areas: during the preparation stage, post analysis and feeding back.

In terms of preparation, Ahern suggests that a reflective journal should be started, before the research has begun, so that the researcher can identify some of their interests relating to the topic of research and potential role conflicts (an account of this can be found in section 2.2.5). Ahern also suggests that the reflective journal can be used to identify the researcher's values base in order to identify possible areas where it may be harder to be objective when analysing the data. It is suggested that it is also important to note the gatekeeper's (the individual who provides access to the participant group) interests and biases. In this research the clinical supervisors were also the gatekeepers.

Ahern highlights several points for the researcher to be aware this includes: considering the researcher's feelings as a sign of a lack of neutrality and the viewing of a lack of new or surprising findings as a possible sign of saturation or a sign of the researcher becoming desensitised to the data. Finally, in terms of preparation, Ahern advises that difficulties with data collection, such as a lack of participants, may suggest difficulties with the method and highlight the need for a change in approach. As guided by Ahern (1999), supervision and discussion with colleagues, alongside the use of a reflective journal, was used by the researcher as a way monitoring these potential difficulties in the preparation of the research.

During the post analysis phase Ahern (1999) highlights the importance of paying attention to how the data is written up. For example, is one person quoted more than another and, if so questioning whether this is a result of bias in terms of an alliance with that individual. Therefore, the results section was discussed and reviewed with the clinical and academic supervisor to reduce the potential for bias. The potential for bias within the literature review is also highlighted as an area that the researcher needs to pay close attention to. Completing a systematic review of the literature provides a clear rationale for the literature review and reduces bias (British Medical Journal (BMJ), 1994).

Finally, Ahern (1999) suggests that, to overcome bias, the researcher should recognise the potential for bias and return to the data with this awareness. It is suggested that this may be achieved by looking at the data with another person. In this research coding was looked at with the supervisors who were involved in the research and with a trainee colleague who did not have a direct role within the research. However, this colleague may have brought their own biases to the data analysis.

2.2.5 Researcher's and gatekeeper's position

The research was conducted by a female Trainee Clinical Psychologist as part of the fulfilment of a doctorate in Clinical Psychology. The researcher has no direct experience of working in youth offending; however, a relative of the researcher works as an Education Officer in a Welsh YOT. Whilst this team is not connected with any of the teams participating in the study, this relationship may influence the impartiality of the researcher.

As part of her current and previous placements and previous employment the researcher has been involved in the assessment of mental health difficulties in young people and adults and, therefore, the researcher's approach to and understanding of assessment may also have an impact.

The researcher has an interest in working with young people post qualification and therefore chose this research, in part, as a means of gaining further understanding and experience of the role of psychology within services for young people. Therefore, the researcher's interests and reason for conducting this study may be a potential source of bias. The researcher was, also, particularly drawn to this area of research because of the high levels of identified need in the youth offending population and the limited focus within the research. The researcher hoped that this research would inform the provision of services for a population that she felt was greatly under resourced in terms of the support available for young offenders' mental health difficulties.

The gatekeepers for this project were the Clinical Supervisors for the research. The Clinical Psychologists work within the tier three forensic CAMHS service. They meet with the CPNs from the team on a monthly basis to provide consultation and advice around mental health difficulties. The Clinical Supervisors, who were new to their post within YOS, were interested in learning more about the service context to inform their consultations and future service development. The Clinical Supervisors both take a social constructivist view of distress and difficulties, which may have influenced their interpretation of the data, as well as influencing the researcher's interpretation and understanding of the data and the service context.

The Clinical Supervisors provided an introduction to the team managers who then provided access to the participants. Participants were recruited via email, and it is not clear what influence the team managers had on who volunteered to take part in the research. Therefore, there is potential for a bias in the sample of participants (Ahern, 1999).

The academic supervisor is a Clinical Psychologist working within a specialist CAMHS team with young people aged 14-18 in another area of South Wales. The academic supervisor is the Clinical Director for the Doctoral Program, on which the researcher is registered, and it is in this capacity that they are supervising the research. Although the academic supervisor has experience of working with young people, they have not had any clinical or personal experience of youth offending. Therefore, when providing credibility checks (see section 2.2.3), they are less likely to be biased by their knowledge of youth offending.

When designing the stem questions a Youth Offending Worker from another area of Wales was consulted to provide advice on the questions from a Youth Offending Worker's perspective. This worker had expressed an interest to the supervisor when the research was discussed with them during clinical supervision. They also had an interest in psychology and are considering completing the Forensic Psychology doctorate. Their interest in psychology and mental health difficulties in young people is a potential source of bias. A fellow trainee was also involved in the data analysis to provide credibility checks (see section 1.3.3). This trainee is currently on a placement within the FACTS team. Therefore they are aware of the working practice

of YOTs across Wales. This may mean that their interpretation of the data may be biased by their understanding of youth offending. However, they were chosen as they were using the same methodology and therefore they would have a good understanding of the methodological approach to data analysis.

2.3 Design

2.3.1 Overview

A qualitative design was applied to this research using semi-structured interviews to explore factors affecting Youth Offending Workers' assessment of mental health difficulties in young offenders. Data was obtained from nine interviews with Youth Offending Workers across three teams in South Wales. Participants were invited to take part in the research, which involved a single individual interview with the researcher focusing on their experience of assessing mental health difficulties in young offenders. The researcher used a set of stem questions (See appendix 7) to inform the interview. These questions were used to focus the interview, but each participant could directly influence their own interview. Questions were also adapted as a result of information obtained within and between the interviews. An example of how questions were adapted in relation to the data can be seen in appendix 14. This approach to interviewing helps to ensure an inductive approach to research is taken (Glaser and Strauss, 1967). The interviews were recorded using a Dictaphone and then transcribed by the researcher. A constructivist grounded theory approach was used to analyse the data (see section 1.8) (Charmaz, 2006).

2.3.2 Service context

YOTs were established in England and Wales in 1998, following the publication of the Crime and Disorder Act (Great Britain, 1998). They were established with the primary aim of providing a multi-disciplinary (including Health, mental health or physical, Social Services, Probation and the Police) approach to prevent offending and reoffending by young people aged 10-18 years. Youth Offending Workers can be employed on a permanent or agency basis and have a range of professional backgrounds, primarily Social Work or Probation.

The Education and Health Workers' specific assessment and intervention relating to education and health is based on the identified needs of the young person at assessment (Ashford and Chard, 2000 and Crime and Disorder Act, 1998). In the research area, each team has a community psychiatric nurse (CPN, sometimes referred to as Clinical Nurse Specialist), seconded from the CAMHS.

YOTs each have a team manager who provides line management, ensures key performance indicators are met, enables service development and ensures that all assessments are completed. The Head of Children's Services within the Local Authority oversee the work of YOTs, and the YOT Managers are directly accountable to them. However, team managers are able to act autonomously and were thus able to give permission for their staff to be recruited for the research. (See appendix 12).

Within the team, Youth Offending Workers maintain case responsibility for the young people and carry out the initial and on-going assessment of all young offenders (Crime and Disorder Act, Great Britain, 1998 and YJB, 2010a).

The Local Health Board provides one day a week of Clinical Psychology time to the three YOTs within the Health Board area. The Clinical Supervisors provide a service to all three YOTs. It was thus decided that the team managers of the three YOTs would be approached to see if they would be interested in participating in the research. All three team managers agreed to allow recruitment from their teams.

2.4 Research governance

2.4.1 Ethical approval

Cardiff University Psychology Ethics Board granted ethical approval for this study on the 16th of May 2013 (Study reference EC.13.05.07.3457RR, see appendix 6). Informed consent was gained from participants before the interviews and participants were reminded of their right to withdraw from the research without any adverse consequences at the start and end of the interview. Participants were also informed that, in order to protect their confidentiality, the audio recording would be destroyed after transcription, and all identifying information would be removed. (See section 2.5.3 and appendix 8).

Three main ethical considerations were identified and addressed to the satisfaction of the Ethics Board. These were:

(i) *The possibility of clients being identified.*

This issue was addressed by advising participants not to mention clients by name or any other identifiable characteristics, and if this should occur, this content would not be transcribed or used in the final write up. Transcription of the data was discussed verbally with participants and was also stated on the information sheet (see section 2.5.3 and appendix 8).

(ii) *The potential for participants to identify unprofessional or unethical practice.*

Participants were advised that practice that was considered unprofessional or unethical would be discussed with the participant and brought to the attention of the relevant team manager. Potential issues included, child protection, risk to self or others and fitness to practice issues. This was discussed verbally with participants and was stated on the information sheet (see section 2.5.3 and appendix 8).

(iii) *The potential for participants to become distressed.*

Participants were advised that they should only discuss issues that they felt comfortable with. This was discussed verbally with participants and was also stated on the information sheet (see section 2.5.3 for further details, and appendix 8). The researcher also 'checked in' with the participants at the end of the interview, and all participants were given a debrief sheet with details of how they could access emotional support if needed (see appendix 9).

2.5 Participants

Participants were recruited from three teams from three different Local Authorities, where the Clinical Supervisors provide input. The total population sample was 44.

2.5.1 Inclusion and exclusion criteria

Participants' were selected using the following criteria:

1. At least one year's experience as a Youth Offending Worker.
2. Completed at least five assessments with young people.
3. Completed assessments with young people where mental health difficulties have been identified.

Participants were excluded from participation based on the following criteria:

1. Having had significant training or a professional background in mental health.

It was felt that having significant training or a professional background in mental health would have significant implications in terms of how the individual approached the assessment of mental health difficulties in young offenders compared to other workers. Having a background in mental health was thought to be likely to impact on how they approach assessment. As the majority of Youth Offending Workers do not have this background it was felt that including such participants would have implications for the generalizability of the results of the study. Participants were asked if they had previous mental health training e.g. as a CPN, a therapist, or a psychologist. None of the participants who volunteered for this project had a mental health background. No other exclusion criteria were considered significant for this project.

2.5.2 Recruitment

Participants were recruited from three YOTs in South Wales. For the purposes of anonymity, individual teams will not be named; however, reference to their context and generic locations will be given. All Youth Offending Workers working within the three YOTs (44 people) were provided with basic information about the study (appendix 12 and 13). After receiving this information, nine people signed the consent form (appendix 10) and agreed to be interviewed. This number was considered to be sufficient for grounded theory based on the guidelines provided by Charmaz (2006). There were an equal number of participants from the three YOTs, three from each team. All participants that volunteered to take part in the study were asked to verify if they met or did not meet the inclusion criteria. They had all worked as a Youth Offending Worker for more than one year; they had completed at least

five assessments with young people and had experience of assessing a young person whom they felt had mental health difficulties. None of the participants stated that they had significant training or a professional background in mental health.

The teams will be randomly assigned a letter, which will be used to refer to the team throughout; these will be Team A, Team B and Team C.

In order to maintain confidentiality whilst providing an overview of the service context, only limited information about the teams has been provided. YOTs A and B are located in semi-urban areas of South Wales and cover rural, suburban and urban areas and YOT C is based in an urban area of South Wales. YOT A has 23 Youth Offending Workers (working part time), YOT B has 10 Youth Offending Workers and YOT C has 11 Youth Offending Workers. Each team consisted of professionals from Social Services, the Police, Probation, Education and Health, as stated within the Crime and Disorder Act (Great Britain, 1998). All three teams have access to their own CPN who is seconded from the Local Health Board.

2.5.3 *Consent and confidentiality*

Participants who had verbally consented to participating in the research were given an information sheet (see appendix 9) which provided a more detailed overview of the study, information on why they had been asked to participate in the study, what participation in the study involved, an overview of the ethical considerations, consent and confidentiality issues and contact details for the researcher, the supervisor and the ethics committee. Participants were given time to read through and discuss the information sheet with the researcher. The main ethical considerations were also verbally discussed with the participants. After reading the information sheet, they were asked if they were happy to consent to participate in the study. Participants were then asked to complete a consent form (see appendix 10). Informed consent was provided by all nine participants.

In order to maintain confidentiality, participant names and the names of the teams have not been included in the final write-up. The teams are not referred to in the order that the research was carried out. Any significant identifiable information such

as client's names, professionals names and genders, locations or specific information that was felt likely to identify the worker, another worker, the team, or any young person was not included in the final transcriptions. Pseudonyms have been given to the participants to protect their identities and these will be used throughout this report (See table 6 in section 2.5.4).

2.5.4 Description of participants

In total, nine Youth Offending Workers were interviewed, three from each of the three teams included in the study. Participants had a range of previous experience, professional backgrounds, length of time working in the YOT and role within the YOT. Out of the nine participants, six were male and three were female. The age of participants was not ascertained, as it was not felt to be relevant to the study, the mean number of years' experience working with the YOS was 12.3 years. The range has not been reported to protect participant's anonymity. Two of the participants were Probation Officers who had been seconded to the YOT, and the remaining seven participants were qualified Social Workers (see table 6).

Team	Participant	Pseudonym	Gender
A	1	Sam	Male
A	2	Katie	Female
A	3	George	Male
B	4	Dave	Male
B	5	Louise	Female
B	6	James	Male
C	7	Peter	Male
C	8	Emma	Female
C	8	Chris	Male

Table 6. Overview of the participants.

2.6 Procedure

2.6.1 Recruitment

The manager for each YOT was contacted by phone to discuss the project and seek their approval to recruit participants from their teams. Following this communication,

email permission to begin recruitment was obtained from all three managers (See appendix 10).

Participants were recruited through the use of a poster (see appendix 11), promotion by the researcher at team meetings and through emails to the team members. Participants either expressed interest in the study face-to-face with the researcher, or they informed their manager who passed on the contact details to the researcher through e-mail. All of the interested participants were contacted by the researcher via e-mail to provide them with more information about the study, including the participant information sheet (see appendix 13).

When the researcher met with the participants, they were given a copy of the information sheet (appendix 8). Participants then had time to ask the researcher any questions before being asked to sign a consent form giving their written consent to participating in the study (appendix 10). All nine people who expressed interest gave consent to participate in the study. Interview times were arranged at a time and venue that was convenient for the participant.

2.6.2 Construction of the interview questions

A qualitative, semi-structured interview schedule was used. This gave a degree of structure through the use of stem questions (see appendix 7), which could then be explored in detail through the use of further questions. This allowed the participants to take a degree of control over the direction the interview would take (Charmaz, 2000).

Whilst it is important when using grounded theory to let the interview be guided by the participant (Glasser and Straus 1967) the literature base was used to develop the stem questions which explored a number of key themes. Table 7 gives an overview of the key themes and examples of the stem questions used to explore these.

Taking a flexible approach to the interviews, whereby an interview schedule is devised but not rigidly adhered to helps to overcome potential researcher bias (Pope

et al. 2002). It allows for the questions to develop and change in response to emerging theories and themes from each interview rather than as a result of the researcher's pre-existing knowledge (Charmaz, 1995, and Elliott *et al.* 1999). (Appendix 15 illustrates how the stem questions developed and changed over the course of the interview).

Topic.	Examples of Stem Questions
Job role	What is your professional background? What do you perceive your job role to be?
Focusing on the welfare of the young person vs. focusing on the offending behaviour and the need to protect the public	What are the purposes of assessment in general and a focus on mental health?
Understanding of mental health	What is your understanding of mental health difficulties? To what extent do you see working with mental health difficulties as part of your role?
Purpose of assessment	What are the purposes of assessment in general and a focus on mental health?
Validity of the assessment tools	How well do you feel the ASSET captures your concerns about a young person's mental health?
Implications of knowledge and background	When thinking about ASSET what factors do you think influence your assessment of mental health difficulties? Can you give examples?
Confidence	Would you say your confidence around assessing mental health has gone up, stayed the same or decreased?
Judgments Decisions	How do you reach your decision on what score to give a young person?
Accessing support	What options are available to you when you identify a mental health need? Do you feel these options meet the young person's needs?
Other	Is there anything that we haven't talked about

Table 7. Key themes and examples stem-questions used within the semi-structured interviews.

Proposed questions and themes were discussed and revised with the clinical and academic supervisors. A Youth Offending Worker from a team in another part of Wales was also consulted about their views about the stem questions.

Throughout each interview stem questions were revised in action and on reflection after each interview in order to inform the next interview. For example, within the interviews the wording or order of questions would be changed based on the content of the interview. Following each interview, questions were revised based on the content of the interview (appendix 14). This allowed for themes to be developed from each interview and allowed the stem questions to be modified in order to inform the next interview. This approach to interviews is recommended within guidelines for grounded theory (Charmaz, 2006).

2.6.3 Interview procedure

Interviews were expected to last for approximately one hour with a range of 41 and 63 minutes and the mean being 53.6 minutes. Every attempt was made to put the participant at ease, minimize any potential power imbalance and allow the participants to feel comfortable in expressing their views. Time was spent at the start of each interview talking with the participant and putting them at ease before beginning the recording. The researcher also explained that she was not an expert in youth offending and was interested in finding out and understanding their views.

Participants were given the option of being interviewed at their place of work or at an alternative venue. All participants opted to be interviewed at their place of work and interviews took place in a private room at a time that was convenient for the participant. Whilst this helped to put the participants at ease, this may have had implications for the participants in terms of worries about confidentiality. However, every effort was undertaken to ensure the rooms were sound proof and that interviews were not interrupted. Interviews took place between September and October 2013. Participants were given an information sheet (see appendix 8) before the interview commenced and they were given time to read it. The key points around confidentiality and anonymity were also verbally communicated to all participants. The aims of the study were discussed, and participants were given time to ask any questions. Participants were then asked to confirm that they were willing to participate by completing and signing the consent form (see appendix 10).

An intensive interviewing approach was used to elicit individual participant's interpretations and associated meaning surrounding the events that they were discussing (Charmaz, 1995). Each participant was, initially, asked general questions about how long they had worked in the YOT and their professional background. Questions from then on were tailored to explore the participant's responses, interpretations and understanding. Follow-up questions and prompts within the interview schedule, such as "can you tell me a bit more about that?" and "can you give me an example?" were used to enrich the participant's responses. Before concluding the interview, the participants were asked if there was anything that had not been covered during the interview that they thought was important to discuss.

In order to align themselves with the participants, the researcher tried to ensure that attention was paid to context, language and interaction style used by the participant through the use of the researcher's therapeutic skills. The researcher used this information to employ the language style used by the participant and asking for clarification when they were unsure what the participant's response meant. The researcher was able to use existing therapeutic skills such as active listening and a client centred approach (Rogers, 1959) to build and maintain a relationship with the participant throughout the interview. It was hoped that this would increase the authenticity and genuineness of responses, helping to ensure that the data collected provided a more complete and rich understanding of their experience (Coyle and Wright, 1996).

2.6.4 Data management

Interviews were recorded on a digital audio recorder; the researcher transcribed the interviews using verbatim speech. In order to protect confidentiality, all names were removed from the transcription. Where it was thought that a third party might be identified through the use of their gender, they were referred to in gender-neutral terms. Place names such as geographical locations and prison names were omitted from the transcriptions. Excel and Word were used as a data management tool and for coding and categorisation (See section 16 for an example of coding).

2.7 Data analysis

2.7.1 Transcription

Interviews were transcribed within 2 weeks of the interview. Transcribing, as well as listening to the audio recordings on multiple occasions allowed the researcher to become immersed in the data, and the act of transcription formed part of the analysis (Glasser and Straus, 1967).

A reflective journal was kept throughout the process, and the researcher made comments within the journal following transcription. The reflective journal focused on content and process issues. For example, content issues included the identification of themes and further ideas to explore in subsequent interviews. Process issues including the feeling within the room, and the experience of the interview. Using a reflective journal helped to ensure that the researcher focused on the process of constructing a theory from the information gathered (Ezzy, 2002 and Charmaz, 2006). It also helped to ensure that the researcher took an open approach to interviews and constructing the theory, reducing the chance for topics or areas to be “closed down” or an area to be over prioritised (Charmaz, 2006) (Appendix 4).

2.7.2 Analysis

Simultaneous data collection and analysis was adopted for each candidate in order to explore emerging themes from each interview within subsequent interviews. The process started with listening back to the interviews on a number of occasions to gain an understanding and overview of the topics discussed. The process of identifying emergent themes from the data, which was then used to inform the subsequent interviews, was central to the iterative process of grounded theory (Elliott *et al.* 1999). Following the transcription process a line-by-line analysis was conducted. Key principles of grounded theory, including coding, memos, categorisation and comparative analysis, were used to guide the analysis of the data (Glasser and Straus, 1967). An iterative approach to analysis was taken, moving between coding and conceptualisation.

2.7.3 Coding and memos

Coding was used to inform the emerging theories from each line. This process involved naming sections of the data in order to summarise that piece of data (Charmaz, 2006). Labels were based on the language used by the participants to maintain the data's authenticity (Willig, 2008). Coding was further elaborated with the use of example data to ensure that they were grounded within the data (Elliott *et al.* 1999) (see appendix 16 for examples).

Memos were used to note personal reflections and ideas, increasing abstraction and informing future interviews. Memos helped facilitate the process of theoretical coding, whereby relationships between categories that were identified initially were further explored (Willig, 2008) (see appendix 16 for an example).

2.7.4 Category formation

Concepts were then grouped together to form sub-categories based on the frequency and significance of the concepts. The sub-categories were developed further through integration to create higher-level analytic categories (Willig, 2008).

2.7.5 Comparative analysis and triangulation

Comparative methods were used to reduce the chance of researcher bias. This included discussing categories and conceptualisations with both the academic supervisor and clinical supervisors and a trainee colleague who was not involved in the research. This technique is also known as investigator triangulation (Guion *et al.* 2011). Comparative techniques allow for an iterative process to be taken whereby the researcher moves back and forwards between codes and categories. This helped to highlight similarities and differences and led to the identification of sub-categories (Willig, 2008). Comparative analysis also helped to ensure the quality of the data (Elliott *et al.* 1999). It allowed for variation within the responses to be highlighted and accounted for through negative-case analysis which identifies and accounts for exceptions that do not fit with the rest of the data (Lincoln and Guba, 1985).

2.7.6 Saturation

Saturation of the data occurs when no further theoretical insight is gained from the data. It is important to note that saturation is not related to presence of repetition in the data but to finding the same theoretical patterns arising in the data (Charmaz, 2006). The decision to stop data collection was informed when the researcher felt they had reached saturation within the data set.

Chapter 3. Results

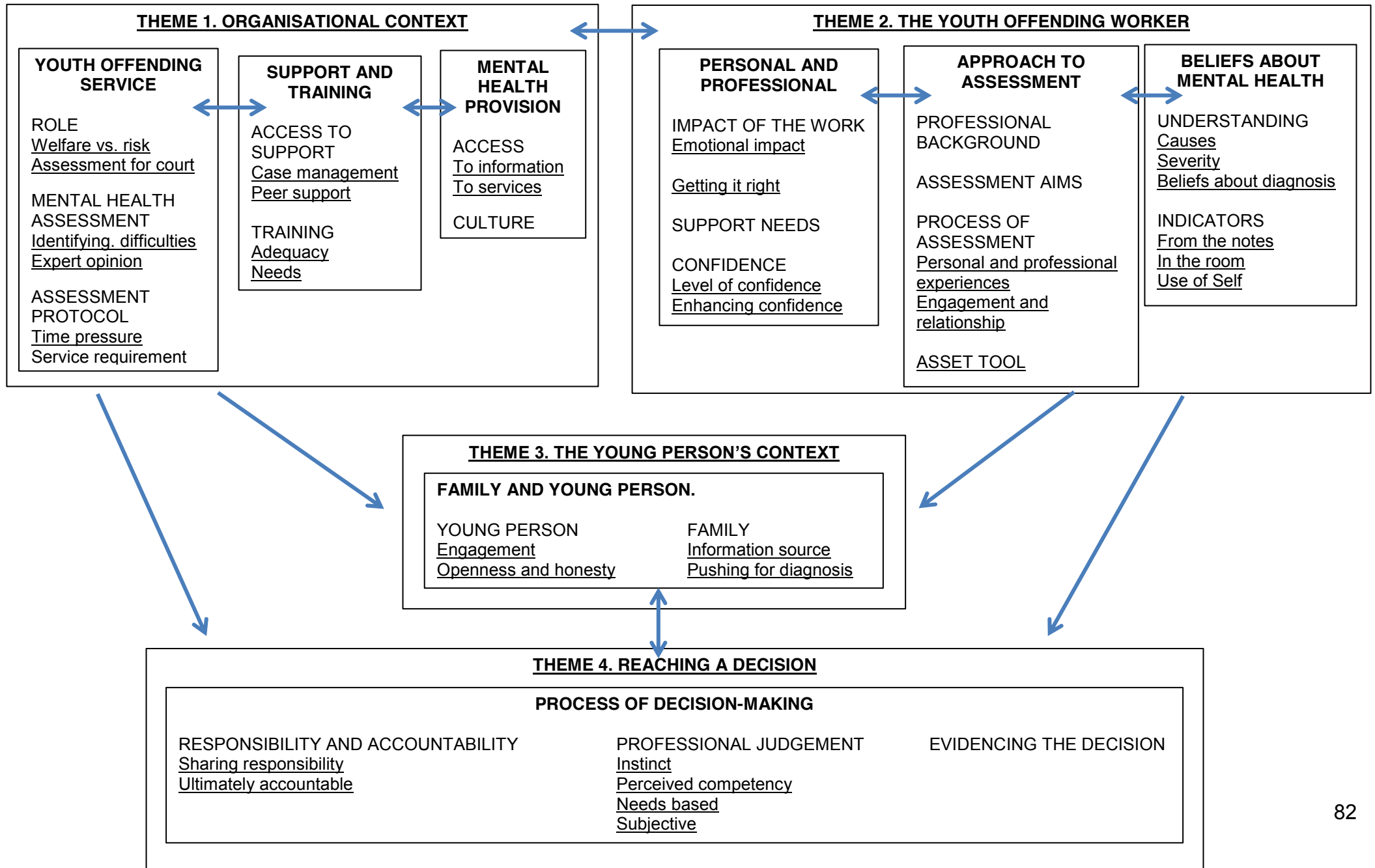
3 Overview

Following analysis of the data this chapter presents a constructionist grounded theory from nine interviews with Youth Offending Staff. Four key themes were identified along with eight core categories, 21 categories and 34 sub-categories. For ease of reading, **THEMES** are highlighted in capitals, underlined and bold lettering; **CORE CATEGORIES** are in capitals and bold lettering; CATEGORIES are in capital lettering and sub-categories are in lower case underlined lettering.

The four **THEMES** were the **ORGANISATIONAL CONTEXT**, **THE YOUTH OFFENDING WORKER**, **THE YOUNG PERSON'S CONTEXT** and **REACHING A DECISION**. A narrative overview, using direct quotes from the interviews, will be presented to describe the **THEMES**, **CORE CATEGORIES**, CATEGORIES and sub-categories and the interaction between these.

A diagrammatic summary of the four **THEMES**, eight **CORE CATEGORIES** and 21 CATEGORIES and 34 sub-categories is presented in Figure 6. The diagram is designed to illustrate the interactional relationship between the **THEMES**, **CORE CATEGORIES**, categories and sub-categories. A diagrammatic representation of each of **THEME** will also be presented within the results section in figures 7, 8, 9 and 10.

