Mental health support for youth offending teams: a qualitative study

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Abstract

The objective of the present study was to examine the views of professionals working in youth offending teams (YOTs) on a new model for providing mental health service support within the context of an interagency setting. Focus groups were used and data were analysed according to the constant comparative method. The setting consisted of two YOTs, one in an inner-city area and the other in a rural/semi-urban area, where primary mental health workers operate at the interface between YOTs and the specialist child and adolescent mental health services. Seventeen YOT professionals participated in four focus groups. Four themes were identified: previous experiences of specialist mental health services; issues of interagency working; the role of the primary mental health worker within the YOT; and recommendations for the future. Overall, the clinical component of the role (assessment and intervention), and the accessibility and responsiveness of the mental health staff were consistently valued, while there were mixed responses on role definitions within the team, consultation and training. It is concluded that mental health service provision through primary mental health workers is a useful model for interagency partnerships for high-risk client groups with multiple and complex mental health needs.

Keywords: child mental health, focus groups, interagency, primary mental health workers, young offenders

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Introduction

It is well established that young offenders have complex mental health needs (Bailey *et al*. 1994, Reiss *et al*. 1996, Lengua *et al*. 1997, Nicol *et al*. 2000). Studies in the UK also suggest that these needs remain largely unmet by specialist child and adolescent mental health services (CAMHSs), which have not been sufficiently accessible or responsive to meet the needs of young offenders as they move through the Youth Justice System (YJS; Hagell & Newburn 1996, Kurtz *et al*. 1997, 1998, Nicol 1999). For example, Dolan *et al*. (1999) reported that a substantial proportion of young offenders were not registered with a general practitioner, and therefore, found it difficult to access secondary and specialist health services through traditional referral routes. Ongoing mental health needs have been identified as a risk factor for re-offending (Farrington 1995, Rutter *et al*. 1998), suggesting that attempts to reduce offending rates and increase social inclusion must deal more adequately with the mental health needs of young people (Bailey 1999).

Youth offending teams (YOTs) were established under the 1998 Crime and Disorder Act (Youth Justice Board 1998), and were fully implemented in April 2000. They are interagency teams which consist of staff from education, probation, police, and health and social services. Their objectives are to: (1) provide an integrated and appropriate response to young people who have offended; (2) reduce youth crime by helping young people to confront the consequences of their offending behaviour; (3) tackle issues which might contribute to the initiation or maintenance of offending; and (4) facilitate effective delivery of youth justice services (Home Office 2000).

Since mental health has been documented as an important contributing factor in the initiation and maintenance of offending (Bailey 1999), it is important to address mental health need in order to meet the stated aims of the YOTs. However, so far, there is no consensus on how best to provide mental health support for YOTs and what service model to adopt. In some areas, mental health support is predominantly provided by specialist mental health staff (usually community psychiatric nurses or psychologists) engaged in the provision of cognitive behavioural programmes targeting the cognitive processes which underlie offending behaviour, but provision also involves outreach work from the specialist CAMHSs or from substance misuse services.

A new model of interagency service provision is through primary mental health workers (PMHWs; Sebuliba & Vostanis 2000; Arcelus *et al*. 2001; Gale & Vostanis 2002), whose role is to cover the interface between YOT and specialist CAMHSs professionals. They provide a direct service to young people with mild mental health difficulty, and fulfil a crucial consultation and liaison service to primary health staff.

More specifically, within YOTs, the role of the PMHWs involves a combination of direct mental health work with young people (assessment, and a range of cognitive, behavioural, psychotherapy and family therapy interventions), and consultation, liaison, training and joint working with YOT professionals to develop their skills in recognising young offenders with common mental health problems as well as in the cognitive and behavioural management of young offenders. The PMHWs are full-time health professionals, located within the YOTs, but attending weekly meetings and supervision sessions within CAMHSs. This provides YOT staff with direct access to mental health personnel on a daily basis, and through the PMHW, provides access to the more specialist services provided by CAMHSs, with whom PMHWs retain a strong working relationship. Other YOTs use a CAMHSs outreach model by receiving sessional input from generic mental health staff, usually community psychiatric nurses, who are based at the local CAMHSs. In the model described in the present paper, the PMHWs are employed by an National Health Service trust and are line managed by a senior PMHW within CAMHSs, but are physically based at the YOTs to facilitate joint working and to improve accessibility. In that respect, their line manager and the YOT manager meet with the PMHW to monitor their role in relation to both organisations.

