WARWICKSHIRE YOUTH JUSTICE

HEALTH AND WELLBEING NEEDS and ASSETS ASSESSMENT

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SECTION ONE – INTRODUCTION

1.1 Purpose of the HWBNAA

This Health and Wellbeing Needs and Assets Assessment (HWBNAA) has been undertaken at the request of Warwickshire's Youth Justice Chief Officers Board, who have responsibility for the effective operation of the statutory Youth Offending Team (in Warwickshire this is team is called the Warwickshire Youth Justice Service). The assessment will also contribute to Warwickshire's Joint Strategic Needs Assessment (JSNA) and as such the findings will be reported to both the Chief Officer's Board and the JSNA Steering Group.

Responsibility for providing health services for those in contact with Youth Justice Services is split between Clinical Commissioning Groups (CCGs) and NHS England (NHSE) – with CCGs being responsible for meeting the needs of young people in the community and NHSE responsible for service provision in secure settings (ie. Youth Offending Institutions, Secure Training Centres and Secure Children's Homes). In addition to this the Police are responsible for commissioning health care for young people in custody.

The vast majority of young people who offend are maintained in community settings, but good co-ordination of care between settings is important for the highly vulnerable individuals who are managed in secure settings. The health needs of young people referred to Warwickshire's Youth Justice Service (WYJS) are met in large part through a health service currently commissioned from Coventry and Warwickshire Partnership Trust (CWPT). This service needs to be re-commissioned and this HWBNAA will provide information to inform the revised service specification.
It is anticipated that the findings will also inform the wider commissioning decisions of CCGs, Warwickshire County Council, NHSE and the office of the Police and Crime Commissioner (PCC). There are expected to be inter-dependencies between this HWBNAA and the current Child and Adolescent Mental Health Service (CAMHS) review and Local Transformation Plan, other children's services plans, as well as plans relating to substance misuse and other risky behaviours among young people. There are also potential links to be made relating to the Special Education Needs and Disability (SEND) reforms as many of the children and young people seen in youth justice services have either been identified as meeting SEND criteria or are identified as having such needs after their referral to youth justice services. In addition, the WYJS is closely aligned with the Priority Families Programme and as such recommendations could inform the scope of further prevention work.

1.2 Defining 'Health' and 'Wellbeing' 'Needs' and 'Assets'

In this document, health refers to both physical and mental health, and to the impact of substance misuse and other lifestyle behaviours, although on occasion each aspect is considered separately.

There is a strong focus on wellbeing. For vulnerable children and young people, including those in contact with the youth justice system, wellbeing is about strengthening the protective factors in their life and improving their resilience to the risk factors and setbacks that feature so largely and are likely to have a continuing adverse impact on their long-term development. Well-being is also about children feeling secure about their personal identity and culture.

Health needs are those needs that can benefit from health care or from wider social and environmental changes (1).

Health assets are the capacities, skills or resources available to individuals or communities that, if mobilised, could enable people to gain more control over their lives and circumstances. Individual assets include resilience, commitment to learning, self-esteem and sense of purpose (2).

1.3 Objectives of the HWBNAA

The scope of this HWBNAA is children and young people resident in Warwickshire who have been in contact with the WYJS (ie age 10 to 17 years). The specific objectives include:

- To quantify the identified health and well-being needs and assets of children and young people accessing the WYJS
- Where relevant, to compare the identified needs of this cohort to young people in Warwickshire who are not in contact with the WYJS and to national profiles of the needs of those who are
- Outline existing models and processes for assessing health needs, and for providing support and interventions to meet these needs
- Assess the quality of existing services and the outcomes achieved
- Evaluate existing models of provision against best practice recommendations
- Identify staff training needs
- Make recommendations to inform the revised specification for the health contribution to the WYJS.

1.4 Key Components of the HWBNAA

Key aspects of the HWBNAA are described below and include:

- Analysis of available data quantifying the health needs of children and young people in contact with the WYJS, comparing this to national findings
- Views on health and health services from the perspective of children and young people in contact with the WYJS
- Views of the parents of children and young people referred to the WYJS
- Views of the WYJS staff delivering services to the children and young people referred to the service
- Views of partner agencies on their perceptions of the health needs of children and young people in contact with the service and the extent to which these are met

In addition to the above, a review of the evidence for different models of health provision to meet the needs of children and young people in contact with Youth

Justice Services is included. Collectively these elements of the HWBNAA have informed the recommendations made by the HWBNAA Steering Group (see membership in Appendix 1).

1.5 Background

Children and young people in contact with the youth justice system have more – and more severe – health and well-being needs than other children of their age. They have often missed out on early attention to these needs. They frequently face a range of other, often entrenched, difficulties, including school exclusion, fragmented family relationships, bereavement, unstable living conditions, and poor or harmful parenting that might be linked to parental poverty, substance misuse and mental health problems (3); (4). There is also a growing consensus and evidence that whilst the volume of young people in contact with Youth Justice Services has decreased over recent years, those that do remain are thought to have more complex, challenging problems requiring more highly skilled and dedicated support (5).

There is a growing body of research identifying the impact of Adverse Childhood Experiences (ACEs) on later life health and wellbeing (6). ACEs include child maltreatment such as verbal, physical or sexual abuse, and factors associated with parental health and wellbeing such as parental separation, domestic violence, mental illness, substance misuse or incarceration. Children who experience 4 or more ACEs are more likely to drink, smoke, have underage sex and are 11 times more likely to be incarcerated as an adult. However, a recent report has pointed out that those with ACEs who exhibit social, emotional or cognitive problems are often misunderstood and are re-traumatised by services (7).

Many of the children and young people in contact with youth justice services in Warwickshire will have experienced ACEs. They are also more likely to be known to children's social care and be among those children and young people who are not in education, employment or training (NEET). If there is due attention to the health needs of this vulnerable group, this should help reduce health inequalities and reduce the risk of re-offending by young people.

SECTION TWO – THE NATIONAL AND LOCAL YOUTH JUSTICE CONTEXT

2.1 Main Policy Drivers for Health-related Youth Justice Work

Youth Offending Teams (YOTs) were established in 1998 under the Crime and Disorder Act and they are overseen by the Youth Justice Board (YJB) at a national level. YOTs embed partnership working through operational and strategic structures in order to reduce and prevent offending behaviours. The initial statutory partners required to contribute to YOTs were Local Authority (education and children's social care), Health, Police and Probation. In addition, elected Police and Crime Commissioners (PCCs) have a duty to co-operate with local authorities and health services to improve outcomes in relation to youth justice, health and safeguarding (8) YOTs provide a mixture of care, supervision and rehabilitation for young offenders.

Since the inception of YOTs there has been a focus on improving the health and wellbeing of young offenders. Initially the emphasis was on identifying issues such as mental illness and substance misuse which are associated with re-offending behaviours, but over more recent years it has been recognised that contact with Youth Justice Services presents the first opportunity many affected young people have had to have chronic health needs identified. Improving the health of young offenders thus presents an opportunity to reduce health inequalities through the provision of targeted interventions.

The main related policy drivers include:

- The Children and Families Act Act (2014)
- The Care Act (2014)
- Healthy children, safer communities (2009)
- Healthy Child Programme 0-19 (2009)
- Working together to safeguard children (2010)
- Public Health and NHS outcomes frameworks (2012)
- CAMHS Transformation based on 'Future in Mind'
- Fair Society, Healthy Lives (the Marmot Review)
- National Troubled Families Programme

Healthy Children, Safer Communities (HM Government, 2009) is a strategy to promote the health and well-being of children and young people in contact with the youth justice service. The strategy recommends that efforts be made to "*improve provision of primary and specialist healthcare services to children and young people who offend, to ensure that courts and bodies who deliver sentences receive accurate information about health and well-being needs and the services to meet them, to promote health and well-being in the secure estate, and to achieve continuity of care when children complete a sentence*".

2.2 The Youth Justice System

The formal youth justice system begins once a child or young person aged 10 or over (and under the age of 18) has committed an offence and receives an out of court disposal or is charged to appear in court.

However, some children and young people will be in contact with the police or with youth justice services even though they are not in the formal CJS. This is because:

- Children younger than 10 might have been identified as at risk of offending and be receiving preventive or early help services.
- Children and young people aged 10 or over might be involved with the police or the WYJS because of anti-social behaviour or because they have committed an offence that can be dealt with by the police without the need for referral to the courts.

This assessment focusses predominantly on the children and young people who have committed an offence (ie statutory or formal young offenders) but some information is included, as specified in the report, about those in receipt of preventative support, as this cohort of young people is growing and has a significant impact on capacity within the WYJS.

2.3 The Warwickshire Youth Justice Service (WYJS)

The purpose of WYJS is to prevent young people from offending and reoffending, to assist those in the CJS to make an accurate assessment of any young person who has committed an offence, and to offer high quality interventions in order to reduce crime and to protect victims.

WYJS is made up of staff from various agencies, including Warwickshire County Council, Warwickshire Police and the National Probation Service, who are working together with young people, parents and families to prevent crime and anti-social behaviour and to reduce re-offending. It is a county-wide service, with offices based in the two Justice Centre's in Warwickshire (Leamington and Nuneaton) plus a delivery centre operating in Rugby. The service employs 55 staff, working across a number of disciplines and includes practitioners, managers and support staff. In addition, the service employs 20 sessional workers, 12 panel member volunteers and 8 parenting volunteers.

The multi-agency composition of YOTs is central to the effectiveness of work to reduce offending and to protect communities and the young people themselves, many of whom have also been victims of crime. WYJS' structure supports this further with practitioners sharing the management of young people and families whilst maintaining their professional disciplines, enabling young people to be supported with a comprehensive package of care which focuses on areas of need, whilst enforcing the order of the court. The service uses a restorative approach to justice with victims and perpetrators, increasing the likelihood of improvements being sustained when the young offender completes their order.

The case managers in the service have shard responsibilities in relation to case management (apart from the Health workers and Educational Psychologists), in addition to the delivery of specialist interventions associated with their professional discipline. The service operates a number of specialist work-streams which include staff managing Tier 1& 2 substance misuse clients, specialist Restorative Justice workers that can facilitate complex and sensitive conferences, 'Assessment in Moving' on (AIM) trained sexually harmful behaviour workers, accommodation support workers and staff skilled in a number of group work activities including parenting and specific offending behaviour programmes. All staff are trained in motivational interviewing techniques.

WYJS currently employs three part-time Educational Psychologists (EPs) that equate to one full time post, funded by the YJB. The EPs have supported the service in piloting the use of the Comprehensive Health Assessment Tool (CHAT), which is described below. The EPs central role involves consultation advice to WYJS practitioners around cases and individual psychological assessment of the young person's needs, where psychological formulation, outcomes, provision and specific

intervention is recommended. The EPs also have a role in supporting the young people in their resettlement from custody and are also involved in assessing all clients transitioning from the WYJS to probation services and supporting formulation of the young person's needs for probation services.. Furthermore, they support vulnerable learners in accessing their educational entitlement and facilitating communication with mainstream, specialist and alternative education provisions. They provide a vital link with the Special Educational Needs and Disability Assessment and Review (SENDAR) team, Pupils Missing in Education, the Ill health team, Right Step Careers, Social Care, the Area Education Partnerships, Attendance, Compliance and Enforcement Service and health, especially regarding speech and language.

2.4 Police Custody Suite Provision

Police custody suites are designated areas in police stations for the processing and, if necessary, detention, of a person who has been arrested. They usually consist of cells or rooms for detention, a room for custody officers to process those who have been detained, interview rooms, and a medical room for the use of clinicians providing health services to the custody suite.

The health service available to those in custody is commissioned by the Police and essentially consists of a GP assessment which is arranged as necessary. There is currently no court Liaison and Diversion service available, as is the case in some other parts of the country but on an informal basis the WYJS will provide support to a young person in need of assessment if this is requested by the Police. A welfare check is conducted and early identification of health related issues can be identified. This acts as a form of triage identifying any needs early on and ensuring that those that can be diverted from custody are identified at the earliest opportunity.

2.5 Assessment of Young Offenders in Community

The Youth Justice Board (YJB) recommends the tools to be used in assessing the holistic needs of young people referred to YOTs. For the period up to April 2015 the WYJS used the Asset screening tool which was designed specifically to assess risk in relation to offending and to measure progress in preventing re-offending. Whilst the tool includes sections on physical, emotional and mental health, and substance misuse, the focus is on the extent to which these health needs are associated with the likelihood of further offending. As a result, evidence shows that physical health problems are often overlooked and the extent of mental health problems underestimated (9); (3).

Thus, as recommended by the YJB, the WYJS has now introduced the AssetPlus screening tool. AssetPlus is designed to provide a holistic end-to-end assessment and intervention plan, allowing one record to follow a child or young person throughout their time in the youth justice system. It focuses on the professional judgement of practitioners and is intended to enable better-focused intervention plans to improve outcomes for children and young people.

In addition to the above, following a review of all of the assessment tools used in youth justice settings the YJB have most recently recommended the use of the

CHAT and as a consequence its use was piloted through this review process as described below.

2.6 Assessing and Meeting Health Needs in Institutional Settings

This review does not include details of the health needs of the small number of young people from Warwickshire who are detained in secure settings (although the numbers are detailed in section 3.12 below). These young people remain the responsibility of WYJS throughout their detention and WYJS is responsible for the young person's sentence plan. There is as a result liaison between the WYJS health team and the respective health service operating in secure institutions to ensure the health needs of this particularly vulnerable group of young people are met, particularly through transition between settings. This is in line with the recommendations made in the Royal Colleges of Pediatrics and Child Health standards for the 'Healthcare of Children and Young People in Secure Settings' (2013) (10) which emphasizes safeguarding, comprehensive assessment of young people on release, and ensuring that there is continuity of care on release, with planning for ongoing assessment and treatment when back in the community forming an important part of healthcare plans and referrals.

SECTION THREE – NUMBER AND SOCIO-DEMOGRAPHIC CHARATERISTICS OF WYJS CLIENTS

3.1 Prevention Activity

Whilst the WYJS is essentially focused on young people formally in the CJS, over recent years the service has invested savings from the reduction in the statutory cohort into increased youth crime prevention. The preventive cases are referred by schools, the Family Intervention Service and the MASH amongst others and anecdotally they are now presenting with very significant health and social care needs. A WYJS caseworker is located in the MASH to help identify appropriate referrals to the service. However, the impact that these referrals, which are shown in Table 1, are having on the overall workload of the service and for the WYJS health and substance misuse services requires more detailed assessment (ie it was outside the scope of this HWBNAA as at the outset of the process the preventive referrals were relatively small in number). Table 1 shows the substantial growth in preventive referrals during 2015/16.

Table 1. Preventive Referrals to WYJS 2015/16

2015/16 Quarter	No. of referrals	Forecast annual total
April to June	4	16
July to September	7	22
Oct to Dec	38	65
Jan to March	22	71

If the preventive referral rates seen over the last six months are sustained the WYJS will be under significant pressure, as this growth in activity, previously funded by savings, now coincides with budget reductions.

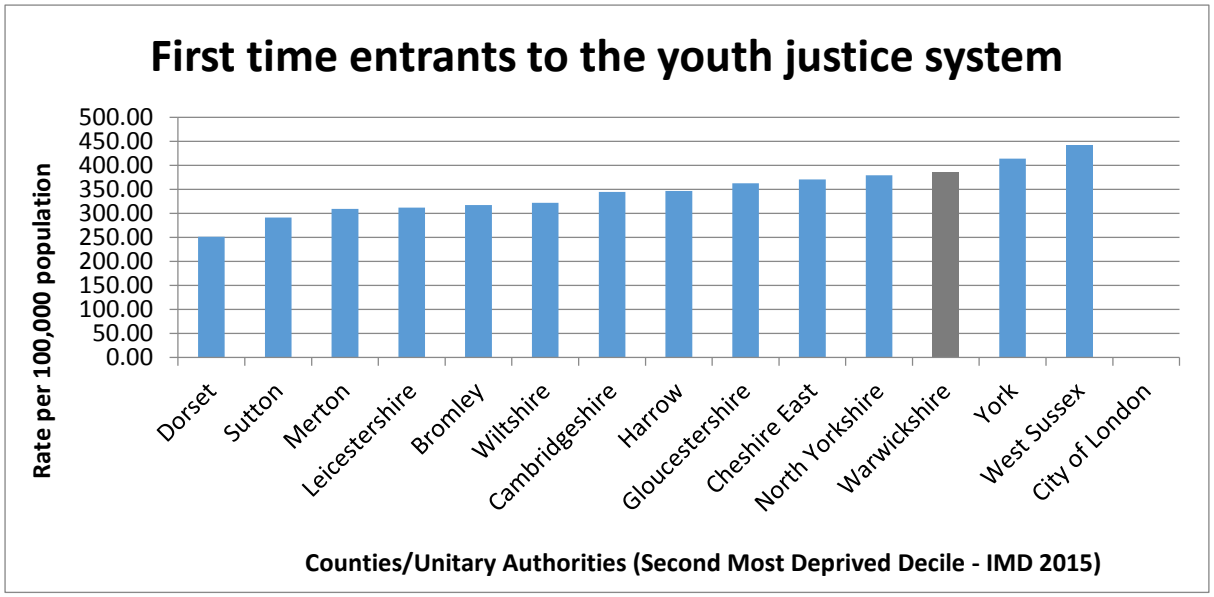
3.2 First Time Entrants to the WYJS

The First Time Entrants (FTEs) statistic is based on data recorded on the Police National Computer (PNC) and includes 10 to 17 year olds. The data relates to proven offences only, where a young person is given a formal out of court or court disposal. As such this is not a measure of the amount of crime committed by young people, as only a proportion of crimes are detected and resolved. An offence is defined as a first offence if it results in the person receiving their first youth caution or court conviction – i.e. they have no previous criminal history recorded on the PNC.

