

HEALTH AND WELLBEING BOARD

10 February 2015

Title:	The Health of Young Offenders		
Report of the Director of Public Health			
Open Report		For Decision	
Wards Affected: ALL		Key Decision: NO	
Report Authors: Dr Marion Gibbon Interim Consultant in Public Health		Contact Details: Tel: 0208 227 3039 E-mail: marion.gibbon@lbbd.gov.uk	
Sponsor: Matthew Cole, Director of Public Health			
Summary: Young offenders (aged 10 – 19) are a marginalised group often having complex health needs that are greater than those of the non-offending population. It includes young offenders in secure children’s homes, secure training centres, and young offender institutions as well as those being managed by Youth Offending Services. Young offenders present unique challenges in terms of health care provision, particularly in terms of access. Use of secondary health care services is high among this group and use of primary health care services is low.			
Recommendation(s) The Board is asked to note and comment on the following key recommendations:- (i) Children’s Services to provide a further report on the support needed and available for those that fall in between troubles families and offending. (ii) NHS Barking and Dagenham Clinical Commissioning Group need to have regard for the adequate provision of health services to support Youth Offending Services with a clear set of outcomes and activity expectations across the breadth of the youth justice system. (iii) All young offenders should have an annual health check encompassing physical, mental health, emotional health and health risk behaviours. The findings and the agreed health outcomes plan agreed with the client should form part of the overall YOS care and support planning records. (iv) YOS Health Services need to be commissioned with adequate resource and a clear set of outcomes and activity expectations across the breadth of the youth justice system. (v) Significant work is needed to educate the wider health community about the needs of young offenders and develop a clear coherent pathway and transition plans for youth offenders; this work could be led by a GP clinical champion who has a special interest in adolescent medicine and the criminal justice system.			

- (vi) Workforce development planning and training programmes for both health and social care staff should include explicit education on youth justice for all front line professionals. There should also be specific training additional training support on health risk assessment and understanding of the NHS for YOS professionals.

1. Introduction

- 1.1 The age of criminal responsibility in England and Wales is 10 years. Children under this age are not considered as criminally responsible for crimes and cannot be charged with a crime. The youth justice system (YJS) was set up under the Crime and Disorder Act (1968), to prevent young people from reoffending. The formal system begins from age 10 years and over when an offence is committed which goes to court. From 2013 the courts now give restorative solutions and cautions rather than reprimands and warnings.
- 1.2 The Crime and Disorder Act requires that local authorities, the police, probation, and from Spring 2013 Clinical Commissioning Groups (CCGs) set up YOSs to work with children and young people who were offending or at risk of offending. The CCGs were required to:
- co-operate with local authorities in establishing Youth Offending Services (YOSs);
 - contribute to their budget; and
 - provide or nominate a member of the YOS team.
- 1.3 The YOS had to include representatives from the police, probation, health, education and children's services and have responsibility for children and young people sentenced or remanded in custody.
- 1.4 With the extension of the Healthy Child Programme to children aged 5-19, guidance for school health teams highlights the importance of providing enhanced support for vulnerable children and young people.
- 1.5 The aims of this report are:
- to outline the main health needs of the young offender population in Barking and Dagenham; and
 - to determine the extent to which current service provision is addressing the needs of the young offender population.

2. The national context

The legal framework and service drivers

- 2.1 Healthy Children, Safer Communities was published in 2009 (DoH, 2009) which set out the strategy of the Department of Health and the Department for Children, Schools and Families to promote the health and wellbeing of children and young people in contact with the Youth Justice System, this was in response to Lord Bradley's review of people with mental health problems and learning disabilities in the criminal justice system. 'You're Welcome' (DoH, 2011) sets out principles to make services young people friendly and the National Service Framework for Children, Young People and Maternity Services (DoH, 2004) set out guidelines for

the quality of care and highlights the importance of equity of offender services that are based on need regardless of race, gender, disability, age, sexual orientation, religion or belief.

2.2 These policies require:

- the harnessing of mainstream services to reduce offending and reoffending, wherever a person is in the youth justice system and when they are at risk of coming into the system;
- addressing health and wellbeing at all stages of the youth justice system. It makes a commitment to improve the provision of primary and specialist healthcare services for young offenders in the community and to support and promote health and well-being in the secure estate;
- effecting change by policy and decision makers at a national, regional and local level championing a strong response to the health inequalities encountered by children and young people at risk of anti-social and offending behaviour.