Leicester, Leicestershire and Rutland cover a population of 900 000 with about 225 000 children and young people under the age of 18 years. There are two YOTs, one covering an urban multi-ethnic area (approximately 2000 annual referrals) and one covering a semi-urban/rural area (approximately 1000 annual referrals). Three PMHWs have been employed as part of a specialist child and adolescent mental health team (which also consists of two psychologists and a psychiatrist). This multidisciplinary team structure and remit facilitates close working links between the YOTs and the local CAMHSs.

The aim of the present study was to examine the perceptions of YOT professionals about the role of PMHWs within their teams, and to explore their views about the success or otherwise of this new model of providing mental health support within the YOT service.

Subjects and methods

Respondents: focus groups

Four focus groups were conducted, with 17 staff members (four in group 1, three in group 2, five in group 3 and five in group 4). These groups comprised team managers, and professionals from bail support, social work, probation, education and policing backgrounds. The same researchers moderated and co-moderated all four focus groups (J.C. as moderator and F.P. as co-moderator). The moderator was responsible for initiating and maintaining discussion in the groups, using a flexible topic guide (Box 1) to provide a loose structure for the group discussion. The co-moderator's role was to monitor the group, observing group dynamics and provide feedback to the moderator on the facilitation of the group. The co-moderator provided a brief summary of the content of the discussion at the end of each session. This allowed participants to correct any misunderstandings and emphasise points which were important to them in the discussion. This summary, together with the co-moderator's debriefing of the moderator, was noted in the field journal and formed the starting point of the authors' later analysis of the focus groups.

The present authors decided to use focus groups in part because it enabled us to access participants within teams which were akin to their everyday work teams, and in part because their interactive nature allows participants to be more active in the research process, asking questions of each other and of the researcher, which facilitates disclosure in turn (Kitzinger 1994, Powell & Single 1996, MacDougall & Fudge 2001). For this reason, they can be described as generative, allowing for the emergence of diverse views and experiences about the topic area (Wilkinson 1998), and the expression of opinions and perceptions beyond that which the interviewer might initially have predicted. Participants were

Box 1. Themes used to guide focus group discussions, with some sample questions: (CAMHSs) child and adolescent mental health services; (PMHW) primary mental health worker; and (YOT) youth offending team

Perceptions of the mental health and mental health needs of young offenders
What do you understand by mental health need?

What sort of mental health needs do you think the young people you work with have?
Is there a need for specialist mental health input into YOTs?

Role of the PMHW
What impact has the PMHW had on YOTs?
Have you been able to access mental health services?
How do you use the PMHW within the team?
How do you decide whom to refer?
The aim of the new service is to provide mental health services which are more accessible, responsive and appropriate. To what degree do you think that these aims have been achieved?

Perceptions of training needs
What kind of training in mental health issues have you been offered?
How useful was that training?
What kind of training do you think would be most beneficial?

Perceptions of traditional mental health services (ordinary CAMHSs, pre-PMHWs)
What experiences have you had of using mental health services for young offenders?
What have been the strengths of the current services? What have been their weaknesses?
How did you access CAMHSs services?

Consultation and liaison role
Theoretically, a third of the PMHW's workload is allocated to consultation, a third to joint working and a third to direct work. How has this been in practice?

Have you found the consultation/liaison role useful?

Recommendations for change
Do you have any frustrations with the role of the PMHW?
Are there any limitations to it which you think should be addressed?
What sorts of future development are needed for the role?
How could services be improved for young people who are quite difficult to engage?
What would improve access to mental health services?

encouraged to speak to researchers afterwards on an individual basis. Groups consisted of both team members and team managers, and therefore, it was particularly important to monitor the role of the managers within the group and to ensure that they did not dominate discussion. This was achieved by asking for dissenting opinions and directing questions evenly across the group. Focus group discussions were tape-recorded and transcribed verbatim.