YJB statistics for 2014/15 show that the number of FTEs to youth justice services has fallen by 75% since 2003/04 (11). However, it is recognised that those who remain in the system tend to have far greater, more complex needs and higher rates of reoffending.

The data in Figure 1a shows the rate of FTEs for Warwickshire alongside that of a socio-demographically similar group of local authorities (ie. the group used for the comparison of Public Health statistics). The FTE values for the group range from 250.85 per 100,000 10 to 17 year olds in Dorset to 441.42 in West Sussex. Warwickshire can be seen to be towards the upper end of the distribution with a rate of 385.72 FTEs per 100,000 (12).

Figure 1a. First Time Entrants to the WYJS; Warwickshire and Like Authorities



From a youth justice perspective the comparison of statistics is undertaken on the basis of a 'YOT family'; a group of 'like authorities' that accounts for socio-demographic differences and for differences in the respective police forces that serve the population. WYJS sits in a 'YOT family' alongside Gloucestershire, Bedfordshire, Cheshire East, Northamptonshire, West Mercia, Nottinghamshire, Leicestershire, East Sussex and Norfolk.

Figure 1b shows the FTEs for WYJS in comparison to those for the 'YOT family' and in comparison with the West Midlands and the national FTE rate. It can be seen that for 2015 the WYJS rate of 315 per 100,000 is lower than all of the comparator groups.

Figure 1b WYJS FTEs in Comparison to 'YOT Family', West Midlands and National Rate

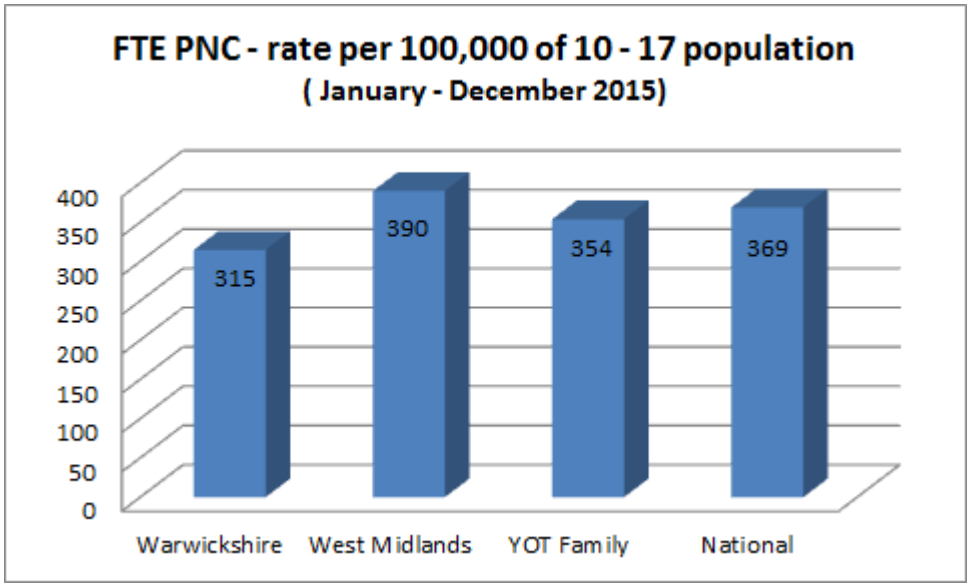
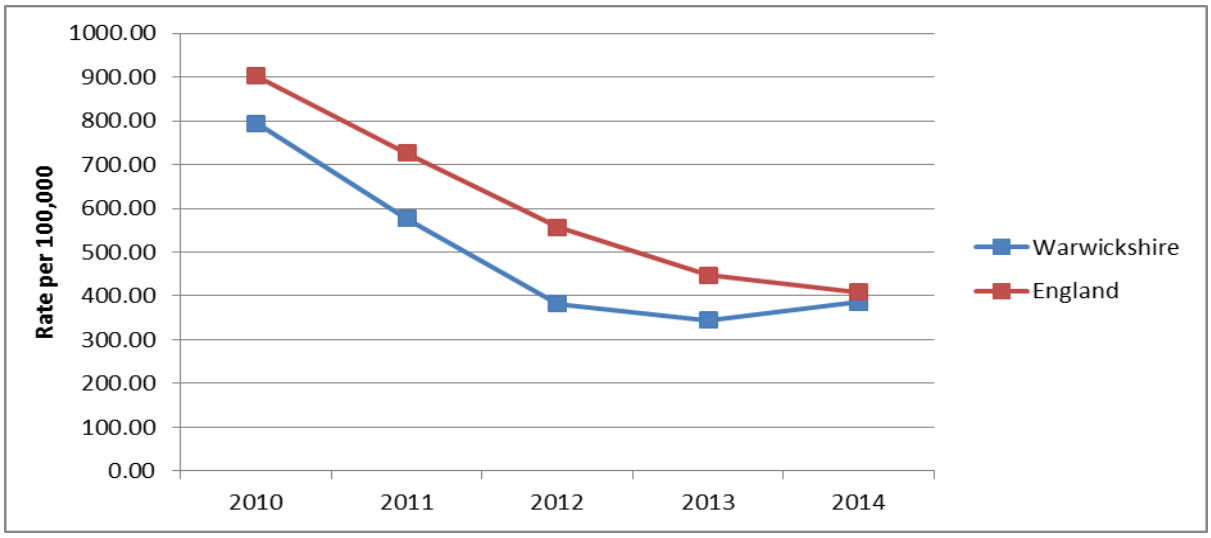


Figure 2 shows the trend in FTEs for the years 2010 to 2014 for Warwickshire and for England. The England rate was 902 FTEs per 100,000 10 to 17 year olds in 2010, whilst the Warwickshire rate was substantially lower at 794 (a statistically significant difference). However, in 2014 whilst both rates are lower, the Warwickshire rate can be seen to have decreased less, such that the 2014 rate of 409 FTEs for England and 386 FTEs for Warwickshire are statistically similar.

Figure 2. Trend in FTEs 2010 to 2014 for Warwickshire and England



Following the inception of YOTs, Warwickshire like all YOTs experienced a substantial increase in FTEs as a result of police performance targets for increasing the number of 'offences brought to justice' and sanction detection rates; this reached a peak in 2006. As a result of influence brought by WYJS to the Police and the Local Criminal Justice Board a change in Warwickshire policing policy was implemented which saw young people who were being inappropriately criminalised no longer receiving criminal convictions. WYJS was successful in influencing this national driver and this was demonstrated in an earlier reduction of FTEs than experienced in other YOTs. This change in policing has been adopted over a number of years in other Police Force Areas, resulting in reductions in FTEs for other YOTs which has now started to 'keep pace' with WYJS.

Spending on youth justice services is also reported as a rate per 10,000 10 to 17 year olds, as shown in Table 2.

Table 2. Spend (£000s) on Youth Justice: Rate per 10,000 10 to 17-year population

	2012/13 Rate	2013/14 Rate	2014/15 rate
Warwickshire	293.28	215	210
England	281.18	286	262

It can be seen that in 2012/13 Warwickshire reported a higher spend per head of population at £293.28 than England at £281.18. However, by 2014/15, the Warwickshire spend on youth justice services had decreased more than the England rate, giving Warwickshire a spend of £210 per 10 to 17 year olds compared to England's rate of £262 (12).

3.3 Number and Characteristics of Children and Young People Referred to the WYJS

The findings described here relate to children and young people formally referred to the WYJS through the courts (ie statutory or formal clients) over the period 2012/13 through to 2014/15. The source of the information is predominantly the information captured through the routine screening and assessment processes undertaken by the WYJS case workers, through use of the Asset and AssetPlus tools.

Table 3. Rate of Young Offenders (per 1,000 10 to 17 year olds) accessing WYJS by Populations (SWCCG, WNCCG and Rugby)

		2012/13		2013/14		2014/15	
	10 to 17 year population	Number of offenders	Rate	Number of offenders	Rate	Number of offenders	Rate
Warwickshire	48,989	337	6.9	296	6	268	5.5
South Warwickshire CCG	22,100	92	4.2	61	2.8	56	2.5
Warwickshire North CCG	16,961	181	10.7	174	10.2	149	8.8
Rugby	9,928	64	6.5	61	6.1	63	6.3

Table 3 shows the number of statutory referrals to the WYJS over the years 2012/13 to 2014/15 relative to the 10 to 17 year old population. Access rates per 1,000 10 to 17 year olds are shown for Warwickshire, South Warwickshire CCG, Warwickshire North CCG and Rugby.

It can be seen that the overall rate of young offenders has decreased across Warwickshire from 6.9 to 5.5. Each year the rate can be seen to be consistently higher for the WNCCG population than for Warwickshire and the other sub-populations. SWCCG can be seen to have the lowest rate of offenders each year. While there has been a decrease in access for all of the populations over the 3-year period, the Rugby rate has decreased very little.

Table 4 provides a summary of the number of referrals (FTEs and re-offenders) over the years 2012/13 to 2014/15, together with some key socio-demographic characteristics.

Table 4

Number and Characteristics of Children and Young People Referred to the WYJS 2012/13 to 2014/15

Year	2012/13	2013/14	2014/15
Number of referrals	337	296	268
% Males	82%	81%	82%
Number aged <12(%)	10 (3%)	5 (2%)	0 (0%)
Number aged 12-15 years (%)	139 (41%)	120 (40%)	133 (50%)
Number aged >16 years(%)	188 (56%)	171 (58%)	135 (50%)
% white	92%	91%	94%
Current LAC	17 (5%)	18 (6%)	30 (11%)
Previous LAC	32 (9%)	32 (11%)	32 (12%)
Current Referral to Children Social Care	49 (14%)	46 (15%)	58 (22%)
Previous Referral to Children Social Care	74 (22%)	78 (26%)	88 (33%)

Suffered Bereavement or loss	47 (14%)	75 (23%)	80 (30%)
Homeless	11 (3%)	11 (4%)	12 (4%)
Bullied	24 (7%)	29 (10%)	30 (11%)
Excluded pupil	26 (8%)	28 (9%)	32 (12%)
NEET	28%	32%	27%
Referral to WYJS Health Team	94 (28%)	79 (27%)	97 (36%)
Smokes	169 (50%)	158 (53%)	154 (57%)
Substance Misuse	153 (45%)	135 (46%)	136 (51%)
Alcohol	158 (47%)	146 (49%)	145 (54%)
Referred to in-house substance misuse	56 (17%)	80 (27%)	86 (32%)
% Referred to Compass	21 (6%)	22 (7%)	21 (8%)

It can be seen that the total number of statutory referrals to the WYJS have decreased over the 3-year period 2012/13 through to 2014/15. In 2014/15 there were 69 fewer referrals a decrease of 20% from the 2012/13 level. Falling numbers entering youth justice services have in part been the result of an increasing use of alternative strategies by the police, such as 'community resolutions' (a sanction received directly from a police officer) or 'on street disposals' (such as issuing a caution) rather than being referred to the YOT or through the court system. However, the preventive work of YOTs and other agencies will also have had some impact as will YOT successes in reducing re-offending..

3.4 Age and gender

Table 4 shows the age and gender of the referrals each year. It can be seen that between 81% and 82% of the annual cohort are males. This mirrors the national picture with YJB statistics for 2014/15 showing 82% of national referrals as male (11).

It can be seen that each year there are none or very few referrals aged 12 years or under. The cohort aged between 12 to 15 years make up 40% to 50% of the total each year and those aged 16 or over constitute between 50% and 58% of the annual totals.

YJB statistics for 2014/15 show that nationally 1.3% of the cohort were aged less than 12, 41% were aged between 12 to 15 years and 58% were aged 16 years or over. Thus it would appear that in 2014/15 Warwickshire had a larger cohort of young offenders (12 to 15 year olds) than seen nationally and comparatively less offenders aged 16 years plus.

3.5 Ethnicity

It can be seen from Table 4 that between 91% and 94% of the annual cohort of offenders are of white ethnic origin. National statistics for 2014/15 show that 12% of

referrals were for young people from ethnic minority groups. It is recognised nationally that there is an over-representation within the CJS of children and young people from a Black ethnic background (7 per cent, compared to 3 per cent of the general population aged 10-17) but an under-representation of young people from an Asian ethnic background (4 per cent, compared to 7 per cent of the general population).

Locally 11% of the Warwickshire population aged 0 to 24 is from an ethnic minority group. Thus as 6% of the offending cohort were non-white ethnic minorities appear to be under-represented in the WYJS.

3.6 Needs related to Social Vulnerability Factors

There is evidence that many children and young people in contact with the CJS have a background of severe social exclusion. This makes it more likely that they will experience risk factors linked both to offending and the development of mental health problems, and so compound the disadvantages they were already facing. The greater the number of risk factors for a child, the greater the risk of their offending or developing mental health problems (6).

Children and young people in contact with the CJS are more likely than other young people to be victims of crime, to have a parent in prison, and to have been exposed to bullying. Bereavement and loss feature significantly in their life. The proportion of young people in custody who have experienced serious maltreatment within their family is twice that of the population as a whole and many children and young people in the CJS have been in contact with children's social care or have been looked after. Finally, young people in the CJS are more likely to be young parents themselves, in comparison with the general population.

3.7 Children in Need or Looked After Children

Although on a national basis there is a lack of precise data on the number of children and young people in the CJS who have also been in contact with children's social care services as a child in need or a looked after child, the evidence indicates considerable overlap between these groups.

A review published in 2009 found that 22% of children aged under 14 years had been living in care at the time of their arrest and a further 6% were on the child protection register (13). This compares with approximately 1% of the general population who are in local authority care.

Local data reflects this relationship. Table 4 shows that between 5% and 11% of the annual offending cohort are currently looked after and that an additional 9% to 12% had been previously looked after. In 2014/15 23% of the young offenders were either

current or previously ‘looked after ‘children (LAC). This compares with 690 (0.6%) of Warwickshire’s population (0 to 17) recorded as being LAC in 2014/15 (12).

In addition to the ‘looked after’ status of children, Table 4 also shows the proportions who were currently or previously referred to Children’s Social Care. Whilst this is likely to include the LAC, it can be seen that children referred to Social Care make up between 36% (in 2012/13) to 55% (in 2014/15) of the total cohort.

3.8 Bereavement and loss

An exploratory study found that 17 per cent of persistent young offenders had lost a parent and that these bereavements were disproportionately traumatic or violent. By comparison, four per cent of children in the general population experience bereavement (14).

There is some limited evidence to suggest that a lack of support for children and young people experiencing the grief of bereavement can contribute to offending behaviour (14). In addition, many children and young people in contact with the CJS experience the loss of significant relationships through family breakdown, through becoming looked after, or through siblings being adopted.

The same study found that only one third of children and young people in the CJS were living with both biological parents (14).

Table 4 shows that between 14% and 30% of the annual WYJS cohort had suffered some type of bereavement or loss.

3.9 Victims of Bullying

Children and young people in contact with the CJS are more likely to have been exposed to bullying than other children. They are also more likely than their peers to be a victim of crime: a self-report study showed that 53% of children and young people who reported committing an offence had also been a victim. This is twice the rate for non-offenders.

Data in Table 4 shows that between 7% and 11% of the annual cohorts were subject to bullying. This is lower than the estimated 57% of Warwickshire children reported as being bullied (12).

3.10 Homelessness

Homelessness is a problem commonly experienced by young people in contact with the CJS. For example a study into the circumstances of 200 sentenced young offenders found that 51% came from deprived or unsuitable accommodation (15). The data in Table 4 shows that between 3% to 4% of the annual cohorts are homeless. There is no recent Warwickshire data available to compare this to.

3.11 Education, Training and Employment

Many children and young people in contact with the CJS have disengaged from learning and struggle to progress and achieve. The YJB has reported that, at the point of referral to a YOT, more than 40 per cent of young people were truanting regularly and 15 per cent were excluded from school (13). A review of young people aged 15 to 17 in Youth Offender Institutions (YOIs) between 2010 and 2011 found that 86 per cent of young men and 82 per cent of young women had been excluded from school and nearly 42 per cent of young men and 55 per cent of young women had last attended school when 14 or younger (4).

The data in Table 4 shows that between 8% and 12% of the annual WYJS cohorts had been excluded from school. This compares with a Warwickshire wide estimate of 5% of pupils excluded (secondary school exclusions) (12).

Table 4 also shows details of the proportion of young offenders who on completion of their order are NEET. It can be seen that in Warwickshire between 27% and 32% are NEET which equates with the 27% reported nationally (15) among offenders and it is much higher than the proportion of young people across Warwickshire who are NEET (5.1%) (12).

3.12 Custodial Sentences

Table 5 Custodial Sentences for WYJS Referrals

	2012/13	2013/14	2014/15
Total referrals to WYJS	337	296	268
Number receiving custodial sentence (%)	12 (3.6%)	13 (7.7%)	4 (1.5%)
Number of males	12	12	4
Range of sentence length	4 months to 72 months	4 months to 54 months	6 months to 44 months
Number of sentences under 12months	8	6	2

Table 5 shows that a relatively small proportion of WYJS clients receive a custodial sentence each year ranging from 1.5% to 7.7% of total referrals to the service each year. This compares to a 5.9% custody rate nationally in 2015 (11).