Figure 6 Overview of constructivist grounded theory



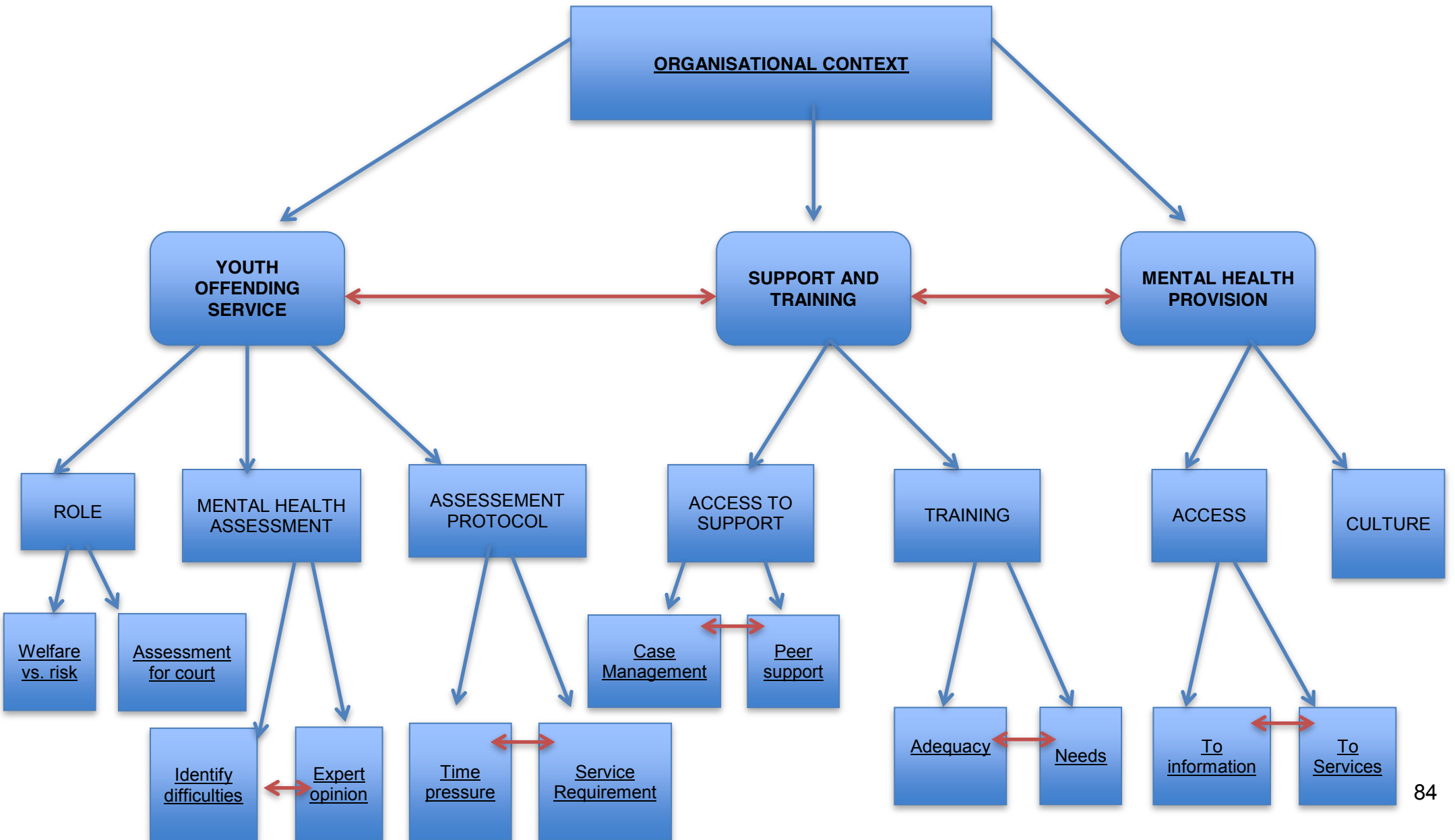
3.1 Presentation of the results

3.1.1 Theme one: **ORGANISATIONAL CONTEXT**

This theme attempted to explore the impact of the **ORGANISATIONAL CONTEXT** on the assessment of mental health difficulties in young people. Participants discussed the impact of working in a **YOUTH OFFENDING SERVICE** and how this affected their approach to undertaking MENTAL HEALTH ASSESSMENTS. This included their **ROLE** in the context of the aims of the YOS, with a need to focus on welfare vs. risk in the creation of an assessment for court. Youth Offending Workers also discussed the organizations expectations regarding MENTAL HEALTH ASSESSMENT, which included identifying difficulties and seeking an expert opinion. Participants discussed the impact of the ASSESSMENT PROTOCOL in terms of time pressures and a service requirement to complete the assessment. Participants highlighted the impact of **SUPPORT AND TRAINING**, including ACCESS TO SUPPORT, both in terms of case management and peer support and TRAINING, both within core professional training and subsequent training within the YOT, in terms of its adequacy and their training needs. This highlighted how core professional training impacts on the type and level of knowledge, skills and experiences the worker had prior to joining the YOT. The impact of professional background was further highlighted by differences in core values which influences the **APPROACH TO THE WORK** that the worker took, with those from a Probation background taking a more risk-focused approach than those with a Social Work background who were more needs focused. Finally, participants identified two key areas within **MENTAL HEALTH PROVISION** that impact on their assessment of mental health difficulties. These were **BARRIERS TO ACCESS**, including access to information and access to services, and a difference in **CULTURE** between health and offending services. These factors made the assessment of mental health difficulties created challenges for the Youth Offending Workers.

Theme one will now be explored through the use of direct quotes from participants, to illustrate the **CATEGORIES** and sub-categories. A diagrammatic overview of theme one can be seen below in figure 7.

Figure 7. Overview of them one: **ORGANISATIONAL CONTEXT**



Core Category one: YOUTH OFFENDING SERVICE

This core category looks at factors associated with working in a **YOUTH OFFENDING SERVICE** and the impact this has on the assessment of young offenders. The core category consists of three categories **ROLE**, **MENTAL HEALTH ASSESSMENT**, and the **ASSESSMENT PROTOCOL**.

CATEGORY ONE: ROLE

This category focused on the worker's perception of their role within the **ORGANISATIONAL CONTEXT**. Within this category two sub-categories were identified, welfare vs. risk and creating an assessment for court.

Sub-Category one: Welfare vs. risk

The impact on assessment of dual requirement to consider the young person's needs, reduce the risk to the young person and protect the public was discussed. Welfare is seen as paramount but, for some participants there was a feeling that risk to the public and punishment were the main foci at an organisational level.

Peter: "...I think it's quite clear...the Children's Act tells us that the welfare of the children is paramount, that's never gone away. So we've got a balancing act between that and protecting the public. So... we have to do... the more punitive stuff and try and balance that with the welfare [and] what's right for the young person".

Emma: "There is a huge debate about whether we are a public protection agency. People say 'no' we are social workers, but I think we are. I think we're managing some potentially very dangerous young people and we've got a responsibility to manage it in whatever way that has to be. And although prison probably wouldn't be the best for the mental health of young people, sometimes you gotta. [The mental health of young people] can't be the highest priority, that can't be why you would keep them in the community, and it weighs heavy on you sometimes".

One participant suggested that responsibility for the identification and management of the young person welfare needs should be deferred to other services so that the YOS could focus on the offending.

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Katie: "...you know offending is offending and welfare is welfare and maybe the two are linked but not necessarily. You can deal with them separately and there are other agencies that are there for welfare".

The conflicting aim of managing welfare and risk has the potential to add complexity to the assessment process for the worker. Participants were however clear that creating an assessment for court was a clear role expectation during the assessment.

Sub-Category two: Assessment for court

Participants identified that the main aim for assessment from an organisational perspective was to create an assessment for court to inform future planning. Participants discussed the importance of obtaining detailed and accurate information about a young person from a range of sources. They described the process of collating information to build a picture of the young person from which they could create a plan.

Emma: "You can get that information... [from] the parents or the carers and the school. They often have a lot of information so it's about information gathering to build the picture for as long as it takes, really".

George: "I think when you do your assessment you try and get as much information [from as many] sources as possible, so it will be parents, schools, social services, CAMHS. (If you get access to CAMHS notes or ring and request them through our clinical nurse specialist)... to try and paint a picture".

One participant talked about the need to gather information before meeting with the young person in order to inform the assessment process.

George: "I think a lot of it is doing the proper ground work before you go out... So it's being prepared for the interview reading past reports if there are any, so having insight so some young people come to us with, like, psychology reports that have been done from their defence, so it's having as much knowledge as you can..."

Category three: MENTAL HEALTH ASSESSMENT

This category focused on the perceived expectations placed on Youth Offending Workers by the organisation regarding mental health assessment. Within this

category two sub-categories were identified, identifying difficulties and gaining expert opinion.

Sub-Category one: Identifying difficulties

One participant talked about the recognition of mental health difficulties in young offenders as a “bare minimum”.

Peter: “... the bare minimum if you like is that we can recognise the young people are unhappy and where there might be some problems...”

The high level of emotional distress and or mental health difficulties and its association with offending behaviour in young offenders was noted by participants.

Peter: “... I would say 90% of our kids have got some emotional problem and if they haven't the family has, so somewhere in their family there are some difficulties”.

Emma: “...the majority of our kids unfortunately have had some kind of emotional distress or traumatic experience in their lives which is why, well, not why they offend but it's a huge factor in their challenging behaviour and why they do not get to school or things like that”.

One participant stated that workers needed to be vigilant and looking out for mental health difficulties in their assessment of young people. They saw themselves as being key to enabling young people to access a more appropriate assessment.

Sam: ...I think because we are the first person that goes out to see that young person I think we need to be sort of vigilant at being able to identify potential mental health concerns because then if we didn't that wouldn't warrant the CPN involvement then”.

However some participants were also aware of their limitations in this respect and the need to seek more expert advice and assessment.

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Sub-Category two: Expert opinion.

Participants saw their role as needing to identify the difficulties and seek an expert opinion in order for “an expert” to make a more detailed assessment of the young person’s mental health difficulties.

Peter: “...I think the next thing is not to sit on that but to refer it on and do your referral so I can signpost on to someone who can do it”.

Emma: “...I'm not a mental health professional so I wouldn't want to put myself on the line, so my responsibility is to refer it on...”

However, other participants felt that just referring on and not working with the young people themselves was not only frustrating but was also risky for the young person and potentially undermined the workers skills.

Chris: “...I feel a bit useless, like, when it comes to mental health [because] you just signpost, signpost, signpost”.

Dave: “I don't think it's a stop thing, like, refer them on and that's it. In fact, perhaps we have done that before [refer on] in the past and it's quite dangerous because then it's kind of a separate thing and you don't really know”.

George: “I think there is sometimes too much emphasis to quickly refer on and people [workers] might not have any... sort of trust in their own ability to manage the case if there is mental health issues...”

This potentially highlights the different expectations participants have for their role in the assessment of mental health difficulties.

CATEGORY THREE: ASSEMENT PROTOCOL

This category focused on the use of ASSET from an **ORGANISATIONAL CONTEXT**. Within this category two sub-categories were identified; time pressure and a service requirement.

Sub-Category one: Time pressure

All of the participants commented on the pressure to complete an assessment within a strict time frame laid down by the YJB and the court. The participants felt that the

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timescales got in the way of completing the assessment and influenced the quality of the assessment in terms of, the information they were able to obtain, and the Youth Offending Worker's ability to build a relationship with the young person. The ability to gather and collate information and the importance of building a relationship with young people were also identified as other factors that influenced Youth Offending Worker's assessment of mental health difficulties in young offenders (see **APPROACH TO THE ASSESSMENT**).

Emma: "...with timescales... you write a pre-sentence report you normally get two or three weeks but its normally two... the first one [report] is very very time pressured which is not very helpful because you might miss stuff because you're so concerned about getting it done".

Louise: "...in those three weeks, obviously, we are not only working on that [assessment] I may have another two PSR [pre-sentence report] on the go, I may have a couple of bureau reports like last week...and obviously you have got your caseload; something will kick off with one of the other people you're working with, somebody will be in crisis, somebody is made homeless. So you haven't really got enough time.... so you know we wouldn't see them more than twice sometimes just once..."

One participant felt that the time pressure to complete the ASSET had a direct impact on their ability to complete a good mental health assessment.

George: "I think the difficulty is a good mental health assessment probably takes as long as the ASSET would on its own and I think people are pushed for time... you learn more about the person as your work with them".

One participant commented on the time pressure being associated with organisational targets rather than meeting the needs of the young person.

James: "There's targets and deadlines that are set that actually have got very little to do with young people is very very process driven. It's about ticking the box basically and if you are not the ticking the box you are not performing basically..."

Sub-Category two: Service requirement

Participants described ASSET, which they are required to complete, as not being a useful tool for assessing the young people they were working with. One participant

talked about the tool not being child-centred and using language that is not very child friendly.

Peter: "Well it is [ASSET] not child-centered words... if you were to go through that I think you would hit a blank all the time".

Another participant talked about the questions inviting a 'Yes/No' response rather than inviting a dialogue with the young person.

Chris: "I've been here for four years now say four and a half years and I probably do, I don't know, 10, maybe, PSR [pre-sentence reports]...reports a month and I don't think I've ever had one young person on the mental health screening questions answer yes to more than two of them. Because they are 'so do you take drugs?' 'Yes' 'Do you feel that your life gets out of control if you take drugs?' 'No'. Do you know what I mean, they are literally like open and closed questions and that's what they're like?"

Core category two: **SUPPORT AND TRAINING**

This core category looks at the support and training provided by the organisation and the impact this has on the workers assessment of young offenders. The core category consists of two Categories ACCESS TO SUPPORT and TRAINING PROVISION.

Category one: ACCESS TO SUPPORT

This focused on the worker's access to support in terms of, case management and peer support.

Sub-Category one: case management

There were mixed opinions from the participants regarding support from management. One participant really valued management support and found that support was given without them even realising it was happening.

Emma: "...management is very supportive...when you perhaps don't even realise you need that support if you know what I mean".

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Another participant questioned the usefulness of support from management because of the detached nature of their relationship with their manager. Peer support was seen as more useful.

George: "...I think it is what you get from your colleagues is more [helpful]. I am not saying its tokenistic, coming from management but because you are that little bit more detached from your managers than the colleagues you are on the ground working with I think that sort of support is more supportive..."

Another participant highlighted the need for supervision and time to discuss the emotional impact of the work. They discussed a model of support and supervision that focused on reflecting on the work and its emotional impact rather than focusing more on procedures and outcomes.

James: "...we do work in an environment where you're working with young people... in difficult circumstances. I think our supervision is not like a clinical supervision; it's not "oh how did you feel about that and how did that affect you," its 'did you do a proper assessment what was the score, did you do a reviews after 3 months'. It seems to me very process driven rather than being able to talk around cases, either confirming that you have done a good job or maybe you should try this or that. No real concern about how these cases impact on your own emotional and mental health... In health I know that they get this type of supervision but ours is very process driven".

Sub-Category two: peer support

All of the participants talked about the importance and value of support from their peers (colleagues) when working with young people with complex needs including mental health difficulties. This support appeared to be given and received in two main ways, either offering a distraction from a difficult event or using peers to share ideas and obtain advice.

Emma: "...this is a very supportive place to work. The colleagues are brilliant because we all have it. We all have a kid or a couple of kids on our case load where you do think 'what are they going to be like today?'. So you come back and will be, like, 'oh, my god,' and have a sort informal debrief or a moan. We will be, like, 'let's just have a cuppa and talk about Eastenders' or something like that. So I think there is support".

One participant spoke about getting people together to discuss difficult assessments and share their knowledge and skills.

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George: "...so they are trying to organise something but it's one of those things trying to get everyone together...to discuss the more risky cases or the ones where you are just banging your head against a brick wall... because we have all got different experiences and different training and you know people bring different things to...different roles".

CATEGORY ONE: TRAINING PROVISION

This category focused on the Youth Offending Worker's perception of the training they received around mental health difficulties. Participants spoke about the adequacy of the training they had received and their specific training needs in relation to mental health assessment. This provided insight into the level of knowledge and the acquisition of knowledge about mental health difficulties. Within this category two sub-categories were identified, adequacy and needs.

Sub-Category one: Adequacy

Eight out of the nine participants felt that the training they received about mental health difficulties was not sufficient and did not meet their needs. The following quotes are examples of comments participants made in relation to the adequacy of their training.

George: Most of my training was done at University [during Social Work training] I've never done anything really specialist... since I've worked here...

James: "I don't think the training we receive meets our needs I think we need a much greater understanding of mental health and what it actually is and what you need to look for and in most cases we depend on gut feelings".

One participant commented that he had received initial training when he qualified as a Social Worker and that this was a long time ago and now forgotten. Since then training had not been up-dated and he felt his knowledge and skills were out of date.

Peter: "...there has not been much at all other than what I did when I was doing the qualifying course [Social Work training] which I have more or less forgotten now and things have moved on over the years I am sure some of its out of date".

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Youth Offending Workers who felt that they had a greater level of training in mental health commented that this was a result of their initial professional training or previous experience. They described this as a choice that they had made rather than a prerequisite for the job.

Dave: "Well, when I did the social work course I did one of my placements in mental health working in an adult mental health team, I guess that's the main bit [of training] but that was by choice..."

George: "I think it's because I had a mental health placement in my third year. I was in assertive outreach [a mental health service]... and it was brilliant. We were working with some sort of really ill people in the community... it tends to put stuff into perspective a little bit because I have exposure to how ill people can be so it's almost a comparison between".

One participant felt that, although they had not had much training, it was sufficient to meet their needs as they were able to rely on the CPN to inform and shape their understanding.

Sam: "I think it's enough because I suppose we have got...a mental health nurse specialist in the team I suppose part of...our job is to liaise with them...so it doesn't really feel like we need any more than what we have got".

Sub-Category two: Needs

Participants identified training which they felt would improve their understanding of mental health and help them when undertaking assessments with young offenders. One of the main needs was for a more consistent, coordinated and structured approach to training. For example, participants highlighted the need for refresher training and blocks of training rather than one-off days.

James: "I think our training needs updating. I think there should be like e-learning maybe every three months you go on training to update yourself...I sometimes feel it would be much better to have a block of training say over two weeks rather than you being taken out of your day job every now and then trying to get your head around it..."

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One participant also commented that it would be useful to extend the training to focus on how to work with a young person with mental health difficulties rather than having to refer them on.

Chris: "...I think we definitely need more training around... mental health and delivering interventions and making plans so we know what type of work to do with them instead of just passing them on".

Core category three: **MENTAL HEALTH PROVISION**

This core category relates to Youth Offending Workers' perception of **MENTAL HEALTH PROVISION** for young offenders with mental health difficulties. The core category consists of two categories ACCESS, and CULTURE.

CATEGORY ONE: ACCESS

Youth Offending Workers described problems with access to health information and access to mental health services and felt that this impacted on their ability to assess mental health difficulties. However, participants were also able to describe strengths in terms of access to mental health provision for young offenders. Within this category two sub-categories were identified, access to information and access to services.

Sub-Category one: Access to information

Whilst all of the participants understood the importance of confidentiality, they felt that difficulties in accessing mental health information about young people negatively impacted on their assessment.

George: "...again, access to notes, that can be quite difficult but that's an organisational struggle..."

One participant commented that if they tried to get information from a GP about the mental health services a young person may have received they would not get a

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response. This highlights an additional pressure on the assessment process especially in the context of a time specific assessment framework.

Chris: "...if they are going to the GP just to get tablets or something like that because they are depressed we might not find that out.... if we write to the GP it's very unlikely we will get any information out of them".

Participants felt that, on the whole, information from CAMHS was accessible but that this was a result of having a CPN in the team who would take responsibility for obtaining information from CAMHS.

Dave: "I think we are pretty lucky really. We do get access [to information from CAMHS] so if we are worried the CPN will contact whoever is dealing with that person and get an update for us...we would ask the CPN to do it... then get a picture of where they are at from mental health services".

Sub-Category two: Access to services

Participants had mixed views on the access to services for young people with identified mental health difficulties. One participant commented on the length of time young people had to wait to be seen by CAMHS.

Peter: "I have a young person that was referred six months ago and is on the waiting list... now we have been waiting six months and he's still at the bottom of the waiting list so that's the problem..."

Another participant described the lack of access to mainstream services such as school counselling as young offenders were often excluded from school.

James: "I don't think that counselling is that readily available to kids who are on orders... every school has got a counsellor attached to them but our kids are excluded".

Another participant described a lack of awareness of services that they might be able to refer a young person to.

Katie: "I guess what might help is to have an awareness... of what services there are out there that we could refer to... So when we go out and see families, rather than saying oh we can make a referral through the CPN who can do an assessment we can say ourselves signpost ourselves or

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suggest...what's out there really.... I know there is the CRUSE bereavement service... but I think that is just a telephone [service]... and there is Childline. But again other than talking on the telephone I don't know what else there is".

Despite most of the participants stating they did not feel there was a difficulty in young people accessing CAMHS services.

Dave: *"I think it's [access to CAMHS] pretty good..."*

Participants were not able to think of any, or if they could only one or two young people who had gone on to access support from CAMHS.

Katie: *"...I don't know I can't think of anyone in particular who I have referred through to the CPN who has then gone on to access [CAMHS] services..."*

Considering the high level of need and the high prevalence of mental health difficulties presenting within their caseloads this was surprising and may suggest that there are more difficulties accessing CAMHS than participants discussed during these interviews.

Participants felt that the CPN was able to speed up referrals to CAMHS by 'speaking the same language'.

James: *"...being a CAMHS worker I think it helps that [the CPN] speaks the same language, knows the right people. Our kids [young offenders] can access that service much quicker than they normally would from outside I think".*

Katie: *"...I think if they [referrals to CAMHS] go through the GP I think it's quite a long winded process to get into CAMHS... whereas with a referral through the CPN they can bypass the delay or, I don't know, speed it up somehow".*

One participant commented that they felt the CPN's time was taken up with assessment which meant that they could not provide direct work, they felt another CPN and/or a psychologist in the team would allow mental health provision to be provided in house rather than needing to refer on.

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Chris: "I think if we had another nurse here you know. The CPN is so rushed of their feet with referrals...If we had someone who was...able to deliver 1 to 1 sessions, like if we had a psychologist here or something, I think that would be a lot better. Because they [young people] have it in secure environments [prisons, young offenders institutions and secure children's homes] when they are locked up. If they have got in secure [environment] why can't they have here as well".

Category two: CULTURE

Participants talked about a difference in CULTURE between mental health services and offending services and the impact this had on young people. Whilst understanding the reasoning behind the decisions of Health Services, participants talked about some of the differences in the procedures implemented by Health.

One participant talked about Health's need for the young person to ask for support rather than offering support to all young people.

Dave: "...I think is difficult is because it's voluntary for them to see the Mental Health Nurse It's voluntary because obviously, you can't make somebody talk about your feelings... [if seeing the CPN was compulsory] I think they might start opening up and so I can't understand really why we can't do that..."

This participant also commented that Health can become too focused on the needs of the young person and this can lead them to forget about the crime, which can have implications for the management plan that the Youth Offending Worker is using.

Louise: "... but sometimes I think they [Mental Health Services] focus too much on their needs [the young person] and not on what offence they [the young person] have committed. I think it stops them [Mental Health Services] looking at the offence because this person [the young person] is too vulnerable because he or she has got these issues that issue and then they [Mental Health Services] forget then what they've actually done..."

Another participant talked about the difficult of Health discharging young people for non-attendance.

George: "...the medical profession work very differently to ours like one of my bugbears is that if they [young person] won't attend or they don't turn up to an appointment then they take them off the list whereas it can take 3, 4, 5 times to get in. So that's a massive sort of frustration".

3.1.2 Theme two: THE YOUTH OFFENDING WORKER

This theme describes the impact of **THE YOUTH OFFENDING WORKER** on the assessment of mental health difficulties in young people. Factors arising from **THE YOUTH OFFENDING WORKER** were split in three core categories, **PERSONAL AND PROFESSIONAL, APPROACH TO ASSESSMENT** and **MENTAL HEALTH**.

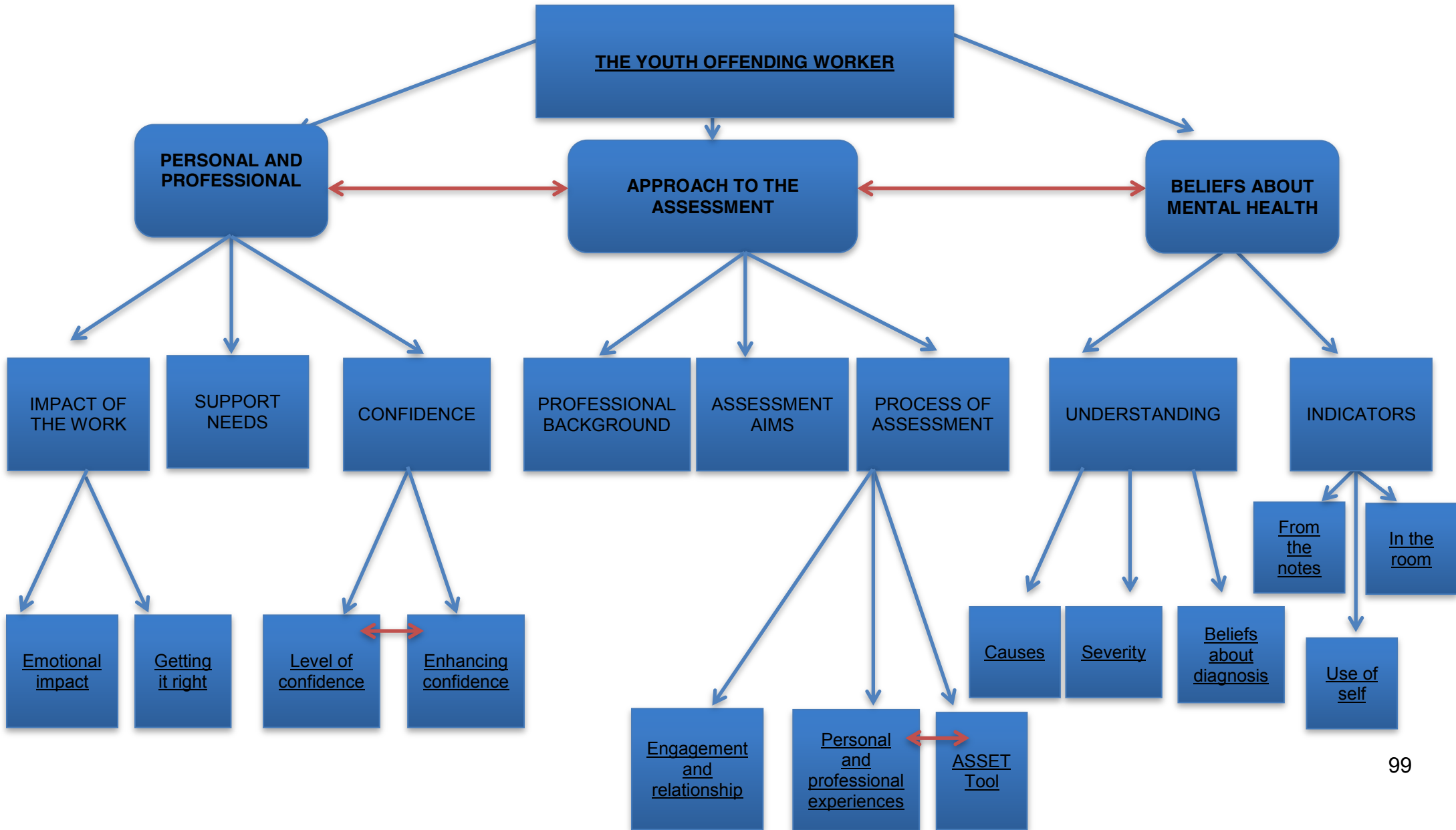
PERSONAL AND PROFESSIONAL described the IMPACT OF THE WORK including the emotional impact and a sense of Youth Offending Worker's getting it right, the professional SUPPORT NEEDS and the worker's CONFIDENCE in their ability to do the job. This included their level of confidence and the things that enhanced confidence.