Analysis

The use of qualitative methods is now well established in the field of health and social care (Murphy *et al*. 1998). Data analysis was based on grounded theory, following the first steps of the process described in Strauss & Corbin's (1990) modified model of grounded theory. This involved a detailed consideration of each paragraph of the transcript, and tentatively developing and labelling concepts of potential relevance to understanding YOT professionals' perceptions of the mental health service support (Pidgeon & Henwood 1996). Each discrete idea or event was coded and represented by the participant's own words (*in vivo codes*). Data collection and analysis occurred simultaneously, so that the content of the interviews and emergent codes were constantly compared and developed to discover relations between the data and begin to generate themes. Related codes were brought together and assigned to emergent themes in an iterative process that aimed to ensure 'goodness of fit' between data and themes, and remain sensitive to negative cases. However, the necessarily small sample (a reflection of the size of the population) meant that theoretical saturation could not be reached, and the present authors claim only to have followed the process of grounded theory: they do not claim to have achieved the kind of theory building that is its preferred outcome.

Field notes were written up after each session to maintain a record of the moderator and co-moderator's impressions of the context. Initial analytic comments were also noted. A record was also maintained of the analysis, using memos (Pidgeon & Henwood 1996) to ensure that the process of the analysis was adequately documented.

Research team

The focus groups were conducted and analysed by two independent researchers (J.C., a research associate, and F.P., a psychiatric registrar within the CAMHSs outreach team). The writing up of the paper was conducted in interaction with a child psychiatric specialist (P.V.) from the Young Person's Team (the specialist CAMHSs team with which the PMHWs are affiliated) and a non-clinical specialist in the use qualitative methods in health research (B.Y.), who was also brought into the team as an impartial supervisor. With the exception of

the psychiatrist, the research team was independent of the clinical project of the PMHWs.

Results

The YOT professionals perceived the young people whom they worked with (both in community and institutional settings) as having extensive mental health needs. They were aware of national policies and previous research on the extent of mental health problems among young offenders, and their references to mental health problems and disorders varied from general terms to specific presentations, particularly self-harm:

Really, I'm looking at mental health issues in general. There is a high proportion of young people with mental health problems in our case load. It is a disproportionate number compared to the population at large. (Group 1, participant 2)

Yeah, there must be a need because of the number of young people self-harming and attempting suicide in young offenders' institutions. I mean that's the starting point that I come from, and the research into young people shows that they have mental health needs that traditionally haven't been met, so yes, I guess there is a need. (Group 2, participant 1)

Therefore, participants broadly perceived a need for some kind of mental health intervention, and their experiences of the services offered by existing CAMHSs suggested that there was a need for a more specialist mental health service tailored to the needs of the young people whom they worked with.

Previous experiences of specialist mental health services

Access, referral procedures and structure of specialist services
Youth offending team professionals were asked about their previous experiences of using specialist CAMHSs, before the development of designated posts or teams working with young offenders. Their comments reflected on both CAMHSs and adult mental health services, with the latter often dealing with clients over 16 years of age. A key difficulty identified was in accessing mental health services. They reported unclear referral routes and criteria, difficulties contacting mental health staff, and *ad hoc* collaborations with mental health workers:

I needed to work with the mental health services; for example, to deal with certain re-offenders and cases in which some nasty violence occurred. However, it was an *ad hoc* collaboration; there weren't any procedural systems to guide us. There were very long delays in accessing mental health systems. (Group 1, participant 1)

These problems in accessing mental health services had consequences for the services offered by the YJS, and created difficulties for YOT professionals, who felt they lacked both the necessary expertise in dealing with clients with mental health problems and 'insider knowledge' of the relevant services:

It was a nightmare trying to deal with mental health services. I did not feel confident in dealing with mental health problems on my own, but I didn't know who to nag, and there was no formalised process fed down at all. (Group 1, participant 2)

Difficulties with access to services were particularly prominent in accounts about young people who were perceived as dangerous, and in relation to working with clients in young offenders' institutions.

Traditional child and adolescent mental health services, young offenders and the Youth Justice System
Problems in accessing services were compounded by the mobility of young offenders within the YJS, their difficulties in engaging with professionals, and the sometimes difficult interface between mental health services and the courts with their different organisational cultures and priorities. Youth offender team professionals must operate under the pressures of the YJS, which requires speedy assessments to meet court and other legal deadlines, or to assess the immediate risk. Staff expressed concerns about the inability of CAMHSs to respond to these requirements and to the needs of young people moving through the court system. For example, meeting court deadlines for psychiatric reports, which can impact on the speed with which young people are seen in court, is of prime importance within the YJS:

Participant 1: Previous to the YOT being established, most of this work was done by Social Services. It was difficult to access the mental health services then. Access to the specialist CAMHSs was very long winded.