SECTION FOUR – HEALTH NEEDS IDENTIFIED THROUGH YOUTH JUSTICE ASSESSMENT PROCESSES

4.1 Sources of Information About Health Needs

Initially it was anticipated that the data captured through routine screening undertaken by the youth service caseworkers using the Asset and AssetPlus tools

would describe the health needs of the WYJS client group. However, compared to national estimates of health needs, data captured through the routine screening tools was found to significantly under represent a number of health needs as shown in Appendix 2. Thus use of the CHAT was piloted on a consecutive sample of 43 referrals to the WYJS over a three-month period January to April 2016. The CHAT assessments were completed by the WYJS health team, together with input from the WYJS Educational Psychologists.

The data shown in Table 4 details some limited health related data captured through the routine screening processes. It can be seen from that a high proportion of the annual cohorts were smokers, ranging from 50% in 2012/13 to 57% of all young offenders in 2014/15. Likewise the number of young people drinking alcohol (47% to 54%per annum) and the proportion engaging in substance misuse (45% to 51% per annum) were high. These compare with estimates for Warwickshire young people of:

- 6% of 15 year olds estimated to be regular smokers
- 10% of 15 year olds who have ever tried cannabis
- 8% of 15 year olds estimated to be regular drinkers

These findings are interpreted together with the findings from the CHAT assessments which are detailed in Tables 6 to 11 below.

Table 6 Estimated Prevalence of Key Physical Health Needs Among the 2014/15 Cohort, Based on a Sample of CHAT Assessments

	CHAT Cohort	**Estimated Annual Number (based on 2014/15 WYJS Activity)**
Physical Health		
Troubling general symptoms (n=43)	16 (37%)	99
Problem with eyes, heart, oral (n=43)	15 (35%)	94
Smoking, alcohol, substance		
Smoke cigarettes (n=43)	29 (67%)	180
Alcohol / other substances (n=37)	29 (78%)	209
Sexual Health		
Are / have you been sexually active? (n=41)	23 (56%)	150
Unprotected sex (n=37)	19 (51%)	137
Tested / treated STI (n=34)	6 (18%)	48
Physical Health Risk Review		
Risk of self-harm, bullying or poor self-care (n=38)	22 (58%)	155
CSE concerns (n=38)	10 (26%)	70
Other safeguarding concerns (n=37)	16 (43%)	115

4.2 Physical Health Needs

There is a lack of data on the range and extent of physical health problems among children and young people in contact with the CJS, particularly those in the community. Information about the physical health needs of children and young people in custody indicates that they have significantly more physical health problems than the general population of young people, and that they have received less in the way of health promotion, screening and preventive services than their non-offending peers. This evidence suggests that physical health needs among children and young people in contact with the YOT are likely to be high (3), (4).

Despite this recognition of increased physical health needs the Care Quality Commission (16) identified that within community settings physical health needs are not fully assessed, and there is a lack of joint working between YOT case managers and health practitioners.

The data shown in Table 6 illustrates that a relatively high proportion of the young people in Warwickshire have 'troubling physical symptoms' (37%) or physical problems related to eyes, hearing or oral health (35%). Without further detail it is not possible to interpret the implications of these physical health needs but to recognise that more than one in three young people could be in need of support with a physical health problem.

4.3 Lifestyle Factors Linked to Health Needs

Table 6 also includes information about lifestyle behaviours that impact on health. It is recognised that there are high levels of smoking, drinking and illegal drug misuse among young people in contact with the CJS. One researcher (17) found that 17% of all young people surveyed reported smoking regularly, while 63% of youth offending respondents smoked regularly and an additional 21% reported occasional use. Young offenders also reported that they started smoking earlier. Youth offending respondents also reported a preference for strong lager as opposed to standard cider, lager, beer or alcopops. A prospective cohort study following adolescents admitted to a secure unit found that as adults, nine out of ten offenders had a substance misuse disorder (18) suggesting that early assessment and intervention in adolescence could play a key role in reducing both long term health problems and reoffending.

There is also often an overlap between substance misuse and mental health problems. Consumption of alcohol and drugs are key risk factors associated with offending for 10 to 15-year-olds. The drug strategy 'Reducing Demand, Restricting Supply, Building Recovery' (19) details the impact of acquisitive crime undertaken to obtain drugs and alcohol, connections with organised crime and the impact on the physical and mental health of children and young people.

4.3.1 Smoking Tobacco

Smoking is the greatest cause of preventable illness and premature death in the UK. Increasing numbers of young people are starting to smoke, with 450 starting every day. 200,000 young people in England aged nine to 15 are smokers. By age 15, 26 per cent of girls and 21 per cent of boys are smokers, and they are highly likely to continue smoking in adulthood (14). Smoking hits poorer people harder, widening inequalities in health among social groups.

It can be seen from Table 6 that a very high proportion of the WYJS cohort smoke; 67% as compared to an estimate of 8% among 15 year olds in Warwickshire generally. This proportion is higher than that seen through the routine Asset screening data although of a similar scale.

4.3.2 Alcohol

Alcohol use among young people is growing faster than the use of any other drug in the UK and it causes them the most widespread problems (20). It is also the least regulated and most heavily marketed drug available. Regular alcohol consumption and binge drinking are associated with physical problems, anti-social behaviour, violence, injuries and road traffic accidents, with school performance and crime also implicated.

Studies indicate that people who binge drink in adolescence are more likely to be binge drinkers as adults. Frequent drinking and binge drinking have been shown to increase the risk of developing alcohol dependence in young adulthood.

Research carried out for the YJB into alcohol and drug misuse among children and young people in the secure estate (age 12 to 18) found that, in the period before entering custody, over 60 per cent drank alcohol daily or weekly, with 66 per cent reporting binge drinking once a week, and over 25 per cent considering that their drinking had been out of control (21).

The data in Table 6 combines alcohol with the misuse of substances and as such direct comparison with other Warwickshire population statistics is not possible. However, the data in Table 4 from the Asset screening processes indicate that between 47% and 54% of the young offenders drink alcohol, as compared to 8% of 15 year olds in Warwickshire estimated to be regular drinkers (12).

4.3.3 Other Drugs

Substance misuse in young people should be taken in the context of ‘normal’ risk taking and adolescent behaviour. It has been estimated that 65% of adolescents will experiment with illegal drugs, mostly cannabis, with only 4% moving on to regular misuse and long-term problems (14).

Risk factors for regular drug misuse include living in an area where substance misuse is prevalent; experiencing exclusion factors such as truancy, offending behaviour and unemployment; experiencing social vulnerability factors including neglect, abuse or domestic conflict; and psychiatric, conduct or emotional disorder.

It is well documented in the literature that the majority of mental health problems are closely linked with substance misuse. When needs are not met, there is a possibility of marginalising and socially excluding this group, which in turn carries a risk of leading to offending behaviour.

Research carried out for the YJB into alcohol and drug misuse among children and young people in the secure estate (age 12 to 18) found that, before they entered custody, over 80 per cent had used an illegal drug once a month. The majority of those using illegal drugs had used cannabis (75%); ecstasy, cocaine and amphetamines were used by between 25% and 35%; and much smaller numbers had used crack cocaine (9%) and heroin (1%) (21).

Table 6 shows that 29 (78%) of the young people assessed confirmed that they consumed alcohol and/or other pyscho-active substances. The Asset data indicates that the most commonly used drug is Cannabis with much smaller numbers of young people abusing solvents and/or taking Heroin or Methadone.

4.4 Sexual Health

Transmission of sexually-transmitted infections, and teenage pregnancy, are important issues related to sexual health in adolescents. Young people in the CJS are more likely to engage in risky behaviours such as sexual promiscuity. Almost 1 in 5 were found to have sexually transmitted infections including Chlamydia and Gonorrhoea (22). These disorders are more common in young people in the CJS as they are more likely to become sexually active younger, have multiple partners and less likely to use condoms.

Information from needs assessments of young people in secure settings identifies sexually-transmitted infections as one of the main physical health problems of young people (14).

Table 6 shows that the Sexual Health of young offenders in Warwickshire is at risk, with 51% confirming that they have had unprotected sex.

4.5 Emotional and Mental Health Needs

The mental health of all offenders has been brought to public attention with the Bradley Report (DH, 2009) (23). This report acknowledges the developmental differences between children and young people and adults, and the key role of youth justice staff in screening for unmet health needs.

Mental health problems in children do not manifest themselves as clearly as they do in adults. They can emerge in ways that are less easily defined or diagnosed – for example, through behaviour problems and emotional difficulties, substance misuse and self-harm. This can lead to under-estimates of the extent of mental health problems among groups of children and young people.

Young people who offend are thought to be at higher risk of mental health problems due to three main reasons: (a) the risk factors leading to offending behaviour also predispose to mental health problems – inconsistent and harsh parenting,

problematic behaviour, and deprivation; (b) offending behaviour itself may cause mental health problems; and (c) the stress of interactions with the youth justice system, particularly being in custody, may lead to anxiety and depression and exacerbate other mental health problems (24).

The prevalence of mental health problems among young people in contact with the CJS is much higher than the general population. Studies have shown high rates of depression (18%) and anxiety (10%) in young offender populations (25) as well as a high prevalence of suicide attempts (5). A review of joint inspections undertaken by the Health Care Commission and HM Inspectorate of Probation in 2009 found that 43% of children on community orders had some emotional or mental health needs (9).

4.5.1 Risk Factors for Mental Health Problems

There is a clear overlap between the risk factors for the development of mental health problems and those for offending behaviour. The risk factors include lax, inconsistent, neglectful or punitive parenting, and parental mental health or substance misuse problems. Family-based problems such as these, particularly when experienced in the first two years of life, can adversely affect the development of the brain, can lead to problems with attachment, and can have long-term consequences for mental health.

4.5.2 Symptoms or Indicators of Mental Illness

The data in Table 7 shows that a high proportion of the cohort in receipt of a CHAT assessment (61%) had current or previous contact with health services or other support specifically for mental health problems. This compares with an estimated prevalence of mental health disorder among 15 to 16 year olds in Warwickshire of 9% (12).

Table 7 Selection of key mental health issues identified among the cohort undergoing CHAT assessment and estimated annual impact.

	CHAT Cohort	Estimated Annual Number
Current or previous GP, Psychiatrist, School Counsellor or other mental health service (n=41)	25 (61%)	163
Depression (3 or more indicators) (n=42)	13 (31%)	83
Deliberate self-harm (n=43)	19 (44%)	118
Suicide risk factors		
Tried to take own life (n=43)	8 (19%)	51
Think of taking own life (n=39)	8 (20%)	54
Anxiety (3 or more indicators) (n=41)	15 (37%)	99
Post-traumatic stress (n=42)	23 (55%)	147
Psychoses (n=42)		
Sometimes hear voices (in the	5 (12%)	32

absence of substance misuse)		
Have unusual thoughts (in the absence of substance misuse)	5 (12%)	32
Attention Deficit Disorder		
Has a medic ever diagnosed hyperactivity / ADHD (n=43)	13 (30%)	80
Eating Disorders (n=42) 3 of 5 indicators	1 (2%)	5
Traumatic Brain Injury (n=42)	23 (55%)	147

4.5.3 Depression

Rates of depression among children and young people who offend are higher than in the general population of the same age, with studies demonstrating prevalences of between 13% to 22% (26). The high prevalence of depression in young offenders may be partially explained by the presence of shared risk factors with the development of antisocial behaviour, including social and familial disadvantage and trauma. Furthermore depression in adolescents may not always present with the typical symptoms associated with this illness and could be manifest through irritability and/or reduced interest and enjoyment in activities, for example, untreated depression is a risk factor for self-harm and completed suicide in young offenders as with adults.

Table 7 shows that 13 (30%) of the cohort who underwent CHAT assessment had 3 or more indicators of depression. This compares with an estimated 3% of young people in Warwickshire estimated to have an emotional disorder (includes depression and anxiety) (12).

4.5.4 Self-harm

Rates of self-harm have increased in the UK and are much higher among adolescents and young adults than older adults. They are particularly high for adolescents with mental health problems such as anxiety and depression. Self-harm is more common in young women than young men, but studies have noted that young men may engage in different forms of self-harm that might be easier to conceal (27).

Self-harm is more prevalent in young offenders as certain risk factors are more common in this age group. Predictors of increased risk include previous attempts, prolonged low mood, ADHD and substance misuse. A study of young offenders within the UK found that 1 in 10 offenders reported an episode of self-harm within the last month (14) and YJB statistics indicate year on year increases in the rate of self-harm (11). It is acknowledged that young people who self-harm are at increased risk of suicide.

Table 7 shows that among the cohort who had a CHAT assessment 19 (44%) had deliberately self-harmed at some point in the past. This compares to estimates of 6% to 10% of young people self-harming in the general population (24).

4.5.5 Suicide Attempts and Suicidal Thoughts

Although the suicide rate among teenagers is falling nationally it is recognised that the risk of suicide among children and young people is much higher if they are in contact with the CJS, especially if they are separated from their families, and if they have mental health or substance misuse problems and/or have experienced abuse or neglect (14). Research analysing serious case reviews into the death or serious injury of children has consistently found that adolescents make up approximately a quarter of cases each year, with the majority dying because of suicide, often linked to a background of abuse and neglect (28). YJB data shows that, in 2010/11, 16 young people under the supervision of a YOT and living in the community died as a result of suicide or accidental death (some likely to be linked to reckless or risk-taking behaviour), and there were 141 cases of attempted suicide (29).

The data in Table 7 shows that 8 (19%) of the cohort had previously attempted suicide. Somewhat unusually, this is the same proportion of cases as those with suicidal thoughts. Ordinarily, those with suicidal thoughts would out-number those attempting suicide.

4.5.6 Anxiety

Anxiety is a feeling of unease such as worry or fear that can be mild or severe. Whilst the experience of anxiety in threatening situations is normal, when people experience anxiety in a range of other situations, it can impact on functioning. Features of anxiety can include worry, struggling to concentrate, irritability and low mood, often combined with physical symptoms; struggling to sleep, fast or irregular heartbeats, dry mouth, fast breathing, pallor, dizziness, nausea, indigestion and diarrhea.

Anxiety disorders include a range of different disorders from generalised anxiety disorder to panic attacks and phobias. Studies have shown prevalences of anxiety of between 21% and 31% among youth offenders (26).

Table 7 demonstrates that 15 (35%) of the cohort had 3 or more indicators of anxiety which compares to 3% of young people in Warwickshire estimated to have an emotional disorder (includes anxiety and depression).

4.5.7 Post-Traumatic Stress

Traumatic and frightening events can trigger a reaction which leads to Post Traumatic Stress Disorder (PTSD). Examples of trauma include sexual abuse, bullying, accidents, and witnessing the physical harm that one person has caused to another person. In the latter case the sufferer may be the person who caused the injury or a peer who was with them. People with PTSD find that they are reliving the experience through flashbacks in the day and nightmares at night. Children and

young people who offend by engaging in high risk activities e.g. stealing cars, breaking into people's houses or getting into fights are also at risk due to exposure to trauma. The prevalence of PTSD among young offenders was 9% in a UK study of young offenders (14).

Table 7 shows that 23 (55%) of the cohort were identified as being at risk of PTSD whilst 2 (5%) of the cohort had 3 or more indicators of PTSD.

4.5.8 Psychoses

Psychosis can be described as losing the ability to distinguish between reality and the experiences inside one's own mind. Symptoms of psychosis include hearing voices that other people cannot hear. This abnormal perception, which is not based in reality, is known as a hallucination. Hallucinations can affect any of the senses, although auditory hallucinations are most common. Symptoms of psychosis include thought interference e.g. having unusual thoughts that other people do not seem to have, feeling controlled by a force or power outside oneself, that appears to be controlling one's thoughts or actions, and worrying that someone is putting or removing thoughts from one's head. People experiencing psychosis can report feeling that some people are overly interested in them or trying to hurt them (ie paranoia).

Table 7 shows that 24% of the young offenders had symptoms (thought to be independent of substance misuse) that could indicate a risk of psychosis. This is a very high rate which would require further validation and/or comparison with the findings made through other CHAT assessments.

4.5.9 Attention Deficit Hyperactivity Disorder

Attention Deficit Hyperactivity Disorder (ADHD) is characterised by early onset and persistent symptoms of inattention, hyperactivity and impulsivity that are more extreme than is typically observed in individuals at a similar stage of development. While prevalence rates of ADHD in the criminal justice system have varied across studies depending on the methodology, rates of 10% among male offenders and 20% among female offenders have been identified, compared with 3-5% of the general population (25). ADHD has been found to increase the risk of offending through the development of conduct disorder, illicit drug use and peer delinquency and is associated with more persistent offending into adulthood (30).

Table 7 shows that 13 (30%) of the cohort who underwent CHAT assessment had been previously diagnosed or advised by a doctor that they might have ADHD, which is up to ten times higher than the general population estimate. There is no reliable estimate of ADHD prevalence for the Warwickshire population in general.

There is however the potential for undiagnosed disease in the ADHD category. While records indicate that 13 of 43 (30%) had been previously diagnosed with ADHD, of the 30 who did not have a previous diagnosis 18 (60%) were found to have three or more symptoms commonly associated with the disorder. This is suggestive of a higher level of ADHD among this population, potentially 31 (72%) of the cohort which is high even in comparison national reports of ADHD prevalence among young offenders.