Participants' **APPROACH TO ASSESSMENT** seems to be influenced by their PROFESSIONAL BACKGROUND, their ASSESSMENT AIMS and the PROCESS OF ASSESSMENT. The PROCESS OF ASSESSMENT is determined by a number of factors including personal and professional experience, the engagement and relationship with the young person and the ASSET tool, specifically focusing on the mental health section of ASSET.

Participants' **BELIEFS ABOUT MENTAL HEALTH** were influenced by their UNDERSTANDING of the causes and severity of the mental health difficulties and beliefs about diagnosis. Participants talked about the INDICATORS for mental health which they looked for during the assessment. INDICATORS included information from the notes, information in the room and the use of self by the Youth Offending Worker to help identify indicators of mental health difficulties in young people.

Theme two will now be explored through the use of direct quotes, to illustrate the categories and sub-categories. A diagrammatic overview of theme two can be seen below in figure 8.

Figure 8 Overview of theme two: **THE YOUTH OFFENDING WORKER**.



Core Category one: **PERSONAL AND PROFESSIONAL**

This **CORE CATEGORY** looks at **PERSONAL AND PROFESSIONAL** factors and the impact this has on the assessment of mental health difficulties in young offenders. The core category consists of three Categories IMPACT OF THE WORK, SUPPORT NEEDS and CONFIDENCE.

CATEGORY ONE: IMPACT OF THE WORK

This category focused on how the work of **THE YOUTH OFFENDING WORKER IMPACTED** on them as a person. Within this category two sub-categories were identified, the emotional impact and getting it right.

Sub-Category one: Emotional impact

Participants discussed the impact of the work on them emotionally and spoke about the challenging presentations and life experiences of many of the young people that they work with.

One participant talked about the experience of working with a girl showing signs of distress and the feeling of not knowing how to respond to this distress.

Emma: "It's very difficult...like the girl in the residential home who put the blanket over her head. I just didn't know what I should do, you know should I be sitting there trying to do a session talking to her through the blanket. It's difficult having the unknown..."

The same participant talked about the difficulty of working with people on fixed length orders (the punishment laid down by the court). This often meant that young people moved on and left the worker not knowing what the outcome was for those young people and what had happened to them.

Emma: "...she [young person] was moved back out of county because her residential placement couldn't cope with her. To this day I don't know what happened with her and it's frustrating because you do put a lot of work in and

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it takes up a lot of your own headspace when you go home. They almost kind of disappear and you never know what happened to them..."

Another participant talked about how the young people's stories can impact on the workers own life and 'feed into' their own issues.

George: "...in my last team there were occasions where some of the staff, maybe were going through their own difficulties. That can be sort of, I don't think challenging is the right word but that can be quite difficult... It's easy to become like a sponge sometimes working in this environment where you sort of, like, [hear] really traumatic stuff that 99% of population never get access... That can feed into your own issues a little bit sometimes".

Sub-Category two: Getting it right

Participants also talked about getting it right and the worry of making mistakes when assessing mental health difficulties. This worry seemed to stem from worrying about the impact that this might have on the young person and the wider public. Participants talked about "horror stories" of missing something in the assessment, which meant that the young person then went on to commit a violent crime.

Peter: "Well in case he does something [risky to self or others] and... you haven't been able to support that young person and make some changes".

Emma: "What I feel is if I missed something it can have a huge impact not just on them but on any kind of future offending. You know you hear horror stories about people going on and committing horrendously violent offences..."

Worry about getting it right appeared to be linked with one participant's sense of his own competence and fear that they might make things even worse for the young person.

Chris: "...I am not qualified to work with someone on that level. I don't want to open a can of worms and cause more problems".

Participants appeared to have a sense of personal responsibility for the future actions of young people and this worry influenced assessment of young people and the actions they take. For example one participant talked about being 'over cautious' in their assessment in order to reduce the risk associated with the young person.

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James: [on the ASSET] "... you tend to be a little bit over cautious and you will score them quite highly until you get to know [the young person] because of the nature of the offence. It's all about what you don't know..."

Category two: SUPPORT NEEDS

This category focused on the workers SUPPORT NEEDS and how the CPN met these. One participant talked about the CPN providing them with support and being available to them. They saw this as highly valuable resource.

Peter: *"We have got the CPN attached to the team who we can go to which is an extremely valuable source and I use the CPN quite a lot"*.

Other participants talked about using the CPN to 'check things out' and obtain advice on what to do even when there were no identifiable mental health difficulties.

Emma: *"The CPN is very supportive even if there's no sort of identifiable mental health needs or anything that you could diagnose. The CPN will always sit and chat with you and offer you advice really...you could work with the young person in this way. The CPN can give you lots of advice on how you could do it, the CPN is fabulous. I wish I could cart the CPN around with me all the time in case there's a problem"*.

One participant also talked about the usefulness of undertaking joint visits with the CPN when the necessary.

James: *"We are lucky. We've got the CAMHS worker... within the team. When I get those sort of feelings that something is not quite right, I always seek advice from the CPN who is very helpful will generally come out and do the assessment for us..."*

Category three: CONFIDENCE

This category focused on the workers own CONFIDENCE in working with mental health difficulties and its impact on their assessment of young people. Within this category two sub-categories were identified, confidence and enhancing confidence

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Sub-Category one: Level of confidence

All of the participants except one felt that their confidence in working with mental health difficulties had increased over the course of their career. However the degree to which their confidence had increased varied greatly across the participants. Some participants felt that their confidence had increased.

Chris: *"Oh it's [confidence] increased massively".*

Sam: *"Umm [my confidence has] probably increased. I would think I think it depends. You can go for a long period where you don't come across any sort of mental health concerns and then suddenly you do..."*

Another participant felt that their confidence had increased but still felt under-confident in working with mental health difficulties.

George: *"...it has increased but I still don't think it is sufficient..."*

One participant did not feel their confidence had increased at all over the course of their career.

James: "Umm I think it's more or less the same".

Sub-Category two: Enhancing confidence

Participants cited two main factors that helped to increase their confidence in working with mental health difficulties and risk issues such as self-harm. These were: experience of working with young people with mental health difficulties and training.

One participant talked about getting better at assessment with experience and feeling more confident in dealing with challenging situations such as risk issues.

Emma: *"I think it is like with anything, the more [assessments] you do it the better you get at it... I've been in situations where young people have said things, threatening self-harm saying they were going to kill themselves and its panic 'oh my god you're going to kill yourself you going to kill yourself' and it's always difficult but it's knowing 'alright don't panic, lets phone the CPN, let's see if we can get an assessment done' and not being scared of it and not*

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taking on responsibility if something did happen. Because as long as you have done everything you can to prevent that, you can't take responsibility..."

Another participant spoke about how training has helped them to feel more confident in talking about risk issues such as suicide.

Dave: "...that has helped having a [CPN] here and [CPN] did some sessions with us and the sort of questions to ask, how to check it [risk of suicide] out really, have they made any plans to do anything about it [suicide] and, if they have what to talk about and what not to not talk about."

Another participant talked about the presence of the CPN increasing their confidence when faced with risk situations.

Louise: "...I took the CPN up to meet him for the first time. It was just pure luck that the CPN was with me because when I went there... His mother came to the door and she said 'he is having some sort of psychotic episode upstairs'. So we said can we go up and have a look and he was curled up in a ball just sort of rocking back and fore on the floor and that scared me... I hadn't seen that before, I didn't expect it from him. [I was] just so relieved that the CPN was with me because I don't know what I would of done"

Core Category two: **APPROACH TO ASSESSMENT**

This core category looks at factors affecting how **THE YOUTH OFFENDING WORKER** approaches the assessment of young offenders. This core category consists of three categories PROFESSIONAL BACKGROUND, ASSESSMENT AIMS and PROCESS OF ASSESSMENT.

Category one: PROFESSIONAL BACKGROUND

This category focused on the impact of the professional background of Youth Offending Worker on their approach to their job. Participants interviewed in this study were either Social Workers or Probation Officers by profession. During the interviews it became apparent that the difference in core professional values of the Youth Offending Worker impacted on how the individual approached their job.

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Participants with a Social Work background talked about being more likely to favour a welfare approach.

George: [Social Worker] *"I am a social worker at heart obviously so it's the general well-being of the young person... but then, we have got a dual role. It's a care and control role so it is a bit of a dichotomy, really because we have got the protection of the public as well looking after their [young person] welfare their health needs, emotional mental health needs, plus education, employment, training. There are all those aspects. Ultimately it is to stop reoffending, that's what we are judged on..."*

Emma: [Social Worker] *"...as a social worker I know it [the focus] should always be about the welfare of the young person but I think, maybe because I have only ever worked in this setting [YOS]...I am very very much risk focused and... that is my first priority..."*

Participants with a Probation background were more likely to favour a more risk focused approach.

Louise: [Probation officer] *"I think that because I have come from Probation... The risk to the public is up there in my priorities...you have got to balance that out with this person's needs as well"*.

One participant talked about the challenge within youth offending of needing to take both a welfare approach and a risk focused approach and how this could reduce their sense of professional identity.

Chris: *"I don't see myself as a true social worker here. You are, kind of, like an agent for the state... It's quite a difficult job because when we work closely with social services obviously it's like child protection and LAC [looked after children] and that sort of stuff. They [other Social Workers] kind of expect us, because we are a social worker, to... sort out the child protection stuff but all we do really is refer on. So it's quite like a mixed boundary really"*.

Category two: ASSESSMENT AIMS

This category focused on what the workers were aiming to achieve from their assessment. Two participants stated that their main aim was to identify the young person's needs in order to understand how to best support them.

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Emma: "... [I aim to] *look at what the main problematic areas in their life are really and what we can do to resolve that and what impact that is having on their offending*".

Dave: "... [I aim to complete] *an accurate, informed assessment really. What I am trying to figure out is what I need to do next really; to give them the best response to that need really,... if they are distressed what do they need...and how urgent is it, as well...*"

Another participant also highlighted the need to focus on the developmental impact of adolescence and the young person's needs, in order to understand the young person and to take this into account rather than simply focusing on the crime.

James: "*A lot of the young people that we work with are adolescents and their brains have not quite developed; their thinking can be quite immature on occasions and they mature at different stages. I think they need to be helped through that process and supported through that transition to adulthood. Addressing the offending behaviour sometimes can be a secondary consideration because what is actually causing that offending behaviour is what they feel and what they think about themselves. Very often they are very negative about themselves and very negative about what they can achieve*".

CATEGORY TWO: PROCESS OF ASSESSMENT

This category focussed on the PROCESS OF ASSESSMENT. Within this category three sub-categories were identified personal and professional experiences, engagement and relationship and the ASSET tool.

Sub-Category one: Personal and professional experiences

Participants talked about the influence of their own life experiences on the assessment of mental health difficulties in young people. One participant stated that the fact he was older meant he had more life experience to draw on.

James: "...*I have been around a long time, I think your life experience is most important in this job and I am not saying that the young people don't do a good job because some of the young people in this team do a fantastic job, but when it comes to life experience you have that to draw on and you can use that to help develop your practice*".

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Professional experience also appeared to influence the Youth Offending Workers approach to the assessment. One participant stated that they are 'quite youth worky orientated' as a result of also being a youth worker and felt this brought something to the role.

Chris: "...I am quite youth worky orientated because I am a youth worker in the evening ...I am kind of like up to date or up to speed with what are current trends with young people at the minute, even though it's in a different area. I feel like I can relate to them quite well in that sense."

Another participant stated that his experience of working in a number of different care environments had helped him when working with young people with complex needs.

George: "...experience I have built up working in different environments like working in children's homes, is a good eye opener because a lot of the young people have massive attachment issues... particularly girls self-harming, and there [are] some quite complex cases, complex needs..."

Sub-Category three: Engagement and relationships.

All of the participants commented on the importance of developing a good relationship with the young person and how this helps the assessment process. For example, two participants talked about it taking time to get to know the young person and that this enabled them to be more able to ask questions and the young person feel more able to answer the questions.

Emma: "...when you have got a good relationship I think it becomes evident and when you put that trust in and the young person, then you get to know the case really really well rather than just sort of seeing them once a week and doing a worksheet on either criminal damage or something. It's when you're actually talking to them...as the order progresses you get to know them better, I find. I feel more comfortable asking questions, they feel more comfortable answering. You get a better picture of how to work with the young person, how they respond to certain ways of working..."

Chris: "I think a lot of it down to trying to build a relationship up with them...get to know them...It's about trying to build up a relationship, really, and trust."

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Sub-Category four: ASSET

All but one of the participants talked about using the mental health section of ASSET to guide rather than dictate their assessments. One participant talked about using ASSET as a guide rather than a tool that needs to be rigorously administered.

Emma: "I think ASSET guides you in the sense of it gives you structure as to the information that you need ... you can take the basic questions that ASSET asks you and expand on them. I think that ASSET is good in theory but I think it's all about the practitioner and how you use it, really, like with anything... It gives you a basis of what you're looking for and what your assessing, as a reminder".

One participant talked about feeling uncomfortable with asking the questions about mental health that are included in ASSET.

Peter: "There is a question [in ASSET] for mental health... It's very difficult to use because I feel very uncomfortable saying to a young person, "have you got a mental problem? You know, you've got to be kind of careful how you phrase things ..."

As a result of feeling uncomfortable they talked about taking a lead from the young person when asking about mental health difficulties.

Peter: "I wouldn't necessarily go straight in there and ask them detailed questions about mental health as I think it is an almost a traumatic experience for a lot of these kids, coming in, anyway, because they're in court system. It's quite scary, so I tend not to go massively in depth [into mental health difficulties] unless it's brought up by them..."

Another participant used humor to ask questions relating to the young person mental health difficulties.

James: "...I tend to use a lot of humour you know. When you have got that feeling that a young person is feeling really low and down then you approach in a different way. But with most upbeat young people I use humour [I say] "I've got to ask you this I know you're not nuts or anything like that but it says on this question have ever self-harmed? Have you ever tried to take your own life?"

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One participant commented that they tended to ask about depression and anxiety and what they described as obvious mental health difficulties such as paranoia.

Dave: "I kind of guess the main things I ask about, if I am being honest, is depression. Are they feeling down all of the time, not seeing the positive in anything or are they anxious and is that stopping them doing things. Then, obviously the more obvious ones [for example] if they are suffering from paranoia".

One participant stated they used the exact questions from ASSET to ask about mental health difficulties and did this more so than they would in any other section.

Katie: "Well I guess I do spend time on asking the specific questions in that section more so than some of the later questions..."

Core Category Three: **BELIEFS ABOUT MENTAL HEALTH**

This core category looks at factors relating to mental health and how they impact on the assessment of young offenders. The core category consists of two categories UNDERSTANDING, and WARNING SIGNS.

CATEGORY ONE: UNDERSTANDING

This category focused on the Youth Offending Workers' UNDERSTANDING of mental health difficulties and how this impacts on their assessment. Within this category three sub-categories were identified, causes, meaning and beliefs about diagnosis.

Sub-Category one: Causes

Participants had a number of explanations for what causes mental health difficulties in young people. One participant spoke about genetic causes and drug induced mental health difficulties.

Sam: "Sometimes it [mental health difficulties] can be heredity. Some of the young people that I have worked with have got a diagnosis of certain mental health traits because their parents have. Or sometimes, perhaps, they have been induced by the use of drugs... for example a young person that I saw

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this week, he's displaying sort of mental health issues... but I think it is induced through his drug misuse".

A number of the participants talked about the added complexity of drug use and its impact on mental health difficulties and obtaining clear a clear mental health assessment and/or diagnosis.

Dave: *"...but the drugs issue and how that clashes with mental health is a difficult one isn't it , ... I have seen that quite a lot where kids take loads of drugs and start tipping into paranoia and hearing voices that's kind of fairly common,... you don't know what drug they are using to get a clear picture of where they are without the drugs or the side effects or the mix to give them".*

Katie: *"...there was one case who is now [diagnosed as] schizophrenic. There were lots of different symptoms and, again, because he had been using substances you never really knew what the cause of his behaviour was".*

One participant commented on the impact of attachment difficulties on the mental health of young people.

George: *"Yeah, because a lot of the issues young people present with will be like classic attachment stuff and it's at a time in their lives where a lot of there [problems are] sort of the by-products of attachment disorders...."*

For one participant there was a feeling that some young people are criminalised because of their responses to traumatic events in their life.

Emma: *"...she's on an order for assaulting residential staff. You, kind of, think she shouldn't be on this order because she is reacting to the past so she's been criminalised for things that happened to her".*

Sub-Category two: Severity

Participants talked about the severity of mental health and using this to distinguish between mental health difficulties and emotional difficulties. One participant talked about the high proportion of cases that he worked with who had emotional problems. He described these problems as not being previously picked up and appeared to distinguish emotional problems from mental health difficulties.

Peter: *"...90% of my case load have certainly got emotional problems and, therefore, we would pick that up. So we start to look at things like when the*

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young person is, perhaps, very unhappy, opting out of education, absconding. We start looking then at why is this happening and, quite often, then it comes down to past background..."

One participant separated emotional wellbeing issues from mental health issues but was not able to clearly describe the distinction. However, the severity of the difficulties and the presence or absence of a formal diagnosis seemed to be one factor that influenced her understanding of whether it was a mental health difficulty or an emotional difficulty.

Louise: *"...to me mental health is when somebody has got a diagnosed condition and it seems more serious than emotional. And a lot of the people we work with have got emotional difficulties and emotional wellbeing issues but they are not diagnosed with anything and to me that's more or less from their upbringing and the events that have happened in their lives".*

One participant also talked about emotional health requiring a different form of intervention, e.g. a more psychological approach rather than a medical approach.

Interviewer: "That distinction between a diagnosable mental health problem and emotional distress?"

Dave: *"Yeah, it's a difficult one and then I wonder then you get mental health involved. But I guess it's more the psychologist you want then, not psychiatry, really, to work out ways of coping with their problems rather than diagnose them. But I guess we get less of that".*

Sub-Category three: Beliefs about diagnosis

Participants had different views on the validity and value of a mental health diagnosis. Some of the participants talked about the value of diagnosis and the frustration associated with not receiving a formal diagnosis following CAMHS involvement. Diagnosis for one participant was seen as necessary in order to inform their work with the young person.

James: *"I mean, to date we've had no sort of diagnosis. I haven't had any diagnosis on any of the kids and the behaviour is still there.... it's frustrating, really, because our task is changing behaviour and the behaviour doesn't change...but if we can't deal with their feelings or we can't help them deal with their feelings then it's just putting a sticking plaster on it, really".*

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Some participants believed that professionals were reluctant to give a diagnosis to a young person.

Peter: *"...it might get easier when he gets past 18 because adult services are easier to access I think, anyway, people don't want to label young people with mental health problems too early in life..."*

Katie: *"...my understanding was, and this has come from a previous CPN was that it was impossible to diagnose or it just didn't happen, that you couldn't diagnose somebody with an emerging mental health problem, like, for example, schizophrenia until they were 18..."*

George: *"I think their age [is the reason for not giving a diagnosis] primarily because, probably, there was maybe two occasions where young people I've worked with have had, like a diagnosis of mental illness".*

For some participants, a diagnosis represented a gateway to services and the reluctance to diagnose was a frustration.

Katie: *"...which was then frustrating because if it was emerging that means they couldn't then access any services until they had the rubber stamp to say that's what they actually had...if you were under 18 they couldn't rubber stamp you with a diagnosis, therefore they were unable to offer you access to any services.... because your saying it's happening but is not going to happen until they are 18 so that's frustrating".*

George: *"...you know you can pretty much predict that they will come into adult mental health services sometime down the line... but then it's about them [young people] accessing services. Because they haven't got a diagnosis of something then they wouldn't be able to access those services so that can be quite frustrating sometimes..."*

One participant also talked about the frustration that arises from the lack of a diagnosis by CAMHS despite clear evidence at the time and then meeting the young person when they have become an adult and finding out that they have since been diagnosed by Adult Mental Health Services.

James: *"I was working with a chap years ago, I just knew his behaviour was not right but I referred to CAMHS. They said there was nothing wrong with him... then I met him 10 years later in the prison and he proudly boasted to me that he was a paranoid schizophrenic and they [Adult Mental Health Services] had diagnosed him recently. Yet those issues were being picked up when he was 15 years old and I was expressing my concern".*

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However, one area where the participants questioned the validity of diagnosis was ADHD. Participants' concerns came from the high numbers of young people whom they had worked with who had a diagnosis of ADHD.

Dave: *"...I don't want to be too cynical and it [a diagnosis of ADHD] has helped them, [young person] you know, where their lives are quite chaotic and it has helped them and the CPN has got them to see the consultant and checked their medication regularly and it has helped them go to training and have a more successful life. But I don't particularly really, believe it [ADHD] even exists... I think it is just created by drug firms to make money and I think it is all behavioural and bad parenting".*

Louise: *"...there seem to be an awful lot of ADHD and when I first came here... I didn't realise so many kids had or were being diagnosed with ADHD".*

One participant, on the other hand, questioned the validity of all mental health diagnoses.

Dave: *"...I would have some idea if there were obvious symptoms but mental health has broadened into, like, personality disorders and conduct disorders which I think are a bit nebulous, really".*

Category Two: INDICATORS

This focused on the warning signs that **THE YOUTH OFFENDING WORKERS'** look out for to help them identify mental health difficulties. Within this category three sub-categories were identified: from the notes, in the room and the use of self.

Sub-Category one: From the notes

Participants all talked about young people who had a significant amount of historical and current involvement with other services. This information was used to inform the assessment and understanding of the young person mental health need before the face to face assessment began. One participant spoke about obtaining a history of social services involvement as part of their assessment.

Peter: *"...most of them come with some background, I mean, when we do the assessment we would also look where Social Services are and have they done any work. I think all the young people that I've mentioned have had Social Work intervention somewhere along the line where there were clues.*

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Participants stated that, in the majority of cases, they were already aware of a history of mental health difficulties. For example

Peter: "...if there is previous information... if there is some information on there that indicates so and so has previously self-harmed, that's something we can take with us to the assessment and it assists us to answer the question...so I, personally, haven't worked with anybody that I can think where it was identified mental health issues from my intervention".

The young person's past experiences were used as a way of understanding difficulties.

Peter: "...the first thing you look for ... is has there been any emotional split ups, any breaks in the family, have the parents separated, if they did, have they seen the children, Was it a very difficult separation? And then I would start to ask how long ago was it and have there been problems with that young person between that separation and now?"

They also looked in the young person's history for evidence of past trauma.

Peter: "...I have another young person who we feel has some sort of post-traumatic disorder from his early childhood experiences..."

Sub-Category two: In the room

Once Youth Offending Workers have identified information from the history, they described turning to the assessment itself and begin to look for signs in the room. Participants talked about signs in the room (during sessions with young people) that would act as a warning sign that mental health difficulties might be present for a young person. These signs came from how the young person interacted both verbally and non-verbally, with the worker.

Two participants talked about how important non-verbal cues are in their assessment of mental health difficulties.

James: "I think I am good at picking out if a young person is depressed or anxious in any way. That's not really, sort of, an issue for me. I've had young people who sit there and say yeah it's all fine blah blah blah but you know that

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they are saying it but all the clues are coming from the facial expressions and body language..."

George: "...then it's about what you're looking out for, like cues...about eye contact and stuff but that could be because they are nervous because they are in a new environment. It can be, sort of, difficult but it's just about being tuned in to the important underlying factors. They might not present themselves straight off, but if you sort, of dig, a little bit then you can, sort of, tease them out a little bit".

Several participants commented on the difficulty of separating out 'normal teenage behaviour' from potential mental health difficulties. For example, one participant talked about just knowing whether a young person is struggling or just can't be bothered.

Emma "...most of the young people don't enjoy coming here and doing work but you can always tell whether it's a general... teenage stuff or whether somebody is generally struggling to even make eye contact with you and I think I can't explain what the differences are but you always know when there is a difference between somebody who is really generally struggling or another young person who perhaps just can't be bothered ..."

Sub-Category three: Use of self

Alongside looking for signs in the room Youth Offending Workers talked about the use of self to help inform their understanding of a young person's difficulties. Participants talked about trying to think how experiences might make them feel in order to gain insight into how the young person might feel.

Peter: "So there are those attachments that are so strong and so powerful and then they are severed, you know, it must do something. I can't walk in their shoes but I could imagine that it would be quite [hard]. My boy [young person] who is 18 now and his has got a restraining order so he can't go to his parents' house. So where is his support? I know my [own] kids live away [from home] they phone up daily. We hear from one of them, 'mum, dad what do I need to do in this situation?' Who does this young person go to?"

Dave: "...you would... think in their [worker's] own life if they didn't have stable accommodation and no one loved them and they had nothing to do, you're not going to feel on top of the world are you?"

Two of the participants talked about using difficult previous personal experiences to further understand young people.

Peter: "...As I say, I've been on my own since I was 15 so I can empathise with young people who also are on their own. At a very early age my parents were supportive but they were a long way away so I think how much worse it would be for them if they [young people] have got parents close but they can't speak to them for various reasons... I've got one boy in prison at the moment, his parents won't have him. He could be on bail but the parents won't have him so what does that tell you, what does that do to your mind when you think 'my mum won't have me home so I have got to stay in jail'. It must impact, so I guess my own life experience does help..."

Chris: "...I suppose, because of my background, I suppose and I wasn't an angel when I was a teenager, I quite openly say to young people, 'if I didn't do what I did career wise at 16 I would probably myself have been in trouble'..."