Police custody suites

2.3 Police custody suites are designated areas in police stations for the processing and if necessary detention, of a person who has been arrested. There is currently no standardised process for screening and assessment of health and wellbeing needs within police custody suites. The treatment of children and young people in custody suites is governed by the Police and Criminal Evidence Act 1984 (PACE). PACE is anomalous with other legislation in the UK in that young people aged 17 are treated as if they were adults for the purposes of police procedure, whereas in all other legislation anyone under 18 is a child or young person.

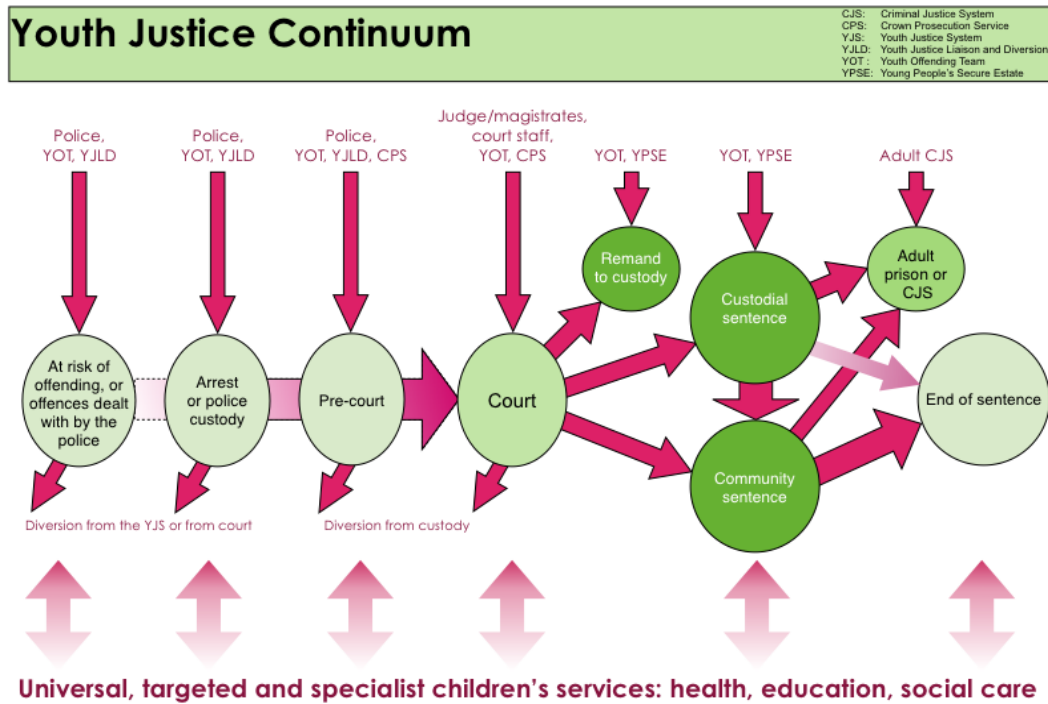
Youth Justice liaison and diversion schemes

2.4 The cross-government Health and Criminal Justice Liaison and Diversion programme, led by the Department of Health, includes a major national programme of pilot young justice liaison and diversion (YJLD) schemes for children and young people with mental health, learning or communication difficulties, or other vulnerabilities affection their physical and emotional wellbeing. The purpose of the programme is to identify all health and social care needs at whatever point children and young people enter the YJS, to ensure a systematic access to services and enabling the police and courts to make informed decisions about charging and sentencing.

The secure estate for children and young people

2.5 The secure estate for children and young people is the umbrella name for the establishments that hold children and young people when they are in custody (See Figure 1).