4.5.10 Traumatic Brain Injury

Traumatic brain injury (TBI) has recently become an issue of concern within the CJS. Moderate to severe TBI (involving loss of consciousness for over half an hour) has wide-ranging cognitive and behavioural consequences which can have a long-term impact. A study looking at self-reported rates of TBI among children and young people in contact with the CJS indicated a moderate to severe level in 16 per cent of the sample. However, other studies have identified much higher levels (65% to 76%) of TBI among offenders (31). There was also evidence of a significant relationship between three or more reported incidents of TBI and the severity of violence in offences committed (32).

Table 7 indicates that 23 (55%) of the WYJS cohort had sustained a TBI which compares to self-reported TBI of between 5% to 24% in the general population. Although details on the severity of the injury was not captured through the CHAT assessment it is likely that some of the offending behaviour among this group is linked to a previous TBI.

4.5.11 Conduct Disorders

Studies show that the prevalence of conduct disorder, among those children and young people in contact with the CJS who end up in custody, is far higher than among the general population (4). There is clear evidence from longitudinal studies that early onset of conduct disorder (under age 10) is particularly likely to result in persistent difficulties and poor outcomes, including offending. There is also evidence indicating that children and young people whose conduct problems are below the threshold for a clinical diagnosis also face an increased likelihood of adverse outcomes. One study estimated that around 80 per cent of all criminal activity is attributable to people who had conduct problems in childhood and adolescence, including about 30 per cent specifically associated with conduct disorder (14).

Neither Asset nor the CHAT specifically identify conduct disorders. However, young offenders who are referred to the WYJS health team are assessed using the Strengths and Difficulties Questionnaire (SDQ), as described in section 5.2 below. These assessments indicate that 52% of those referred to the team have some

degree of conduct disorder. In addition 13 (30%) of the CHAT cohort had three or more factors associated with ADHD, which correlates strongly with conduct disorder.

4.5.12 Co-Morbid Mental Disorders

Studies show that children and young people in contact with the CJS frequently experience two or more disorders at the same time, for example conduct disorder with depression, or conduct disorder with depression and/or attention deficit disorder. There is also evidence of the co-occurrence of mental health problems with learning disability and with substance misuse. Young people with hazardous drinking or drug misuse problems are more likely to have three or four other disorders. Rates for multiple disorders are particularly high amongst young women in custody (14).

Detailed analysis of the Mental Health CHAT assessments was undertaken to explore the severity of mental illness and the extent of comorbidity in terms of co-occurring symptoms of mental illness.

In terms of the severity of mental illness there is no evidence based objective means of determining how ill a young person might be based on the data captured through the CHAT assessment. However, the following methodology was used to define more significant illness for the purpose of this analysis:

More significant mental illness was considered to be present if:

- Ever attempted suicide: n=8
- Psychotic symptoms (not associated with substance misuse): n=10
- Depression, self-harm, anxiety, PTSD and ADHD – 3 or more symptoms / indicators (see table 6) within each illness category

Table 8 shows the number of young offenders who have been categorised through this analysis as potentially having more significant mental disorder. It can be seen that rate of anxiety, depression and self-harm are all independently high. However, those with indicators of these conditions can also be seen to have indicators of other mental health conditions indicating the potential for more severe and complex illness.

Table 8. Co-morbid Mental Illness Symptoms among Those with Indicators of More Significant Disorder

		Also had more significant symptoms in these categories					
Indicators of More Significant Mental Illness	**Depression**	**Self Harm**	**Suicide**	**Anxiety**	**PTSD**	**Psychoses**	**ADHD**

Depression (3 or more symptoms) n=3	x	7	4	6	2	5	4
Self harm (3 or more factors) n=14	7	x	4	7	2	6	4
Suicide (previous attempt) n=8	4	4	x	5	1	6	3
Anxiety (3 or more symptoms) n=15	6	7	5	x	2	8	7
PTSD (3 or more factors) n=2	2	2	1	2	x	2	0
Psychotic thoughts or hallucinations (not associated with substance misuse) n=10	5	6	7	8	2	x	2
ADHD (3 or more symptoms) n=13	4	4	3	7	0	2	X

Clearly any young person who has previously attempted suicide is vulnerable to more severe mental health illnesses. Among this cohort 8 has previously attempted suicide and of these 4 (50%) had 3 or more symptoms of depression. 4 had self-harmed, 5 (62%) had 3 or more symptoms of anxiety and other co-morbid disorders, as shown in table 6.

Likewise, those young people who hear voices or have psychiatric thoughts (not thought to be associated with substance misuse) are vulnerable to more severe mental illness. Among the CHAT cohort 10 (23%) fell into this category, which is a comparatively high proportion. Of these young people a high proportion had evidence of more significant disorder in other categories as follows: Anxiety (80%), Depression (50%) and Self Harm (60%).

Whilst the data in Table 8 can't be considered to be definitive, it does give a good indication of the complex nature of the young offenders' mental health with the high degree of assumed mental disorder (psychotic symptoms or previous suicide attempt or 3 or more symptoms with a single category) and a high degree of co-morbidity (reaching the criteria for more significant illness in more than one category).

For example, 15 young people with 3 or more symptoms of anxiety 6 also had 3 or more symptoms of depression, 7 had previously self-harmed and 8 had psychotic symptoms. These findings do concur to some extent with the Strength and Difficulty Questionnaire (SDQ) assessments routinely undertaken on WYJS mental health referrals described in section 5.2 below, which indicate a high degree of complexity and severity among the referrals.

4.6 Speech, Language and Communication Needs

Communication disorders relate to problems with speech, language and hearing that significantly impact upon an individual's academic achievement or day-to-day social interactions. This incorporates a wide range of conditions. Problems with speech include aspects of dysfluency, such as stammering, speech impediments and articulation difficulties. Language impairments may relate to the expression

(expressive impairment) or comprehension (receptive impairment) of words during communication or the pragmatic (social) use of language.

There is evidence of higher levels of speech, language and communication problems amongst young people in custody. In their paper 'Doing Justice to SLCN' (November 2014) (33), the Communication Trust wrote: *The Bercow Report (2008) identified an estimate by the Royal College of Speech & Language Therapists that at least 60% of the then 7000 children and young people passing through Young Offender Institutions (YOIs) each year would have difficulties with speech, language and communication, sufficient to affect the young person's ability to communicate with staff on a day-to-day basis. Additional research in one UK establishment with young people who have offended has shown that 66-90% (depending on the exact sub-test used to assess the need) had below average speech, language and communication skills on standardised tests, with 46-67% having language skills which were 'poor or very poor'.*

This compares with 7-10% in the general population. The report went on to observe that:

The profile of SLCN changes over time; social communication difficulties can become more prominent than at primary school and the nature of difficulties more complex. As a child's age increases, good 'surface' language skills or clear speech might make everyday conversation manageable, effectively masking underlying SLCN. Associated behaviour, emotional and social difficulties (BESD) or literacy difficulties may be most visible and be identified as priorities; it is likely that this will be the case particularly where a child or young person has ended up in contact with the secure estate.

It is important to acknowledge that the language and communication demands of navigating the justice system are high (34) and include:

- Police interview – recall, recount, self-monitor, deal with stress, read statement

- Court appearance – follow schedule, communicate appropriately, understand language used including unfamiliar legal vocabulary, understand consequences

- YOT – introduce, understand, decipher reports, discuss, recount from memory, understand commitments agreed

Getting a better quantification of SLCN among the WYJS population was thus felt to be a priority and was one of the main drivers for piloting the CHAT.

For the cohort undergoing CHAT assessment any history of SLCN needs was recorded and a screen of the young offender's current speech and language functioning was carried out. Receptive language (understanding) was screened by

observation and how frequently the assessor had to break down the language used, repeat or re word a phrase. Expressive language was screened by asking the young person to describe how to carry out a familiar activity.

Table 9 details the findings of the SLCN assessment undertaken as part of the CHAT health assessment.

Table 9. **Results of Speech Language & Communication Abilities of the CHAT Cohort with Estimated Annual Impact**

	CHAT COHORT	ESTIMATED ANNUAL IMPACT (2014/15)
Does the young person have a history of speech and language delay or difficulties? (n=42)	13 (31%)	83
Has the young person had previous speech and language therapy? (n=42)	8 (19%)	51
Does the young person have difficulty understanding what I say? (n=42)	8 (19%)	51
Does the young person find it hard to understand long or complicated words/instructions? (n=41)	11 (27%)	72
Are their responses minimal or very limited to one answer with minimal spontaneous elaboration or description? (n=40)	13 (32%)	86
Does the young person find it hard to explain things or gets stuck on words when speaking? (n=36)	12 (33%)	88
Does the young person have a speech problem or find it hard to say words clearly? e.g. stammer or its difficult to understand them (n=42)	11 (26%)	70

The data in Warwickshire indicates that a quarter to a third of the young people assessed showed evidence of SLCN. This is well above the population average of 7-10%. However, the numbers are lower than the national figures for young people who have passed through YOIs and it could be that the national estimates were made using a different methodology and/or that a SLCN specialist would identify additional needs. For example, of the 29 young people who did not have a previously diagnosed SLCN, 4 (13%) had 3 or more indicators of disorder. Thus the overall prevalence of SLCN could be considerably higher.

4.7 Learning Disability and Educational Needs

A definition of learning disability is included in the 2015 SEND Code of practice (35), as follows: A child of compulsory school age or a young person has a learning difficulty or disability if he or she:

- Has a significantly greater difficulty in learning than the majority of others of the same age or

- Has a disability which prevents or hinders him or her from making use of facilities of a kind generally provided for others of the same age in mainstream

Defining and assessing learning disability is complex; however, young people with a learning disability are overrepresented within the CJS. Generalised learning disability is significantly more common in young people in custody, with one study suggesting a prevalence of 23-32% (36) and another report specifying that 25% of children who offend have very low IQs of less than 70 (15).

Table 10 shows that 8 (19%) of the cohort undergoing a CHAT assessment had been in contact with Learning Disability services and there were records indicating an IQ of <70 for 4 (10.5%) of the young offenders (ie. severe learning disability). This compares with a Learning Disability prevalence in the general population of 2 to 4% (36). However, for 19 (45%) of the cohort concerns had been expressed by education staff about their learning needs and as such the proportion of young people seen by the WYJS who have either a learning disability or a learning difficulty are likely to equate with the high levels seen nationally.

Table 10 Learning disability and educational needs identified among the cohort who underwent CHAT assessment.

	CHAT cohort	Estimated Annual Number (Based on 2014/15)
Has an existing statement of SEN	9 (21%) 18% - MOJ: Transforming Youth Custody Consultation 2013 2.8% - Children with SEN: an analysis 2014	56
Attend a specialist school	12 (28%)	75
Been in contact with Learning Disability Service	8 (19%)	51
Concerns expressed by education staff that young person has learning needs	19 (45%)	121
Records indicate that young person has an IQ <70	4 (10.5%)	28
Young person previously assessed or diagnosed with ASD or related disorder	5 (12%)	32

With respect to Special Educational Needs (SEN), new arrangements for joint commissioning for children and young people with special educational needs and disabilities (SEND) were introduced under the Children and Families Act 2014. This intended to improve the way in which the needs of children or young people (aged up to 25 years) are assessed, and how these needs are met. Following a co-ordinated assessment of needs, an individual outcomes-focused Education, Health and Care (EHC) plan is now agreed. This replaces the previous Statutory Statement of Special Educational Needs (SEN).

A statutory code of practice applies to all organisations who work with and support young people with SEND and YOTs must now have regard to this guidance.

As such YOTs may identify a child or young person who should be assessed as having SEN. From April 2015 additional requirements have been introduced governing the way in which SEND needs are met for young people in custody which will be relevant to the small sub-set of offenders who serve custodial sentences (37).

It can be seen from Table 10 that 9 (21%) of the cohort had an existing statement of Special Education Needs, which compares to a national average of 2.8% of students and for Warwickshire, 3% of students. It also compares with a national report of 18% prevalence of SEND among youth offenders (37). In addition, it can be seen that 12 (28%) of the cohort undergoing CHAT assessment had attended a specialist school.

4.8 Autistic Spectrum Disorder

Autism is a neurodevelopmental disorder characterised by impairments in social communication. These include qualitative differences and impairments in reciprocal social interaction and social communication, combined with restricted interests and repetitive behaviours (38).

The National Autistic Society (2008) suggested that young people with Asperger's syndrome are seven times more likely to come into contact with the criminal justice system than their peers (39). Furthermore, a study of young people in the CJS suggest an increased prevalence of ASD of 2.3-15% compared with 0.6-1.2% of the general population (36).

Certain features of ASD may predispose young people to offend including poor empathy, social naivety and misinterpretation of social cues. In addition, there is agreement that children and young people on the autism spectrum who come into contact with the CJS as perpetrators of offences are likely to experience additional distress and difficulty because of their condition (4).

Table 10 shows that 5 (12%) of the cohort who underwent CHAT assessment had previously been assessed and/or diagnosed with an ASD or a related disorder, which equates with national estimates of the prevalence in youth justice settings.

SECTION FIVE – CURRENT HEALTH SERVICE PROVISION

5.1 Healthcare Service Provided Through WYJS

In recognition of the high levels of physical and mental health problems among children and young people in contact with the CJS, legislation places duties on CCGs to contribute to the YOT budget and to provide or nominate a member of the YOT team as detailed in section 39 of the Crime and Disorder Act 1998 and Schedule 5, Part 1 of the Health and Social Care Act 2012. In Warwickshire funding currently comes from the Public Health budget and at £103,000 per annum it makes up 3.7% of the total WYJS budget. Nationally the average contribution from health to YOT budgets is 6%.

There are various models for providing health input into a YOT, as described in a report by the Centre for Mental Health (40). CWPT are commissioned to provide a 'health team within the YOT' type of service whereby the health team is co-located within the WYJS, working alongside practitioners from other disciplines. The service originally commissioned was specified to be delivered by 0.5 WTE clinical psychologist, 0.5 (band 7 nurse), 0.5 (band 6 nurse/primary mental health worker) with administrative support. The service is now, however, currently provided by one WTE Registered Mental Health Nurse (RMN) and 0.6 WTE British Association of Counselling and Psychotherapy (BACP) Registered Counsellor.

In addition, a clinical supervisor (family therapist) with previous WYJS experience was commissioned by CWPT CAMHS to provide clinical and strategic oversight to the health teams in both WYJS and the Coventry Service. The time dedicated specifically to WYJS is 2 sessions per month i.e one day and amongst other things this post-holder supports the health team in delivering evidenced based interventions.

The health team discuss individual cases with the youth justice caseworkers and/or receive referrals from them. The criteria for referral to the WYJS health team for Mental Health assessment are shown in appendix 3. The team undertake health assessments and provide mental health interventions, as described below, as well as making referrals to mainstream or specialist services as necessary. Whilst there are distinct advantages associated with this model of provision it is important that there are arrangements for effective clinical supervision and that the health team has good links into specialist services, as is currently the case.

All young people who are to be sentenced by the courts receive a detailed health assessment as part of their pre-sentence report. In doing this the health team work closely with the courts to ensure that wherever possible appropriate health support can be provided in the community, such that a custodial sentence can be avoided.

A critically important characteristic of the health service provided in Warwickshire is that the professionals can provide therapeutic interventions (some services assess needs and refer young people into CAMHS or other services for support). In addition, the health team, as is characteristic of the rest of the WYJS, adapt their intervention to overcome barriers to access, such that the young people do engage with the service. This means that in Warwickshire young people can benefit from timely interventions delivered flexibly, often on an outreach basis.

The interventions offered include solution focused Cognitive Behavioural Therapy (CBT), Counselling and Family Therapy, all of which have been demonstrated to be effective in improving mental health and in reducing re-offending (41) and (42). As evidenced through the assessments undertaken by the WYJS the complexity of the young people now being seen by the service is increasing. This is reflected in increased referrals to both the health team and the substance misuse service (described below) as shown in Table 11.

Table 11
Annual Referrals to Health and Substance Misuse Services

Year	**2012/13**	**2013/14**	**2014/15**
Number of WYJS clients	337	296	268
Referral to WYJS Health Team	94 (28%)	79 (27%)	97 (36%)
Referred to in-house substance misuse	56 (17%)	80 (27%)	86 (32%)
Referred to Compass	21 (6%)	22 (7%)	21 (8%)

5.2 Effectiveness of Mental Health Service Provision

The data that is routinely recorded by the health team in relation to mental health and wellbeing of those referred to the service at the start and at the end of treatment demonstrate that the service is dealing with a highly vulnerable group and that the service provided is effective.

The Strengths and Difficulties Questionnaire (SDQ) **-** is a brief behavioural and emotional screening tool used for assessing children and young people. It can be easily completed by the child using a simple 3-point scale; *Not True (0), Somewhat True (1), or Certainly True (2).* The SDQ comprises 25 items that measure different domains; Emotional Symptoms, Conduct problems, Inattentive/Hyperactivity, and Peer Relationship Problems. High or very high scores on the subscales indicate a high or very high level of complex psychiatric difficulties. These subscales can be

added together to generate a 'total difficulties' score. Young people seen by the WYJS health team are asked to complete an SDQ as appropriate.

The CAMHS Outcome Research Consortium (CORC), suggest that a total difficulties score of higher than 17 is an indicator of serious mental health or neurodevelopmental concerns.

