Transforming Youth Custody
Putting education at the heart of detention

The UK ADHD partnership (UKAP) has provided this response to the consultation on Transforming Youth Custody.

We believe that we have a unique and important contribution to make to this consultation due to the robust scientific evidence reporting high rates of ADHD in offenders.

UKAP was established in January 2013 by a group of healthcare and educational professionals who share an interest in improving outcomes and securing better futures for children and young people affected by Attention Deficit Hyperactivity Disorder (ADHD), together with their carers and families. The Partnership brings together practitioners with a wealth of experience from a range of services who are committed to raising awareness and understanding about ADHD and fostering positive outcomes. UKAP recognises ADHD as a complex but treatable condition which can have a profound impact on individuals, families and society as a whole. ADHD is a condition that crosses all cultural and socio-economic boundaries and UKAP is committed to reaching this multi-cultural and diverse population.

UKAP sees the timely identification and treatment of ADHD and other frequently comorbid neurodevelopmental and medical conditions as a vital precursor for improving the outcomes of young offenders. ADHD is now thought to be prevalent in 25% of the prison population. Treating the condition through evidence based interventions, both psychopharmacological and psychological, can have a profound impact on the young person's ability to learn. Combined with increased awareness and management skills in the workforce, a new opportunity exists to reduce reoffending, improve educational and personal outcomes and encourage better social environments within the custodial system and the wider community.

Consultation questions

(a) How should we best engage young people in custody (both sentenced and remanded) in education and training? What evidence is there of different approaches that work well?

Effective engagement cannot take place until young people have been appropriately assessed and their needs identified. This would mean that a trained and skilled workforce, able to ensure that individual young people's needs are accounted for in their education plans, is at the forefront of any change.

Given the high proportion of young offenders who have;

1. Neuro-developmental disorders such as Attention Deficit Hyperactivity Disorder (ADHD – national prevalence of c. 5%) and Autism Spectrum Disorder (ASD – national prevalence of circa 1%)
2. Mental health problems
3. Specific learning difficulties
4. Adverse early lifetime experiences
5. Parents with mental health problems

6. All of the above

It is important to develop a comprehensive assessment framework to construct accurate profiles as recommended in the recent National Institute of Clinical Excellence (NICE) Guidelines on Conduct Disorder. Such profiling will inform the development of appropriate plans which should address specific developmental as well as training and 'educational' needs. The significant likelihood of comorbidity of these conditions must be recognised and understood as the combination of diagnosis often results in highly complex young people.

In order to ensure that the best outcomes are attained, the needs of an individual must be considered. For example, interventions for a young person with autism will differ from those for a young person with ADHD and again for a young person diagnosed with both conditions together with other phobias or learning difficulties. The prevalence of multiple co-existing conditions cannot be overstated, and their impact on the young person's ability to learn and socialise, fundamental. ADHD, in particular, has high prevalence rates in young offenders (prison studies suggest rates of around 25%). Further, ADHD carries with it a biological lack of self-control, predicting greater levels of impulsivity and consequently, if undiagnosed, the increased likelihood of re-offending.

There are already highly effective evidence based psychopharmacological and psychological treatments available. The ability to positively engage with the education system and to sustain attention and perseverance can be greatly enhanced with appropriate interventions. Well targeted use of psychopharmacological treatments in a Swedish study has been shown to reduce the re-offending rate in ADHD sufferers by one third (Lichtenstein et al., 2012 [1]). In addition, an offending behaviour treatment programme (based on Cognitive Behavioural Therapy (CBT) R&R2 (Young & Ross, 2007) has been shown to significantly reduce anti-social attitudes and behaviour. Details can be found on http://www.cognitivecentre.ca/.

'Education' should be viewed not only in terms of academic attainment and skills acquisition, but as a means by which developmental needs can be addressed. Reduction of antisocial/violent attitudes and beliefs and the formation of a strong sense of self, empathy, moral reasoning skills and an internal locus of control are learning imperatives.

Education and training will only be effective if appropriate treatment regimes are established. Thus it is crucial that strong collaborative relationships exist between custodial institutions and Child and Adolescent Mental Health Services.

(b) How would you segment the young people in custody to deliver education and training?

By screening and assessing for mental health, developmental and other disorders/learning difficulties and tailoring programmes to address young people's individual or small group needs. Age and sex must also play a part.

(c) How might the educational balance in Secure College's best be struck between basic skills (literacy, numeracy, etc.), traditional academic subjects, vocational learning and wider life skills such as self-respect and self-control, communication and teamwork?

Alongside the academic curriculum, specific programmes (such as R&R2 referred to above) that provide pro-social competence training (including critical thinking, social problem solving, moral reasoning and emotional control skills) need to be introduced.

Impact is likely to be highest in environments in which a consistency exists across different learning contexts. So work carried-out in the classroom should extend into the residential

environment via a common understanding of aims, and the careful use of specific instructional multidisciplinary 'scripts'. R&R2 achieves this through a 'two step' group and individual intervention model that supports youths to transfer skills acquired in a group treatment setting into their daily lives.