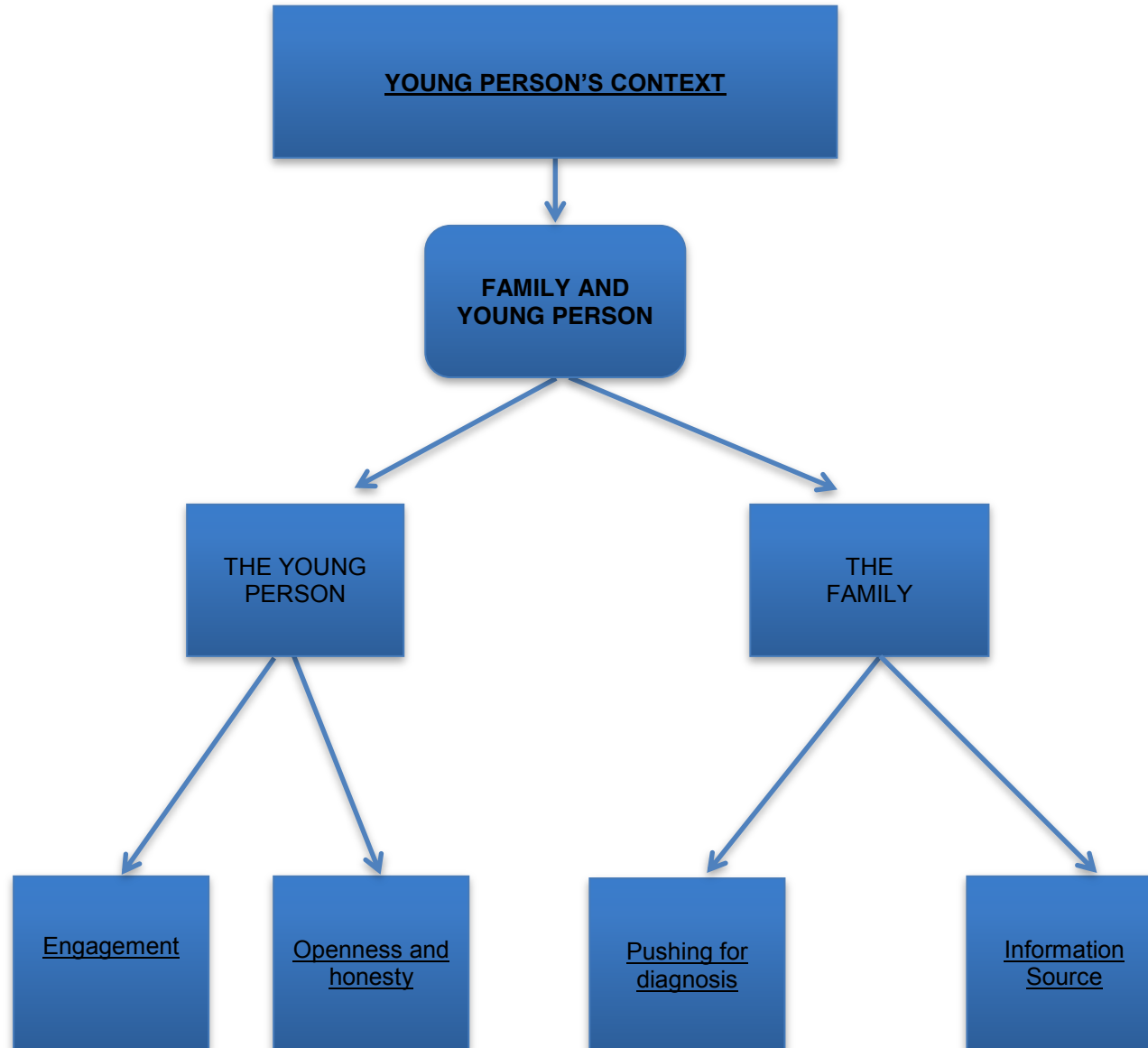
3.1.3 Theme three: THE YOUNG PERSON'S CONTEXT

This theme described the impact of THE YOUNG PERSON'S CONTEXT on Youth Offending Workers' assessment of mental health difficulties. Participants described two main ways in which THE YOUNG PERSON'S CONTEXT influences the assessment process, this included the FAMILY AND YOUNG PERSON. These were factors in THE YOUNG PERSON, including the young person's engagement with the process were described as having implications for the assessment. Participants felt also, that the young person's openness and honesty during the assessment was key.

The young person's FAMILY was seen as an information source as they were seen to be the people who knew the young people best. However, participants also felt that families were often pushing for diagnosis as a way of understanding their child's difficulties and, possibly, absolving them of any blame for their child's offending behaviour.

Theme three will now be explored through the use of direct quotes, to illustrate the categories and sub-categories. A diagrammatic overview of theme three can be seen below in figure 9.

Figure 9. Overview of theme three: **THE YOUNG PERSON'S CONTEXT**



CORE CATEGORY ONE: CLIENT AND FAMILY

Participants described two main ways in which the **CLIENT AND FAMILY** influences the assessment process; these factors were THE YOUNG PERSON themselves and THE FAMILY. The young person's engagement with the process was seen to have implications for the assessment. The young person's perceived openness and honesty was also seen to be important. THE FAMILY was seen to be a good information source as they were seen to be the people who knew the young people best. However, participants were also mindful that the quality of this information could be affected by the families' own difficulties. Finally participants felt that families were often pushing for a diagnosis as a way of understanding their child and absolving themselves from blame for their child's offending behaviour.

CATEGORY ONE: THE YOUNG PERSON

This category focused on how the young person themselves impact on the assessment. This acknowledges that the outcome of the assessment is not only dependent on the Youth Offending Worker but is also influenced by the young person themselves. Within this category two sub-categories were identified, engagement and openness and honesty.

Sub-Category one: Engagement

Participants talked about the difficulties young people find in engaging with the process of assessment. Engagement was thought to be difficult for a number of reasons. One participant talked about young people's difficulty with talking openly and honestly about their difficult experiences and feelings as a barrier to engagement.

Chris: "...we have got this mental health screening it's just to flag up if they have got any obvious mental health issues but I have never come across somebody or somebody new to the system with obvious mental health issues. Who is going to come in and go 'I was in car crash with my parents, my parents died and I keep dreaming about them I find it upsetting and I am drinking and I feel out of control with my life'. You know they are not going to and that's what the questions are like".

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Another participant highlighted problems with young people's attention as a barrier to assessment.

Peter: "...the young person's attention span doesn't help. For most of them an hour is as much as you are going to get out them so you've got to do their life in an hour..."

This participant went on to talk about how young people are often unable to express themselves through words and the need to be creative in helping them to express themselves in other ways.

Peter: "I learned that young people don't really do well talking all the time so there have got to be other ways of allowing them to express themselves. So we do have systems in place and different ways of working, videos, visual stuff, practical stuff, tick boxes, if they can't read or write I can ask them questions and fill in thing..."

Sub-Category two: Openness and honesty

All but one of the participants questioned how open and honest young people are able to be during the assessment about mental health difficulties. It did not appear that a lack of honesty was a result of young people wanting to hide information but as one participant described it, as a result of young people not having a close enough and confiding relationship with the Youth Offending Worker to feel able to open up to them.

Emma: "...sometimes the young people tell you, but very often they won't tell you at all or they certainly won't do it for a while. I've got girls particularly who I have worked with for a long time like the girl was talking about. I have worked with her for about three years now and she still won't talk to me about any of the issues..."

Another participant spoke about the stigma associated with mental health difficulties and the impact this has on young people's ability to open up.

Peter: "...with mental health stuff because it's kind of got a taboo about it for a start so people are not going to volunteer too much information..."

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Furthermore one participant commented that they did not think young people who were genuinely suicidal would be likely to tell anyone.

Dave: "...so if they are suicidal immediately which is quite rare, isn't it, and if they were, would they tell you that anyway..."

However, one participant felt that young people were able to be open and honest about talking about mental health difficulties and had techniques that they felt helped to make the young person more comfortable discussing their difficulties.

Katie: "Mostly people are quite ok about it [mental health difficulties] I mean... I have never had anyone who has been particularly cagey about it but then maybe they have and I just haven't known it".

CATEGORY TWO: THE FAMILY

This category focuses on how the family impacts on the assessment process. This acknowledges that the outcome of the assessment is not only dependent on the Youth Offending Worker and the young person but also the family. Within this category, two sub-categories were identified, an information source, and the family pushing for a diagnosis.

Sub-Category one: Information source

Youth Offending Workers saw the family as a good source of information and felt that they could make a valuable contribution to the assessment because they know the young person best.

George: "... I think a lot of it [information] doesn't come from the young person, I think the parents are very significant in this. They live with the young person. They probably know him or her better than anybody and I have had Mum say to me 'he's not eating like he used to', or, 'he's not talking like he used to', or, 'he is angry with his little brother all the time', or, 'he's not sleeping'".

Visiting the young person's family at home also gave a useful indicator of the young person's circumstances.

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Peter: *"...by going to the home you are seeing the family, you are picking up on home conditions and you can see if things are not quite right. So I kind of favour going to the home and I think that tells you lot".*

However, several participants also commented on how the family might also impeded the assessment process. For example one participant talked about the family *"winding them [young person] up"* during the assessment.

Louise: *"... the family can, perhaps, wind them [young person] up and start an argument and, you know, you want to sort of, de-escalate things and calm the situation down but the family are getting, sort of, aggressive at the young person. Then instead, of sort of, making things better they just, sort of make the situation worse because they [the family] don't know how to cope, they might have got their own issues".*

Another participant also talked about the transference on to young people, with a family member saying that they have a mental health problem so therefore the young person must also have difficulties.

James: *"The other thing impacting on our kids are the parents with mental-health problems...The transference on the kids, I found that I had it quoted from one parent, well I've got bipolar and this is why he is always down".*

Alternatively some families were described as a *"closed book"* and unwilling to contribute to the assessment process.

Sam: *"... sometimes you might find the parents are open and will give you the information and sometimes parents are like a closed book they won't open up and they try to hide things".*

One participant also commented on how 'socialised' the parents may have become in relaying information in order to achieve a desired outcome as a result of having had lots of involvement with services.

George: *"...by the time they come to us a lot of them would have had Social Services involvement...or other professional involvement, so they know the pattern. They know what to say and how to say it, when to say it and what will happen...so trying to unpick all of that can be quite challenging sometimes especially if it is a short order, so three months or six months ..."*

Sub-Category two: Pushing for a diagnosis

All of the participants talked about the experience of families trying to get a mental health diagnosis for their children to provide an explanation of their child's difficulties. The participants saw this push from the family as arising from a need to absolve themselves of responsibility and to reduce the feeling of blame that they might have for causing the young person's difficulties.

Louise: *"...one mother in particular, she was desperate to get her son diagnosed with something...it excused her behaviour and then it wasn't her fault, then it wasn't how she had brought him up. Then that made me think well why would you want to label your child with something, with any sort of condition"*.

One participant described the family giving them information about mental health diagnoses which latter turned out to be false information.

George: *"... [parents] want a label, it's nice to have a label. How many time have I worked with a family, 'oh he has got ADHD' [and he] never had any diagnosis of ADHD but it's a label they can put on them, it's not because of my lack of parenting skills of early life experiences that the young people have had, it's because they are born that way*

This participant went on to describe how parents pushing for a diagnosis can get in the way of assessing what other factors may have led to the offending behaviour.

George: *"...I think kids aren't born bad, they are not born evil like the Daily Mail [would have us believe], they are products of their environment, nine times out of ten. Sometimes I don't think parents don't really want to face up to that, they would rather just chuck a label on it so it absolves them of any sort of blame or responsibility..."*

3.1.4 Theme four: REACHING A DECISION

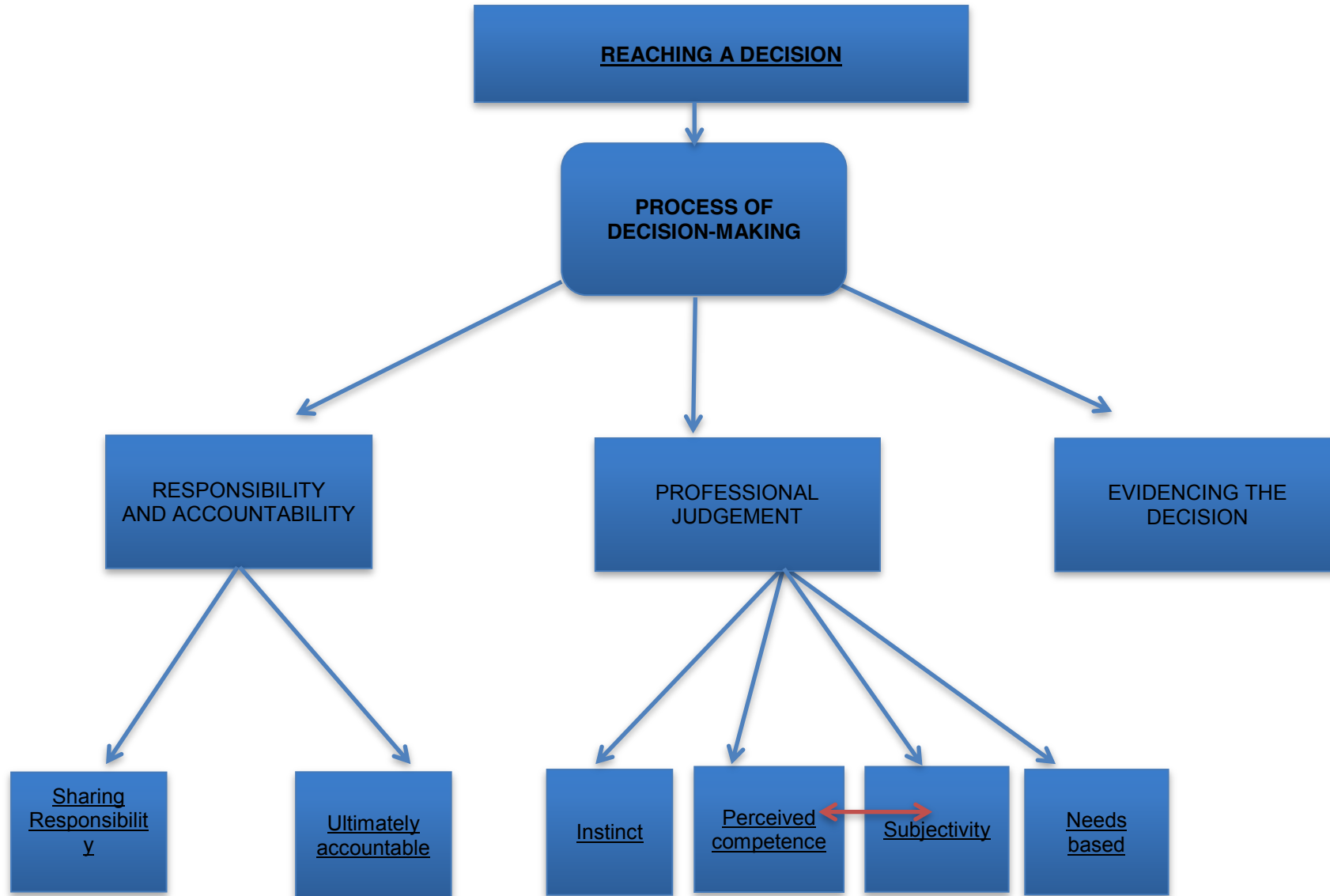
The final theme attempts to explore the process of **REACHING A DECISION** about the presence or absence of mental health difficulties in young offenders. The **PROCESS OF DECISION-MAKING** included RESPONSIBILITY AND ACCOUNTABILITY for making a decision, using PROFESSIONAL JUDGMENT and EVIDENCING THE DECISION to support the ASSET score. Participants talked about sharing responsibility, but they also perceived themselves to be ultimately

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accountable for the decision that was made and any future implications. Participants also talked about the use of PROFESSIONAL JUDGMENT and the need to rely on gut instinct to help them make decision, they also spoke about a low level of perceived competency to make decisions and the importance on being needs based whilst highlighting the subjective nature of decision-making process. Finally they spoke about the need for evidencing the decision.

Theme four will now be explored through the use of direct quotes to illustrate the categories and sub-categories. A diagrammatic overview of theme four can be seen below in figure 10.

Figure 10 Overview of Theme four: **REACHING A DECISION**



CORE CATEGORY ONE: PROCESS OF DECISION-MAKING

This core category looks at the **PROCESS OF DECISION-MAKING** in order to understand how participants reach a decision regarding mental health difficulties in young offenders. The core category consists of three Categories RESPONSIBILITY AND ACCOUNTABILITY, PROFESSIONAL JUDGEMENT and EVIDENCING THE DECISION.

Category One: RESPONSIBILITY AND ACCOUNTABILITY

This category focused on the workers' sense of responsibility for young people's mental health and the implications this has in terms of their decision-making process. Within this category two sub-categories were identified, sharing responsibility with the CPN and a sense of being ultimately accountable.

Sub-Category one: Sharing responsibility

One participant talked about wanting to share the responsibility for decision-making about mental health with the team and the CPN.

Emma: "...yeah it's a team decision. The CPN is very much involved and I think [the CPN] is very respected here so people will trust what [the CPN] is saying about risk or [the CPN's] opinions about whether there are any concerns and what we should do ..."

At times this desire to share responsibility became a need for someone with more expertise to take responsibility for the decision.

Peter: "...I want to get someone who knows more about it to see the young person and come up with some conclusion..."

George: "...probably, from my own point of view, I've erred on the side of caution sometimes and referred into the clinical nurse specialist...to validate my own feelings or to say actually this is emotional stuff have you tried this that and the other..."

Sub-Category two: Ultimately accountable

Despite wanting to share responsibility participants also perceived that they were ultimately accountable for the decisions they made and the outcome of these decisions. As a result participants spoke about erring on the side of caution.

Emma: "But ultimately, because it's my name on the order, I am going to go with 'cover my back' really. I hate working like that but sometimes you have to. So I am going to err on the side of caution and probably be more risk-focused than other people might be..."

Another participant spoke about being accountable for the decision he makes.

James: "...you know when the shit hits the fan it is basically 'what did you do to protect this young person'".

And one participant, whilst recognising that he was ultimately responsible did not feel he would be, necessarily, held to account if things did go wrong.

George: "...but I suppose ultimately, if it your case,...then I suppose that you are ultimately responsible to it but...I don't think you would be hung out to dry if something did happen".

Category two: PROFESSIONAL JUDGEMENT

Within this category four sub-categories were identified, use of instinct, perceived competency, needs based and subjectivity.

Sub-Category one: Instinct

Some of the participants talked about depending on a gut feeling, or a professional instinct which they used to inform their decision-making. They also spoke about trusting this feeling and instinct and going with it.

James: "...in most cases we depend on gut feelings. You know you go out you interview a person and you think, something is not quite right here but I don't know what is".

James: *"I'd say don't ignore your gut feelings... I tend to term it as professional intuition. It's what's gone before and there is something there that triggers a concern..."*

George: *"...don't be scared to use your sort of gut instinct because a lot of the time I think it can get forgotten. It's like the intuitive stuff, I know something's not right but I don't know what and it's about then doing a bit of digging..."*

Sub-Category two: Perceived competency

Several participants talked about responsibility for assessment of mental health difficulties as something that they are not trained in or expert in. One participant suggested that such assessment should, perhaps, be undertaken by someone more qualified than them.

James: *"...when we are looking for emotional mental health problems, I don't know whether that needs a fuller assessment from, maybe, a more qualified person".*

Another participant spoke about not feeling adequately trained to undertake mental health assessment.

Emma: *"... I think its [mental health assessment] such a huge thing to be having responsibility [for] and I am not trained for it [mental health assessment]..."*

A perceived lack of competency also needs to be viewed in the context of Youth Offending Workers feeling as though they have ultimate responsibility for the protection of the young person and the public.

James: *"I think sometimes were asked to, sort of, go out of our depths with young people and, you know, when the shit hits the fan it is basically, what did you do to protect this young person".*

It is important to note that participants were talking about a perceived lack of competency rather than an actual lack of competency. However, a perceived lack of competency is likely to affect Youth Offending Workers' experience of assessing mental health difficulties in young people.

Sub-Category three: Needs based

Despite guidance from the YJB that scoring the ASSET should relate to the impact of the identified needs on the risk of reoffending, all of the participants stated that their score and decision making is significantly influenced by the need and 'not need' in the context of the risk of re-offending. For example,

Peter: *"I think we, kind of, look at how that person is now, how that person presents and we score on that regardless of the offence".*

Emma: *"if they are not committing offences which are related to that [need] they would be scored zero but I would still make a referral... With mental health; if the young person is shoplifting, maybe not necessarily linked to their mental health or anything like that, it still needs to be addressed..."*

Dave: *"I am not too concerned about the offence..., we are dealing with people and we should be looking at that. It's their wellbeing that matters really".*

Sub-Category four: Subjectivity

Some of participants discussed the subjective nature of decision-making and the use of the ASSET score as the final determinates of a decision. They felt that different people would be likely to score ASSET differently and that the approach to scoring was based on the individual's own set of rules or guiding principles.

Louise: *"...I think all of us would have a different way of scoring [the ASSET] and it's in your mind, it is very subjective, and I tend to be a low scorer".*

James: *"Well mental health as I say, it's quite subjective really... sometimes what you don't know is more impacting on a young person's behaviour and their ability to cope with their emotions than what you do know".*

One participant highlighted the lack of a standardised approach to assessment and a sense that this would never change as every worker is different.

George: *"...I might think that this is the major concern and that it is [scored] a 4 or a 3 when someone else might think, well, actually I think something else*

[is a major concern]... *There is never going to be a standardised assessment because each person is different*".

CATEGORY THREE: EVIDENCING THE DECISION

This category focused on the use of evidence to justify the decision that the Youth Offending Worker reached following the assessment. Participants talked about the need to find evidence to support their thinking and justify their decision-making. Individuals appeared to seek reassurance about their decision-making when they were able to evidence the reasoning behind their decisions. Evidencing decisions relies on the Youth Offending Workers ability to use professional judgment to inform decision-making.

Emma: *"...find the evidence, everything is evidence based so if there is evidence that the young person is likely to go on to commit a serious violent offence then you have to protect the public"*.

James: *"...you have got your evidence box underneath so what you're saying is you know if the young person has self-harming issues, for instance, there you would put 'this person has self-harmed, however, has not be admitted to hospital, the wounds are generally superficial and the young person has assured me that there no intention of taking their life'...in your evidence box.."*

One participant also described using the evidence as a way of justifying when they had done things differently to the assessment protocol.

Chris: *"...I generally do what I think is best and as long as I can justify why I have done it then I think that should be good enough..."*

3.2 Summary of results.

The aim of this study was to explore the factors that influence Youth Offending Workers' assessment of mental health difficulties in young offenders. Whilst there is a growing literature base around the prevalence of mental health difficulties in young offenders, there has only been one study looking at the process of assessment of mental health difficulties in young offenders (Knowles *et al.* 2012). However,

Knowles *et al.* (2012) study only looked at Youth Offending Workers' experience of assessing for self-harm in young offenders.

The current study aimed to add to the literature base on mental health assessment in young offenders. It was hoped that this would help in understanding the assessment process and identify factors that influence Youth Offending Workers' mental health assessments in order to identify training needs and clinical and service implications.

A constructivist grounded theory of the factors that influence Youth Offending Workers' assessment of mental health difficulties in young offenders was created from interview data from nine Youth Offending Workers'. Four key themes emerged from the data **ORGANISATIONAL CONTEXT** (which explored the impact of organisation factors, including the YJB, Professional factors and mental health services), **THE YOUTH OFFENDING WORKER** (which explored the impact of the Youth Offending Worker's personal and professional life, their approach to the assessment and factors relating to mental health difficulties), the **YOUNG PERSON'S CONTEXT** (which explored the impact of what the young person brought to the assessment process, this including factors in both the young person themselves and their family) and **REACHING A DECISION** (which explored how Youth Offending Workers reach a decision regarding about the presence or absence of mental health difficulties in young people and the need for further involvement from mental health services). All four themes were found to interact with and affect each other. These findings will be considered in relation to the research base and any identified clinical and/or service implications will be discussed in the following chapter.

4 Discussion

4.1 Overview

This chapter will summarise the results of the study and discuss the findings in relation to the existing literature. Clinical and service implications arising from the findings will be discussed. Methodological strengths and limitations will be outlined and recommendations for future research will be provided in the context of the research findings.

4.2 Research findings and existing literature

The study aimed to explore the factors that influence Youth Offending Workers' assessment of mental health difficulties in young offenders. One previous study by Knowles *et al.* (2012) has looked Youth Offending Workers' attitudes towards working with self-harm in young offenders. The study identified two dimensions which influenced Youth Offending Workers' approach; an 'active/passive' dimension, which related to their perceived confidence around working with self-harm. The second dimension was a 'positive/negative' dimension which related to beliefs about the benefits of screening for self-harm and access to mental health services.

This study aimed to extend the understanding of Youth Offending Workers' approach to the assessment of mental health difficulties in young offenders by looking at the factors that influence their assessment of mental health difficulties more broadly.

To aid the reader **THEMES** are written in capitals, bold lettering and underlined **CORE CATEGORIES** are written in bold capital lettering, CATEGORIES are written in capital letters, and sub-categories are written in lower case and underlined.

Four themes were identified from the analysis of nine interviews with Youth Offending Workers from three YOTs in South Wales: **ORGANISATIONAL CONTEXT**; **YOUTH OFFENDING WORKER**; **YOUNG PERSON'S CONTEXT** and **REACHING A DECISION**. The study's main findings will be outlined below in

relation to the literature on mental health difficulties in young offenders, professional decision-making, the use of the ASSET assessment tool and Criminal Justice staff's experiences of working with offenders with mental health difficulties.

4.2.1 Theme one. ORGANISATIONAL CONTEXT

This theme related to factors arising from the **ORGANISATIONAL CONTEXT** and its influence on the assessment of mental health difficulties in young offenders. The need to address barriers to assessment at an organizational level was also identified by Knowles *et al.* (2012) study. Within this theme three core categories were identified: 1) **YOUTH OFFENDING SERVICE** 2) **SUPPORT AND TRAINING** 3) **MENTAL HEALTH PROVISION**, and these will be discussed below.

1) Within the core category, **YOUTH OFFENDING SERVICE**, participants described a number of ways in which factors relating to the service context impacted on their assessment of mental health difficulties. These factors were understood in terms of three categories: the Youth Offending Worker's **ROLE**, the expectations around **MENTAL HEALTH ASSESSMENT** and the **ASSESSMENT PROTOCOL**.

Two sub-categories emerged from the participants' descriptions of their **ROLE** as Youth Offending Workers. These were the need to produce an assessment for court, which could be used to inform the punishment and future planning, and the identification of a conflict within the role between welfare vs. risk, in terms of meeting the young person's needs and maintaining public safety.

Participants saw part of their role around assessment as completing an assessment for court, which could then be used to inform the court's decisions regarding punishment and identify the work that was needed to reduce the risk of reoffending. This assessment required the Youth Offending Worker to gather and collate information from different sources to build a bigger picture. Participants talked about how they gathered information, but they did not discuss the analysis of the information, including how they weighted the information and how they assessed the validity and reliability of that information. This highlights a need for supervision to

help Youth Offending Workers with the process of collating information in a meaningful and useful way (Butterworth and Faugier, 1992; Carpenter *et al.* 2012; Department for Health; 2003 and Dorsey *et al.* 2008). This is especially important in the context of research by Dorsey *et al.* (2008), which found that Social Workers are effective at obtaining information but are less skilled in analysing information. Dorsey *et al.* (2008) found that the decisions Social Workers make based on the information they obtain are only slightly better than would be obtained from guessing.

Participants talked about the difficulty of needing to focus on welfare and risk within their assessment. This was understood in terms of welfare vs. risk as participants seemed to feel that, at times, they had to focus more on one need than the other. Eadie and Canton (2002) highlight the impact of the conflict between welfare and risk on the working practices of Youth Offending Workers. They suggest that managing this conflict makes it harder to meet the individual needs of young people and may impact on the level of impartiality found within their reports. Also, the presence of mental health difficulties has been found to influence Criminal Justice staff's assessment of risk negatively, including Probation Officers, (Eno Loudon & Skeem, 2012) and Prison officers (Kropp *et al.* 1989 and Callahan, 2004).

Despite participants regarding the welfare needs of the young offender as paramount, they appeared to believe that there was an expectation within the organisation that they focused on the risk to public and the need to punish the young offender. This belief does not fit entirely with the guidance given by the YJB, which states that the welfare needs and the risk needs are equally important (Crime and Disorder Act, Great Britain, 1998 and YJB, 2008a, 2010b). However, despite this guidance, Youth Offending Workers and YOTS are evaluated primarily on the reduction of reoffending rates (YJB, 2005 and 2010b), which may explain why Youth Offending Workers feel pressured in to focusing more on risk than welfare.