SDQ scores can be grouped into four category bands indicating problem severity – average, borderline, high and very high. In the general population:

- 80% of children score within the average range
- 15% score within the borderline range
- 5% score within the high or very high range

Initial session SDQs were analysed for the period April 2013 – December 2015 (7 quarters). The total number of SDQs analysed were 73.

High or very high scores were seen in following categories:

- Total Difficulties – 41% (n 30)
- Emotional Difficulties– 32% (n 24)
- Conduct Difficulties – 52% (n 38)
- Inattention/Hyperactivity Difficulties 35% - (n 26)
- Impact Difficulties – 59% (n 43)

The impact score indicates how the combined difficulties impact on daily life.

When comparing these scores against the general population where 5% will score within the high or very high range, the WYJS cohort at 41% indicates a very high level of complexity.

In terms of outcomes following intervention the numbers of SDQ's obtained have been consistently low due to a number of factors, including loss to follow up. However, out of the 18 closing session SDQ self-reports obtained over the above period, every young person's self-report recorded a 'total difficulties' score within the average range, indicating substantial improvement in each case.

The routinely captured health data on those receiving mental health interventions is regularly analysed alongside recidivism data and this consistently shows a reduction in reoffending and in the severity of offending for the cohort receiving mental health interventions, compared to the overall WYJS cohort of offenders. Recent evidence on desistance (43) indicates that young people who turn their back on crime often do so because of a trusting, open and collaborative relationship with a youth justice professional. In successfully improving the mental health and wellbeing of the young people they see the health team will be building strong personalised relationships with their clients; the type of relationship that is consistent with desistance theory.

The health team perform well against the YJB waiting time standards with 96% of all routine referrals being seen within 15 days of referral. The health team also provides support to the small number of young offenders who receive a custodial sentence. They work with secure estate staff in resettlement planning with a particular focus on ensuring that the health needs are met. As young offenders in secure settings are now assessed using CHAT it is likely that a wide range of health needs could be identified.

5.3 Substance Misuse Service Provision

All young people receiving a substantive court outcome with intervention or a youth conditional caution are screened by a specialist CJS substance misuse worker. This screen is in addition to the initial assessment completed by their case manager and identifies the tier of intervention required. Those meeting tier one criteria receive a programme of 'staying safe' work including general education relating to drugs and alcohol, which is undertaken by the case manager. Those meeting tier two criteria receive a six session structured substance misuse programme using the 'Drugs and Me' resource and is undertaken by the WYJS specialist substance misuse staff. Those individuals requiring a therapeutic tier three intervention for poly substance misuse are referred to Compass. It can be seen from Table 6 that in 2014/15 there were a higher proportion of referrals to both the in-house substance misuse team and to Compass than in previous years.

The WYJS and Compass work together as necessary to ensure that substance misuse services are available to young people being discharged from secure settings.

5.4 Pathways to Universal and Mainstream Services

5.4.1 Lifestyle Health Related Behaviours

The WYJS caseworkers and the health team can direct young people to universal services such as smoking cessation services and sexual health services. However, as indicated in the WYJS staff survey (see section below), 25% of respondents indicated that they did not know how to direct young people to smoking cessation services.

5.4.2 School Nursing Service

In Warwickshire schools now receive support from the School Health and Wellbeing Service. Historically there has not been a strong relationship between the school nursing service and the WYJS although a strong case is made for joint working by Public Health England, the Department of Health and the YJB (44). There is the potential for improved collaboration including the sharing of information between the services which should be explored.

5.4.3 Learning Disability Services

A high proportion of the young people have a learning disability or some type of neurodisability including ADHD but there is currently no pathway to specialist support

from the WYJS. Responses to the WYJS staff survey (see below) indicate that staff would value some support in dealing with this client group.

5.4.4 Speech Language Communication Needs

Over recent years there has been increased recognition of the extent of SLCNs among youth justice populations. There is no specific support to the WYJS from Speech and Language Therapy (SLT) services or a pathway to services for individual clients. A recent report from The Communication Trust (45) has recommended that there be improved access to SLT services, as previously recommended in the Bercow review (46).

SECTION SIX- FEEDBACK FROM CONSULTATION

6.1 Consultation Undertaken

The HWBNAA has included consultation with:

- Children and young people referred to the service
- The parents of young people referred to the service
- The WYJS staff
- Wider partner agencies (health, social care, police, probation, education, community safety)

6.2 Consultation with Young People

Two methods of involvement were used to engage young people; a questionnaire and a focus group. The key issues to be explored included the young people's perceptions of what undermined their health and wellbeing, their experience of previous support with health issues and what they felt would best enable them to enjoy good health and wellbeing in the future.

A brief questionnaire was devised which was administered by the WYJS caseworkers with their respective clients. In total there were 20 responses. The detailed findings of questionnaire are included in appendix 4, but some of the key issues identified are:

- Key factors that undermine the health and wellbeing of the young offenders include pressure from family and friends (including through social media) and emotions (including anger)
- In considering who young people turn to when they need support with health issues, unsurprising family and health services featured strongly in responses
- In terms of resolving previous health issues the young people reported that speedier access to health services would have been beneficial as would having 'someone to talk to'
- When thinking of a time when help was needed but not available, the key desire would have been 'to have someone to talk to'
- When reflecting on what has helped to improve the health and wellbeing of the young people they most frequently cited health services and the WYJS

- In considering their future health and wellbeing, the young people felt this would be enhanced through learning and skills development, supportive relationships and developing self-confidence featured strongly
- When considering what the WYJS could offer to best support their health and wellbeing a considerable number made reference to counselling/anger management

In addition to the questionnaires a focus group was held with a group of three young offenders (eight young people had been scheduled to attend), as summarised in appendix 5. Key issues that emerged through this process were:

- That 'boredom' was an underlying factor which predisposed the young people to substance misuse, even though they acknowledged that their wellbeing was occasionally undermined by 'post drug paranoia'
- There was a strong reliance on family for advising on health issues
- In considering when help was needed but not received, the young people chose to speak about substance misuse services. They felt these services told them what they already knew and introduced them to substances they had not yet tried
- In considering what would help them improve their wellbeing (reduce their boredom such that they didn't want to use psychoactive substances), they made reference to 'having money', 'getting a job' and gaining the skills to do so.
- In considering what the WYJS could do the young people said that drug testing was helpful in supporting abstinence from drug-taking. They agreed that they needed motivation and that opportunities for skills development would be welcome.

6.3 Consultation with Parents and Carers

Ten parents attended the parents/carers focus group through recruitment undertaken by the WYJS parent liaison lead. There was good participation by parents in discussing a range of questions related to the health and well-being of young people and a summary of the key points raised is included in appendix 6.
It is clear from the perspective of the parents involved in this process that there are many factors affecting health and well-being of young people but the overriding feeling was that they knew from an early age that their child needed support but this generally was not provided and problems escalated as a result.
Key issues identified as affecting health and well-being include:

- Peer pressure
- The use of social media
- Low self-esteem precipitating experimentation with drugs and alcohol

Parents identified the positive impact of some programmes such as 'Triple P' and 'protective behaviour training' but many parents expressed the view that there was insufficient support from schools when problem behaviours were first manifest. Whilst some courses like 'safe use of the internet' were valued parents felt they were

not always alerted by schools to the opportunities to be involved (letters home with a pupil are not an effective form of communication).

The school nursing service was also considered as a potential benefit but was often not accessible (ie. too little school nurse time). Likewise, parents found that other services such as CAMHS were inaccessible because access criteria were perceived to be too high and parents referred to unhelpful delays in other assessment processes (eg in identifying young people with SEND).

Parents felt young people need help in understanding their emotions and in building their self-esteem. They suggested that non-academic children should have alternative opportunities through schools, for example to develop skills through low cost sporting opportunities and/or through appropriate work –experience. They also thought young people needed more information and education in relation to sexual health and parents felt that if they were given more support themselves they could do much to prevent problems escalating. The parents valued the support provided through the WYJS.

6.4 Consultation with the WYJS Team

In order to gain the views of the WYJS team a staff survey was undertaken and a focus group was held. The WYJS staff survey was based on a previously validated tool and was intended to identify whether the team were clear about the screening tools available to identify health issues, their knowledge and confidence in identifying and managing health issues, and their perception of the adequacy of the WYJS to adequately respond to young people with specific health related needs. The survey was sent to 40 members of staff and 25 responses were received (62% response rate).

Details of the findings are included in appendix 7 but key points are as follows:

- The vast majority of staff (92%) are clear about the health screening tools used and know who to ask for help when necessary
- 25% of staff are unsure how to refer to smoking cessation services
- The majority are able to provide basic lifestyle advice but are less sure about sources of specialist help
- In terms of WYJS capacity to respond to substance misuse, 79% think the service responds well or very well, compared to 87% for MH issues, 54% for a Learning Disability, 68% for a Speech, Language or Communication difficulty, and 73% for a physical health problem.
- There appears to be less clarity about the relationship of WYJS caseworkers and substance misuse staff than for health team (ie to respond to mental health problems)
- There was particular recognition of the challenges to the health of young offenders caused by emotional and mental health problems
- A number of suggestions for improvement are made including increased capacity within the health team and more opportunities for joint assessment between the WYJS caseworkers and the health team

The focus group was held to share the findings of the staff survey and the survey of wider partners (as detailed below). A summary of the issues discussed is enclosed as appendix 8, but key points raised include:

- Staff recognised their role to be primarily associated with reducing re-offending, but do play a role in supporting access to services
- Whilst there had been improvements there was still some potential to clarify access to substance misuse services.
- There is potential to re-look at health screening tools at exit panel meetings.
- Staff experienced difficulty in accessing the Integrated Disability Service for support with young offenders.

6.5 Consultation with 'Wider Partners'

Engagement with 'wider partners' was undertaken to gauge the perceptions of a wide range of professionals with respect to the health challenges faced by young people, their confidence that the WYJS was able to support resolution of these problems and to identify opportunities for improvement.

The survey was distributed via a wide range of networks, as informed by members of the Warwickshire Safer Partnership Board, Multi Agency Public Protection Arrangements (MAPPA) and Multi Agency Safeguarding Hub (MASH) boards. There were 88 responses, from the following agencies: Police n=40, Probation n=1, Social care n=4, Education n=7, NHS n=8, Other public sector n=21, community/voluntary group n=3, other n=4.

To some extent the responses indicate a good deal of uncertainty among partner agencies around the role of the WYJS in identifying and responding to health issues, which could reflect poor targeting of the survey. However, there were a number of interesting comments and insights as detailed in appendix 9. Key points that were raised include:

- Areas where it was felt improved support was required by young people include in relation to mental health problems, substance misuse, health literacy and SLCN, ADHD and transition to adult services
- Others felt that health matters particularly well managed by the WYJS include mental health and substance misuse
- In terms of interventions or developments that would most improve the health of young people respondents identified early identification of problems and interventions with families, improved specialist support, increased promotion of wellbeing, better access to mental health support and improved education.

SECTION SEVEN – ANALYSIS AND RECOMMENDATIONS

7.1 Overview WYJS Activity

Whilst there is a reduction in the statutory workload of the WYJS, there has been a commensurate increase in the number of 'preventive' cases, particularly during 2015/16. It is unlikely that the growth seen can be sustained within existing

resources and it will also be necessary to agree what access preventive cases should have to the WYJS health team or whether these young people should receive mental health support through mainstream CAMHs.

The data indicates that Warwickshire has a higher rate of FTEs to youth justice services, when compared to the rate in 'like' authorities (from a health perspective) being towards the upper end of the range (although not statistically different). The decrease in FTEs seen nationally over recent years has been less in Warwickshire such that whilst Warwickshire still has a lower rate of FTEs, it is now closer to the national average. This is a reflection of the fact that Warwickshire addressed the issue of the inappropriate criminalisation of young people earlier than other YOTs. Thus, the slowing in the decrease in FTEs in Warwickshire that has coincided with a reduced spend per head of population on youth justice services, is not thought be related.

As expected there are differences in the rates of offenders across the County with the North having higher rates than the South. The Rugby rate appears to have decreased very little compared to other parts of the county (and country), however the numbers are small and confidence intervals would be wide such that without further information, no conclusion can be drawn in relation to this finding.
There is also evidence indicating that for 2014/15 the youth offending population in Warwickshire is younger than the national profile. Future years will determine whether this is the start of a trend or a random variation.

7.2 Overview of Findings: Social Factors

The profile of those who enter the WYJS shows a high degree of vulnerability with referrals presenting with complex and entrenched problems. There is national evidence that while the youth justice population is falling those who remain are more complex. The findings of this HWNAA lend support to this as demonstrated through the following statistics for 2014/15:

- 55% of the WYJS clients were either currently or previously 'looked after'
- 30% had experienced significant bereavement or loss
- 12% were excluded from school
- On leaving the WYJS 27% were NEET

In conclusion it can be said that there is evidence of severe vulnerability and disadvantage, matching or exceeding that described in national reports and research.

7.3 Overview of Findings: Health Statistics

High proportions of the WYJS population smoke, drink alcohol and/or misuse substances. There is evidence of sexual health needs and a high proportion of the young offenders reported 'troubling' physical health symptoms.

In terms of Mental Health there is evidence of significant need, as indicated through the CHAT assessments, including:

- 61% had previous input from mental health and related services, prior to referral
- 44% had self-harmed
- 19% had attempted suicide
- At least 30% had ADHD
- 55% had sustained a TBI

There may be some limitations with the CHAT assessments as the tool is relatively new and the health team had no previous experience of using it. However, the findings do demonstrate high levels of complex need which concurs with other assessments. For example, the SDQs undertaken on referrals to the health team amplify the mental health problems suffered by this population with 41% having a high or very high score for 'total difficulties', as compared to a population value of 5%.

A high proportion of the offenders have substance misuse and alcohol related problems, with 78% of the CHAT cohort being identified as such.

7.4 Overview of Findings: Learning Disability and SEN

The findings among the WYJS clients, mirrors the national picture with high levels of Learning Disability and SEN being identified, including the following:

- 21% had an existing SEN
- 28% had been to a 'special' school
- 45% had some type of learning need
- 10.5% had documented evidence of an IQ <70
- 12% were identified with ASD

It can be concluded that there is a high level of neurodisability and learning needs among the population, comparable with those nationally reported.

7.5 Overview of Findings: SLCN

The findings among the WYJS clients, demonstrates high levels of SLCN with a quarter to a third of the young people assessed showed evidence of SLCN, which is well above the population average of 7-10%. This significantly undermines the potential for interventions to have any impact, which may play some part in explaining the relatively high re-offending rates seen across all YOTs. WYJS does it best to tailor interventions to the young offenders' needs but with SLT support there could be improvements, which could impact on re-offending rates.

7.6 Overview of Findings: Current Service Provision

There is evidence that the WYJS case workers need more support in screening for health needs. The current 'in house' health and substance misuse services appear to be well-understood and accessed appropriately by the caseworkers. The mental health outcomes for those managed by the health team appear to be good and there is evidence that they contribute to reduced re-offending. The capability of the team in

providing mental health interventions is considered a key attribute of the service and should remain a priority in terms of the future service specification.
Areas of concern include:

- The lack of collaborative assessment (ie caseworkers should undertake the Asset assessment, refer to the health team if indicated and then review their original assessment through a joint meeting with a member of the health team). (This is being addressed in part through the introduction of AssetPlus)
- The detection and management of SLCNs
- The detection of physical health problems
- Access to Learning Disability/Neurodisability services for those with identified problems
- Ensuring referrals are made to lifestyle behaviour support, in particular smoking cessation and sexual health services
- The lack of a mental health/learning disability liaison and diversion service for young people

There are opportunities for improved connection to mainstream universal services, in particular to the School Health and Wellbeing Service.

7.7 Overview of Consultation Findings

Consultation with the young people accessing the WYJS confirms the extent to which the wellbeing of adolescents is undermined through social factors and pressures, including through social media. In considering 'what would work' having 'someone to talk to' featured strongly in the responses provided through the questionnaire. This is wholly consistent with the findings of a recent national report on desistance among youth offenders (44).

In both the focus group and through the questionnaire a number of young people seem to recognise the importance of gaining skills, but certainly from the focus group, a key challenge would appear to be motivation. Whilst, it must be recognised that the focus group was small and as such unlikely to be representative of the wider WYJS population, caseworkers concur with this finding.

In considering the engagement with parents, again it must be acknowledged that the group who participated are unlikely to be representative of the WYJS population. It must also be recognised that much has changed over recent years, and continues to do so, especially in relation to early years and school services. However, the parents who did contribute to the group, seemed clear that that behavioural problems were evident in their children from an early age, but they did not get the support they needed. The role of schools in particular was a focus of attention, with unhelpful pupil exclusions and delays in SEND assessments and decisions. They also commented on the need for alternative opportunities for 'less academic' children. Whilst there was less emphasis on access to health services than there might have been, parents did make reference to unhelpful access criteria/thresholds related to CAMHs.

The consultation with the WYJS staff indicated that they are generally clear on their role in screening for health problems, but face particular challenges in identifying and managing those with SLCNs and those with neurodisabilities including Learning

Disabilities. This is compounded by challenges in accessing the Integrated Disability Support service and health services for those with neurodisabilities. The caseworkers recognised that they needed to have opportunities to undertake joint assessments of clients with their health colleagues, which accords with best practice, but it appears are difficult to deliver in practice. If the health team were larger this might be more practical.

The 'wider partners' survey drew out some interesting observations, including the need for better identification of SLCNs and the need for early intervention more generally in these young people's lives. The need for better access to specialist support and for the promotion of wellbeing was also referenced by a number of respondents.