The development of 'literacy' is crucial because this underpins the capacity of each individual to organise their own behaviour and to follow a positive trajectory after leaving the service. Literacy skills can be developed in the classroom, but only to a limited extent and it is important that young people develop their understanding in a language-enriched environment.

This requires all adults, including those for whom the security of the institution is a paramount concern, to share a common approach in managing challenging young people. In other words, learning does not only take place in academic or training environments but across all custodial experiences and contexts.

We estimate that a notional one-third of available time should be spent on core academic skills. A further one-third should advocate social and personal development and address dysfunctional attitudes and behaviours. The final one third should be directed to recreational activity including sport.

(d) How can we best meet the needs of young people with learning disabilities, special educational needs or mental health needs, and how might Education, Health and Care Plans be used to ensure appropriate special educational provision is in place?

1. Effective assessment (both educational and clinical) that goes beyond screening of all young people in custody
2. The Education and Health Care Plan (EHCP) will ensure that this support will be in place until the age of 25 with a regular review of the care plan. A key worker across the disciplines will be in a position to respond to the changing needs of the young person and adapt the plan accordingly.
3. Prioritisation of individual/developmental goals and targets
4. Plans will be implemented throughout the secure setting and be seen as part of a life plan.
5. The construction of an appropriate educational curriculum that meets the specific academic and social needs of the young people
6. The provision of informed learning support
7. Effective teaching/learning mentors teaching in small groups
8. Tracking and reporting of progress, and effective feedback to young people
9. Increased use of Release on Temporary License (ROTL) with appropriate work experience and educational placements.
10. Specific offender behaviour programmes to address pro social development (see 'a')
11. Schemes, such as the Duke of Edinburgh Award being available whilst in the secure setting and continuing on release.

Meeting the wider needs of young people in custody

(e) How would young people best be kept safe and secure in your model of a Secure College?

It is clear that young people are unable to learn effectively when placed in a state where their arousal levels are heightened and when they are displaying signs of hyper-vigilance. As a consequence, not only must the curriculum be appropriate, but also the environment

conducive to learning. Fundamentally, relationships within the educational setting must be calm, positive and mutually respectful.

In addition, it is imperative that all staff work toward the same individual care plans.

(f) How should we best approach the particular challenges of a group of young people in custody (such as, the youngest, the most vulnerable, the most dangerous and most disruptive) and ensure their needs are met? Could this group be managed within your model of a Secure College?

Many young people who fall into this category will not have had the benefit of a mental health assessment. This is essential as, aside from their individual needs being unmet which in turn hampers their ability to engage meaningfully in their education and rehabilitation, they may present as a management problem within the custodial system. This has been seen as a particular problem for young offenders with ADHD – with studies reporting a strong association between ADHD symptoms and institutional aggression.

A simple and free screening tool (e.g. Goodman's Strengths and Difficulties Questionnaire) could be used with all young people on entry to the judicial system to ensure that those who display features that place them a risk of having an underlying disorder or mental health condition can be provided with an assessment of their needs.

Upon entry into the custodial centre, those who screen positively should be clinically assessed for an underlying health or neurodevelopmental disorder. This could be achieved through an EHCP assessment within each secure setting. A multi-disciplinary team could exist within the setting to develop and review systematically the EHCPs as proposed under the Children and Families Bill.

Any system would require high structure and motivational tools to support progress, for example, a token economy reward system.

Staff should assess young people on an on-going basis to ensure that changes in demeanour, mood and behaviour can be identified and then supported. This will require a level of understanding of child development and regular training in developmental disorders, learning difficulties and mental health.

(**g) What are the other key services you would deliver, or establish partnerships with, within a Secure College both to support the provision of high quality education to young people in custody and to prevent them from offending on release?**

- 'Normal' activities - balance of education, physical activity (sport) and leisure.
- Liaison with Mental Health Team
- Occupational training/resources / multimodal interventions
- Work placements/apprenticeships (in house and/or with local businesses for those in step-down facilities)
- Custodial - Community liaison to support move back to community
- Community Substance Misuse Team

(h) How can we best meet the needs of young people in custody who are looked after children or care leavers?

The model proposed would identify children.

(i) What skills, competencies and experience should staff have to successfully meet the needs of young people in custody? As a provider, how would you ensure that your workforce met these requirements?

1. Training in;
    a. Attention Deficit Hyperactivity Disorder
    b. Conduct Disorder
    c. Substance Misuse
    d. Management of physically Aggressive behaviour
    e. Oppositional Defiant Disorder
    f. Deliberate Self Harm and Suicidal behaviour
    g. Autistic Spectrum Disorder
    h. Anxiety
    i. Attachment Disorder
    j. Dyspraxia, Dyslexia and Dyscalcula
    k. Learning disabilities and Challenging Behaviour
2. Behaviour management and the stress response
3. Understanding resilience
4. Basic child development

Custodial, educational and social/health care staff should be trained and competent to work with young people of all levels of learning ability, cognitive capacity, emotional maturity and social development. They should be well versed in the neurodevelopment conditions described. Their interaction with the young person is important to reinforce the education process and pivotal in supporting their developing social skills.