Managing potentially conflicting aims has the potential to add complexity to the assessment process, as the Youth Offending Worker may become unsure of which need to focus on. One participant suggested that the welfare needs of the young person should be deferred to other services to allow the YOT to focus on the risk/offending needs. Managing the conflict between welfare and risk may have

implications for the identification of mental health difficulties, as they may be seen as welfare issues which should be addressed externally to the YOT. This conflict has the potential to influence the Youth Offending Workers' assessment of mental health difficulties and may make the task of assessment more difficult. Therefore, the conflict between welfare and risk highlights the importance of good supervision in order to allow Youth Offending Workers the opportunity to discuss and explore these conflicting aims on a case-by-case basis (Butterworth and Faugier, 1992, Carpenter *et al.* 2012 and Department for Health, 2003).

Participants identified two aims for their MENTAL HEALTH ASSESSMENT from an organisational perspective. These were the need to identify difficulties which may be related to mental health and then seek an expert opinion on the difficulties that they had identified. These two aims fit with the mental health screening guidance provided by the YJB, which outlines the process of assessment of mental health difficulties and outcome of this assessment (YJB, 2003). However, part of the reason for seeking an expert opinion seemed to result from a lack of confidence in Youth Offending Workers' ability to assess mental health difficulties.

Participants recognised that there was a high level of emotional distress and/or mental health difficulties in young offenders. This is supported by previous research, which highlights the high level of mental health need in the offending (Vermeiren, 2003) and youth offending population (Atkins *et al.* 1999, Hagell, 2002, Teplin *et al.* 2002, Stallard *et al.* 2003, Vermeiren *et al.* 2003, Dixon *et al.* 2004 and Leaderman *et al.* 2004). It is positive to note that participants identified mental health difficulties in young offenders as an issue as it suggests, at least in part, that the mental health assessments that they carry out help them to identify mental health needs.

Participants felt that being able to identify difficulties relating to mental health in young offenders was an important part of their role. This supports the views of the YJB, who state that mental health assessment should form part of the initial ASSET assessment process (YJB, nd e and YJB, 2003).

Despite seeking an expert opinion being seen as an important part of their role, several participants felt that just referring on and not working with the young people

themselves was not only frustrating but also potentially dangerous and undermined their skills. This potentially highlights that participants have a different set of expectations for working with young people with mental health difficulties than is set by the YJB.

Finally, the participants identified two factors that influence their assessment of mental health difficulties, which arose from the ASSESSMENT PROTOCOL set by the YJB (YJB, 2003, 2011b). This included the impact of time pressure on the quality of the assessment and the service requirement to complete the ASSET, despite some participants feeling that the tool was not suitable for the client group that they were working with.

Participants highlighted the impact of time pressure on the quality of their assessment. Often, the initial assessment was based on a one hour interview. This initial assessment covers all aspects of a young person's life including mental health difficulties, which means there is little time to focus on mental health difficulties. Time pressure will impact on the amount of information they are able to obtain and the level of rapport they will have built up with the young person. Time pressures are also likely to influence how well Youth Offending Workers are able to adapt the tool to meet the individual needs of the young person and subsequently influence how well the assessment is completed.

Participants felt that ASSET was not child centered, which resulted in a lack of openness and honesty from young people. This suggests that Youth Offending Workers may have to spend time trying to adapt the tool in order to complete the assessment in a way that suited the young person. Whilst it is important for tools such as ASSET to be used in a dynamic way (Baker *et al.* 2011, YJB 2010a), Youth Offending Workers may need training in how to identify when ASSET might need adapting and how to make these adaptations.

2) Within the core category, **SUPPORT AND TRAINING**, participants described how ACCESS TO SUPPORT for themselves as workers and the inadequacy of TRAINING, impacted on their assessment of mental health difficulties. These two areas appeared to impact on their ability to work with young people with mental

health difficulties and their understanding of mental health difficulties in young people.

Participants talked about ACCESS TO SUPPORT, which took two main forms: case management, offered by their manager, and peer support. There were mixed views on the usefulness of support offered by managers, with some participants valuing the support that was offered and others highlighting that the relationship with the manager can impinge on the quality of the support.

Case management provided by their manager appeared to take the form of checking protocols had been followed, timescales had been adhered to and that the appropriate intervention and risk management plans were in place. One participant highlighted the need for more clinical supervision, which he had experienced in health settings. Clinical supervision would differ from case management as it would allow the worker to focus more on the impact of the work, the feelings that arose in the worker as a result of the work and the implications of this on the work. Due to the high level of emotion and trauma identified within young offenders, clinical supervision is considered to be important to help Youth Offending Workers manage the impact of the work on their own emotional wellbeing and prevent vicarious trauma (Rothschild & Rand, 2006). Clinical supervision has been shown to reduce the risk of burnout, help increase workers' skills and also increase confidence (Hyrkas, 2005). Clinical supervision may also help Youth Offending Workers to increase their skill level and think through difficult cases or situations such as the conflict between welfare vs. risk (Butterworth and Faugier, 1992, Carpenter *et al.* 2012, and Department for Health, 2003).

Participants all appeared to value peer support which seemed to be given in two main ways, either offering a distraction from a difficult event or using peers to share ideas and gain advice. One participant talked about their team trying to formalise peer support in the form of weekly peer supervision sessions. Peer supervision has been shown to have a number of benefits for workers, including increasing skills and gaining support from peers (Counselman and Weber, 2004).

TRAINING for Youth Offending Workers is the responsibility of the YOT managers (Baker *et al.* 2003 and YJB 2008a), which means that training may vary across the three teams. However, eight out of the nine participants felt that the adequacy of TRAINING within the YOT was not sufficient. Participants commented on the fact that training was often out of date, and that they had to rely on the training they had received during their core-profession qualification. They felt the training they had received did not cover mental health in enough depth. Gaps within Youth Offending Workers' knowledge of mental health difficulties could affect the quality of assessment. Gaps in knowledge may mean they are not aware of certain difficulties or know helpful ways to identify specific difficulties. The one participant who felt their training was sufficient to meet their needs commented that this was due to the fact they had a CPN within the team who they could liaise with.

Baker *et al.*'s. (2005) study concluded that the implementation of training on ASSET should have increased Youth Offending Worker's skills on assessment and mental health difficulties. They felt that training would result in the future reduction in the number of Youth Offending Workers who felt that the training did not meet their needs. Although only nine participants took part in this study, the feeling that training did not meet their needs appeared to be still present. Knowles *et al.* (2012) study, which interviewed eight participants from a different YOT to this study, also highlighted a lack of training as an issue. Therefore, it is likely to be the case that the majority of Youth Offending Workers still do not feel that the training meets their needs around mental health.

The adequacy of mental health training has been highlighted as a concern by professionals working in a number of Criminal Justice services in the UK, USA, Canada and Hawaii. Menzies, (1987), Teplin and Pruett, (1992), and Green, (1997), all studied Police Officers' experiences of working with mental health difficulties. All three studies found that the Police Officers did not feel they had enough training on mental health difficulties. Callahan (2004) and Kropp *et al.* (1999) found that Prison Officers also felt they needed more training on mental health difficulties and working with prisoners with mental health difficulties. Eno Loudon and Skeem's (2012) study of Probation Officers highlighted the need for further training around mental health difficulties. Knowles *et al.* (2012) and Baker *et al.* (2003 and 2005) and Wilson and

Hinks (2011) all interviewed Youth Offending Workers who felt that the training they had received on mental health difficulties did not meet their needs. A study by Roberts *et al.* (2001) found that 20% (n350) of Youth Offending Workers had received no formal training on the use of ASSET and most participants wanted more training.

Participants who felt they had a greater level of training commented that this was a result of choices they made when completing their core-professional training. For example, electing to have a mental health placement. These choices are not prerequisite for employment within the YOT (Skills for Justice, nd). This highlights the need for management to have a good overview of the Youth Offending Worker's previous employment, in order to highlight any potential gaps in knowledge at an early stage so that the appropriate training can be given. Wilson and Hinks' (2012) study also found that training helped improve staff's confidence around assessment.

Participants were able to identify their training needs, which included a more consistent, coordinated and structured approach to training. This is important for YOT managers and policy makers to be aware of when designing any future training packages.

3) Within the core category, **MENTAL HEALTH PROVISION**, participants described how potential difficulties with ACCESS to information about the young person's previous involvement with mental health services and difficulties with ACCESS to services such as CAMHS when a mental health difficulty had been identified impacted on their assessment.

Participants were able to understand why it is difficult to gain access to information, such as notes from previous mental health involvement. However, they appeared to find the process of accessing information frustrating. A difficulty with ACCESS to information also has implications, considering the time pressure on assessments. Delays or difficulties in accessing information may impact on the quality of the assessment, as some information may be missing. Time pressures may mean that the court report is incomplete, which, in turn, may impact the judgment made by the court. It may also mean that the young person enters custody without a full

assessment of their mental health needs, which, in turn, may increase the risk of suicide or self-harm. Lack of information about mental health risks has been cited by Coles and Shaw (2012), the Lambert Report (2005) and the Prison Reform Trust and Inquest (2012), as one of the failings that resulted in the self-inflicted deaths of young people in custody. Access to information was highlighted as one of the barriers in protecting young people in custody from suicide (Coles and Shaw, 2012, Lambert Report, 2005 and the Prison Reform Trust and Inquest 2012). However, the participants talked about the CPN helping to improve the ACCESS to information as they had direct links with CAMHS and they felt the CPN could speed up referral as they 'spoke the same language'.

Participants' views about ACCESS to services for young people with identified mental health difficulties were mixed. One participant commented on the length of time young people had to wait to be seen by CAMHS. This suggests that CAMHS are not following the Welsh Government (Welsh Government, 2012 and YJB, 2004) time frames for assessment of Youth Offenders with mental health difficulties. However, it may be that an assessment by the CPN is recorded at the start of treatment and therefore CAMHS would be seen to be meeting the Welsh Government targets. A lack of access to services may increase anxiety for Youth Offending Workers as they may feel they are left holding cases that they do not feel adequately trained to work with.

Participants highlighted that many mainstream mental health services such as school counselling are not accessible to young offenders due to their situation, for example, having been excluded from school. It is important that policy makers look at the access to mainstream mental health services by young offenders.

One participant talked about a lack of knowledge of services in the community that they could directly refer to. Together for Mental Health focuses on preventative mental health support, primary care intervention and third sector mental health support (Welsh Government, 2012). Therefore it is important that Youth Offending Workers are made aware of services that they are able to directly refer to, this may also increase their confidence in working with young people with mental health difficulties.

Despite most of the participants stating they did not feel there was a difficulty in young people accessing CAMHS services, participants were not able to think of any, or if they could, only one or two young people who had gone on to access CAMHS services. Considering the high level of need within their caseloads and the high prevalence rates of mental health difficulties in young offenders identified in the research (Atkins *et al.* 1999, Hagell, 2002, Teplin *et al.* 2002, Stallard *et al.* 2003, Vermeiren *et al.* 2003, Dixon *et al.* 2004 and Leaderman *et al.* 2004) this was surprising and may suggest that there are more difficulties accessing CAMHS than participants discussed during these interviews.

Finally, participants talked about a difference in CULTURE between mental health services and offending services. This seemed to impact on the workers' experience of CAMHS and led to frustration around CAMHS services. Examples of these differences included the voluntary nature of mental health as opposed to the compulsory nature of youth offending, health becoming too needs focused and forgetting the crime and discharging young people for non-attendance. Research such as Bailey and Williams (2000) and Holdaway *et al.* (2001) has highlighted that different organisational cultures can cause disharmony between services and thus impact on service provision. Whilst some of these differences may not be able to be changed, it may be important for YOS and CAMHS to engage in dialogue to help address, or at least understand, these differences.

4.2.2 Theme two. THE YOUTH OFFENDING WORKER

This theme related to factors arising from **THE YOUTH OFFENDING WORKER** and the impact they have on the assessment of mental health in young offenders. Key findings related to the three core categories that were identified. 1) **PERSONAL AND PROFESSIONAL** 2) **APPROACH TO ASSESSMENT** 3) **BELIEFS ABOUT MENTAL HEALTH** will be discussed below. The need to address barriers to screening for self-harm at a professional level was also identified within Knowles *et al.* (2012) study. For example, they highlighted the impact of perceived competency on Youth Offending Workers' screening for self-harm.

1) Within the core category, **PERSONAL AND PROFESSIONAL**, participants described how the **IMPACT OF THE WORK** affected their assessment, what **SUPPORT NEEDS** they had regarding mental health difficulties and their **CONFIDENCE** in working with and assessing young people with mental health difficulties.

Youth Offending Workers talked about the **IMPACT OF THE WORK** on them as individuals. The **IMPACT OF THE WORK** took two forms: the emotional impact of hearing about the lives of young people and getting it right in terms of the decisions they made, and the outcome of their assessment. In terms of the emotional impact, one participant talked about the nature of the work, meaning young people move on before they have recovered and then not knowing what has happened to them. This experience is likely to have a significant impact on the worker as it leaves them with the unknown. It may also mean that they do not experience young people either recovering or gaining control over their mental health difficulties. This may have implications for what the individual believes can be the outcome of mental health interventions.

Participants talked about being with young people in distress and not knowing what to do. This again highlights a potential lack of training around supporting young people in distress. Not feeling like they know what to do in a distressing situation is also likely to cause potential distress for the worker and decrease their sense of confidence.

Another participant talked about how the information they hear can impact on the individual's own difficulties, which, in turn, can increase their own mental health difficulties. The impact on the worker is especially important to consider alongside the perceived lack of clinical supervision, as this would be the most likely place for Youth Offending Workers to gain support and reduce the emotional impact of their work (Hyrkas, 2005).

Participants talked about getting it right in the context of worrying about making mistakes. This need to get it right appeared to arise from 'horror stories' that occur when risk has been missed. Whilst participants did not explicitly state what these

'horror stories' were it seemed as though they were referring to events such as violence or attempts at suicide by the young person. Worry about getting it right may also be linked to a belief that young offenders with mental health difficulties are more likely to be violent. This belief was found in criminal justice staff working with adult offenders (Kropp *et al.* 1989 and Eno Louden and Skeem, 2012). One participant described worrying about making young people's mental health difficulties worse as they did not feel qualified to work with mental health difficulties. This feeling of not being qualified to work with mental health is also highlighted in Knowles *et al.* (2012) study, which, again highlights potential training needs.

Worry about getting it right seemed to affect the way in which some of the participants carried out the assessment, for example, being over cautious. Worrying about getting it right might also explain why studies such as Kropp *et al.* (1989), Eno Louden & Skeem (2012) and Callahan (2004) found that Criminal Justice staff's risk assessments were influenced by the presence of mental health difficulties. Clinical supervision may help to increase skills and allow Youth Offending Workers to think through risk issues with another professional (Butterworth and Faugier, 1992, Carpenter *et al.* 2012, and Department for Health, 2003).

Participants talked about how the CPN met their SUPPORT NEEDS by allowing them '*to check things out with them*' which helped the workers to gain reassurance. Being able to liaise with the CPN may help to reduce their worry about making mistakes, however it may also disempower the Youth Offending Workers from trusting their own ability to assess and work with young people with mental health difficulties.

The majority of the participants felt their CONFIDENCE had increased; however, this increase in confidence needs to be viewed with caution, as some participants did not feel their confidence was at the level required for their job. The importance of confidence and its impact on assessment was also highlighted by Knowles *et al.* (2012).

Participants talked about training and experiences of working with young people with mental health difficulties as factors that helped with enhancing confidence. It is

therefore important that management and the YJB is fully aware of the relationship between training, experience, supervision and confidence in order to support Youth Offending Workers in increasing their confidence and assessment skills.

2) Within the core category, **APPROACH TO ASSESSMENT**, participants described the impact of their **PROFESSIONAL BACKGROUND**, their own **ASSESSMENT AIMS**, the **PROCESS OF ASSESSMENT** and their use of **ASSET**.

Participants' **PROFESSIONAL BACKGROUND** appeared to influence how they approached their work. Participants were either from a Social Work background or a Probation background, which are the most common professional backgrounds for Youth Offending Workers. However, it is not necessary to have a core profession to become a Youth Offending Worker (Skills for Justice, nd). A Social Work background appeared to lead to a more welfare based approach, and a Probation background to a more risk focused approach. Whilst both of these approaches have value in terms of assessment of mental health difficulties, it is important that both welfare and risk needs are taken into account when assessing mental health needs. Therefore, it may be necessary for training for Youth Offending Workers to take into account their professional backgrounds to ensure both approaches are incorporated within their work. Moreover, clinical supervision may help the Youth Offending Workers to adopt a new approach to their assessment. Supervision may also help Youth Offending Workers to hold onto their professional identity whilst also incorporating both welfare and risk into their assessment of young people.

Identifying all of the young person's needs seemed to be the main aim of carrying out an assessment from the Youth Offending Worker's perspective, whereas the YOS stated that the assessment should focus on identifying factors relating to the risk of reoffending (YJB, 2005b and 2010c). One participant highlighted the impact of development on young people and the need to support the transition into adulthood rather than focusing on the offending behaviour. This would support literature on the Criminal Career Paradigm which suggests that by addressing core needs, the risk of reoffending can be reduced (Blumstein *et al.* 1988 and Graham and Bowling, 1995). However, the extent to which Youth Offending Workers are able to do this will be

influenced by how strongly they are governed by the YJB and/or supported by their manager to be needs focused rather than risk focused.

Participants highlighted three factors which they felt influenced the PROCESS OF ASSESSMENT: their own personal and professional experiences, the quality of engagement and relationship with the young person and the use of the ASSET Tool.

Personal and professional experiences were used by the Youth Offending Workers to help them understand young people. One participant valued their life experiences and used this to help them develop as a professional. Participants were also able to draw on previous professional experiences to give them ideas of how to work with young people with complex backgrounds.

The impact of personal and professional experience is important, as everyone will bring their own set of values and experiences to the job which may impact on how they approach the assessment. Therefore, it is important that the team managers have a good understanding of Youth Offending Workers' previous experience in order to identify training needs and potential biases in their approach to working with young people.

Engagement and relationships were seen as key to carrying out a good assessment. However, participants felt that relationships took time to build, which impacted on their assessment. The time needed to build relationships is understandable in the context of the large number of young offenders who present with attachment difficulties (Seifert, 2003 and YJB, nd g). Attachment difficulties are likely to make it harder for a young person to develop trusting relationships with adults quickly (YJB, nd g). Therefore, the importance of building relationships and the potential difficulty of doing this in a short timeframe, with young people who have complex needs, needs to be taken into consideration.

The ASSET Tool appears to be used to guide the Youth Offending Worker's assessment of mental health difficulties. This fits with the YJB guidance on the use of ASSET as a dynamic tool to inform assessment (YJB 2010a). However, one participant stated they used the exact questions on the ASSET, which is an

understandable approach to take as the tool is set out in a questionnaire format, suggesting that the questions should be asked exactly as presented. It may also imply that the worker does not feel confident adapting the tool.

One participant highlighted how uncomfortable they felt asking directly about mental health and therefore took the lead from the young person in terms of how much to ask about mental health. This may potentially mean that information is missed as it relies on the young person feeling comfortable enough to bring the topic up. Another participant used humour as a way of introducing mental health. Feeling uncomfortable and using humour may mirror societal approaches to mental health that arise as a result of the stigma attached to mental health. Wilson and Hinks' (2012) study also found that staff found it difficult to talk about mental health. Therefore, it may be useful for training to be provided around normalisation of mental health difficulties and helping staff to feel more comfortable talking about mental health (Rusch, Angermeyer and Corrigan, 2005).

3) Within the core category, **BELIEFS ABOUT MENTAL HEALTH**, participants discussed their **UNDERSTANDING** of mental health difficulties and the **INDICATORS** that they looked for which highlighted a potential mental health difficulty.

It was felt that Youth Offending Workers' **BELIEFS ABOUT MENTAL HEALTH** were likely to have a significant impact on the assessment of mental health difficulties in young offenders as they would influence what the Youth Offending Worker was looking for during the assessment.

Participants' **BELIEFS ABOUT MENTAL HEALTH** were influenced by their **UNDERSTANDING** of mental health in terms of its causes, the severity of difficulties and the workers' beliefs about diagnosis.

Participants had a number of explanations for causes of mental health difficulties in young people: genetic cause, drug induced mental health difficulties, attachment difficulties and traumatic life experiences. Whilst participants were able to identify a number of the known risk factors for mental health difficulties, they did not discuss

several key risk factors, including; growing up in care (Social Exclusion Unit, 2001) poor parental relationships (Boswell, 1995 and Margo, 2008) and the experience of being involved with YOS (Mrazek and Haggerty, 1994 and WHO, 2012). They also did not appear to link risk factors, but rather looked at each potential cause in isolation. In contrast, a more bio-psycho-social approach would integrate potential causes of mental health difficulties (Johnston and Dallos, 2013). This highlights a potential role for psychology in terms of providing an integrated formulation for young offenders to help the young offender and the Youth Offending Worker see the link between potential causes of difficulties and work towards addressing the potential causes and their links (Johnstone and Dallos, 2013).

The severity of difficulties appeared to guide the Youth Offending Worker's understanding of whether the young person was presenting with a mental health difficulty or an emotional difficulty. They seemed to perceive emotional difficulties as being less severe and requiring a more psychological intervention and mental health difficulties as being more severe and requiring a medical intervention. This potential distinction between mental health difficulties and emotional difficulties may arise from the YJB referring to the mental health section of ASSET as 'emotional and mental health'. However, despite this distinction the YJB does not provide an explanation for the difference between emotional health and mental health. The distinction between emotional and mental health may mean that young people with 'emotional difficulties' miss out on access to services. Therefore, it is important that training focuses on Youth Offending Workers' understanding of emotional and mental health difficulties and the spectrum of potential difficulties. This view would fit with the YJB's (YJB, 2003) guidance on the need to look at mental health more holistically than focusing solely on diagnosis.

Beliefs about diagnosis varied between the participants, and there were mixed views about the validity of some mental health diagnoses. However, participants also wanted young people to be given a diagnosis, which was seen as the key to accessing services. Participants appeared to be frustrated by the lack of a diagnosis, which they felt impacted on their ability to help the young person change their behaviour. Whilst participants saw the reluctance to diagnose as being due to the age of the young person, they felt that when the needs were apparent a diagnosis

was important to ensure the need could be addressed. Despite wanting young people to be given a diagnosis, participants had strong views about the validity of a diagnosis of ADHD. Whilst the frustration around diagnosis is understandable, it may be useful for there to be more dialogue between CAMHS and the YOTs in order to help meet the young person's needs when a diagnosis is not given. This may help to reduce frustration and improve relationships between CAMHS and the YOTs.

Participants talked about INDICATORS for mental health difficulties that they looked out for when working with young people. These included INDICATORS obtained from the notes, in the room and the use of self.

As expected, participants used previous information from the notes e.g. previous involvement, Social Services' involvement and health involvement, as a starting point for their assessment. Whilst obtaining and using background information to inform the assessment is an important step in gathering and collating information, it may lead to either the confirmatory bias (Mahoney, 1977) or the adjustment bias (Tversky and Kahneman, 1974) being used in the assessment when the worker meets the young person. For example, if there is no history of mental health difficulties the worker may be less focused on mental health as a risk factor and miss signs that there is a potential difficulty for the young person (Mahoney, 1977). On the other hand, if mental health difficulties are present in the history, the worker may over focus on mental health difficulties and incorrectly identify difficulties (Tversky and Kahneman, 1974 and Borum *et al.* 1993). The confirmatory bias (Mahoney, 1977) was potentially highlighted by one participant who stated that they could not think of any young person where mental health difficulties were evident that had not already been identified. Whilst this could suggest that previous involvement had been effective at identifying mental health difficulties, this is unlikely given the high level of need within this population (Atkins *et al.* 1999, Hagell, 2002, Teplin *et al.* 2002, Stallard *et al.* 2003, Vermeiren *et al.* 2003, Dixon *et al.* 2004 and Leaderman *et al.* 2004) that all mental health difficulties would have been identified during previous involvement with services.

Participants also talked about looking for past experiences that may indicate potential mental health difficulties such as family break ups and traumatic events. In

order to complete a file review accurately, Youth Offending Workers need a good overview of potential indicators of mental health difficulties. This may be an area which needs addressing in training.

INDICATORS seen in the room included both verbal and non-verbal signs. For example, saying they are 'fine', but their body language saying something different and difficulties with eye contact. Participants commented on the difficulty of separating out 'normal' teenage behaviour from potential mental health difficulties. This is also important to consider alongside time pressure, which can mean the young person has only met the Youth Offending Worker on one or two occasions before the initial pre-sentence report is completed. It may be helpful to adapt the ASSET to remind Youth Offending Workers to consider non-verbal signs of mental health difficulties.

Finally, participants talked about the use of self as a way of helping them to understand the impact of a child's situation. Participants tried to empathise with the young person by imagining what it would be like to be them. Some of the participants had personal experiences that meant they felt able to relate to the young person. This appeared to help the Youth Offending Workers identify potential mental health difficulties in young people who perhaps were unable to express these feelings themselves. Whilst the use of self is a valuable tool in helping to identify mental health difficulties without adequate supervision, it has the potential to increase the emotional impact of the role and the risk of burnout (Hyrkas, 2005).

4.2.3 Theme three. YOUNG PERSON'S CONTEXT

This theme related to factors arising from the YOUNG PERSON'S CONTEXT and its impact on the assessment of mental health in young offenders. Key findings related to the core category 1) **FAMILY AND YOUNG PERSON**, will be discussed below.

1) Within the core category, **FAMILY AND YOUNG PERSON**, participants described the impact of the YOUNG PERSON and their FAMILY on their assessment of mental health difficulties.

The YOUNG PERSON impacted on the assessment through their engagement with the process and their openness and honesty. In terms of engagement, participants outlined a number of barriers to engagement for young people. This included the ASSET tool and the use of direct questions to which, they felt, young people struggled to respond. The attention span of young people was also considered a barrier. One participant stated that an hour was as long as most young people could manage, which meant covering their whole life in an hour. Issues with attention may also cause difficulties in terms of time pressure, as the Youth Offending Worker may not be able to split the session up due to needing to complete a report in time for court. Finally, the emotional literacy level of young people was a potential barrier to them being able to engage with the process. Young people literacy levels required Youth Offending Workers to use other tools such as videos and visual information. This is important to consider in the context of recent research which shows a high level of speech and language needs in young offenders (Bryan, 2010).

Participants also questioned the openness and honesty of young people. A lack of honesty did not appear to be seen as a malicious act of deception by young people but more as a result of not having a close relationship with the Youth Offending Worker. Given the high rate of attachment difficulties in young offenders the lack of close relationships with the Youth Offending Worker and a potential lack of trust, it may be difficult for young people to be open and honest (Seifert, 2003 and YJB, nd).

One participant highlighted the impact of stigma around mental health, making it hard for young people to open up. This highlights a potential need for YOS to link in with and support anti-stigma campaigns such as Time to Change as a way of helping to reduce the stigma associated with mental health. Service user involvement groups could be created to help support promoting openness and honesty around mental health. Examples of collaboration with service user groups around mental health issues include a consultation with User Voice around the development of NICE guidelines for conduct disorder (NICE, 2013 and User voice, nd b)

Another participant felt that young people would not be likely to say if they were genuinely suicidal, which could have implications for how likely workers were to ask questions about suicide and other difficulties. This belief also goes against research

which suggests that if anxiety associated with talking about suicide can be reduced, people are likely to respond honestly to questions about suicide (Bryan and Rudd, 2006). This highlights the needs for further training around suicide risk assessment. Engagement and relationships between the Youth Offending Worker and the young person were seen to be one of the key factors in being able to produce a good assessment of mental health difficulties. Therefore, it is important that the YJB try to address potential barriers to engagement in order to improve the quality of mental health assessment.