7.8 Overview of Assets

There was limited scope to identify the individual assets of the young people, as meaningful engagement was understandably difficult. However, the questionnaires administered by the WYJS caseworkers, with whom the young people have developed a relationship, did indicate that a number of young people recognised the importance of developing skills (in particular in relation to future work) and that they were aware of some of the issues that they needed to deal with (eg. anger management). In terms of the assets available to the young people and their families there was some evidence that the WYJS and the health team were a valued resource. For parents, there was a sense that some benefitted from community resources and groups, whilst others, often through lack of knowledge, did not.

7.9 Evidence for Models of Health Input into YOTs

A literature review, contact with Public Health England colleagues and with the YJB, did not identify any recent evidence in relation to the strengths and weaknesses of different models of health provision within YOTs. The Centre for Public Health published a paper (40) in 2011 that outlined six different models of health provision each with its' own merits. On reflection the model of provision in Warwickshire, whereby the team is embedded in the wider service, has considerable strengths. However, ensuring continued close working with specialist mental health and other services is important to sustain, along with effective clinical supervision for the WYJS health team members.

7.10 Recommendations in Relation to Commissioning

NHS Commissioners of the WYJS Health Service need to ensure that:

- In keeping with the requirements set out in legislation CCGs should be represented on the Chief Officers Board that oversees the delivery of Youth Justice Services in Warwickshire.
- The commissioning of the WYJS Health Service is aligned with the commissioning of other health and support services for young people, so the holistic needs of this client group can be better addressed by all services.
- Consideration is given to commissioning a therapeutic SLT service for WYJS clients with SLCNs, as justified in appendix 10.

- That the role of the wider WYJS in relation to 'prevention' is clarified and quantified and that the role of the WYJS Health Service is specifically considered in this context.
- Consideration is given to the level of health funding to the WYJS. Current investment (3.7%) falls short of the national average (6%). This would increase the health contribution from £103,000 to £165,000 per annum.
- Consideration is given to the merits of providing the health input into youth justice services on wider footprint (eg. Across Coventry and Warwickshire) to give economies of scale and the potential for a more diverse skill-mix within the health team.
- Should funding become available for a liaison and diversion service, consideration should be given to enhancing the WYJS health team to enable them to deliver the young people's aspect of this service.
- In relation to CAMHS services commissioners should seek to ensure that there is better integration between specialist and mainstream services and that information is shared with interested parties (eg schools) as appropriate (and without contravening data protection requirements).

7.11 Recommendations in Relation to the Specification for WYJS Health Service

It is recommended that commissioners should:

- Be clear about the balance between assessing and identifying need versus the capacity and capability of the WYJS health service (or other services) to address the needs identified.
- The capacity and capability of the health team needs to be sufficient to sustain evidence based therapeutic mental health support/ interventions that are highly valued by young people and both keep them out of mainstream CAMHS and out of custodial settings
- Ensure that there are sustainable arrangements in place to provide the required clinical supervision for the WYJS health team.
- Ensure that the WYJS Health Service provides more support for WYJS caseworkers so they are better able to screen for the range of health problems that may be present including
    - Physical health problems, including sexual health issues
    - Poor Mental Wellbeing and Mental Health problems
    - Substance mis-use problems and associated health risks
    - Neurodisabilities including Speech Language and Communication difficulties,
      Learning Disabilities/difficulties, traumatic brain injury ADHD and ASD
- Ensure the commissioned service includes staff with a wide range of skills and competence in relation to: Physical health problems, Mental health problems, substance misuse, and neurodisabilities as well as lifestyle related behaviours including risks to sexual health. As identified above specific separate consideration needs to be given to meeting SLCNs.
- The health team should support delivery of the outcomes agreed for the general CAMHs population.

- The health team should provide training and support to WYJS caseworkers and other relevant services (eg the School Health and Wellbeing service).
- The opportunity for closer working between the Educational Psychologists and the health team should be explored.
- For young people in custodial settings the service should meet YJB recommendations in relation to planning and resettlement.

In relation to introducing CHAT assessments, it is recommended that:

- A trial of use of the CHAT assessment should be undertaken on a defined cohort of young people with the express aims of determining how the CHAT can be undertaken:
    - through drawing on the Asset Assessments already undertaken.
    - through working with the WYJS caseworker in completing the CHAT.
    - with a view to identifying the difference completing a CHAT makes in terms of referral and/or outcome for the young people (ie what benefit does it confer in terms of improved outcome).

It is important to recognise that whilst there may be benefit in undertaking CHAT assessments this cannot be at the expense of capacity to provide therapeutic interventions. Separate resourcing of CHAT assessment should be considered in light of the findings of the trial.

7.12 Recommendations for the Wider WYJS in Identifying Health Needs

- WYJS caseworkers need to be supported in improving their ability to screen clients in relation to health problems and in relation to health risk factors, enabling appropriate referrals. This should include training for the caseworkers by the health team in using the Asset screening tools. In addition, specialist training could be provided by external agencies where there are gaps in the health worker's skill base.
- WYJS caseworkers need to skilled in enabling young people to engage with wider health services such as:
    - Lifestyle services (smoking, healthy weight, sexual health)
    - Universal health services (GP, Dentist, etc)
- Information should be made available to caseworkers about available services and referral pathways (eg Warwickshire has well-being hubs and lifestyle services that they could refer clients to).
- There should be ongoing supervision and periodic routine audit of the health screening undertaken by WYJS caseworkers to identify any training or support needs.
- WYJS caseworkers should adopt best practice, which states that the Asset assessment should be officially reviewed once a health assessment is completed.
- On an annual basis the routine health report should be expanded to include details of the health needs of the entire WYJS cohort as identified through routine screening processes (ie not just the health needs of the smaller cohort who are referred to the health team).

7.13 Recommendations in Relation to Prevention

- Commissioners of Early Years, Children and Young People Services need to agree how the evidence in relation to Adverse Childhood Experiences should be implemented in local strategies and services

Early years providers and schools need to ensure:

- The early identification of social, emotional and mental health needs of pupils and the consequent presenting behaviours, establishing effective early intervention, engaging family members and wider support as appropriate
- The early identification of children with SEND and/or SLC difficulties, ensuring effective early intervention
- The provision of effective support to pupils who have difficulties that might not reach SEND criteria

Those commissioning/supporting or monitoring the provision of education services need to ensure:

- That schools are appropriately supported in tackling pupil non-attendance and in avoiding pupil exclusions
- That there is appropriate support and safeguarding of excluded pupils and that the length of time pupils are excluded is minimised
- Consideration should be given to referring excluded and other 'at risk' young people to the WYJS for preventative work.

Those commissioning children's social care services and the 'Priority Families' programme should ensure that:

- There is adequate support and training for staff working with children and families to recognise needs and behaviours among children that could pre-dispose to youth offending.
- There is training and support available to foster parents and LAC to tackle problems behaviours that could lead to youth offending.
- There is access to appropriate behavioural support services, including CAMHS, to address behavioural problems among children and families.

There is a strong evidence base for interventions in early years to tackle behaviour and conduct disorders that indicate good cost-effectiveness (47).

7.14 Recommendations in Relation to Other Services

The WYJS is advised to work with the relevant commissioners and providers of services to ensure that:

- Universal services, in particular the School Health and Wellbeing Service, make information that they have (eg. from previous health assessments) available to the WYJS and that the two services should work in partnership in addressing health needs.

- Appropriate links between Speech, Language and Communication services and the WYJS are developed aimed at ensuring the service provides a 'communication friendly' environment.
- A pathway between the WYJS and mainstream Learning Disability/Neurodisabilty services needs to be established.
- Specific consideration should be given to identifying joint commissioning opportunities with other agencies and organisations for example to provide consistent and streamlined support to young people with substance misuse problems.
- With the support of the educational psychologists the WYJS should develop a strong working relationship with the SEND team, to support those who require a EHC plan and/or have other support needs, including SLCN.
- Wherever possible work is aligned with services such as targeted youth support, to ensure the best possible use of collective resources.

WYJS has a clear focus on building motivation and raising aspirations of the young people they supervise. Desistance theory is applied and the relationships WYJS develop with young people are effective in supporting the interventions delivered, resulting in the demonstrated reduced re-offending rates. Whilst the use of positive role models is included in the work with young people opportunities to increase this should be explored so that more young people are able to experience first-hand the benefits of adopting a crime free life.

Berni Lee
Public Health Warwickshire
August 2016

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Appendix 1

Steering Group Members

Tony Begley – WYJS Service Manager, Chair
Mark Phillips –Clinical Supervisor Health Team
Etty Martin - Sexual Health Commissioning Manager
Will Johnston - Joint Commissioning Manager (Adult Treatment & Care)
Andrew Sjurseth – CAMHS Commissioning Manager, Children's Social Care
Berni Lee – Locum Public Health Consultant, Project manager
Tracy Underwood, Educational Psychology Service

Appendix 2

Applied Prevalences to WYJS Population
Compared to Identification Through Screening

Issue and estimate in Youth Justice Populations	**Warwickshire YJ estimate N=268 (f=47, m=221)**	**2014 WYJS screening**
Total LAC (previous and current) 40-49% (incl community) 50% of females, 25% males (YOI)	107 to 131 23 females, 55 males	23%
Total ref to children's 71% 'had social worker'	190	54%
Suffered bereavement/loss 4% in general population 17% YJ population	46	30%
Homeless 40% in YOI 'at some point'	107	4.5%
School age excluded 15% on ref to CJS 86% of boys previously 82% of girls previously	 40 190 males 38 females	 11.9%
Truanting 40%	 107	
Smoker 83% secure estate	 222	 57.5% n=154

Alcohol		
66% binge drinking	177	54.1% n=145
25% drinking ‘out of control’ pre-custody	67	
Illegal drugs		
60% in custody	161	48% n=127
ADHD (1 -2%)		
(3-9% broader criteria in general pop)		
10% boys (R&T)	22 males	3%
11.7% males (CC)	26 males	
18.5% females (CC)	9 females	
SEN statement		5.6%
>50% in custody lit/numeracy < 11 yrs (R&T)	>134	13.6% (screening tool)
Autism 0.6% - 1.2%		
15% (CC)	40	0.4%
Previous suicide attempt		7.8%
Self harm		14.6% (total WYS pop)
33% girls in YOI	15 females	8% (screening tool)
Formal MH diagnosis		7.1%
		8% (screening tool)
Chronic health problem		
36% in YOI	96	0.4% ‘disability’
11% but under-identification noted	29	
36% audit in London (R&T)	96	

12% males	26 males	
Other review in custody 25% males	55 males	
30% females (YP 15-17 in custody)	14 females	
Other review in custody 33% females	15 females	
Learning Disability (IQ <70 plus social factors) 2-4%		
27% in SCH	72	
43% IQ 70-85	115	
23 – 32% (CC)	62 - 85	
SLC (Gen pop 9% poor/v poor speech Listening. General SLC 1-7%)		
73% in YOI poor language score (R&T)	196	
67% poor/v poor speech	180	
62% poor/v poor listening (R&T)	166	
60 - 90% (CC)	161 - 241	
Dyslexia (Gen pop 10%)		
43 – 57%	115 - 153	
TBI 5 – 24% (self reported)		
65 – 76% (CC)	174 – 204	26% (screening tool)
Risk factors for CMH probs		
85% at least one RF	228	

51% 3 or more RFs (R&T)	137
MH (under estimates – more defined Through behaviour/emotion/substance Self-harm) (20% of pop ‘MH problem’ 10 – 13% diagnosable disorder – gen pop)	
25 – 77% diagnosable disorder	67 - 206

Appendix 3

Criteria for Referral to WYJS for Mental Health Assessment (section 5.1)

Fits Mental Health Criteria
This referral category is used when there are concerns with a young person's mental health and additional support is required. The eligibility criterion may fit one or more of the below; ☐ All PSR requests MUST request MH assessment as part of the PSR assessment process. ☐ Any Immediate concerns about emotional and mental health ☐ Any mental health concern requiring further investigation ☐ Previous and/or current history of self-harm and/or suicide ☐ Previous and/or current involvement with other mental health services ☐ Any young person scoring 2 or more on SQIFA or 2 or more on the mental health section of ASSET

Appendix 4

Summary of Responses to Questionnaire for Young People in Youth Justice Services

Introduction: Caseworker to give a brief overview of 'what health is' to the young person ie. Includes physical problems (like asthma, acne or STIs), issues related to mental health and wellbeing (stress, anxiety, depression), and is influenced by lifestyle factors (smoking, alcohol, drugs). Other issues like housing, employment, education and the environment you like in also affect health.
It's important that we understand what the health needs of young people are and what services would help them – and how these services or 'self-help' could best be delivered.
Total of 20 responses received.

1. What prevents you feeling good about yourself or makes you feel ill?

   No response= 4
   Alcohol/cannabis=2
   Physical health problem=1
   Lack of sleep=1
   Family/friends pressure=9
   Emotions/anger/upset=8
   School exam pressure=1

2. If you do think you need help with any health problem where do you go (eg service)? Or what do you do (eg talk to friend, or use google)?

   Family=12
   Friend=5
   GP=8
   Other health service=7
   Google=4
   YOT=2
   School=2
   No-one=1

3. Looking back on any health issue you might have had, what would have helped you (*thinking about support/intervention/service*) to have felt better about yourself/your life or helped you to get better more quickly?

Nothing=8
Quicker service access=7
Someone to talk to=6
Help with lifestyle=1

(please state the health issue and the respective service/intervention)

4. Was there a time when you needed help but didn't get it? What would have

helped? Was there a trigger to feeling you needed help?

Nothing=9
People to listen=7
Help at school=1
Help with lifestyle=1
Help with accommodation/housing=1
Referred to social care but didn't get help=1

5. What has worked for you (*thinking about support/intervention/service*)? Have you ever had support or a service that has helped?

Health service=10
YOT=5
Nothing=3
Family/friend=3
School=2
Other service=2

6. Looking forward – what would help you to feel good about yourself and live the kind of life you want? (*Thinking about building resilience – what are the risk and protective factors?)*

Learning/qualifications=8
Supportive relationships=7
Self-confidence=5
Lose weight=2
Information=1
Accommodation=1
Help with bullies=1

7. What kind of help or support (health related) could be provided through the Youth Justice Service?

Nothing=9
Anger management/counselling=10
As is=2
Sexual health=2
Lifestyle=1

Additional notes

Appendix 5

Youth Justice Service
Young People's Focus Group
June 23rd 2016

Background

3 young people attended the focus group, 2 males and 1 female. The purpose of the focus group was explained and each young person signed a consent form**.**

The following questions were discussed:

1. **What prevents you feeling good about yourself? What prevents you feeling like you're 'doing well' in life in general?**

The overriding response from the young people present was that boredom is the main factor that undermines their wellbeing. They feel they have nothing to do and nothing is of interest to them. This boredom draws them to cannabis use 'everything feels better when you're stoned'. There is also an element of rebelling against family tied up in smoking cannabis, but the main motivator is that cannabis and other substances distract the young people from the boredom of everyday life.
The young people admitted that their wellbeing is undermined by 'post-drug paranoia and sometimes by the 'trips' experienced whilst they are high.
When questioned about what would provide the motivation to stop drug use the young people responded with 'something to stop boredom' but couldn't readily identify the types of interventions that would be effective. On further prompting they suggested that access to gym facilities might be helpful.

2. **Looking back, what would have helped you (*thinking about support/intervention/service*) to have felt better about yourself/your life? What would kept you feeling well?**

The young people had no response to this question.

3. **When you need help do you know where to go?**

The young people most frequently identified asking a family member ('I ask my mum') or using 'google'

4. **Was there a time when you needed help but didn't get it? What would have helped?**

In response to this question the young people were critical of substance misuse services saying 'they don't work'. 'They tell you what you already know' The young people explained that they already know about the dangers of substance misuse and that hearing about the problems from professionals will not stop them using drugs. In addition they felt that the approaches used by the services were counterproductive. 'They just give you ideas about other drugs that you haven't yet tried'.
When challenged about what would give them the motivation to stop the young people said that they would most likely stop 'when I grow up' or perhaps if they had a 'bad experience' as a consequence of drug taking, but not otherwise.

5. **Looking forward – what would help you to feel good about yourself and live the kind of life you want? (*Thinking about building resilience – what are the risk and protective factors*)**

The immediate response was ‘if I had loads of money, I wouldn’t bother with drugs’ The young people recognised the need to ‘get a good job’ and that to do that they will need skills and would perhaps ‘need to learn a trade’.

6. **What can the WYJS offer that will help?**

The young people said that drug testing was helpful in supporting abstinence from drug-taking. They agreed that they needed motivation and that opportunities for skills development would be welcome.

Berni Lee
June 2016

Appendix 6

Key Issues Raised by Parents Involved in the Focus Group

A total of 10 parents attended the Bloxham Centre in Rugby to participate in the Focus Group. They had been told about the event by case workers in the Warwickshire Youth Justice Service (WYJS).

Key Issues Raised

There was a wide-ranging discussion in response to each of the questions raised. Most parents contributed to the discussion in the focus group but some also added additional points after the meeting (raising points that they didn't particularly want to discuss in front of others). The key issues raised in response to each question is summarised as follows:

What are the key challenges to health and wellbeing for young people?