Participant 2: Waiting lists were a problem.

Participant 3: We need mental health workers to respond immediately and perform an on-the-spot assessment. We often need an expert opinion whether a young person can be kept safely in a certain situation; for example, in a police cell. We often used to refer a number of cases to CAMHSs previously. After a long delay, they would simply say, 'There's nothing wrong with them.' (Group 3)

This suggests a disparity between the operation of the YJS and the capacity of traditional CAMHSs to provide mental health support that is sufficiently flexible and responsive to avoid extensive delays in the court process. Furthermore the nature of young people's experience when moving through the YJS is crisis ridden and rapidly changing, and for this reason, YOT professionals perceive a need for a very rapid response to referrals.

The YOT professionals' accounts also emphasised their view that there is a fairly narrow window of

opportunity for intervention with young offenders once their needs have been identified, and the young people are motivated to change. If this opportunity is missed, they suggest young people are unlikely to take up the service:

> Getting someone seen at an appropriate time, with that waiting list, is impossible. I mean, we need a rapid response. The young people are motivated to change, and you need to be able to strike when the iron is hot … and this has really been a big issue in the past. (Group 4, participant 2)

Participants in the groups generally agreed that the overall quality of service was good, once they 'had a foot in the door'. However, there were some concerns that the general CAMHSs adhered to a therapeutic culture that did not fully recognise the needs of excluded and often difficult to engage young people and their parents. They suggested that a more direct approach in the assessment and intervention of this client group might be more appropriate:

> The help received by the families was good, but judging from the feedback I received, parents found it difficult to engage. I am not sure if this is the system used at CAMHSs, but the parents felt anxious because they were not prompted. They felt the therapist was not responsive. They were expected to do the talking and opening up. Parents felt vulnerable and under observation – 'I had to say the first thing that came into my head, because I didn't know what to say' – so it was difficult. Perhaps this is considered the best approach at CAMHSs, but parents would prefer to be asked questions they could answer rather than a blank 'talk to us'. (Group 1, participant 2)

Researchers in mental health have wrestled with the difficulties of simply applying Western, middle-class therapeutic models to members of other groups for a variety of reasons and these concerns appeared to be echoed by the YOT officers in the focus groups. For example, Gift *et al*. (1986) found that social class correlated strongly with therapeutic outcome in an inpatient unit, with people of higher socio-economic status showing far greater improvement than those of lower socio-economic status. The above authors suggested there is a need to adapt existing therapeutic models so that they are more acceptable to a wider range of social groups and for practitioners to be more aware of the dominance of middle-class cultural biases inherent in much of their practice. Other authors (e.g. Mama 1995, Burman *et al*. 1996) have suggested that the Western model of therapy is inherently problematic, particularly in its application to people who are socially excluded, in that it is built on conceptions of self (typically humanistic ideas of the individual) which are inconsistent with ideas of self and society which might be prevalent in groupings for which the therapeutic method was not developed. They argue that uncritical application of these models may serve to further alienate marginalised people. The YOT officers' comments may indicate a need to revisit some of these concerns in developing the role of mental health workers with marginalised groups and to question the therapeutic models which are used.

A particular difficulty in engaging young people was perceived to be related to the inaccessibility of health services for their clients, the perceived stigma of mental illness and the fragmentation of the mental health interventions from other aspects of their care:

> Our clients are often 'medic-phobic'. They would not see a doctor for a physical ailment, let alone psychiatric needs. They are very much excluded from health services in general. (Group 3, participant 5)

Difficulties of interagency working and issues of role definition

Youth offending teams are new interagency initiatives, with different professionals and agencies working together and redefining their roles in this context. The issue of interagency team working and the attendant difficulty of role definition for specialist workers within the team emerged as a key tension for most of the participating YOT professionals. A particular point of tension was the distinction between the specialist and generic worker. It was indicated that working within an interagency setting required a period of adjustment, as roles settle, and relationships between team members become clearer:

> *Participant 2*: Some of us came into the team often working for 10 years in a certain way. Then we were suddenly expected to work to the new mandate of the team.
>
> *Participant 3*: I don't mind the work, but I need my role to be defined. This is happening now, because I know what I am expected to do. (Group 1)

These tensions have consequences for the definition of the PMHW's role within the team, particularly their consultative capacity:

> *Participant 2*: I feel it's a matter of 'defining roles'.
>
> *Participant 3*: It has been a problem for all members of the team – and not just for the PMHW – to define our roles.
>
> *Participant 2*: I think we're all specialists in our own right – we all have special interests and skills. You do need to have a specialism in mental health, but you also need to have a full understanding of everything else that goes on in the team, and doing pre-sentence reports, for example, is one good way of doing that. (Group 2)

Some participants commented that these tensions may ease over time, as YOT staff become clearer about their own role, and the relationships between themselves and other members of the interagency team stabilise:

Initially, I experienced stumbling blocks which limited the delivery of psychiatric help within our team. The main reasons for these stumbling blocks was that the PMHW's role was not clearly defined. (Group 3, participant 1)

It was clear from discussions with YOT professionals that they experienced their jobs as fairly stressful and that their remit to deal with young people with mental health difficulties was perceived as an additional source of stress. In particular, they were concerned about undertaking risk assessments and feared missing, or not adequately managing, underlying mental health problems:

It increases your anxiety levels as well. When you see a potentially dangerous person about to leave prison, you feel responsible. (Group 1, participant 2)

Many YOT professionals did not feel confident in their ability to deal with mental health work on their own and felt under-prepared for such work:

My role was in arresting people who needed to be sectioned under the Mental Health Act, for their own safety or the safety of others. When female offenders were arrested, the cell door had to be kept open. So I had to sit down looking after female prisoners for up to 20 h. They would welcome an opportunity to talk, as if I was the first person they could latch on to. I lacked any experience in mental health issues. Then you knew that most of them were out again, back in the community. It was a negative experience. As a police officer, you're trained to deal with the legal side of things, but we are not prepared for mental health issues. (Group 1, participant 3)

Role of the primary mental health worker within the youth offending teams

Accessibility, responsiveness and communication

For YOT professionals, key advantages brought by PMHWs were their accessibility and their potential to improve the responsiveness of external mental health agencies. In particular, they valued the incorporation of mental health professionals within YOTs: adding a mental health component to the remit of the YOT was perceived as enabling them to provide a more rounded or holistic service, and to be mutually beneficial to all members of the team:

In the YOT, the role of the PMHW is highly valued. Our PMHWs benefit from their experience within the YOT team. They, in turn, make an important contribution which enhances the service provided by the teams. In our YOT, we have a good balance of skills, including those of the PMHW. (Group 3, participant 3)

All the group discussions reflected the importance of having someone on site to provide consultation and direct work. Many felt that this improved their access to other CAMHSs, provided them with an important sounding-board for their concerns about the young people they were working with and contributed to speedier processing through the courts:

Since this can be done at an early stage, it avoids delays in the court process and in sentencing. The court process may be adjourned for the silliest of reasons, which leads to a lot of anxiety. The mental health workers have been effective in reducing delays by helping the court to reach a decision, by contributing to our reports. (Group 1, participant 4)

Although the YOT professionals were clear that the presence of a PMHW did not always resolve the problem of delay, and they recognised that psychiatric reports were still sometimes needed, it was perceived to facilitate the court process and the process of rehabilitation. The availability of the PMHW on site could also assist with the problem of difficult to engage young people:

It helps when you can say to a young person, 'There's someone in my team, a colleague of mine you can talk to,' rather than having to suggest that you refer them through to the specialist service. (Group 2, participant 1)

The PMHW is herself an accessible person. She can speak to youngsters and diffuse their fears about the consequences of them accepting psychiatric help. (Group 3, participant 4)

Being able to see someone within the YOT was thought to reduce the stigma associated with seeing a professional about mental health difficulties. The PMHWs were well placed to demystify some of the processes and to help young people come to terms with their need to seek assistance. The YOT professionals also highlighted the value of having a PMHW on site in terms of the way in which they felt it helped to streamline their access to CAMHSs and other services:

In another case, there was a young person who'd committed some very high-profile offences. Again, there were concerns about mental health issues. [The PMHW] did an assessment, and specialist CAMHSs got involved in a consultative role. And that was really helpful. But then, he got too old for the CAMH service, but adult mental health wouldn't take it on. It was frustrating because he obviously needed more of a service. But the lad was difficult to engage. At 18, he should have been transferred to probation, but we couldn't get this problem sorted, and I was reluctant to hand it over until the service was in place. But the problem is, we really don't know who to talk to. In the end [the PMHW] took it on, and because he understands the mental health system, he was able to sort it out, so in the end, they did pick it up. But if it hadn't been for him, I don't know what would have happened to that lad. (Group 4, participant 5)

Mental health assessment, intervention and consultation of youth offender team staff

Staff highly valued the skills of PMHWs to undertake assessment and direct interventions. However, as

mentioned earlier, there was often lack of clarity and ambivalence about their consultation and training role, and YOT professionals varied quite widely in their views on the form that the PMHWs role would eventually take as teams developed. Some welcomed the training, advice and consultation that PMHWs could provide, while others felt that they would prefer the PMHW simply to take on whatever mental health work needed to be completed, regardless of whether the case-holding YOT staff member could handle the work themselves with assistance from the PMHW. Staff were generally very approving of those cases where PMHWs took on full case responsibility and completed extensive pieces of work:

> Recently, I was involved in the case of a young person on remand. I was concerned about his mental state, but [the PMHW] took on the case 'lock, stock and barrel'. He provided the necessary assessment and management. He arranged the necessary referrals to get reports from a psychiatrist and a psychologist. I had not reached the stage where I was able to access that, but [the PMHW] felt it was appropriate for him to take on the case and then fed back to me. (Group 1, participant 1)

Satisfaction with clinical interventions provided by PMHWs was quite consistent, and some YOT professionals commented on how much overlap existed between the priorities of the PMHWs and those of YOTs.

However, there was a tension in attitudes towards consultation, with YOT professionals appearing to both value and struggle with the consultative role of the PMHW. Particularly well received was the role that PMHWs played in improving YOT professionals' confidence in providing appropriate mental health interventions; for example, with the support of PMHWs, YOT professionals felt better able to apply the principles of cognitive, behavioural, psycho-dynamic and family therapies in their practice.

The consultation role was seen as a way of providing a speedy mental health intervention, where staff had to respond quickly to a problem within a restricted time frame. It also helped to avoid unnecessary referrals and duplication of work, by generic (case-holding) staff. However, some professionals also expressed a degree of ambivalence about the value of this aspect of the PMHW's work. This mainly related to their own time and skills constraints in undertaking interventions such as anger management, and their wish for clearer boundaries between mental health and casework:

> The PMHW informs the work we do. The assessment of family history and family tree helps us understand what is going on in the family that may be leading to offending. The PMHW helps us at various levels. As a result, we feel more confident in our work; service users are now more confident that we have the skills to help them. (Group 3 participant 2)

> We are not trained to be mental health workers. I would appreciate a clear distinction about when issues should be dealt with directly by a PMHW or other members of the psychiatric service. (Group 1, participant 2)

This ambivalence to the consultation role was expressed in numerous ways. For example, one staff member appeared to feel that there was little to be gained having someone else within the team to consult with, indicating that the PMHW added little to her existing professional skills:

> I think I had already learned the process with my previous experience over a period of time … I personally didn't find the training so useful to me, probably because I had been doing this secondment work for a while. I had practised the skills already. So, it did not add anything particularly new. (Group 1, participant 1)

A further reason for the resistance to the consultation role within YOTs was the pressure that many YOT professionals felt around bearing a heavy caseload. When PMHWs provide a consultation service to YOT professionals, encouraging them to provide appropriate mental health interventions for themselves, it can be perceived as increasing the burden on already stretched team members:

> So, there's two things: one is the expertise that that person brings; and secondly, what coming and joining a team, taking on a team role means. If one more person joins the team, that should be proportionately less duty for everybody. (Group 2, participant 2)

On the other hand, some staff expressed a perception that the 'expert' mental health worker might hold greater influence with clients, and that their intervention might in some way be more effective than a 'proxy' service offered by other YOT professionals:

> *Participant 2*: For example, I had a parent insisting for her child to be prescribed medication such as Ritalin [Methylphenidate for attention deficit-hyperactivity disorder]. She expected that the medication will solve all of the child's problems. I had doubts about this, but I was not sure how to advise the parents.
>
> *Participant 3*: Yes [the PMHW] then intervened. He worked with the mother, and the family improved as a whole. The advice about medication wouldn't be any good coming from me. We don't have the expertise to advise about the effects of medication. (Group 1)

For these reasons, there was both an embracing of, and a resistance to, the consultative component of the work of PMHWs. On the one hand, it was perceived as something which helped YOT professionals, by providing them with skills to work with young people with mental health difficulties and building their confidence in this aspect of their practice. On the other hand,

staff considered having to work with young people with mental health difficulties as burdensome, creating added and unwanted responsibilities.

The future

The YOT staff identified operational and resource issues as priorities for the future. They would welcome guidelines from the Youth Justice Board to clarify definitions of YOT professionals' roles and standardise YOT models across the UK, including their mental health support, and welcomed the extension of PMHW posts and the protection of their mental health remit:

> On the other hand, we have to be careful not to overload the PMHW. We need to maintain realistic expectations of what they can achieve. (Group 3, participant 2)

However, they also commented on the need for clearer definitions and further development of the role of PMHWs within YOTs, particularly in relation to direct group work interventions and their consultative role within YOTs, where priority topics were group therapy (cognitive-behavioural, social skills training) and mental health promotion:

> I think part of that could be promoting health, particularly mental health. I think that is something that the PMHW should be addressing – but with just one PMHW, I know they don't really have the time. (Group 4, participant 2)

Finally, they were aware that the YOTs and the mental health workers involved will need to consider long-term plans for young people after they have moved on from their care, particularly if they are over 18 years of age.

Conclusions

The YOTs provide an interagency community service that includes assessment, intervention and preventative services for young people with complex and severe mental health, social and educational needs (Corrado *et al*. 2000, Curtis 2001). The integrated mental health model described in the present paper consists of primary mental health workers operating on the interface of the YOTs and specialist CAMHSs. This paper reports on the characteristics, strengths and constraints of such work from the perspective of multi-professional YOT members within the first year of their operation.

The findings of the present study indicate that there may be several advantages of such an interagency service response. The YOT workers perceived that the presence of PMHWs within YOTs improves their access to CAMHSs, through consultation, referral and direct therapeutic interventions. They felt that this ensured a more responsive service for YOT staff and young people, providing a rapid service, and fast-tracking referrals if necessary, to specialist mental health professionals such as psychiatrists and psychologists. Furthermore, the focus group participants suggested that the PMHW provided a more acceptable and engaging mental health service for young people because of their location within the interagency teams rather than a mental health setting. In that respect, they can co-work with other professionals and relate the mental health interventions to offending work or educational placements.

Most components of the mental health role were well received by participants, particularly the response, accessibility, and ability to provide mental health assessment and treatment. Other aspects generated some less positive views. In particular, participants described tensions around interagency working and role definition, especially in the initial stages of implementation. This illustrates the need for a consistent working through of the team relationships and role definitions of all professionals based within the interagency setting. There were also mixed reactions to the consultative and training role of mental health staff. This may be because of the association of consultation with unequal or hierarchical relationships rather than genuine partnership between agencies, and with the tradition of separation between mental health and social interventions (although it is recognised that this is often inappropriate for dealing with the needs of young offenders) (Farrington 1996, Bullock & Little 1999).

The design and method of the present study had several limitations. For example, it did not access young people's accounts of their experiences, nor did it examine the outcomes of mental health and offending behaviours. These are important targets of the Youth Justice Board and will be increasingly evaluated by further research as the YOTs evolve. However, this study has provided a much needed and timely insight into the philosophy and working patterns of the YOTs focusing on the integrated mental health service component, as well as indicating some of the potential tensions. Nevertheless, the provision of mental health support by PMHWs and their role within the teams was generally well received by YOT members. This model of mental health provision may have much to offer to other groups, particularly vulnerable and socially excluded young people and families, such as the homeless or those looked after by local authorities (Department of Health 1997, Tischler *et al*. 2002).

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