THE FAMILY was seen as a good information source as they knew the child best. One participant commented on how home visits can give a considerable amount of information that would not otherwise be known. However, time pressure may impact on the ability to conduct home visits. Despite the family being seen as a good information source, participants also noted that sometimes the family's own difficulties could obstruct the assessment process. Families could either provoke the young person, or assume that because there are mental health difficulties in the family the young person will also have mental health difficulties. Working with multiple people in the room is a complex skill. It may be helpful for Youth Offending Workers to receive more training on engaging with the family during the assessment process.

Finally, participants all commented on families pushing for a diagnosis, which appeared to be mostly in relation to ADHD. This push was believed to be a way of parents understanding their child's difficulties and absolving themselves from blame, which fits with the literature on parental attributions to ADHD diagnosis (Harborne *et al.* 2011 and Kildea *et al.* 2011). Participants appeared to find this push for a diagnosis frustrating and potentially getting in the way of identifying other difficulties for the young person. Supervision around these issues may help Youth Offending Workers to understand why the families were pushing for a diagnosis and help the young person and their family address their difficulties without the need for a diagnosis.

4.2.4 Theme three. REACHING A DECISION

This theme related to factors arising from **REACHING A DECISION** and the impact this process has on the assessment of mental health in young offenders. Key findings related to the core category 1) **PROCESS OF DECISION-MAKING** were identified and will be discussed below.

1) The core category, **PROCESS OF DECISION MAKING**, was explored in terms of the Youth Offending Workers' sense of RESPONSIBILITY AND ACCOUNTABILITY, their use of PROFESSIONAL JUDGEMENT and EVIDENCING THE DECISION that they make regarding mental health difficulties.

Participants discussed their RESPONSIBILITY AND ACCOUNTABILITY for decision-making within the YOT. Youth Offending Workers talked about sharing responsibility for decision-making within the team, which is the approach favoured by the YJB (YJB, 2003). Participants appeared to favour deferring the responsibility to the CPN as they were seen as the expert. However, despite sharing responsibility, participants appeared to have a sense of being ultimately accountable for the decisions that were made. They felt that as it was their name on the order, and if adverse incident occurred it would be considered their fault. In terms of accountability for decision-making, it is not clear what the YJB policy is. However, if the policy supports shared responsibility, more work is needed to ensure that the Youth Offending Workers believe that responsibility is truly shared within the team.

Youth Offending Workers are expected to make use of their PROFESSIONAL JUDGEMENT when making decisions (Baker *et al.* 2011). Professional judgment requires the workers to use theoretical knowledge, alongside their working experience and understanding of the young person to help them reach a decision. Participants talked about using instinct to guide their decision-making. Instinct was often used to highlight to the Youth Offending Worker the need to discuss the case with the CPN in order to seek advice and/or information. Participants seemed to value the use of instinct as another tool/technique for informing their assessment.

Green's (1997) study also highlighted the high use of instinct in decision-making by Police Officers.

Whilst the use of professional judgment and instinct is a valuable tool in decision-making (Schwalbe, 2004) when making complex decisions, it is also important to incorporate actuarial evidence. Participants talked about using actuarial evidence to support their instinctive decision-making by EVIDENCING THE DECISION they make. Again, supervision and training may help to strengthen the Youth Offending Worker's ability to combine professional judgment and instinct with actuarial data to inform their decision-making (Baker *et al.* 2011). The YJB plans to implement training and guidance that focuses on the use of professional judgment, when they implement AssetPlus (YJB 2013a).

Youth Offending Workers' perceived competency around mental health assessment appeared to be low. This lack of perceived competency seems to be a result of not feeling adequately trained to undertake assessments of mental health needs. Whilst this perceived lack of competency may not be an actual lack of competency, it is important that it is addressed, as it is likely to impact on the Youth Offending Worker's trust in their own abilities. This perceived lack of competency and feeling as though they were making decisions that they were not trained for was also found in Wilson and Hinks' (2012) study and Knowles *et al.* (2012) study. The ability to use professional judgment will be affected by the worker's perceived competency. The less competent a worker feels the less confident they will feel about their ability to make professional judgments. However, given the potential inadequacy of training around mental health this may show that the workers are working at their competence level.

All of the participants used their professional judgment in their decision-making to focus on the needs of the young person as their primary focus for the assessment. This is opposite to the YJB guidance for assessment, which states that the assessment should focus on the needs that are related to risk of reoffending (YJB, nd b). To increase workers' use of professional judgment, the new version of ASSET, AssetPlus, aims to identify both universal needs and needs relating to the risk of reoffending. Focusing on all of the needs will help to ensure that the workers

are able to exercise their professional judgment without going against the organisational guidance for assessment.

Finally, participants talked about the subjectivity of ASSET as an assessment tool. Given that a large number of potential factors have been found to affect the assessment of mental health difficulties in young offenders, it is understandable that Youth Offending Workers may perceive the tool to be subjective. However, research by Baker *et al.* (2003 and 2005) and Wilson and Hinks (2012) has shown ASSET to be a reliable and valid tool. Therefore, it may be that ASSET is less subjective than the participants believe it to be, or it may be that mental health as a specific element of ASSET is more subjective than ASSET as a whole. However, Baker *et al.* (2003) and Wilson and Hinks' (2012) interviews with Youth Offending staff also found that staff felt the tool was subjective.

Despite the validity and reliability of the ASSET tool (Baker *et al.* 2003, 2005 and Wilson and Hinks, 2012), the YJB have decided to remove the scoring from AssetPlus to allow professional discretion around when to refer on, rather than using the score to trigger a referral (YJB 2013a). Removing the scoring should stop Youth Offending Workers from needing to inflate a score in order for a young person to access services. However, it may make the tool seem more subjective as there would be no score to compare assessment outcomes across practitioners.

4.3 Clinical and service implications

A number of clinical and service implications have been identified from the findings of this research. This includes implications for service delivery, Youth Offending Workers, CAMHS and the Clinical Psychologists as well as Policy makers in England and Wales. Addressing these implications should improve the quality of the assessment, which, in turn, should increase the likelihood of mental health difficulties being correctly identified in young people and the likelihood of the young person going on to access appropriate support.

The results of this study highlight three significant service delivery implications regarding the assessment of mental health in young offenders, which will be discussed in detail. These implications should help to support Youth Offending Workers in their assessment of mental health difficulties. Most importantly, they should help to ensure young people receive an adequate assessment of their mental health difficulties which allows them to go on to access further mental health support. The service delivery implications include the need for better training, the need for adequate supervision and a more robust understanding of mental health difficulties and mental health services at a statutory and non-statutory level. A number of other clinical and service implications will be discussed briefly. These implications were considered to be important, as they directly impact on all of the factors that have been identified as affecting Youth Offending Workers' assessment of mental health difficulties. Therefore, by addressing these service delivery implications it should be possible to reduce the impact of these factors on assessment of mental health difficulties and better support young people.

The skills of a Clinical Psychologist including their knowledge of supervision, training, mental health needs and assessment could be used to support the implementation of these recommendations.

4.3.1 Training

Eight out of the nine participants felt that the training they had received around mental health did not meet their professional needs. Several areas where training may be lacking were identified by participants. These included risk assessment, understanding of what mental health is, the validity and usefulness of a diagnosis and the integration of multiple causal factors in the development of mental health difficulties. Without a good understanding of these issues it is likely to be difficult for a Youth Offending Worker to carry out an accurate assessment of a young person's mental health needs. A lack of training also appears to impact on the Youth Offending Worker's perceived confidence and competency, which, in turn, will impact on the assessment. Training should help to increase confidence and competency around mental health assessment (Oordt *et al.* 2009).

At present the YJB does not provide a national training package for assessment and mental health (Baker *et al.* 2003 and YJB, 2008a). Youth Offending Workers rely on training provided in-house and their previous professional training. The participants stated that they would like a more consistent, coordinated and structured approach to training. The Clinical Psychologists may be able to work with the CPN and CAMHS to create a training package that could be provided to all Youth Offending Workers when they started in the YOT. This training could include information on indicators of mental health difficulties. Training should be provided by various mental health practitioners including Psychiatry, Psychology and Mental Health Nursing to ensure a range of perspectives are provided within the training. This approach would also help to highlight the wide range of support that is available to young people with mental health difficulties.

A training package would mean that all of the Youth Offending Workers had the same level of understanding of mental health difficulties despite their professional background, which would reduce the variation in knowledge. Youth Offending Workers could then choose to specialise further in mental health with the addition of extra training programmes. Whilst initially this approach would be taken on at a local level, it may be possible for the YJB to consider implementing a standardised training package across England and Wales.

When AssetPlus is rolled out, it is important that all of the Youth Offending Workers take part in the YJB training (YJB, 2013a). It may be useful for the team managers to arrange peer supervision or consultation groups during the initial rolling out of AssetPlus to enable workers to share their experiences and understanding of using the new tool.

Good quality training should also help to improve the experience of mental health assessment for young people. It should help to ensure that the assessment they receive results in a good understanding of their mental health difficulties and enables them to be referred on to the appropriate support services.

4.3.2 Supervision

Participants talked about the emotional impact of the work and the support structures that are in place. Some participants found support with difficult cases or events from their manager helpful, whereas others preferred to have support from their colleagues. One participant discussed the lack of clinical supervision. Due to the high emotive content of their work, a lack confidence regarding mental health difficulties and a perceived lack of competency, clinical supervision could add real value. Supervision could take a number of forms, including one to one clinical supervision, group clinical supervision and/or reflective practice sessions (See Milne, 2009 for an overview of supervision models). One participant talked about trying to set up peer supervision sessions. Peer supervision may be on way of up-skilling the workers and enabling them to understand each other's strengths and weaknesses (Counselman and Weber, 2004).

As Youth Offending Workers have not been used to clinical supervision, the process of talking about their emotions relating to their cases may make them feel exposed, especially if clinical supervision was provided by a manager who also evaluates their work. Therefore, group supervision facilitated by a Clinical Psychologist or peer supervision may be a 'safer' way of initially introducing clinical supervision to the YOTs. Clinical Psychologists knowledge and skills could be used to help set up supervision or reflective practice groups (Milne, 2009). As a starting point it would be useful for the Clinical Psychologists to arrange a consultation with the managers of all three YOTs to see how they would like to proceed on these issues. Again, the issues of supervision at a national level should be considered by the Welsh Government and the YJB.

Access to clinical supervision should help Youth Offending Workers address some of the challenges associated with assessing mental health difficulties. Clinical supervision should improve the young people's experiences of mental health assessment and improve the quality of the assessments. Ensuring mental health difficulties are identified and the young person receives the appropriate support should help to reduce the impact of their mental health difficulties.

4.3.3 Understanding of mental health difficulties and mental health services

Participants talked about having a limited understanding of mental health difficulties and what services were available to young people, both at a statutory level and a non-statutory level. Without an accurate and detailed knowledge of mental health issues it is extremely difficult for Youth Offending Workers to assess these difficulties. As discussed above, training is one way of improving Youth Offending Workers' understanding. Moreover, partnership working with CAMHS and engaging in discussions around mental health difficulties may also improve workers' understanding.

It would be useful for the CPNs in the team to meet with the Youth Offending Workers to discuss mental health difficulties and service provision. Consultation and liaison with CAMHS could also be used to further improve the working relationship between CAMHS and the YOTs, given that differences in culture were highlighted as one of the factors that influence mental health assessment. It may also be possible to create a booklet, outlining the services available in the local area and the referral process for these services, which could then empower the Youth Offending Workers to feel able to respond to mental health needs directly, where appropriate.

The YJB and the Welsh Government may need to look at barriers to access to mainstream services by young offenders. For example, participants highlighted that many of the young offenders are excluded from school and therefore, cannot access school counselling services. If this is the case, alternative provision for counselling needs to be provided for young offenders.

Currently, the Clinical Psychologists meet with the CPNs as part of the Tier 3 Forensic Team; however, Youth Offending Workers are not routinely part of this team. Consequently, one way of increasing their understanding of mental health provision and mental health difficulties, in general, would be to allow the Youth Offending Workers to attend these meetings. It may be possible to rotate these meetings throughout the three teams, so that the Youth Offending Worker that is involved with the specific case that a CPN is bringing to the meeting could also be

present. This would allow the Youth Offending Worker to be part of the consultation process, which would not only up skill them, but also inform how they and the CPN work with the young person (Caplan, 1970).

A team formulation approach (Johnston and Dallos, 2013) could be adopted to help Youth Offending Workers take a more holistic view of the young person's difficulties and the causes of the difficulties. Team formulations may also allow Youth Offending Workers to explore the issues of diagnosis in relation to specific cases. This approach should also help the young person to feel understood by the Youth Offending Worker and help to highlight the young person's needs in terms of their mental health difficulties.

Youth Offending Workers being more aware of non-statutory support for mental health difficulties may help young people access support more quickly, which may allow more preventive measures to be put in place to reduce the escalation of their difficulties. Young people may also find accessing non-statutory support for mental health difficulties is less stigmatizing than receiving support from CAMHS.

4.3.4 Other clinical and service delivery implications

Other potential implications arising from this study include the need for stigma reduction around mental health difficulties. The YOTs could consider signing up to stigma reduction campaigns such as Time for Change. They could also contact mental health charities such as Young Minds to obtain up-to-date literature that can be given to young people and their families and/or displayed in the YOTs. This may make young people and their families feel more comfortable discussing mental health difficulties, which, in turn, may help to them to address their difficulties.

Whilst liaison and access to notes are well known issues between Social services and health services, it is important that at a strategic level the two organisations work together to minimize the disruption in services that arise from difficulties in accessing information. Currently, the CPNs appear to take responsibility for liaison with CAMHS, and whilst this is understandable, it may, in turn, increase the potential for

the work of CAMHS to become enshrouded in mystique, increasing the perception that mental health is a role for experts. Therefore, where appropriate, Youth Offending Workers should be encouraged to liaise directly with CAMHS. This may also help Youth Offending Workers feel more comfortable talking about mental health and make them more aware of the services that young people are receiving. This knowledge may help the Youth Offending Worker to encourage the young person to continue to access mental health support.

The initial stages of the research identified a lack of community based service user involvement groups for young offenders. In Wales the researcher was only able to locate service user involvement groups in secure settings such as the prison. In England, User Voice (User Voice, nd a) have helped to set up service user involvement groups within several YOTs and have used these groups to consult on issues relating to youth offending. Creating a community based service user group for young offenders in Wales should be seen as a priority for the Welsh Government and the YJB. These groups could then be consulted on mental health assessment and future research, thereby ensuring that young people's views about mental health were heard and incorporated into the work of the YOS.

The findings of the research could also be used to inform any future revisions of AssetPlus, for example, it may be helpful to include a section on non-verbal signs of mental distress. Where possible, the YJB should review and make changes to identified barriers to engagement and relationships, such as the time pressure around assessments. However, it may not be possible to fully address these issues. Managers should also address accountability issues with the YJB and then clarify them with their teams.

The new AssetPlus requires further use of professional judgment, which has been noted as an area of difficulty for Social Workers (Dorsey *et al.* 2008). The YJB training (YJB, 2014) should start to address the issue of the use of professional judgment, however the specific details of this training are not known. Therefore, consultation groups could also be created to further enhance these skills.

The final clinical implication involves ensuring that the findings of this research are shared with participants, managers and the YJB. An overview of the findings and clinical implications will be sent to all of the participants and the YOT managers, a copy of will also be emailed to the YJB. A copy of the thesis will be available on request. The researcher also plans to present the research findings to the Regional Forensic Interest Group, the Tier 3 Forensic Team and the local child psychology department.

4.4 Strengths and Limitations

The current study explored the factors that influence Youth Offending Workers' assessment of mental health difficulties in young offenders. The literature showed that whilst there is a high rate of mental health difficulties in young offenders (Atkins *et al.* 1999, Hagell, 2002, Teplin *et al.* 2002, Stallard *et al.* 2003, Vermeiren *et al.* 2003, Dixon *et al.* 2004 and Leaderman *et al.* 2004), there has been little research focussing on the assessment of mental health difficulties in this population (Vermeiren, 2003). Only one study could be found which investigated Youth Offending Workers' attitudes towards screening for self-harm in young offenders (Knowles *et al.* 2012).

This study intended to increase the knowledge base of mental health assessment in young offenders. It is hoped that the results of this study can be used to generate further ideas for research on this topic, with the aim of being better able to support young offenders with mental health difficulties.

4.4.1 The Sample

Participants were recruited from three of the 18 YOTs in Wales (YJB, 2004). The length of experience of working as a Youth Offending Worker ranged from four-23 years. The participants had a range of experience prior to coming into youth offending, including mental health experience, probation and Looked After Children's Services. Out of the nine participants, six were male and three were female. Whilst males may be over represented in this study this does address a limitation of

Knowles *et al.* (2012) study in which men were under represented. Data is not published on the characteristics of Youth Offending Workers; therefore it is not possible to state the extent to which the participants' views are representative of Youth Offending Workers in general. However, there is no reason to believe that is an unrepresentative sample.

The study included participants from three different YOTs, all of whom are managed by a different manager who is overseen by the Head of Children's Services from three different County Councils. Therefore, similarities in the findings are not likely to be a result of management process or specific County Council policies and therefore it should be possible for these results to be extrapolated to other Youth Offending Teams in Wales.

Limitations of the study include the fact that the CAMHS provision for the three YOTs is provided by one Health Board, therefore results relating to CAMHS provision and the interface between CAMHS and the YOTs may not apply to all YOTs in Wales. The CPN for each team is different, but the psychology provision is the same across all three teams, which means that some of the training the teams have received has been the same.

The three YOTs included in this study are geographically close together; therefore, there may be similarities in the youth offending population that would not be present in other areas of Wales. However, the YOTs cover rural, sub-urban and urban areas, which should mean that the Youth Offending population is representative of the wider area.

As the data was collected in Wales, which has jurisdiction for Health, Education and Welfare (YJB, 2004), the results of this study cannot be directly extrapolated to England. However, there is no reason to believe that the general themes would be different in England. The study would need to be repeated with a number of YOTs in England to see if there were similarities within the data.

This study only looked at Youth Offending Workers' views on mental health assessments. Future research should aim to research young offenders and their

families' views and experiences of mental health assessment and provision with the youth offending service. During the initial stages of this research, the researcher tried to include young offenders in the design of the research, such as informing the interview questions. However, it was not possible to locate a community based service user group within Wales that could be consulted; which means that young people's voices are not heard within this research.

Participants were recruited to the study on a voluntary basis through their manager, which may mean that the people who volunteered have a greater interest in mental health difficulties in young offenders. Alternatively, participation in the study may have been as a result of pressure from their manager, or their manager may have selected them due to the views that they hold.

Whilst the researcher believes that they reached saturation in the data, the number of participants is small (a small sample is to be expected in grounded theory) (Charmaz, 2006). However, having a smaller number of participants enabled a detailed analysis of the results and provides a richness of data which may not have been possible with a larger sample.

4.4.2 Methodological approach

Elliott *et al's.* (1999) criteria for qualitative research were adhered to during the research, which included triangulating (providing credibility checks) the data with a number of sources. Consequently, emergent themes and ideas were discussed and amended with the clinical supervisor, academic supervisor and a fellow trainee. This process helps to ensure the credibility of the data and reduces the potential for research bias during analysis. In terms of limitations the credibility of the research could have been further enhanced by reviewing the finding with the participants and seeing if the themes fitted with their experience. Due to time constraints for both the researcher and the participants this was not possible. The option of carrying out a focus group with the CPNs was also considered as another way of triangulating the data. However, it was not possible to obtain ethical approval in the research timescale to enable a focus group to happen.

Using a constructivist grounded theory approach as opposed to the more traditional Straussian grounded theory approach had a number of perceived benefits. Constructivist grounded theory has been suggested to be a suitable approach when researching areas where there has been little previous research (Fossey *et al.* 2002). Moreover, it allowed the researcher to explore the co-construction of meaning between the participants and the researcher (Charmaz, 2000). This enabled participants' interpretations and experiences of mental health difficulties in young offenders to be explored in order to gain insight into the meaning of these experiences and the subsequent impact on assessment of young offenders. This was thought to be important given the researcher's view that mental health and offending are socially constructed terms. Therefore it felt important to pay greater attention to the co-construction of meaning between the researcher and the participant than might have been achieved by using a more traditional Straussian approach (Glaser and Strauss, 1967).

In order to reflect on the co-construction of meaning between the participant and the researcher a reflective journal (see appendix 4), memo writing (see appendix 16), supervision and Ahern's guidance on reflective bracketing was used throughout the research. These processes helped to increase the transparency of the reflective process used within the research (Ahern, 1999).

It might have been possible to take the analysis of the data to a further level, which could have enabled a testable theory to be developed rather than a descriptive account of the data. However, it was decided in conjunction with the supervisors that as this was an area of research with very limited previous research, it would be more appropriate to provide a descriptive account. This descriptive account can then be used to highlight the need for changes within YOS and to support the introduction of suggested service improvements. It would then be possible to replicate the study and see if these changes had brought about any affect. At this point it would be possible to create a testable theory based on the data obtained from that study.

Limitations of a constructivist grounded theory approach included the impact on the construction of meaning due to the researcher not having an in-depth knowledge of the Youth Offending Service. Attempts were made to overcome this by discussing

specific aspects of YOS with the clinical supervisor and a Youth Offending Worker from another team, However, this may mean that some of the construction of meaning would not fit entirely with the participants' experiences. Nevertheless, as noted by Charmaz, (2006) this theory is one interpretation of the data and it is not proposed to be the only interpretation.

As a Trainee Clinical Psychologist the researcher was able to bring their understanding or mental health difficulties, assessment, supervision and training to the research. This psychological understanding allows for a broader view of assessment to be taken. Therefore, a rich account of the factors that influence Youth Offending Workers' assessment of mental health is provided.

4.4.3 The interview questions

The data has highlighted a potential distinction between emotional and mental health by Youth Offending Workers. It is not clear how they distinguish between emotional health and mental health, which may have implications in terms of the response of participants to interview questions. For example, when answering questions about mental health we cannot be sure exactly what the participants mean and understand by the term mental health, which may have implications for the results.

4.4.4 Systematic review

The systematic review looked at criminal justice staff's experience of mental health difficulties in offenders. This review looked at English language journals, consequently, articles were reviewed from the UK, USA, Canada and Hawaii. This poses two potential problems, firstly the criminal justice system in the four countries is likely to be different, as is the mental health provision, and therefore the generalizability of the studies to the UK may be limited. However, similar findings were found in all of the articles reviewed. Also, only reviewing English language journals means the research does not account for a wide range of cultures which may mean findings from different cultures would be different.

4.5 Recommendations for further research

This study offers further insight into the factors that influence Youth Offending Workers' assessment of mental health in young offenders. A number of recommendations for further research are proposed as a result of the findings of this study.

The results of this study could be used to research the CPNs' views on the assessment of mental health difficulties in young offenders. Individual interviews and/or focus groups could be used to explore the role and relationship between the CPNs and the Youth Offending Workers. Research could also be carried out with CAMHS to explore their role with young offenders and their relationship with the YOTs.

This study only focuses on the views of Youth Offending Workers; as noted by Knowles *et al.* (2012), the impact of the assessment process on young people should be researched. This would then allow the results from Youth Offending Workers and Young Offenders to be compared to see if there are any clinical or service implications arising from this.

Professional background was highlighted as one of the factors that impacted on Youth Offending Workers' assessment of mental health difficulties in young offenders. Further research could be conducted to see if the impact of professional background has implications in reality (i.e. the assessment) or whether this difference is a perception. The implication of professional background was also identified by Knowles *et al.* (2012) as an area for further research.

Training was one of the factors affecting Youth Offending Workers' assessment of mental health difficulties in young offenders and one of the main clinical recommendations of this study. It would be useful to create, implement and evaluate a training package and then repeat this study to explore the impact of a training package on Youth Offending Workers' mental health assessments. The implications

of training were also identified by Knowles *et al.* (2012) as an area for further research.

Finally, due to the generalisability of the data it is important that this study is replicated both in Wales and in England to see if the findings are representative of all YOTs or specific to the YOTs included in this study. This would enable the YJB to see if widespread policy change was needed as a result of this study or if changes should be made at a more local level.

4.6 Conclusions

Youth Offending Workers have a key role in the initial assessment of mental health difficulties in young offenders. This initial assessment is seen as the gateway to accessing specialised services such as CAMHS and informs the risk assessment, helping the court decide what outcome should be given, and informing the secure estate (YOI/Prison) of any possible risks. Lack of information being provided to the secure estate has been cited as a failing in a number of inquests following the deaths of young people in custody. Therefore, accurate and up-to-date mental health assessments are essential to help ensure the safety and welfare of young people.

Without an accurate mental health assessment, the young person's mental health difficulties may be missed, resulting in the young person not accessing the appropriate mental health support. Not accessing support has the potential to increase the risk of reoffending and the risk to the young person in terms of self-harm, suicide and a further deterioration in their mental health.

There has only been one previous study which has looked at this area, focusing on Youth Offending Workers' attitudes towards screening for self-harm in young offenders (Knowles *et al.* 2012). Therefore, this study aimed to increase the understanding in this field.

This study also aimed to investigate the factors that influence Youth Offending Workers' assessment of mental health difficulties in young offenders. It was hoped

that this study could inform the practice of Youth Offending Workers and highlight potential areas of improvement in terms of service delivery and policy. Nine Youth Offending Workers from three YOTs in South Wales were interviewed about their experience of assessing mental health difficulties in young offenders. A constructivist grounded theory approach was used to analyse the data.

The study identified four themes in which the factors that influence Youth Offending Workers' assessment of mental health fit. These were the **ORGANISATIONAL CONTEXT**, **THE YOUTH OFFENDING WORKER**, **THE YOUNG PERSON'S CONTEXT** and **REACHING A DECISION**. These four themes interacted with one another and influenced the overarching assessment process. A number of the findings in this study can be linked to previous literature and research looking at clinical decision making, mental health needs in young offenders and assessment within the YOT.

The study provided a detailed overview of factors that influence Youth Offending Workers' assessment of mental health difficulties in young offenders. These findings provide useful insight into the process of assessment and identify a number of clinical and service delivery implications. Most specifically they identify a need for further training of Youth Offending Workers, the need for clinical supervision and a greater understanding of mental health difficulties and mental health services. Addressing these issues should help to increase the quality of mental health assessments and, most importantly, help to support young people with mental health difficulties. Further research is needed to confirm if these results are generalisable to other YOTs. It is also important that young people's views and experiences of mental health assessment within the YOT is the focus of future research. These findings can then be understood in the context of the findings of this study to provide a thorough overview of mental health assessment in YOTs.