- Peer pressure – the need 'to look cool'
- Social media – constantly 'being connected' creates problems affecting a young person's wellbeing
- Young people lack communication and social skills because of the social media environment
- Low self-esteem underpins the use of drugs, alcohol and often underlies underage and unsafe sex
- Parents need to understand that the way in which they parent has a massive impact on their child's wellbeing; communication and mutual trust are key
- If a parent's wellbeing is not promoted and supported they will not be able to be a good parent

What, if anything, could have prevented these health and wellbeing needs from becoming problems?

- Alcohol and its availability (cheapness) is an issue but some were of the view that making it more expensive wouldn't help ('they will still get it somehow')
- There should be more education about how to 'stay safe' – with friends encouraged to understand how they can help keep other friends safe
- Some parents commented that there is a danger of parents losing focus on their fundamental role as a parent (they should not try to be the 'child's friend')
- Parents described a lack of early intervention; in particular in relation to problems at school and in accessing appropriate mental health services.
- In terms of support in school 'it takes forever to get a statement but without it the school wont help' and other children were told they couldn't stay all day in mainstream school, but weren't offered an alternative school.
- It was noted that children excluded from school or those who truanted were at much increased risk of 'getting into trouble'. Parents want help where their children refuse to go to school, but the group felt this generally wasn't provided.

- There were differing views about the role of social services in prevention: some parents expressed a fear that telling social services about problems might lead to children 'being taken into care' whilst others felt that despite telling social services about the challenges they faced, they were not supported. Not getting support reinforced bad behaviours by leading children to believe they could 'do what they like' and nobody could intervene.
- It was noted that young people could refuse services such as those for substance mis-use and this reinforced a young person's belief they could 'do what they want'
- It was noted by some parents that 'Protective Behaviours' training is available in some schools (which helps children understand and talk about their emotions) and this was felt to be a positive development.
- More action in schools to prevent and deal with bullying would impact on the wellbeing of young people
- There was a view that there should be more promotion of the services and self-help opportunities that were available. Not everyone knows what is there to help them.
- If there were more opportunities for parents to support each other this would help (looking after parents wellbeing and providing them with opportunities to help each other)

What type of support or services have you or your friends received to help deal with the health or wellbeing issue(s)?

- Some parents had experience of a 'carers support group', which was helpful
- The 'Triple P' programme was described as 'a good experience' by some parents and the West Midlands Autism helpline was useful for others
- A 'Facebook group' had been helpful for some parents, but others didn't know about it
- Parents groups (such as the former Youth Justice Lunch Club) were valued by parents who had participated and youth clubs were felt to be positive for young people
- In general parents 'do not want to be endlessly assessed' they just want to be given some support in dealing with problems
- The IAPT service is not flexible enough and the threshold for support through CAMHs is too high

What type of help or support would have been most beneficial for you and/or your friends in dealing with the problem(s)?

- There should be more opportunities for parents to connect with each other
- Getting help must be easier – access criteria are a barrier to support
- Young people need to have choices, not 'one size fits all'

- Young people need help to understand their emotions and build their self-esteem
- Parents should be told at the outset – by the midwife and the health visitor – what help and support is available to them
- Social media should be used to raise awareness of the services and support available.

Looking forward what type of help or support would help young people to be resilient and able to maintain good wellbeing despite the pressures and challenges faced?

- Young people and their parents need to be educated about safe use of the internet (acknowledged that this does happen to an extent in schools, but generally not felt to be sufficient)
- There needs to be more courses in schools (like 'stay safe courses') and parents need to know about these (schools should not rely on children handing them a letter from school, as a minimum school should text parents to alert them to events…..in a similar way to texting when a child is off sick)
- There needs to be more opportunities for sports and a wider range of physical activity opportunities. These also need to be affordable.
- Children and young people who are not academic need to be given alternative opportunities through schools (a day at a hairdresser or with a skilled worker like a carpenter)
- There needs to be a safe place for young people to go to where they can have fun through semi-structured activities
- Encourage young people to express their feelings from an early age

Is there anything that we should know about the health and wellbeing of young people, how we can prevent needs from emerging or anything about the services or support that is available that we haven't asked about?

- There needs to be more awareness about safe sex and more information about sexually transmitted infections
- There is still an element of embarrassment for young people and their parents in talking about sex
- Young people generally don't know how they can get free condoms
- There needs to be more opportunities for young people to talk confidentially to health and other professionals (eg. not in a crowded waiting room)
- The school nursing service would be more widely used if the nurse was in the school more (nurses perceived to little time in each school)
- There would be a value in school providing counselling services (a little like the old 'Connections' service.
- There should be alternative routes into health services rather than having to go to the GP for every referral

- Mental health services should be more accessible; for example with referral through schools rather than via a GP
- There were positive experiences of the REACH mental health service but CAMHs waiting times were too long
- Not everyone's experience of CAMHs has been positive; one parent found the service insensitive and unhelpful
- The overriding feeling of parents was they knew from an early age that their child needed support but this generally was not provided and problems escalated as a result.

Appendix 7

Youth Justice Staff Survey
Analysis

Q1 Are you clear about which health screening tools are currently being used in the WYJS?

Yes	92.00%	n=23
No	8.00%	n=2

Q2 please specify what needs to be clarified:

1. I feel semi-clear. needs some clarification, as the tools/ paperwork has changed a few times in recent times.
2. No training for this in my post

Q3 If I have a general question about a young person's health, I have someone I can ask.

Yes	**92%**	**n=23**
No	**4%**	**n=1**
Don't Know	**4%**	**n=1**

Q4 I know how to refer a young person to stop smoking services if they want to give up.

Yes	**75.00%**	**n=**18
No	**20.83%**	**n=**5
Don't Know	**4.17%**	**n=**1

Q6 I know how to support a young person in registering with a GP or dentist.

Yes	**95.83%**	**n=** 23
No	**4.17%**	**n=**1
Don't Know	**0.00%**	**n=** 0

Q7 I know the basic advice to give a young person about their diet.

Yes	**91.67%**	**n=**22
No	**8.33%**	**n=**2
Don't Know	**0.00%**	**n=** 0

Q8 If a young person needed specialist dietary help I would know who to ask.

Yes	**58.33%**	**n=**14
No	**20.83%**	**n=** 5
Don't Know	**20.83%**	**n=**5

Q9 I know the basic advice to give a young person about their physical activity.

Yes	**95.83%**	**n=**23
No	**4.17%**	**n=**1
Don't Know	**0.00%**	**n=** 0

Q10 I know about local physical activity schemes I could tell a young person about.

Yes	**66.67%**	**n=**16
No	**25.00%**	**n=**6
Don't Know	**8.33%**	**n=** 2

Q11 I would know where to direct a young person if they needed sexual health advice.

Yes	**95.83%**	**n=**23
No	**0.00%**	**n=**0
Don't Know	**4.17%**	**n=**1

Q12 Young people can access condoms, lubricants and barrier protection through the WYJS.

Yes	**83.33%**	**n=**20
No	**4.17%**	**n=**1
Don't Know	**12.50%**	**n=**3

Q13 If a young person needed advice about pregnancy I would know where to direct them.

Yes	**91.67%**	**n=**22
No	**4.17%**	**n=**1
Don't Know	**4.17%**	**n=**1

Q14 If a young person has a chronic health condition, their specific needs are addressed.

Yes	**66.67%**	**n=**16
No	**8.33%**	**n=**2
Don't Know	**25.00%**	**n=**6

Q15 The WYJS is able to identify the risks and respond appropriately to young people misusing substances

1: Not well at all	**0.00%**	**n=**0
2:	**0.00%**	**n=**0
3:	**20.83%**	**n=5**
4:	**12.50%**	**n=3**

5: Very well	**66.67%**	**n=**16

Q16 When you have a client with a substance misuse problem are you confident in providing the required support where the threshold for referral to Compass has not been reached?

Yes	**78.26%**	**n=**18
No	**13.04%**	**n=**3
Don't Know	**8.70%**	**n=**2

Q17 When a client requires referral to Compass, does the service offer a timely response?

Yes	**47.83%**	**n=**11
No	**17.39%**	**n=**4
Don't Know	**34.78%**	**n=**8

Q18 Communication with the Compass case manager/specialist is satisfactory.

Yes	**43.48%**	**n=**10
No	**17.39%**	**n=**4
Don't Know	**39.13%**	**n=**9

Q19 Links to offending and associated substance related risks are addressed.

Yes	**86.96%**	**n=**20
No	**0.00%**	**n=**0
Don't Know	**13.04%**	**n=**3

Q20 The role of the Compass substance case manager/specialist is clear.

Yes	**43.48%**	**n=**10
No	**34.78%**	**n=**8
Don't Know	**21.74%**	**n=**5

Q21 Movement of responsibility between services (WYJS and Compass) based on the changing needs of the young person is clear and happens appropriately

Yes	**43.48%**	**n=**10
No	**17.39%**	**n=**4
Don't Know	**39.13%**	**n=**9

Q22 Statutory appointments are supported by the Compass case manager/specialist, as appropriate to need.

Yes	**52.17%**	**n=**12
No	**8.70%**	**n=**2
Don't Know	**39.13%**	**n=**9

Q23 I am satisfied that the collective service available between both the WYJS and Compass meets clients needs

Yes	**43.48%**	**n=**10
No	**17.39%**	**n=**4
Don't Know	**39.13%**	**n=**9

Q24 What would you change, if anything, to improve the outcome of a substance misuse referral and intervention?
Answered: 9

1 Communication with the Compass case manager/specialist is satisfactory but is not always as good as it could be. The role of the Compass substance case manager/specialist is not always as clear as it could be. Statutory appointments supported by the Compass need to be clear about their responsibilities.

2 Referral process for Compass to be put in directory and I think the staff turnover has made it difficult to know who to contact but SME practitioners in WYJS screen and refer anyway.

3 I have had limited need to be working with Compass and therefore only have one case history experience. To have staffing issues resolved for the sake of worker consistency/ contact for the yp.

4 Young people are often not ready to address their SMS needs or are in denial that it is a problem. Compass will only engage with them when they are ready and this can be problematic. Also if the young person does not engage the case is closed, however, some engagement techniques from Compass may help to engage that young person before closing the case. I realise this may down to resources available

5 Nothing. The WYJFIS SMU worker are very good at sharing information and advising staff on the referral process and the level of intervention needed.

6 I think generally a substance misuse intervention works best when it is delivered by the Youth Justice specialist worker rather than externally via Compass.

7 More education face to face with multi agencies

8 Faster intervention by Compass and WYJS substance misuse better communication

9 It's difficult to encourage young people to engage with Compass as this is a voluntary intervention and YP are not always willing

Q25 The WYJS is able to identify the risks and respond appropriately to young people with mental health issues

1: Not well at all	**0.00%**	**n=**0
2:	**4.35%**	**n=**1
3:	**8.70%**	**n=**2
4:	**34.78%**	**n=**8
5: Very well	**52.17%**	**n=**12

Q26 When you have a client with a mental health problem are you satisfied with the support provided by the WYJS health practitioner?

Yes	**95.45%**	**n=**21
No	**0.00%**	**n=**0
Don't Know	**4.55%**	**n=**1

Q27 Communication between the case manager and health practitioner is satisfactory.

Yes	**95.45%**	**n=**21
No	**0.00%**	**n=**0
Don't Know	**4.55%**	**n=**1

Q28 Links to offending and Mental Health issues are addressed.

Yes	**95.45%**	**n=**21
No	**0.00%**	**n=**0
Don't Know	**4.55%**	**n=**1

Q29 The role of the health practitioner is clear.

Yes	**90.91%**	**n=**20
No	**9.09%**	**n=**2
Don't Know	**0.00%**	**n=**0

Q30 What would you change, if anything, to improve the outcome of a mental health referral and intervention?

Answered: 8

1 there are more YP with health needs then the current number of health practitioner can deal with.

2 This area is a core component when working holistically with yp's complex needs. Therefore increased camhs staffing within WYJS may be beneficial.

3 Since we have the mental health practitioner on site this has been extremely helpful and makes the service easily accessible. Plus the knowledge of staff is excellent and their willingness to support

4 The WYJFIS health workers are very supportive and will help guide and support all staff to make an appropriate referral and also the correct intervention

5 A better joined up working arrangement between health worker and practitioner - ie the opportunity (if agreed by the YP) for the practitioner to undertake joint sessions with the health worker

6 more mental health workers

7 nothing

8 Nothing. The WYJS Health Staff offer an exceptional service.

Q31 The WYJS is able to identify the risks and respond appropriately to a young person with a Learning Disability
Answered: 22

1: Not well at all	**0.00%**	**n=**0
2	**13.64%**	**n=**3
3	**31.82%**	**n=**7
4	**13.64%**	**n=**3
5: Very well	**40.91%**	**n=**9

Q32 What support would you need to better identify and respond to a Learning Disability?
Answered: 9

1 practitioner to use the tools to identify the need

2 Improved ability to identify and understand.

3 Better understanding of the services that are available to young people with disabilities and access to resources to support engagement with them.

4 I don't know

5 triangulation of needs into reports and plans could be better

6 more training for staff including managers. There is limited understanding around this

7 More specialist knowledge

8 Good communications with school

9 assessment tools

Q33 The WYJS is able to identify the risks and respond appropriately to a young person with a Speech Language or Communication difficulty
Answered: 22

1: Not well at all	**0.00%**	**n=** 0
2	**9.09%**	**n=**2
3	**22.73%**	**n=**5
4	**22.73%**	**n=**5
5: Very well	**45.45%**	**n=**10

Q34 What support would you need to better identify and respond to a Speech Language or Communication difficulty?
Answered: 5

1 practitioner to use the tools to identify the need

2 I understand that this may be addressed through our mental health practitioner who can support referrals to the right team depending on the need

3 I don't know

4 More specialist knowledge

5 understanding of what I am looking for

Q35 The WYJS is able to identify the risks and respond appropriately to young people with a physical health problem
Answered: 22

1: Not well at all	**0.00%**	**n=**0
2	**4.55%**	**n=**1
3	**22.73%**	**n=**5
4	**22.73%**	**n=**5
5: Very well	**50.00%**	**n=**11

Q36 What support would you need to better identify and respond to a physical health problem?
Answered: 3

1 practitioner to use the tools to identify the need

2 Basic links to community

3 not sure where we go specifically if not the young person’s local GP but I am new to the Service so will find out

Q37 Is there any particular training around health you feel would help you do your job?
Answered: 7

1 Autism/ASD and Dyslexia training

2 Learning Disability

3 I need to develop my knowledge around the services available to young people locally

4 Better understanding around working with young people with mental health difficulties/learning disabilities. Yes we have health practitioners but we are also working with these young people and are not always equipped

5 the more the better

6 Ways of working with YP on Autistic Spectrum

7 Further substance misuse training

Q38 What ONE THING could we change to most improve the health of young people?
Answered: 7

1 practitioner to use the tools to identify the need in the first place.

2 there are limited young people friendly services in the nhs including local GP's. Services appear not to be targeted for young people but they do have specific needs

3 A seconded physical nurse

4 Access to appropriate services in a timely fashion. Some young people who require specialist intervention from psychologist/psychiatrist is taking too long

5 Full time health workers

6 There's loads of things for different people

7 improve assessment and willingness of all practitioners to engage with health related issues.

Q39 Is there anything else you would like to tell us about the health of young people in the WYJS or the services they receive?
Answered: 4

1 the work that is currently done is a very high standard we need more hours to more work.

2 It is brilliant that assessments and counselling support can be identified quickly rather than waiting for months for a young person to be seen by CAMHS. Also Ed/Psychs have been a great support in identifying yp with special needs and working with schools and colleges to ensure the yp reach their potential

3 I am new to the Service so my gaps in information may relate to that. Having a member of specialist staff in the team is significantly helpful in supporting access to services and resources for the team

4 The mental health workers based on the team are excellent, it would be nice to have at least another worker so young people would benefit more from this intervention.

Appendix 8

WYJS Staff Focus Group in Support of Health Needs Assessment
Monday 14 March 2016

Present: Rachel Judson
Marie Fitzer
Sean Briggs
Rosanna New
Iain Bache
Tony Begley
Jenny Stringer
Bernie Lee
Isobel Ackerley
Aimee Williams
Julie Low

1. The meeting was held to obtain the view on health needs within the Youth Justice Service. The key findings will be shared. The Chat assessment may be embedded within Youth Justice Service.

2. A summary of the HWBNAA was provided, including the processes for assessing health needs and gaining staff, partner agency, young people and family views.

3. From an early look at data findings, mental health/SMU needs are fairly similar to national levels. The routine screening data under estimates existing physical health needs; autism etc. MF stated that all young people in contact with have mental health needs/issues.

   Staff explained that assessments are informed by 'gut feelings', background information perspective; level of need identified able to be managed by case manager..

   25% of staff said they didn't know where to refer for cessation advice for example. It is difficult for young people to engage with these services. Certain chemists are not willing to work with young people who want to stop smoking. Professionals do not know where/when or how to refer. The Youth Justice Service' role is to reduce offending behaviour not to stop young people smoking. They could direct the young person to the relevant service. Compass is linked to school health.

   The role of the Mental Health team is clear. People were less clear on the role of the SMU team. IB stated that the Mental Health team have no tier system within it. The tier system for SMU referral was not clear. Communication between Compass/Youth Justice Service is improving. Work has been done around communication between the two services.

4. Screening tools now inform Asset plus. There is a time frame over which things get completed. Assessments are done over two working days (national standards) to inform the report.

   Screening tools are better now and they could be revisited at exit panels.