Figure 1: Youth Justice Continuum

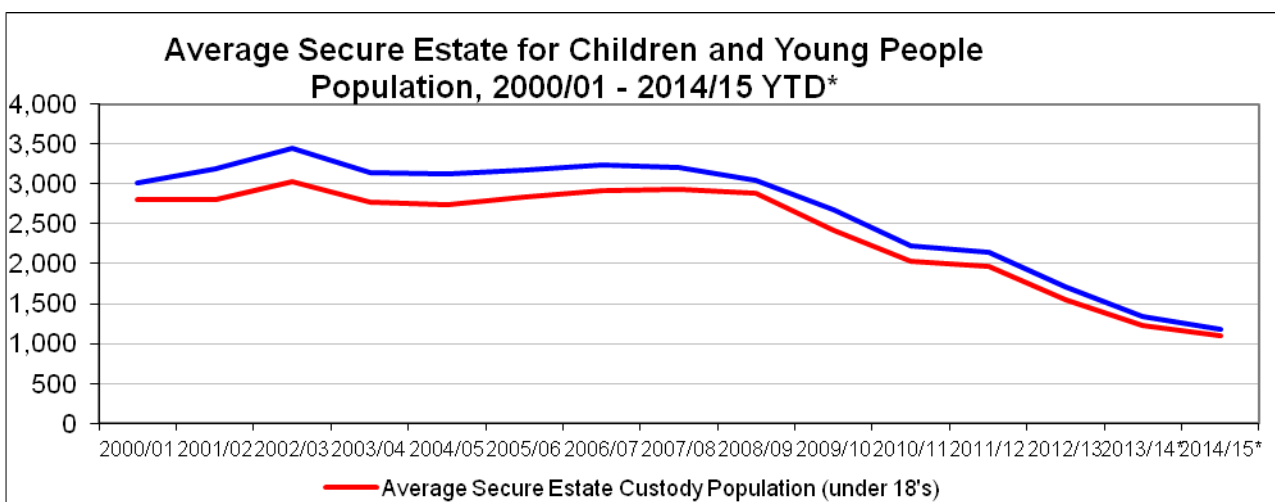


Source: DoH, 2012

Young Offenders – the national picture

2.6 The number of young offenders in custody has fallen over the last six years (See Figure 2).

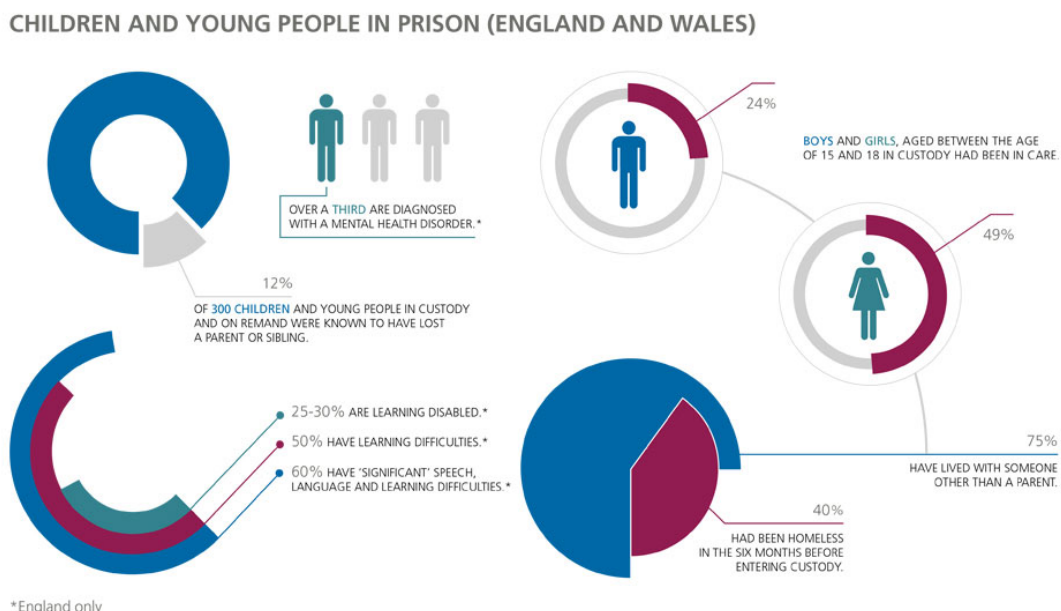
Figure 2: Trend of Young People in prison between 2000/1 – 2014/15



Source: Youth Justice Board 2014 Young Offenders Report September 2014

- 2.7 In 2012-2013 the average population of young people in custody in England and Wales (under 18s) was 1,544. In the 12 months to March 2013, 2,780 young offenders were placed in custody.
- 2.8 Many of the young people who end up in the criminal justice system come from chaotic home lives, often characterised by violence, abuse or neglect, and are not thriving socially, emotionally or physically. They are unable to thrive socially, emotionally or physically, and are among the most vulnerable individuals in our society long before they reach detention.
- 2.9 Three quarters of children and young people in custody have lived with someone other than a parent and 40 per cent had been homeless in the six months before entering custody. 24% of boys and 49% of girls, aged between 15 and 18 and in custody, have been in care. Of 300 children and young people in custody and on remand, 12% were known to have lost a parent or sibling. Approximately 60% of children in custody have 'significant' speech, language and learning difficulties; 25-30% are learning disabled and up to 50% have learning difficulties. Over a third of children in custody were diagnosed with a mental health disorder.