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Appendix 1 Key words and Databases used for literature review

Key Words	Databases
Mental health	ASSIA
Emotional health	British Nursing Index
Emotional wellbeing	Cochrane Library
Mental health needs	ERIC
Mental illness	GoogleScholar
CAMHS	PsychArticles
Emotional and mental health needs	PsychINFO
Young Offender	Pubmed, Social Care Online
Youth Offending	Scopus
Youth Crime	Sociological Abstracts.
Youth Offending Teams	JB Publications
Youth Offending Service	
Youth Justice Board	
Youth Offending Institution	

Appendix 2 Emotional and Mental Health' section of ASSET. With example scoring. (YJB, nd h). Reproduced with permission from the Youth Justice Board. Copyright Youth Justice Board 2003.

9. Emotional and mental health

a) Is his/her daily functioning significantly affected by emotions or thoughts resulting from the following?

	Yes	No	<u>D/</u> <u>K</u>
i) Coming to terms with significant past event/s e.g. feelings of anger, sadness, grief, bitterness	X		
ii) Current circumstances e.g. feelings of frustration, stress, sadness, worry/anxiety	X		
iii) Concerns about the future e.g. feelings of worry/anxiety, fear, uncertainty		X	

Evidence (please explain reasons for any D/K responses)
 Craig would not accept these judgements but I would see his lack of connection at home and reliance on peers as linked to past difficulties with his step-father and difficult family relations. He does express feelings of anger and rejection about his family and his own father but minimises their significance.

b) Has there been any formal diagnosis of mental illness?
 Any other contact with or referrals to mental health services?

Yes	No	D/K
Yes	No	D/K

Details (specify type of illness, medication, whether s/he co-operates with treatment etc. Please explain reasons for any D/K responses)

c) Are there indications that any of the following apply to the young person?

	Yes	No	<u>D/</u> <u>K</u>
i) S/he is affected by other emotional or psychological difficulties e.g. phobias, eating or sleep disorders		X	
ii) S/he has deliberately harmed themselves		X	
iii) S/he has previously attempted suicide		X	

Evidence (please explain reasons for any D/K responses)

Rate the extent to which (9) is associated with the likelihood of further offending

(0=not associated, 4=very strongly associated)

0	1	2	3	4
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Appendix 3 Mental Health Screening Questionnaire Interview for Adolescents (SQIFA) (YJB, 2003). Reproduced with permission from the Youth Justice Board. Copyright Youth Justice Board 2003.

THE MENTAL HEALTH SCREENING QUESTIONNAIRE INTERVIEW FOR ADOLESCENTS

Name _____ Date _____

Scoring System for Sections A & C	0 - No	1 - Sometimes	2 - Yes, often
--	---------------	----------------------	-----------------------

SECTION A All of the following questions are to be answered by the young person.

ALCOHOL USE	Score
Do you think alcohol takes over your life and is out of control?	
Do you feel depressed, angry or anxious if you are not drinking?	
Total Score	

DRUG USE	Score
Do you think your drug use takes over your life and is out of control?	
Does the thought of not using make you worried, angry or depressed?	
Total Score	

DEPRESSION	Score
Do you feel really miserable or sad?	
Do you dislike yourself or your life?	
Total Score	

TRAUMATIC EXPERIENCES (PTSD) e.g. serious accidents, abuse, assaults	Score
Do you have currently flashbacks of past upsetting events, which you can't stop?	
Do you have powerful memories of past upsetting events, which make you feel unwell, scared or angry?	
Total Score	

ANXIETY/EXCESSIVE WORRIES/STRESS	Score
Do you have panic attacks i.e. overwhelming fear, heart pounding, breathing fast and stomach churning?	
Do you feel worried/scared for long periods of time?	
Total Score	

SELF HARM	Score
Do you harm yourself e.g. cut yourself or take overdoses?*	
Do you think about harming or killing yourself?*	
Total Score	

*if yes full interview

Recommendations	0/1 no problem	2 consider repeat	3 or 4 consider full interview
------------------------	-----------------------	--------------------------	---------------------------------------

SECTION B More questions for the young person to answer (yes/no answers)

	YES/NO
Have you ever had treatment for any of the issues that we have just talked about (prompt: depression, PTSD, anxiety, drug/alcohol use, self-harm)?	
Have you ever seen a GP/counsellor/therapist or other professional about any of these issues?	
Have you ever taken tablets/medication related to your behaviour or how you were feeling?	

Yes answers to any of these questions	consider full interview
--	-------------------------

SECTION C The following questions are based upon your observations and other information that you may have obtained from a teacher/parent/person who knows the young person well.

ADHD/HYPERACTIVITY	Score
Does the young person have longstanding and severe overactivity and impulsive behaviours more than you would expect?	
Does this overactivity and impulsive behaviour occur at all times and in all settings?	
Total Score	

PSYCHOTIC SYMPTOMS	Score
Does the young person appear unduly preoccupied/suspicious or frequently misinterpret situations?	
Does the young person have odd behaviours or appear to respond to voices or see things that are not there?	
Total Score	

Total Score	0/1 no problem	2 consider repeat	3 or 4 consider full interview
--------------------	-----------------------	--------------------------	---------------------------------------

'NEXT STEP' INSTRUCTIONS

Repeat	repeat screening tool in 4-6 weeks or if a significant change or event occurs
Full interview	referral to designated health worker for full interview

Action Plan

Signed _____

Users of this questionnaire should consult the Screening for Mental Disorder Manual.
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Appendix 4 Extract of reflective journal

June 2012. Initial Idea

Met with the Clinical Supervisors today who are interested in a trainee conducting a piece of research within Youth Offending. They are new to their role and seem really excited and motivated to find out more about Youth Offending. I am really pleased how engaged they seem with the process. I really wanted to work with supervisors who were keen and enthusiastic. Left the meeting with loads of ideas buzzing round my mind. Need to go away and have a look at what is out there around mental health and youth offending

November 2012. Formalising the idea.

Met with the CPNs manager today. This really helped me to understand the process of assessment within the YOT and gave me some ideas about how to formulate my questions. I tried to arrange to sit in on an assessment but unfortunately I was not able to get permission to do this. This is really shame as it would have been really helpful to see the process in action. However I managed to find some YJB video role plays of assessments on YouTube which helped to understand the process a bit more.

May 2013. Ethical approval

Got Ethical approval today, really excited that I can get going with this now.

August 2013. First interview

First interview today feeling really nervous. What if they have nothing to say? What if it's over with in a few minutes?

Wow that went well for the first one. It felt like they were really open and discussed lots of different things. It really struck me how reliant they seem to be on the CPN which is interesting. It doesn't look like they feel that confident in their ability to assess mental health. I wonder if confidence is going to be a strong theme throughout the interviews. One of the main things they discussed was the debate between whether they should focus on welfare or punishment. It really feels as though it is welfare vs. punishment. I wonder why it is so difficult to address both simultaneously. I think I need to follow the issue of welfare and punishment up in the next interview to see if this is potentially a theme or if it relates to just this interview.

September 2013. Transcribing the data.

Transcribing continues. It is very slow and laborious process but I really feel like I am getting to know the data inside out. When I read the quotes I can almost see and hear the person saying it to me. It does feel as though themes or at least links between the data are starting to emerge. For example confidence and a sense of a lack of skills seem to come across really strongly in all of the interviews. One of the

things I have been really struck by is this sense that there is a difference between emotional health and mental health. The difference seems to be defined by severity of the difficulties. One person even said depression is not very serious so it wouldn't be seen as a mental health difficulty. This is really worrying and has the potential to have massive implications for young people.

January 2013. Coding the data.

Met with XXXX (fellow trainee) today and looked at coding the data. This process really helped me to identify the links between the data within an interview and across the interviews. It was helpful to do it alongside XXXX she helped point out when I was becoming more concrete in my coding.

April 2013. Reviewing the quotes and the connection to the theory.

Met with my academic supervisor today to look at the quotes that I have chosen to support my theory. She thought the quotes really illustrated the theory well. However, she questioned the sub category separating emotional health. I really feel this is important as this distinction may mean young people miss out on accessing services that they really need because the youth offending workers are down playing the severity of the issues. However, I can see her point the interview data doesn't fully support this. Will think about whether I am too wedded to the idea and it needs to be removed or if there is another way of including this data but thinking about it differently. This has really highlighted the values of the academic supervisor being separate from the process. I don't think I would have spotted this myself.

May 2014. Writing the discussion.

Writing this chapter has really helped me to feel surer about the theory. The data I have collected links back to the literature in a number of ways and supports many of the ideas from Knowles et al. (2012). It really feels like these findings could help to shape Youth Offending services at least at a local level. I feel really excited about the possibility of this research making a real difference to young offenders.

Appendix 5. Outcomes of the systematic review searches.

Search Number	Database
1	ASSIA, British Nursing Index, Social Service Abstract, Sociological Abstracts
2	Cochrane
3	Psychinfo Psycharticles
4	Social Care online
5	PubMed
6	Scopus
7	Eric
8	Google Scholar
9	Reference lists

Search	Hits	Non English	Total	Exclusions										Total excluded	Included
				Duplicate	Tool	Mental health needs	Service Delivery	Mental Health Act	Young person's experience	Carers experience	Not offending	Not mental health	Training		
1	175	0	175	18	12	46	50	8	0	0	38	0	2	172	3
2	17	0	17	12	1	0	4	0	0	0	0	0	0	17	0
3	233	0	233	57	19	27	49	4	0	0	76	0	0	232	1
4	66	0	66	12	0	4	14	2	0	0	31	0	0	63	3
5	281	0	281	55	6	48	26	13	0	0	129	0	0	277	4
6	450	2	448	203	7	35	33	7	0	0	159	0	0	444	4
7	10	0	10	4		2	2				2	0	0	10	0
Total	1232	Total	1230										Total	1215	15
8	1	0	1	0	0	0	1	0	0	0	0	0	0	0	0
9	11	0	11	0	0	2	0	0	0	0	0	2	2	6	5
Total	1244	Total	1242										Total	1221	21

	Exclusions										
Articles to be reviewed in Full	Tool	Mental health needs	Service Delivery	Mental Health Act	Young person's experience	Carers experience	Not offending	Not mental health	Training	Total excluded	Included Studies
21	1	4	5	1	0	0	0	0	3	14	7

Appendix 6 Ethical approval for study reference EC.13.05.07.3457RR.

Ethics Feedback - EC.13.05.07.3457RR



psychethics

Thu 16/05/2013 10:24

To: Laura Morris;

Cc: @wales.nhs.uk;

Dear Laura,

The Chair of the Ethics Committee has considered your revised postgraduate project proposal: Factors that influence youth offending workers assessment of mental health and emotional difficulties in young offenders (EC.13.05.07.3457RR).

The project has now been approved.

Please note that if any further changes are made to the above project then you must notify the Ethics Committee.

Best wishes,

Natalie

School of Psychology Research Ethics Committee
Tower Building
Park Place
CARDIFF
CF10 3AT

Appendix 7. Interview stem questions

Topics to cover in interview. Final Version.

Can we start by looking at some questions to gain an understanding of your background and training in relation to the assessment of young people's emotional wellbeing?

- What is your professional background?
- What training have you received in this role and in previous roles around mental health difficulties and emotional distress?
- How long have you been working in the youth offending services?

Job role

What do you perceive your job role to be?

Prompts

What has been as expected what has been different?

Mental health

Could you give talk to me about a case you have been working with recently where mental health problems have been apparent.

Prompts

What's your understanding of why they have those difficulties?

What did you see in that young person that led you to believe that mental health difficulties were apparent for them?

What do you think helped you to see those things?

To what extent do you feel working with their mental health difficulties has been part of their role?

Purpose of assessment

If you were to carry out a new assessment tomorrow what would your broad goals be for that assessment?

Prompts

How would you know it was a good assessment?

Are certain goals harder or easier to obtain?

Are certain goals more central than others?

Where does mental health sit within those goals?

Validity of assessment

Can you tell me about a time when you think you have had a good understanding of a young person's mental health needs?

Can you tell me about a time when it didn't feel possible to get a good understanding of a young person's mental health needs?

Prompts

If yes why?

If no, what do you think it is about the ASSET that doesn't reflect this? How do you capture your level of concern? How do you manage your concerns about a young person?

What changes do you feel are needed?

Process vs. products- other factors/influences

Apart from the ASSET what other things do you think about and include as part of your assessment? Can you give some examples.

Implications of knowledge and background

What things about you do think might influence how you carry out an assessment compared to a colleague. Things that people say might influence them include values, beliefs and experiences. I am wondering what you think influences your assessments.

Prompts

Personal- skills, knowledge, beliefs, attitudes

Organisational- targets, protocols politics

Previous experience of ASSET

Previous professional experience

When think about assessment of mental health needs can you think of the sorts of cases that you find easy to think about mental health needs?

What sort of cases are harder to think about mental health needs? What do you think are the main differences between these cases?

Prompts

Young person- presentation, previous information, obvious signs e.g. self-harm

Offence

Confidence

Do you feel your confidence around assessing mental health needs has increased or decreased since working in the YOS?

Prompts

What has helped or hindered?

So if a new person was about to start in the YOS what advice would you give them

Judgments Decisions

What are you listening out for during the assessment?

So thinking about x [case] how did you reach your decision on what score to give them?

Have there been times when it has been difficult to reach a decision?

Prompts

What do you think made it difficult?

What does the scores mean to you?

What implications do the scores have?

What if it doesn't relate to offending

Actions and Other agencies

Can you tell me what options are available to you when you identify a mental health need? How has it been getting support for young people? Has this influenced your assessment in any way?

Other

Is there anything that we haven't talked about today that you feel would be important to discuss?

Appendix 8 Participant information sheet

Participant information sheet



NHS
WALES
GIG
CYMRU

School of Psychology
Ysgol Seicoleg

South Wales Doctoral Programme in Clinical Psychology
De Cymru Rhaglen Doethuriaeth mewn Seicoleg Glinigol



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Adellad y Tŷr
Plas y Parc
Caerdydd CF10 3AT
Cymru Y Deyrnas Unedig

My name is Laura Morris (Trainee Clinical Psychologist, South Wales Doctoral Programme in Clinical Psychology). As part of my doctorate I have to complete a research thesis. I have chosen to research the factors that influence youth offending workers' assessment of mental health difficulties in young offenders. This sheet should give you all the information you need to make an informed choice about your participation in this study. Please read all of the information before deciding if you would like to take part in this study. If you have any questions please feel free to ask; my contact details are at the end.

What is the purpose of this study?

Mental health difficulties are a known risk factor for reoffending. Therefore, it is important that the assessment of mental health difficulties in young offenders identifies young people who may need further support. This research will look at how youth offending workers understand and assess mental health difficulties in young offenders.

The aims of this research are to:

1. Gain a better understanding of the factors that influence the decision making process around assessment and identification of mental health difficulties in young offenders.

2. Gain a better understanding of the process of assessment and identification of mental health difficulties in young offenders.
3. Explore the extent to which youth offending workers feel equipped to carry out assessments of mental health difficulties in young offenders.
4. Identify training needs for youth offending workers and associated teams e.g. CAMHS.
5. Identify implications for service delivery.

Why have I been invited to take part in this study?

This information has been sent to all youth offending workers in the Gwent area. As youth offending workers are often the first person to assess a young person and decide if further support is needed, it is important to get your views on the assessment process.

Do I have to take part in this study?

No, participation is voluntary. This sheet is intended to give you the information required to make an informed choice as to whether you would like to participate. If you decide to participate you will be asked to sign a consent form to show that you understand what the study is about and have agreed to take part. If you would like to withdraw from the study your data will be deleted. You have you have the right to withdraw your data without explanation, however you can only withdraw your data up until the point at which is transcribed and therefore anonymised.

What does the study involve?

Taking part in this research will involve an interview conducted by myself. I have a set of questions that I would like us to discuss. The interview will take place, at a time and place that is convenient for you. The interview will be one-to-one and **will last approximately one hour**. The interview will be recorded on a dictaphone in

order to transcribe the content. Once the interview has been transcribed it will be anonymous and so you will not be identifiable.

It would be helpful if you could think about some cases or examples where mental health difficulties have been part of your assessment as this will inform our conversation. For example it may be useful to have in your mind a case where mental health difficulties have obviously been present; a case where there were some doubts as to whether mental health difficulties were an issue; and a case where you were able to establish that mental health difficulties were not a presenting issue. Any cases you refer to in the interviews will need to be anonymised so you will be asked not to use the young person's name.

Will my participation in this study be kept anonymous and confidential?

This study has been reviewed and granted ethical approval by Cardiff University School of Psychology. All data will be kept anonymous and confidential and your responses will not be identifiable in the final report. The final report will be shared with youth offending service in Gwent, however service managers will not know which comments belong to which youth offending worker.

Interviews will be recorded and transcribed. Recordings will be kept securely and destroyed at the end of the study. The content of the interview will be anonymised. Anonymous transcribed data will be kept securely for a period of up to two years when it will be destroyed.

However, normal rules of confidentiality apply. Therefore any information that is disclosed that presents a risk to you or somebody else will be discussed with your line manager or appropriate person. You will be informed if this is felt to be necessary.

Are there any benefits to taking part in a study?

The final report will be shared with the Gwent youth offending service. This is an opportunity for your views about the assessment of mental health difficulties to be

shared with the managers of the service. Depending on the outcome of the research, this may lead to changes in the way mental health difficulties are assessed within Gwent.

Are there any disadvantages to taking part in the study?

Talking about the assessment of mental health difficulties may be distressing for you depending on the nature of the conversation. If you do not feel comfortable talking about mental health assessments you are advised not to take part in the study. If you become distressed during the interview the interview will be terminated immediately and sources of support will be recommended.

What will happen with the results of this study?

The results will be written up as part of my Doctorate in Clinical Psychology at Cardiff University. The study may also be submitted to relevant journals or publications. You will be invited to a follow up meeting to discuss the findings from the report and will be offered a summary of the results or a copy of the final project. If you decide not to take part in the study but would like to see a summary of the results please inform the researcher and a copy will be given to you. A copy of the report will also be given to the Gwent Youth Offending Service.

What if I have a problem with the way the research is being conducted?

If you have any concerns or questions throughout the whole process you are welcome to talk to researcher or associated supervisors named below. You are also able to log a complaint with the university by contacting the Secretary to the Ethics Committee Ethics at Cardiff School of Psychology

By email: psychethics@cardiff.ac.uk

Or by letter:

Secretary to the Ethics Committee Ethics
School of Psychology

Cardiff University
Tower Building
70 Park place
Cardiff
CF10 3AT

Who has reviewed the study?

This study has been given full ethical approval by Cardiff University Psychology Ethics Board.

How do I take part in the study?

Participation in this study is entirely voluntary. If you would like to take part in this study please e-mail me on Laura.Morris@wales.nhs.uk and we can arrange a suitable time to meet.

Further information

If you have any questions before during or after the interview please feel free to ask. This research is being supervised by Dr [REDACTED], Clinical Psychologist ([REDACTED]), Dr [REDACTED] and Dr [REDACTED] Clinical Psychologists with the Tier 3 Forensic CAMHS team ([REDACTED]). You may also contact these people to ask any further questions.

I hope this information sheet answers your questions about the research however if you have any further questions or would like to discuss this in any detail please e-mail me on Laura.Morris@wales.nhs.uk

Contact details

Laura Morris, Lead Researcher [REDACTED]@wales.nhs.uk
Dr [REDACTED], Academic Supervisor [REDACTED]@wales.nhs.uk
Dr [REDACTED], Clinical Supervisor [REDACTED]@wales.nhs.uk
Dr [REDACTED], Clinical Supervisor [REDACTED]@wales.nhs.uk

Thank you taking the time to read this information sheet. Please keep this sheet safe so you are able to refer to in the future.

Appendix 9 Participant debrief.

Participant Debrief form.



“Understanding the factors that influence youth offending workers’ assessment of mental health difficulties in young offenders”.

Many thanks for taking the time to participate in this study. This study aims to look at the factors that influence youth offending workers’ assessment of mental health difficulties in young offenders. All participants have been asked a series of questions focussing on the assessment of mental health difficulties. These interviews will be transcribed and analysed using Grounded theory. This approach to analysis aims to create concepts and categories from the interview data to create a theory about the factors that influence YOT assessments of mental health difficulties.

The aims of this study include:

1. Gaining a better understating of the factors that influence the decision making process around assessment and identification of mental health difficulties in young offenders.
2. Gaining a better understanding of the process of assessment and identification of mental health difficulties in young offenders.
3. Explore the extent to which youth offending workers feel equipped to carry out assessments of mental health difficulties in young offenders.

4. Identifying training needs for youth offending workers and associated teams e.g. CAMHS.

5. Identifying implications for service delivery.

The data collected during your interview will be held securely. Any data used in the final write up will be anonymous. You have you have the right to withdraw your data without explanation up until the point that your data is transcribed when it will become anonymous.

If you have any questions please feel free to contact myself or my supervisors using the contact details below.

Laura Morris, Lead Researcher	██████████@wales.nhs.uk
Dr ██████████, Academic Supervisor	██████████@wales.nhs.uk
Dr ██████████, Clinical Supervisor	██████████@wales.nhs.uk
Dr ██████████ Clinical Supervisor	██████████@wales.nhs.uk

If today's discussion been difficult for you please consider speaking to your line manager or supervisor who can advise on suitable support services such as employee wellbeing.

Appendix 10 Participant consent form.

Participant Consent Form



NHS
WALES
GIG
CYMRU

School of Psychology
Ysgol Seicoleg

South Wales Doctoral Programme in Clinical Psychology
De Cymru Rhaglen Doethuriaeth mewn Seicoleg Glinigol



Cardiff University
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www.cardiff.ac.uk/psych
Prifysgol Caerdydd
Adellod y Tŷr
Pias y Parc
Caerdydd CF10 3AT
Cymru Y Deyrnas Unedig

“Factors that influence youth offending workers assessment of mental health difficulties in young offenders”.

Researcher: Laura Morris

South Wales Doctorate Programme of Clinical Psychology

School of Psychology

Cardiff University

Tower Building

70 Park place

Cardiff

CF10 3AT

- I have read and understand the Participant information Sheet Version 1 and have had the opportunity to ask question.
- I understand that participation in this study is entirely voluntary. I have the right to withdraw my data without explanation however I understand that I can only withdraw up until the point at which my data has been transcribed.

- I give permission for the interview to be recorded. The interview will be transcribed and anonymised. All recording will be destroyed once they have been transcribed.

- I understand that the information I provide will be shared anonymously with the research supervisors and may be used in subsequent publications.

- I understand that the transcriptions will be retained for up to 2 years when they will be destroyed.

- I understand that at the end of the study I will be provided with additional information and feedback on the results of the study.

- I agree to take part in the study.

I, _____ (NAME) consent to participate in this study conducted by Laura Morris Trainee Clinical Psychologist, under the supervision of Dr [REDACTED], Clinical Psychologist, Dr [REDACTED], Clinical Psychologist and Dr [REDACTED], Clinical Psychologist.

Signed (Participant:

Name

Date

Signed (Researcher):.....

Name

Date:

**Volunteers needed for psychology project
looking at YOT workers'
assessment of mental health difficulties.**

I am conducting research on YOT workers' assessment of mental health difficulties in young offenders. This involves an interview with a trainee clinical psychologist. You will be asked a series of questions relating to assessment of mental health difficulties in young people. The interviews will be arranged at a time that suits you and will last approximately one hour.

Time required: 1 hour

Place: YOT offices

If you would like to take part, or want further information, please contact Laura Morris by email [REDACTED]@nhs.wales.uk

This project is supervised by Dr [REDACTED] and [REDACTED]
Clinical Psychologists in the tier 3 forensic CAMHS service.



This study has received ethical approval from Cardiff University School of Psychology and is being conducted as part of my Doctorate in Clinical Psychology.

Appendix 12 Written permission from YOT managers to recruit participants

Re: FW: Research Project Laura Morris

[REDACTED]

Follow Up. Start by 29 October 2013. Due by 29 October 2013.
You replied to this message on 11/02/2014 15:47.
Extra line breaks in this message were removed.

Sent: Wed 21/08/2013 09:14

To: Laura Morris ([REDACTED] - Psychology Training)

Dear Laura

It was very helpful to speak to you this morning and learn more about your proposals.

I can confirm that I am happy to give permission for you to recruit [REDACTED] YOS staff to participate in interviews relating to your research.

I will be in touch soon regarding prospective dates.

Regards

[REDACTED]

[REDACTED]

Youth Offending Service Manager

FW: Research Project Laura Morris

Follow Up. Completed on 15 November 2013.
You replied to this message on 11/02/2014 15:48.

Sent: Tue 06/08/2013 09:46

Cc: Laura Morris (Cardiff and Vale UHB - Psychology Training)

Message
Ethical Consent From Cardiff University for Laura Morris.doc (111 KB)
Information for managers.doc (151 KB)
Project rationale and relevant paperwork ethically approved by Cardiff University

Hi all

Please see below and above. Laura Morris would like volunteers from our YOS to be involved. If you are willing please can you email Laura direct. DMT & [REDACTED] have agreed to our involvement however it is up to individual staff to decide if they would like to participate.

Many thanks

[REDACTED]
Service Manager

[REDACTED] Youth Offending Service

Research study

Follow Up. Start by 29 October 2013. Due by 29 October 2013.
You replied to this message on 11/02/2014 15:47.

Sent: Tue 22/10/2013 16:13

To: Laura Morris (Cardiff and Vale UHB - Psychology Training)

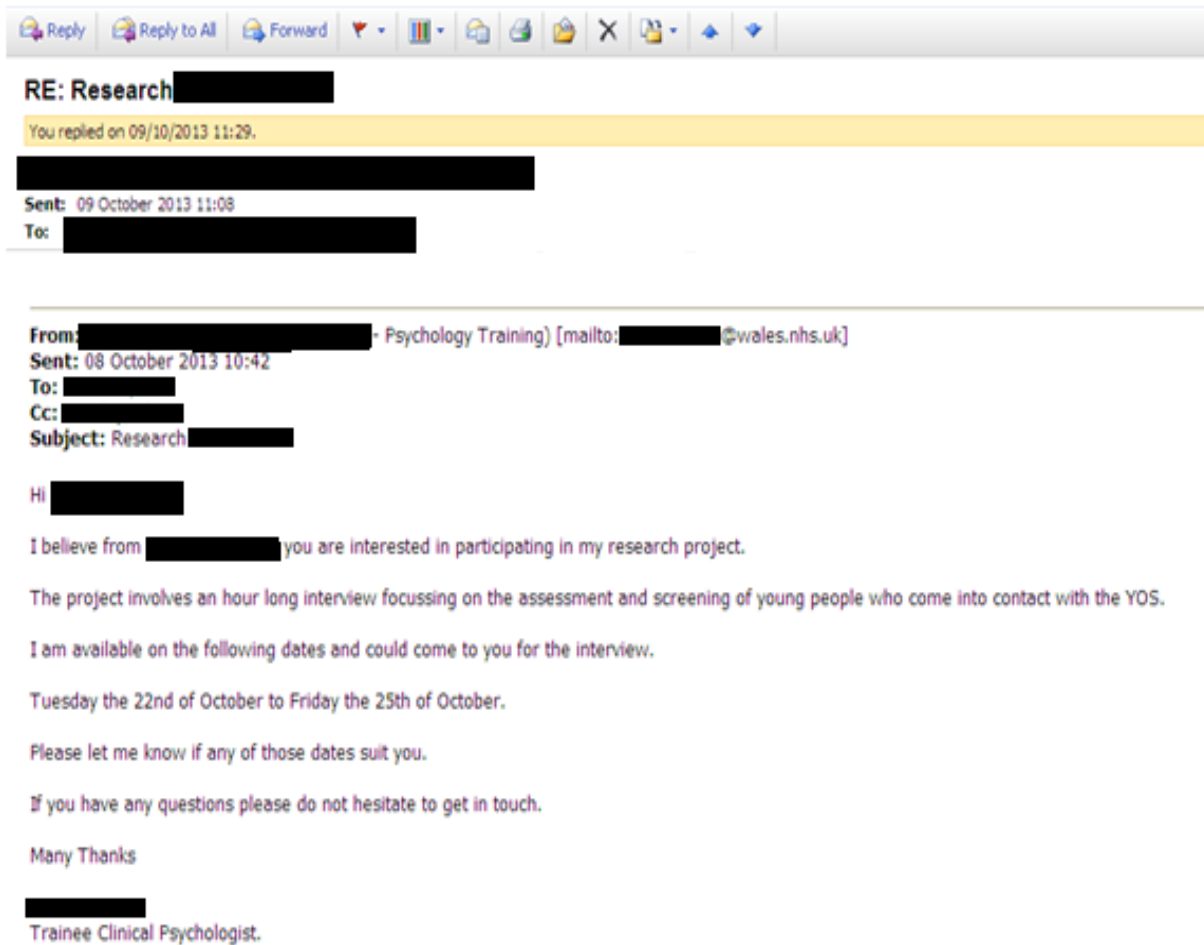
Hi Laura,

I am writing this email to confirm that I am happy for you to recruit participants from the Youth Offending Service for your research study.