5. Referral pathways are clear to practitioners.

   It was felt some young people should have a diagnosis that haven't had one. SB can refer to CAMHS if needed. Practitioners struggle to get IDS on board and there was a query over when Youth Justice Service can refer to IDS. The new MASH service might help with this and make the connections better.

6. Practitioners help young people with GPs and dentists. A phobia of needles is a factor in young people not seeing these professionals. One young person has rotten teeth and will not smile because of this. Practitioners can do research for options available. Immunisations may also not have been done due to needle phobia. There is a disparity on what would happen; some practitioners offer help/others don't. Parental agreement would also be needed. Consistency is needed regarding responding to physical health needs.

7. Training in ongoing. Internal training will be the way forward. Generic basic/practical training would be more beneficial rather than specific training. The training budget for 16/17 will be greatly reduced and creative/joint training may be an option.

   Referral pathways are available to practitioners. The school nurse can provide information on immunisations and what the young person has/has not had. JS wanted more info regarding a young person's sexual health. The Chat assessment highlighted issues that the young person was having and the support being provided to the young person. The Chat assessment was very useful.

Appendix 9

Partner Agency Survey
Interim Analysis

Q1 How important is the health of young people in contact with the YOT to your work or to the work of your organisation?

1: Not important at all	1.15%	n=1
2:	5.75%	n=5
3:	21.84%	n=19
4:	25.29%	n=22
5: Very important	45.98%	n=40

Q2 Which of the following best describes the organisation you work for:

Police	45.45%	n=40
Probation	1.14%	n=1
Social Care	4.55%	n=4
Education	7.95%	n=7
NHS / Other Health Service	9.09%	n=8
Other Public Sector	23.86%	n=21
Community/voluntary group	3.41%	n=3
Other	4.55%	n=4

Q3 Are you confident that the health needs of young people referred to the YOT are identified in a timely manner?

Yes	25.29%	n=22
No	9.20%	n=8
Don't Know	65.52%	n=57

Q4 Are you confident that through the YOT there are appropriate and timely interventions to address identified health needs?

Yes	24.71%	n=21
No	14.12%	n=12
Don't Know	61.18%	n=52

Q5 Does the YOT provide adequate support and information about the health of young people to enable you to do your job well?

Yes	26.44%	n=23
No	17.24%	n=15
Don't Know	56.32%	n=49

Q6 If you answered 'no' to Question 5, please specify what the difficulties are: Answered: 20 (selected responses)

1 I think people do what they can, based on information that they are given, however people still fall through the system, when the connections in how they feel and behave are not always analysed out through a full mental health and wellbeing assessment. Transition in and through services could be better, between different elements of the criminal justice pathway.

2 students unable to access

3 Not enough awareness of this service

4 Lack of communication/sharing of information

8 I don't think GPs are informed about which patient's access the YOT so I can't be sure their needs are met.

9 Communication between our YOT and the wider partnership is limited and could be improved through attendance at partnership meetings. It is more a case of not knowing what work is being done so that other partners can complementor fill in the gaps to complete a holistic service.

10 From a Community Safety Partnership perspective young people can present with health related needs from alcohol and drug misuse.

11 We have an agreement with youth offending but I have never been contacted by them about any young people.

12 reluctance to share information

13 Lack of communication

14 lack of communication, lack of proactive engagement from YOT workers to partner agencies

15 This really depends upon the worker I have had some very good experiences and some not so positive- this also depends upon the willingness of the young person to engage .

16 We are never told about the content of meetings with the young person.

19 I chair XX community safety partnership and am a member of the safer Warwick board. Accepting I have only performed these roles since May 15 I don't recall having had any contact with YOT.

20 The flow of information from the YOT through to our Team is via WYJS staff in Family Intervention. This does not work well and we would all benefit from a direct and dynamic link with YOT. WE also need to ensure that the information when sent relates to the YP within the context of their family life. Also there is a lack of coherence and priority given to establishing an appropriate personal and professional development programme for FI staff on health, related issues, and career progression

Q7 Are there particular health issues which you feel are less well addressed through the YOT and subsequent services?
Answered: 41

1 'No' *(cited as a response by 5 respondents)*
'Mental health' *(cited as a response by 5 respondents)*

2 As above - reports following deaths of young people in custody, often show a breakdown in care systems where there has been a lack of understanding on aggressive behaviours, or the right interventions early enough leading to self-harm or suicide...- I think mental health and substance misuse sit very closely together, and an integrated approach for dual diagnosis and case management would be helpful, as only the most severe cases tend to be recognised. Most people take substances to change how they feel, which connects strongly with mental health. Aware that most young people will have access to CAMHS. Sexual Health is covered, but in most settings, I think it tends to be the 'poor relation' Access to services for specialist Tier 4 beds can be challenging

4 Mental health support and assessment for family intervention young people

5 overall preventative services especially around mental wellbeing

6 health literacy, speech and language,

7 There can be issues at transition into adult services as the same services are not provided for adults as for children and this transition can be difficult to manage. in particular, autism, adhd, speech, language and communication issues, conduct disorder have no clear adult referral pathways also access to psychiatric assessment for clients not known that present in custody with serious mental health issues can be unclear who has responsibility

8 Not sure as Probation do not take over responsibility until individual is 18. Impression is that health interventions are more readily available/better resourced in YOT than when transferred to probation. Probation is reliant on general community health services and so take up by offenders is very mixed.

15 Mental Health provision could be better

16 I am not familiar enough with the services a YOTS however Im sure that CAMHS access will be an issue

18 There is a lack of resource for mental health in all services

21 There are high levels of young people in prisons and attending the recovery partnership with undiagnosed and unsupported ADHD. I have been told by workers in both these areas that levels reach 60% and whilst they may not need medication if we could identify children with lower levels of ADHD, ASD and dyslexia in schools and target them with appropriate support, behavioural techniques and teaching it may enable them to deal better with society.

22 Alcohol and Drug risk reduction work seems ineffectual. It is a difficult area of work but in my experience alcohol and drug habits remain unchanged following intervention. perhaps referrals to compass should be made for this area of work?

23 I don't think I have a sufficient informed view to answer this question. From my experience substance misuse issues will be picked up and referrals will be made to Compass who provide the specialist treatment services for young people.

24 Not known as they have not contacted me.

25 self harm, mental health issues

26 Emotional well being

34 Identification and working with those who have speech and language difficulties and ADHD

35 Not really sure how YOT assesses the health of young people so hard to comment

36 Living conditions.

37 Personality Disorder

39 Link of crime to learning problems due to chronic health issues relating to ability to interpret text (i.e. read)

40 No but I would be keen to ensure that all sexual /alcohol / drug harm reduction Services are robust, and that sexual violence and domestic abuse signposting and treatment services are first class at the point of access and delivery.

41 Mental Health and Emotional Well Being issues of both the YP and their relevant family members need to be identified and communicated as early as possible

Q8 Are there particular health issues which you feel are particularly well addressed through the YOT and subsequent services?
Answered: 35

1 Drug and Alcohol issues *(cited as a response by 5 respondents)*
‘No’ *(cited as a response by 2 respondents)*
‘Mental health’ *(cited as a response by 2 respondents)*

2 General health care assessments in YOI's are thorough, with the use of CHAT assessment.

3 Access to emotional well-being and CAMHS particularly valued. Ability for CAMHS and health professionals to contribute to a holistic assessment of young person highly valued.

9 Great for advice and knowledge of the kids.

19 I think the needs are identified quickly but the interventions are ineffectual.

22 contraception and sexual health

26 Nutrition

29 YOT identify drug misuse and make timely referrals for appropriate support.

33 physical injuries

Q9 Are there clear lines of accountability in terms of responsibility for identifying and responding to health needs between your service and the YOT?

Yes	**35.63%**	31
No	**14.94%**	13
Don't Know	**49.43%**	43

Q10 If you answered 'no' to Question 9, please specify what the difficulties are: Answered: 15

1 I have read reports, which indicate transition between services, or transition between child/adult environments can be managed better, particularly for those young people, who have come through the system, with 'looked after care' status.

2 I'm not sure if lines of responsibility are 'clear'. There will be an understanding of health needs as identified in handover arrangements and previous assessments. What may be less clear is responsibility of specific health providers.

5 I would say they are covered in conversation rather than formally, have not had unhealthy young people through my hands though

6 Not aware of any processes in place to ensure info is passed on

7 I don't think GPs are informed. Information from priority families which might help identify children at risk of engaging with the youth justice system is not routinely shared with the patients GP on a named patient basis.

8 There is no communication to allow the identification of accountability.

9 The involvement of youth justice services in our local community safety related work has been inconsistent. We have had some engagement and input during the last year regarding a problematic group of youths in Atherstone. More joint work and involvement in our partnership work could be developed.

10 i work across a number of agencies and groups all with different policies and procedures

11 I am not sure if there has ever been a discussion to outline this except that on referral to my service it would need to be expressed.

12 I am not clear about who's responsibility this is.

13 We have limited experience of our clients involved in the YOT so clear lines of accountability are unclear

Q11 Is there any particular training around health you feel would help you do your job?
Answered: 39
1 No *(cited as a response by 12 respondents)*

2 I think greater awareness of the connections between substance misuse, which is often minimised, mental health and behaviours, and how to engage/react/manage and respond, would be helpful.

3 How to deal with self-harm.

5 Confidence in recognising mental health presentations in children and young people

6 Training for staff on generic health assessments and resources in order to manage individual and agency expectations.

7 Yes any training to do with it would be beneficial.

12 It would be better to fully understand how the various agencies can improve communication and information sharing

13 Not required

15 Mental Health awareness

17 drug and alcohol

18 Need more information sharing Training for identification of ADHD, Dyslexia, ASD, anxiety and depression in schools, and ADHD/ dyslexia in the recovery partnership would help I think.

19 No training but reflection on what has worked well in other areas and sharing a best practice seems weak to me.

20 Nothing specifically relating to my role in Community Safety. There maybe some training needs for front line staff in Leisure & Community Development and Housing.

22 no have taken personal steps to keep informed.

23 MH in young people

24 how MH impacts on the emergency services in deployment times

26 yes more training in mental health

27 Apologies I am fairly new to this role, and I have not yet worked with any young people where YOT is involved. I imagine that training around the mental health of young people - stress, anxiety, anger etc issues would be helpful.

28 Self-Harm

29 Understanding the impact of mental health and how to get the right support for the young people I work with.

30 Yes more training would be nice as I don't know much

32 Would be helpful to have an update from the YOT team for our service

33 I would like to know more about the role of WYJS

34 Understanding how to identify different forms of mental health problems including personality disorders.

35 ADHD/PDA

36 Yes. I know little about health in general and would appreciate training, particularly mental health.

38 Info about service signposting, opportunities to enhance joint working and performance info about YOT activity to identify gaps and opportunities.

Q12 What is the ONE THING we could change to most improve the health of young people?
Answered: 52

2 Take the stigma out of mental health and normalise it - it affects everyone, mental health and wellbeing is how people feel, if their level of resilience is demolished, then it can lead to mental illness. Work on reducing self harming incidents.

3 More direct workers!

4 The Stigma around accessing Sexual Health Services

5 Focus on well-being and the basics of diet and exercise - make it cool.

6 Steering young offenders away from addiction to substances.

7 better access to mental health support

8 more mentally resilient

9 Early identification and intervention with children, young people and their parents and carers

10 early multi agency intervention focusing on family, education and social needs

12 More education on mental health and diversity in schools

13 Reduce bullying

14 Easy access, communication regarding this service

15 Get them help sooner.

17 Education *(cited as a response by 4 respondents)*

18 Early intervention.

20 More education relating to drugs/sex

22 Access to young peoples health services (14-25 year olds)

23 timely support. collaboration/ communication amongst agencies

25 Reduce drug use.

26 Parental Education/family meals

28 Ensure they are kept active and occupied either by Training or Education.

29 Better communications between agencies

30 be able to take time to listen to their needs in a safe environment

31 We need to have targets for emotional well being in schools as well as SATS targets, as this could be the biggest issue affecting some of our young people.

32 Partnership working. It isn't just YOT's responsibility to improve the health of young people.

33 More partnership work locally on our responses for engagement with problematic young people.

34 Better actual links with the Youth Justice Service.

35 more support from CAMHS

36 Provide more information

38 increased MH services

40 I imagine that education around what young people can do themselves would help, and publicity about what support you offer.

42 Encourage smoking cessation, educate around safe disposal of smoking materials, education around effects of counterfeit cigarettes.

43 CAMHS

44 Minimum unit price of alcohol

45 Responsivity to mental health needs

47 Prosecute parents.

48 Providing, through other agencies suitable move on accommodation, when the home environment is deemed unsuitable.

49 limit the hours any one device can spend on gaming

50 I generally think harm reduction education services are very good. The challenge is to improve the endgame and efficiency of all you services.

51 For the YOT to engage directly with the Priority Families Programme rather than through FI staff acting in a proxy role.

52 Better availability of specialist support for young people who have experienced or are at risk of violence and abuse, as this has a significant impact on their health and well-being over their entire lifetime.

Q13 Is there anything else you would like to tell us about the health of young people in contact with Youth Justice Services?
Answered: 31

2 Mental health and physical health cannot be separated.... Good to teach young people how to communicate on their health, minimise stigma and embarrassment which is often acutely felt, and addressing health needs depends on having good trust relationships with individual young people.

4 need to be more integrated into the overall needs of young people and need to be more exposed to Health service commissioners

5 it seems that YOT are picking up an increasingly high level of need around helath where issues are already very complex and have been present fr a number of years

11 Any person is asked when bought into custody if they have any health problems and need to see a doctor

13 I think I am in a fairly healthy area

14 We are an over 18s services and don't really have much contact with YOT so sorry I cannot be of more help.

15 social pressures at such a young age.

16 Many will have mental health problems and risk factors for vulnerability in their back grounds.

18 Not sure, there seems a hardcore of young people who use alcohol, cannabis and other substances.

19 We have never been notified of anyone via Youth Justice.

20 emotional well- being and their communication with their family is a major issue in working with young people

24 I have concerns about young people who do not meet Children's services criteria but for whatever reason cannot return home. This is a very "grey" area! pretty quickly physical and mental health deteriorates for this group.

25 Statistically, the cohort I work with who are under Youth Justice Services misuse drugs. This significantly impacts on the likelihood that they will be permanently excluded from school, which in turn reduces their chances of success in life as a whole.

27 Often these young people will have had a negative experience from other agencies so a respectful and person centred approach is important

Appendix 10

How should we support SLCN needs in Youth Justice?

There is some evidence of the impact of Speech & Language Therapy. In their written evidence to the House of Commons Justice Committee in 2013, The Royal College of Speech & Language Therapists quoted: *9.6 In Leeds the speech and language therapist worked with the Leeds YOT Intensive Supervision and Surveillance Program (ISSP) and provided training to the staff. The results showed that the staff made significant gains in their knowledge and confidence working with young people with communication difficulties.*

There is less direct evidence around the impact on young people's re-offending.

A paper entitled **The Special Educational Needs and Disability Reforms and Speech, Language and Communication Needs in the Youth Justice Sector: Findings from a Survey of Youth Justice Services in England** October 2015 identified the following:

- Staff training around SLCN was valued with examples referring to visual aids to enable young people to participate in verbally mediated interventions.
- The negative impact of SLCN on engagement with Youth Justice Services and the CJS was highlighted, specifically court situations which require a certain level of language and communication competence.
- A lack of identification and intervention for SLCN was considered to contribute to further offending behaviour.
- Speech & Language Therapy (SLT) provision was described as important and needed over and above offering advice and assessment only.
- Access to SLT provision within Youth Justice Services was considered limited.
- SLT provision was valued highly both for increasing the knowledge and understanding of Youth Justice staff and in working directly with the young people themselves.

Together these can enable the young person to engage more effectively in Youth Justice Services and the CJS as well as ensuring the full implementation of the SEND reforms.

The paper recommended that all Youth Justice Services have access to speech and language therapy provision as recommended in the Bercow Report.

Appendix 11

Source of Warwickshire Statistics

Children in Care - Aged Under 18 (2014/15) *Source: PHE Fingertips*

	Count	Rate per 10,000
Warwickshire	690	61.5
England	69540	60.0

Rate of Children in Need referrals during the year - Aged 18 and Under (2014/15) *Source: PHE Fingertips*

	Count	Rate per 10,000
Warwickshire	5965	531
England	-	548

Percentage who were bullied in the past couple of months - 15 year olds (2014/15) *Source: PHE Fingertips*

	Count	Proportion - %
Warwickshire	-	56.8
England	-	55.0

Percentage of Pupils with Special Educational Needs - School age pupils (2015) *Source: PHE Fingertips*

	Count	Proportion - %
Warwickshire	12325	14.6
England	1301445	15.4

Percentage of Pupils with a SEN statement - School age pupils (2015) *Source: PHE Fingertips*

	Count	Proportion - %
Warwickshire	2658	3.15
England	236165	2.8

Prevalence of ADHD among young people: 16-24 year olds (2013) *Source: PHE Fingertips*

	Count
Warwickshire	8088
England	849422

Percentage of regular smokers - 15 year olds (2014/15)

	Count	Proportion - %
Warwickshire	-	5.9
England	-	5.5

Percentage of regular drinkers - 15 year olds (2014/15)

Source: PHE Fingertips

	Count	Proportion - %
Warwickshire	-	8.5
England	-	6.2

Estimated prevalence of emotional disorders - Aged 5-16 (2014)

	Count	Proportion - %
Warwickshire	-	3.4
England	-	3.6