Closing the gap between custody and community

(j) How would your model of a Secure College support young people leaving custody to get placements in education, training or employment on release and support them to maintain this engagement?

The model could build in the development of contacts and mentoring in the community whilst the young person is still in custody. If there is an underlying need, the EHCP would detail on-going support and track success. A transition package could support this process.

For those with long term custodial sentences, as the young person moves through the staged custodial process, it would be important to shift from an academic performance to a skills focused training/work experience model. Furthermore, it would be important to introduce 'critical time interventions' to secure a constructive and supportive pathway between services for offenders and maximise community engagement.

(k) More broadly, how would your model of a Secure College support greater co-operation between or integration of custodial and community services?
Approved teachers, careers advisers and SEN learning support policies could be shared as good practice.

27 Transforming Youth Custody

(l)
What scope is there for education provision in a Secure College to be continued when a young person is released from custody, and does the current legislative and policy framework provide sufficient flexibility?

Follow up training in a community college and a mentor could be detailed in the transition package.

(m) How long is required to achieve tangible progress with groups of young people in custody, and between custody and community?

What can be achieved will be limited by short term custodial sentences; a minimum is 6 – 12 months. Longer term sentences provide the opportunity for realistic tangible progress, e.g. over a two-year period as the model at HMP ISIS.

(n) What incentives or accountabilities could be put in place to promote custodial and community services to work effectively in partnership before, during and after a young person is in custody, with the aim of securing improved longer-term outcomes?

The terms of the EHCP will place an obligation on schools/colleges for those young people identified and assessed as having additional needs. It will be important to follow-up educational, occupation and health outcomes. It will be essential to assess the effectiveness of the newly proposed model and to determine the impact this has on short and long term health and social outcomes. A health economic evaluation and analysis will be important to include as this will provide the economic argument for sustaining the model if a reduction in service related costs can be demonstrated. For the institutions, the payment by results model will motivate service integrity.

(**o) How can we design our approach to ensure that the widest range of providers with relevant experience can participate?**

The physical environment and meeting demand

(**p) How many young people should be held in an individual Secure College?**

The total number is less significant than the way that the organisation is structured and staffing teams organised. As with mainstream schools, small functional units can be created within large settings but the key is in establishing and sustaining effective professional relationships and a positive ethos.

(**q) Where should Secure Colleges be located, and how might a network of such establishments that served England and Wales be configured? How would you manage the impact this might have on family and community links?**

We propose a two-step model. Each secure setting could have its own educational unit where assessments and plans are developed. Should students show a particular aptitude for further study they could be offered a place at a secure college to develop more advanced skills and qualifications ahead of release into the community.

We would suggest a local configuration with direction from and accountability to a central regional steering group. The central steering group should commission multi-agency guidance, e.g. youth justice, health, education and occupational services.

(r) What physical environment might be required? How and to what extent could such a model be implemented within the existing youth secure estate?

There is strong evidence to suggest that the behaviour of young people with mental health/developmental disorders difficulties can be improved when they learn how to access

the benefits of an outdoor lifestyle. Active training weekends could be developed alongside the secure colleges to encourage this.

For those young people with ADHD, ASD or with anxiety disorders, maintaining a structured environment with low levels of unpredictability, sensory challenge and social complexity, may reduce the incidence of challenging behaviour and improve their capacity to learn.

(s) What are the key ways in which the costs of youth custodial provision can be driven down, recognising the constraints on public finances and the need to make significant savings?

The accurate and thorough assessment of young offenders on entry into custody would highlight underlying mental health needs and neurodevelopmental disorders. Managing these conditions through evidence based treatment would reduce the cost of management and improve outcomes.

(t) If you have a proposed model, what is your estimate of how much it might cost to (i) set up and prepare for opening, and (ii) operate?

(u) If the physical environment envisaged by your proposed model could not be delivered within the existing youth secure estate, what would be the estimated cost of securing new facilities and how might this be funded?

A focus on outcomes

(v)How can tangible educational progress for different segments of the young people in custody best be measured, including by qualifications?

'Educational progress' should be assessed not only in terms of academic attainment and employability, but with respect to health, wellbeing and resilience. In other words, academic success may be of little long-term benefit unless young people emerging from custodial services are equipped for life rather than solely for further learning or employment.

Numerous instruments exist to measure health and wellbeing e.g. The Development and Wellbeing Assessment (DAWBA) for details see -http://www.dawba.info/).

(w) How might a payment by results or incentive approach apply to a Secure College, and what outcomes should it focus on?

Longitudinal studies suggest that some benefits of effective intervention may only become apparent in the medium to long term.

Equality and diversity

(x) What are the likely impacts of our proposals on groups with protected characteristics? Please let us have any examples, case studies, research or other types of evidence to support your views.

(y) Do you have any further comments on our proposals in this document for transforming youth custody?

28

References

1) Lichtenstein, P., Halldner, L., Zetterqvist, J., Sjölander, A., Serlachius, E., Fazel, S., Långström, N., & Larsson, H. (2012). Medication for Attention Deficit–Hyperactivity Disorder and Criminality. New England Journal of Medicine, 367(21), 2006-2014.

Contact UKAP : info@ukadhd.com