Regards,

[REDACTED] Operational Team Manager
[REDACTED] Youth Offending Service

Appendix 13 Email giving information to participants.



Appendix 14. Examples of adaption to interview stem-questions based on responses during the interviews.

Changes have been marked in bold text and the original questions are provided in grey text. The interview numbers that the changes arose from are noted in brackets.

Can we start by looking at some questions to gain an understanding of your background and training in relation to the assessment of young people's emotional wellbeing.

What is your professional background?

What training have you received in this role and in previous roles around mental health difficulties and emotional distress?

How long have you been working in the youth offending services?

Additional questions

What sort of training have you had?

Job role

What do you perceive your job role to be?

Prompts

What has been as expected what has been different?

Additional questions

What do you perceive your job role to be? So as a social worker or a probation worker within a youth offending team what's your role? (Participant 1)

People have talked about needing to balance welfare and manage risk is that something you have found? If so how easy or difficult is it to balance welfare and risk? (Participant 9)

Thinking about mental health and emotional needs and how much do you feel that it is part or should be part of your role? (Participant 8)

Thinking about ASSET it has got vulnerability section, a risk section and a risk of offending section. Which section do you think as a youth offending worker is your main priority or do they all feel the same? (Participant 4)

Mental health

Could you give talk to me about a case you have been working with recently where mental health problems have been apparent.

Prompts

What's your understanding of why they have those difficulties?

What did you see in that young person that led you to believe that mental health difficulties were apparent for them?

What do you think helped you to see those things?

To what extent do you feeling working with their mental health difficulties has been part of their role?

Changes or additions

Can you think of a case where maybe it's been less apparent at the point at which they were referred to you that they had mental health difficulties? (Interview 8)

Does it feel like mental health would you say a significant number of your cases have got mental health problems or is very much the minority how does it feel in terms of your caseload? (Participant 2)

Purpose of assessment

If you were to carry out a new assessment tomorrow what would your broad goals be for that assessment?

Prompts

- How would you know it was a good assessment?
- Are certain goals harder or easier to obtain?
- Are certain goals more central than others?
- Where does mental health sit within those goals?

Validity of assessment

Can you tell me about a time when you think you have had a good understanding of a young person's mental health needs?

Can you tell me about a time when it didn't feel possible to get a good understanding of a young person's mental health needs?

Prompts

If yes why?

If no, what do you think it is about the ASSET that doesn't reflect this? How do you capture you level of concern? How do manage your concerns about a young person?

What changes do you feel are needed?

Process vs. products- other factors/influences

Apart from the ASSET what other things do you think about and include as part of your assessment? Can you give some examples.

Additional questions

do you think there are any organisational factors that influence how your work in terms of thinking about targets, policies or protocols that kind of feel like they sort of influence you? (Participant 9)

you talked about the things that make it easier to have that understanding so like a good relationship, rapport and time what things do you think get in the way of being able to build those relationships and build that understanding? (Participant 5)

Implications of knowledge and background

What things about you do think might influence how you carry out an assessment compared to a colleague. Things that people say might influence them include values, beliefs and experiences. I am wondering what you think influences your assessments.

Prompts

Personal- skills, knowledge, beliefs, attitudes
Organisational- targets, protocols politics
Previous experience of ASSET
Previous professional experience

When think about assessment of mental health needs can you think of the sorts of cases that you find easy to think about mental health needs?
What sort of cases are harder to think about mental health needs? What do you think are the main differences between these cases?

Prompts

Young person- presentation, previous information, obvious signs e.g. self-harm
Offence

Confidence

Do you feel your confidence around assessing mental health needs has increased or decreased since working in the YOS?

Prompts

What has helped or hindered?
So if a new person was about to start in the YOS what advice would you give them

Additional questions

Emotional impact of the work was highlighted by participant 8

If somebody walked in here tomorrow to start their career in youth offending and they have never worked in offending before what advice would you give them around mental health and working with it? (Participant 6)

And do you think there are the support mechanisms in place to help you manage with those feelings? (Participant 8)

Judgments Decisions

What are you listening out for during the assessment?
So thinking about x [case] how did you reach your decision on what score to give them?
Have there been times when it has been difficult to reach a decision?

Prompts

What do you think made it difficult?
What does the scores mean to you?

What implications do the scores have?
What if it doesn't relate to offending

Actions and Other agencies

Can you tell me what options are available to you when you identify a mental health need? How has it been getting support for young people? Has this influenced your assessment in any way?

Questions and additions

And then sort of finally focusing on so once you have identified the mental health problems what is your opinion around the options and access to services for young people? Do you think young people get access to services kind of beyond the CPN? (Participant 3).

Thinking about what happens when a need is identified without a link to offending.

What happens when you might have identified some mental health problems, but you don't see a link between those difficulties and the offending? (Interview 9)

Other

Is there anything that we haven't talked about today that you feel would be important to discuss?

Questions and additions

In interview I have done previously people have talked about sometimes feelings as though parents are looking for diagnosis for people. I wonder if that is something you have experienced? (Participant 1)

Ok and thinking about mental health do you think there is a distinction between mental health and emotional health difficulties? (Participant 2)

Ok and so you talked there a bit about your responsibility in terms of mental health and I wonder where it sort of feels your responsibility in terms of mental health should sit. Does it feel like it should be something that you are responsible for? (Participant 3)

Appendix 15. Example of coded transcripts.

Interview 4 Peter, page 2 to 6 of 24 pages.

Right so it feels like you have had some training but it sound as though you're saying it doesn't feel as though you have had loads and the training you have had feels like it's enough but not like you have got a detailed knowledge would you say?

No I wouldn't say I have a detailed knowledge but what I would say is that we have got the CPN attached to the team who we can go to which is an extremely valuable source and I use the CPN quite a lot.

So it feels as though you have got that person to bounce things of?

Yeah if you've got a problem, so if I think someone has got some issues then I would refer or have a chat first with the CPN so an informal chat and then if required we make the referral

Ok

And sometime those referrals are dependent on the serious of the offence not necessarily detecting any mental health issues.

Right so it might be you detect some issues but they are not related to the offence?

If I can explain there are two young people on my case load with attempted murder. It's the first offence for one of them he has never had a conviction before and the other person who was linked to it has never had any violent offences so we don't know what the triggers are so because of the heightened concerns because it was such a serious offence immediately the CPN would of gone and seen these two clients and done a basic assessment. So that's safeguarding really because we didn't know where this came from.

So there are some case where you wouldn't necessary of picked something up it's just because it's so out of the blue you think we need to be thinking about everything here.

Absolutely

Ok that's makes sense and the next question it might a bit of tricky one but I wonder what you perceive your job role to be? So as a social worker within a youth offending team what's your kind of role do you feel?

Well I think it's quite clear in the youth offending service part of it is obviously the Children's act tells us that the welfare of the children is paramount that's never gone away so we've got a balancing act between that and protecting the public. So I see that role as very well defined which means then we have to do our breaches and the more punitive stuff and try and balance that with the welfare of what's right for the

Laura Morris 16/5/14 14:38

Comment [1]: Lacking detailed knowledge

Laura Morris 16/5/14 14:38

Comment [2]: Relying on the CPN for detailed knowledge

Laura Morris 16/5/14 14:38

Comment [3]: Recognising limits of own competencies

Laura Morris 16/5/14 14:38

Comment [4]: Valuing the CPN

Laura Morris 16/5/14 14:38

Comment [5]: Using the CPN frequently for consultation

Laura Morris 16/5/14 14:38

Comment [6]: Liaising with the CPN

Laura Morris 16/5/14 14:38

Comment [7]: Guided by the seriousness of the offence

Laura Morris 16/5/14 14:38

Comment [8]: Concerning when can't identify triggers for behaviour

Laura Morris 16/5/14 14:38

Comment [9]: Seriousness of offence influencing decision making

Laura Morris 16/5/14 14:38

Comment [10]: Involving CPN when unsure/not clear and wanting explanation.

Using the CPN for a second opinion assessment.

Laura Morris 16/5/14 14:38

Comment [11]: Using the CPN to help safeguard

Laura Morris 16/5/14 14:38

Comment [12]: Perceiving role to be clear

Laura Morris 16/5/14 14:38

Comment [13]: Balancing welfare of the child with a focus on public safety

Laura Morris 16/5/14 14:38

Comment [14]: Maintaining protection of the public Whilst keep the child in mind

young person. But if we come in with an attitude that prison is unacceptable for all young people then we are maybe not protecting the public so we've got a conflict. But its I think its manageable because I think the structure of the YOT is quite good you know your role and what you're doing

Laura Morris 16/5/14 14:38

Comment [15]: Potential for personal attitudes to impact on professional role.

So it feels maybe quite structured and kind of clear compared to maybe other roles that you have had would you say?

Laura Morris 16/5/14 14:38

Comment [16]: Finding the structure helps to manage to conflict in role

Yeah I think so yeah it's always more difficult taking children away and adoption and removal. So I suppose that if he is found guilty by the courts then we accept the fact of guilt even if the young person is saying I am not guilty.

Laura Morris 16/5/14 14:38

Comment [17]: Finding the role easier that previous work

So that sense almost that the decision is made externally to you whereas in childcare you're the one that having to make the decision?

Laura Morris 16/5/14 14:38

Comment [18]: Externalising the decision making to reduce personal conflict

Yes so within the role we manage risk and I think that's one of the most important things we do is to manage the risks that young person is to self and the community.

Laura Morris 16/5/14 14:38

Comment [19]: Seeing risk management as fundamental

And you talked about that kind of balance between welfare and managing risk and I wonder how easy or difficult that kind of balance is to kind of maintain?

Laura Morris 16/5/14 14:38

Comment [20]: Dual management of personal and community risk

I think on occasions it is difficult but quite often is quite clear cut as well on numerous occasions like these young people with attempted murder I mean one is in custody now because he didn't keep to his bail package. So my view is that he has his put himself there by not complying with the opportunities that the court has given him but we never feel that prison is the best place if we can keep them in the community and keep them safe and other people safe. So yeah there is a conflict but we actually had asked the court to put him lock him up. So you always feel could we have managed differently but we don't work in isolation either we have other disciplines that we work with and if nothing is working then we would want to ensure I suppose the bottom line is that the public are kept safe.

Laura Morris 16/5/14 14:38

Comment [21]: Some decision "clear cut e.g bail

Yeah I suppose it sounds from what you're saying there is quite a clear structure to what people have to do and what they don't have to do and so you can kind of you have something to support your decision-making really as well.

Laura Morris 16/5/14 14:38

Comment [22]: Decision to use prison is difficult but "bottom line" guides decision making

Yes at the end of the day we don't make that final decision it is the court that makes it but we do influence the courts quite significantly I think.

Laura Morris 16/5/14 14:38

Comment [23]: Feeling a failure if person goes to prison

So you provide the information so with that person who was breached you provide that information to the court and then the court decides what happens as a result of that.

Laura Morris 16/5/14 14:38

Comment [24]: Sharing responsibility and decision making.

Yeah

Laura Morris 16/5/14 14:38

Comment [25]: Maintaining safety key responsibility. "bottom line"

Right that makes sense and has there been parts of the role that has been different to how you might have expected when you first thought about coming into youth offending work?

Laura Morris 16/5/14 14:38

Comment [26]: Court responsible for final decisions

Laura Morris 16/5/14 14:38

Comment [27]: Having influence over decisions

No not really anything that's because when I was in childcare I took on a lot of the youth Justice stuff before the YOS was started so I've always had an interest in that side of the work. My disappointment in those days was that always childcare came first so if there was a child that was a risk of harm not necessarily in the criminal side the young people that were on my case load because of youth Justice stuff were put to one side because you would always respond to a greater need or the perceived greater need. So you could have a young person on a supervision order that would be seen randomly throughout the order whereas now we have that structure so I think it has improved a lot and there was nothing that I didn't expect because of what I have been doing presentence reports from the day I started work.

So you already had that experience so it wasn't like you were coming into fresh as such okay, can we now start to think about maybe bringing a case to your mind where you feel mental health needs have been quite apparent for a young person. I wonder if you could give me some sort of examples of a case or a couple of cases where you think that been the case.

I am sure I can. Yeah there's one case where I have got a young person that was found guilty of a sexual offence but he was also found unfit to plead so obviously that started the concerns about his mental health state. He has quite acute learning difficulties and he was convicted of a sexual assault [REDACTED]. He would [REDACTED] at the time and he had got marked learning difficulties but then again it wasn't myself that was leading this it was he was referred immediately to the CPN who felt the concerns were sufficient that that it would go to the FACT team and then the FACT team started doing assessments. From the outset we felt as a YOS we could not work with his offending behaviour it would take more specialised disciplines and the facts team then decided that they felt that this young person was actually sectionable and then the AMHP and the doctor didn't feel that was right so he wasn't sectioned and then another alleged offence is in the pipeline now so we have gone back to looking at sectioning him again. So it has been a very very complex case we started the process in 2012 and we still haven't had an outcome yet that is satisfactory for YOS. So to me it [mental health] is a very complicated system to get anything actually done and YOS feels when I say YOS I'm speaking for me I joint work it with my manager as well we feel quite out of control because we can see clearly what is needed and that was kind of reinforced when we had the training with the psychologist the other day because she was talking about before you can do work with some people they have got to have that safe place and we feel at the moment he does not have a safe place. So that's one young person with a complex problem but we are not actually doing very much with it.

Laura Morris 16/5/14 14:38

Comment [28]: Having Yots allows workers to prioritise young people who have offended and attend to their needs-give them time.

Laura Morris 16/5/14 14:38

Comment [29]: Identifying initial concerns

Laura Morris 16/5/14 14:38

Comment [30]: Awareness of other difficulties

Laura Morris 16/5/14 14:38

Comment [31]: Referring immediately if concerned

Laura Morris 16/5/14 14:38

Comment [32]: Escalating referral pathway defined by nature of offence (sexual) context (LD)

Laura Morris 16/5/14 14:38

Comment [33]: Feeling unable to work with certain offences.

Awareness of limits of competence/role.

Laura Morris 16/5/14 14:38

Comment [34]: Looks to CPN for 2nd opinion and FACTS for 3rd opinion

Laura Morris 16/5/14 14:38

Comment [35]: Having concerns recognised by other agencies.

Laura Morris 16/5/14 14:38

Comment [36]: Finding conflicting opinions between mental health professionals.

Laura Morris 16/5/14 14:38

Comment [37]: Repeating a process

Laura Morris 16/5/14 14:38

Comment [38]: Defining cases as complex

Laura Morris 16/5/14 14:38

Comment [39]: Dissatisfaction with service, when refer on unable to influence even if have clear sense of what is needed.

Further assessments take a long time

Laura Morris 16/5/14 14:38

Comment [40]: Joint working for serious cases

Laura Morris 16/5/14 14:38

Comment [41]: Feeling out of control. Feel can see what is needed but unable to influence

Laura Morris 16/5/14 14:38

Comment [42]: No role with complex cases

Interview 7 Dave Pages 5 to 8 of 20 pages

So it sounds like he would say something which would spark something in your mind and you would go away and think this doesn't feel quite right and then you would check it out with somebody like the CPN and then check it out with the boy and then he would put your mind back at ease and the next time it would be something else.

Yeah and he finished with us in June this year and I know his drug use did escalate highly we referred him to another drug agency and they kept working with him and I know his valium use increased dramatically and he was kicked out and one point but it was interesting another CAMHS worker went to see him recently and her view was quite different she thought he had ADHD he had autism and she thought he was incoherent and rambling, it may of got worse obviously but it was interesting her view kind of differed from our CAMHS worker view.

Do you find that often happens?

Well I don't know I am a little bit I am slightly I have some scepticism about mental health can I say that?

Of course you can.

Like certain consultants will give everyone ADHD and others won't give it at all. So it's not very precise.

No it's not something you can have a blood test for and you have this or you haven't

Exactly so it depends which theory they lean towards doesn't it I don't think it's an exact science so it depends on people's point of view. Obviously there are some clear obvious examples. So I will be interested to see where that goes really so the person who made that statement isn't a doctor so I suppose they will have to refer them on and see what the psychiatrist makes of him. But yeah it's interesting the way it kind of evolved.

So yeah its sounds like it was quite up and down quite, anxiety provoking then quite calm then up again.

Yeah and different people have got a different views on what's wrong with him from within the same professions its quite interesting.

And does that make your position does that make it difficult for you?

Well I didn't realise that until the end but it is interesting. I suppose I guess they can both be true he did have lot of problems with parenting and his parents went on a course and his dad punched him at one point and his parents were quite split on him and I guess you can have both, its not either or is it you can have

Poor parenting and ADHD you can have poor parenting because you ADHD there are so many combinations.

Laura Morris 16/5/14 14:38

Comment [43]: Experiencing different views from different CAMHs workers

Laura Morris 16/5/14 14:38

Comment [44]: Feeling unsure about the reliability of Mental health assessment

Laura Morris 16/5/14 14:38

Comment [45]: Feeling diagnosis if not very accurate

Laura Morris 16/5/14 14:38

Comment [46]: Feels opinion about Mental health are subjective and influenced by beliefs

Laura Morris 16/5/14 14:38

Comment [47]: Valuing the opinion of the doctor over other professionals

Laura Morris 16/5/14 14:38

Comment [48]: Difficulty of differing opinions within CAMHs

Laura Morris 16/5/14 14:38

Comment [49]: Considering that you may have mental health difficulties and parenting/behavioural issues.

Yeah it's interesting, what was the question I can't remember now.

It was talk through a case so I was thinking with him it sounds as though he came and mum flagged up that she was concerned and when you did a bit of digging he had been seen by CMAHs

yeah he had been and they thought there was nothing wrong, but the drugs issue and how that clashes with mental health is a difficult one isn't it obviously because he was using drugs cannabis at least throughout the whole time I knew him which has a possible psychological, well I have seen that quite a lot where kids take loads of drugs and start tipping into paranoia and hearing voice that's kind of fairly common and then it's the problem is if they see a psychiatrist it's hard for them to prescribe anything isn't it because you don't want to know what drug they are using to get a clear picture of where they are without the drugs or the side effects or the mix to give them.

The other case I was on about the more severe one he when I hadn't this is going back a few years I knew he was prescribed I think it was risperidone it's a mild antipsychotic I think and he was fairly stable for the majority of the time but his drug use took off and he was using amphetamine, he was using loads and loads and loads and he was losing weight and he was in a right state and he went to prison for about four months which kind of helped him really in terms of his physical health he got his weight back up and he was taking the medication regularly and when me and the CPN saw him in the prison he had just moved to being an adult he was 18 whilst he was inside and he was fine mentally he was presenting normally coherently and calmly and when he came out he stopped taking risperidone and used a range of drugs and the down cline in his behaviour his whole personality the way he presented was horrendous really he was literally walking up the road moving involuntary really bad paranoid really really severe. That was shocking to see really how quickly he declined within weeks.

And you talked about in both of these cases the link you see between drug use and mental health do you think that is something that young people accept or take on board or not?

It varies I guess some of them are alarmed I think some have a psychotic episode and they are alarmed by that and would sort of back of the drug use which is great but some aren't some just see it as an acceptable risk or part of the thing really. It varies really I had one recently and he said he was hearing voices when he took methodrone they call it meow meow up here. Methodrone is quite rife up here and he said he was hearing voices and when he stopped using it he still heard it for a little while but then they went away and I said did that worry you and he said no it didn't, just bravado I don't know.

Is interesting that he told you that his was hearing voices but said it didn't bother him.

Yeah and he didn't keep taking it he moved on to something else. Cannabis but even that in sufficient doses can if you're what's the word it affects you like that.

Laura Morris 16/5/14 14:38

Comment [50]: Awareness of the potential impact of drugs on mental health.

Laura Morris 16/5/14 14:38

Comment [51]: Awareness of the potential impact of drugs on mental health.

Laura Morris 16/5/14 14:38

Comment [52]: Drugs get in the way of mental health diagnosis and intervention.

Laura Morris 16/5/14 14:38

Comment [53]: Seeing medication as beneficial

Laura Morris 16/5/14 14:38

Comment [54]: Awareness of fluctuating nature of mental health

Laura Morris 16/5/14 14:38

Comment [55]: Seeing prison as having a positive impact on mental health in terms of access to treatment

Laura Morris 16/5/14 14:38

Comment [56]: Feeling shocked by how quickly someone's MH can decline

Laura Morris 16/5/14 14:38

Comment [57]: Some young people shocked by psychotic experience on drugs

Laura Morris 16/5/14 14:38

Comment [58]: Feel some young people see psychosis from drugs as a risk worth taking

Laura Morris 16/5/14 14:38

Comment [59]: Feeling young people don't want to admit they don't like the effect of drugs

Laura Morris 16/5/14 14:38

Comment [60]: Seeing drugs as a risk factor for developing MH

Yes people are susceptible to drugs and some people can take loads of drugs and seem fine.

But yeah we do see that a lot.

And both those cases sound as though they were young people who had come with a history of mental health problems. I'm just wondering whether you can think of, and you might not be able to, but if you can think of a case where you didn't really know there were mental health problems and it was part of your initial assessment that they were highlighted.

Umm I am trying to think and it does happen.

So I guess I am wondering what sort of things are you looking out for to help you think is mental health an issue of not.

I guess the form we've got well if they had a bereavement I guess the questions how have they coped, do they feel it's still affecting them and their life and how they cope daily functioning isn't it. I guess the worry is that is obviously a natural process but is it going into a depression. I kind of guess the main things I ask about if I am being honest is depression are they you know feeling down all of the time, not seeing the positive in anything or are they anxious is that stopping them doing things. Then obviously the more obvious ones if they are suffering from paranoia. I saw one boy and he said he saw a ghost and that sparked something of. I suppose you could think "oh he might have seen a ghost". But I don't partially believe that I would think that's more not based in reality so therefore why is he saying that. I have had that with a girl once who said she had seen ghosts I was bit concerned about that really and I referred her to CAMHS.

So it sounds like there are a couple of things like depression and anxiety that you might question about and then for other things its more about picking up on the subtleties or the kind of things that people might say that's doesn't sit with reality.

Yeah my view of reality.

Laura Morris 16/5/14 14:38

Comment [61]: Using the ASSET to identifying triggers for mental health

Laura Morris 16/5/14 14:38

Comment [62]: Highlighting the normal grieving process but looking out for depression

Laura Morris 16/5/14 14:38

Comment [63]: Focussing on depression

Laura Morris 16/5/14 14:38

Comment [64]: Has a strategy for assessing for depressions

Laura Morris 16/5/14 14:38

Comment [65]: Looking for obvious signs of paranoid

Laura Morris 16/5/14 14:38

Comment [66]: Using own views and values to decide if a belief is normal or not.

Laura Morris 16/5/14 14:38

Comment [67]: If view doesn't fit with own feeling concerned and obtaining a second opinion

Appendix 16. Example of a memo.

Extract of a memo based on the first 10 pages of an interview.

Interview 4. (Dave)

Themes and ideas generated from the interview.

- Welfare vs. offending has come up for the fourth time. - *Welfare vs. offending.*
- Experience of working with young offenders before YOTs existed. I wonder how this impacts on their attitudes towards the YOT. - *Previous experience.*
- Not all Social Workers have a core mental health placement. Need to understand more about core training. - *Professional background.*
- Describing different parts of the YOT e.g. different levels of YOT provision.
- Describing the tool (ASSET) as not meeting the needs of the YOT. - *Adequacy of the tool (ASSET).*
- Discussed the impact of inspections on working practice. - *Organisational impact.*
- Participants commented “can I say this”. I wonder how comfortable Youth Offending Workers feel talking about mental health with an “expert”. - *Role of expertise.*
- Highlighting difference between the values of the YOT and the values of health. - *Difference between YOT and health.*
- Mental health difficulties had been previously identified. What happens to the young people where the difficulties haven’t already been identified? - *Already aware of mental health difficulties.*
- A sense that the participant worried about their cases where there were mental health difficulties. – *Worry.*
- Close relationships with the CPN uses this relationship to gain advice. – *relationship with the CPN*
- Channing perspective on the importance of welfare needs as result of inspections. I wonder whether this change would have come about naturally or if it was related to the inspections. - *The importance of welfare.*
- Scepticism about mental health diagnosis due to the wide range of different disorders. - *Mental health diagnosis.*
- ADHD has been discussed by all the participants so far. Need to look at the literature around prevalence of ADHD in the youth offending population. - *ADHD prevalence.*
- Highlighting the impact of drugs on mental health. - *What causes mental health difficulties?*
- Describing the backgrounds of the young people in YOT and the impact

this has on mental health. –Young person’s background.

- Not feeling young people are able to talk about their background. This may be an issue with openness or it may be an emotional literacy problem. - *Engagement with the process.*
- The impact of the family’s negativity on the assessment process. -*Impact of family.*
- Parents wanting a diagnosis especially of ADHD as a way of getting money, reducing blame. -Pressure for a diagnosis.
- Questioning the responsibility they should have around mental health considering they are not experts. -Level of responsibility for mental health.
- Seeing emotional health as being separate to mental health. -*Separating emotional health from mental health.*

Observations

The participants seemed unsure about saying they had reservations about mental health diagnosis. I wonder what impact me being a trainee Clinical Psychologist has on the openness and honesty of participants. Need to think about how I might be able to get across that there are no right or wrong answers. Will think about this in supervision.

The participants seemed to want to engage me in conversation and ascertain my views and opinions on the subject. I think this really helped the participant to explore their own ideas but I need to be careful that in taking this approach I do not end up leading the interview. Hopefully the fact that I was aware of this potential process during the interview will have helped to reduce the impact of it on the data.

Themes/ideas to think about in future interviews

- The impact of me as a clinical psychologist on the openness/honesty of the participants.
- Ascertaining more information of the participants previous experience to see if previous impact on current practice.
- Continue to explore the welfare vs offending debate.
- What brings about changes in practice?
- Does worry play a role?
- Continue to look at the barriers to a good assessment.
- Follow up on “pushing for a diagnosis”
- Follow up on the level of responsibility they feel they should have for mental health.
- Is emotional health different to mental health?