Figure 3: Children and young people in prison

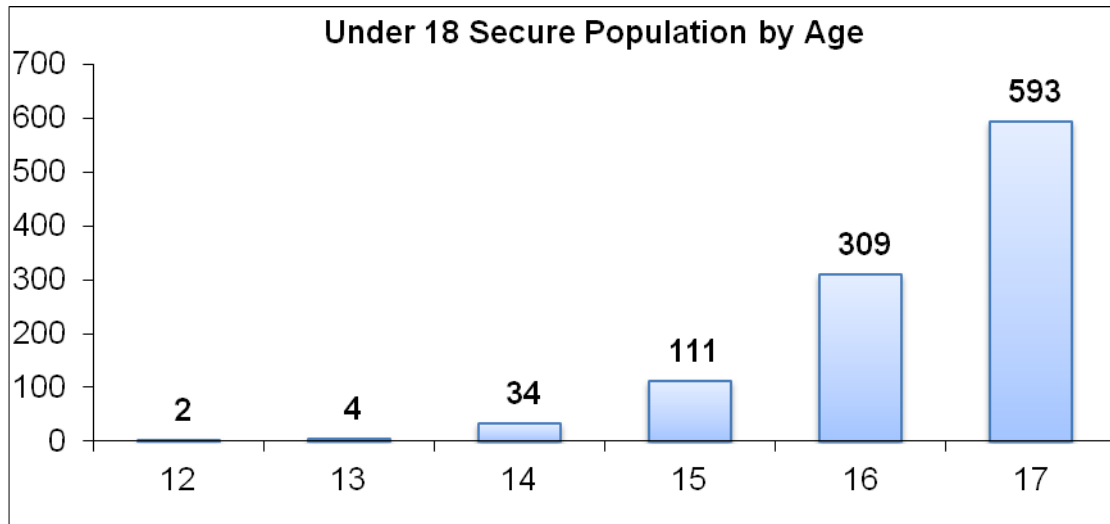


Source: BMA, 2014

Young offenders by age

- 2.10 There is a huge increase in the number of young people in secure units with age (See Figure 4).

Figure 4: Under 18 Secure Population by Age

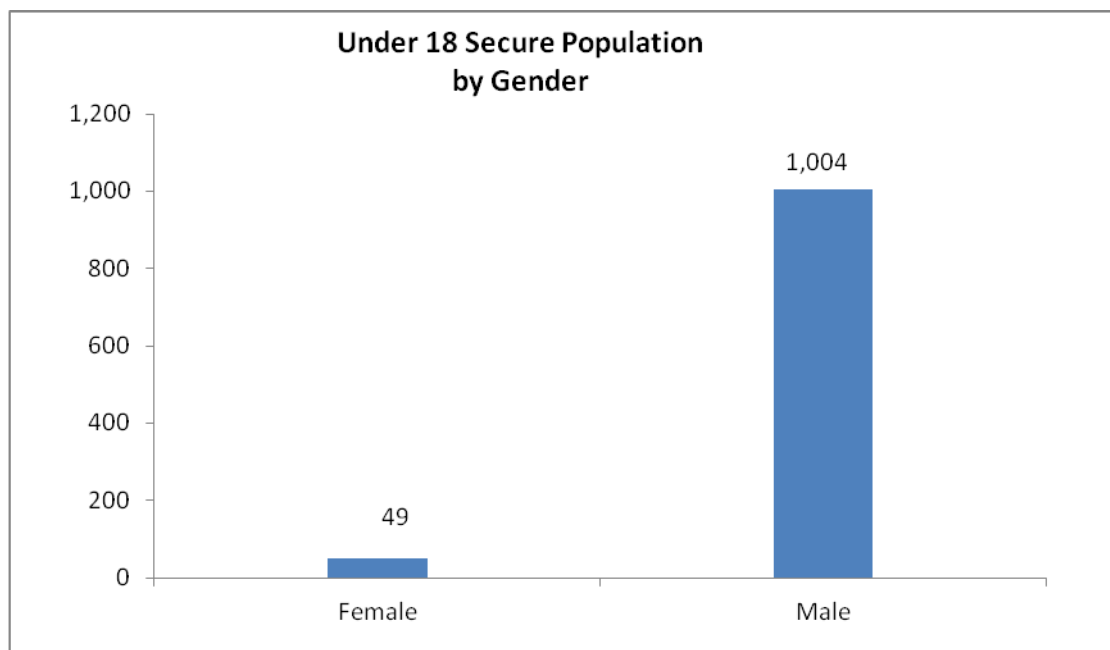


Source: Youth Justice Board 2014 Young Offenders Custody Report September 2014

Young offenders by gender

2.11 Young offenders are predominantly male (See Figure 5)

Figure 5: Under 18 Secure Population by Gender

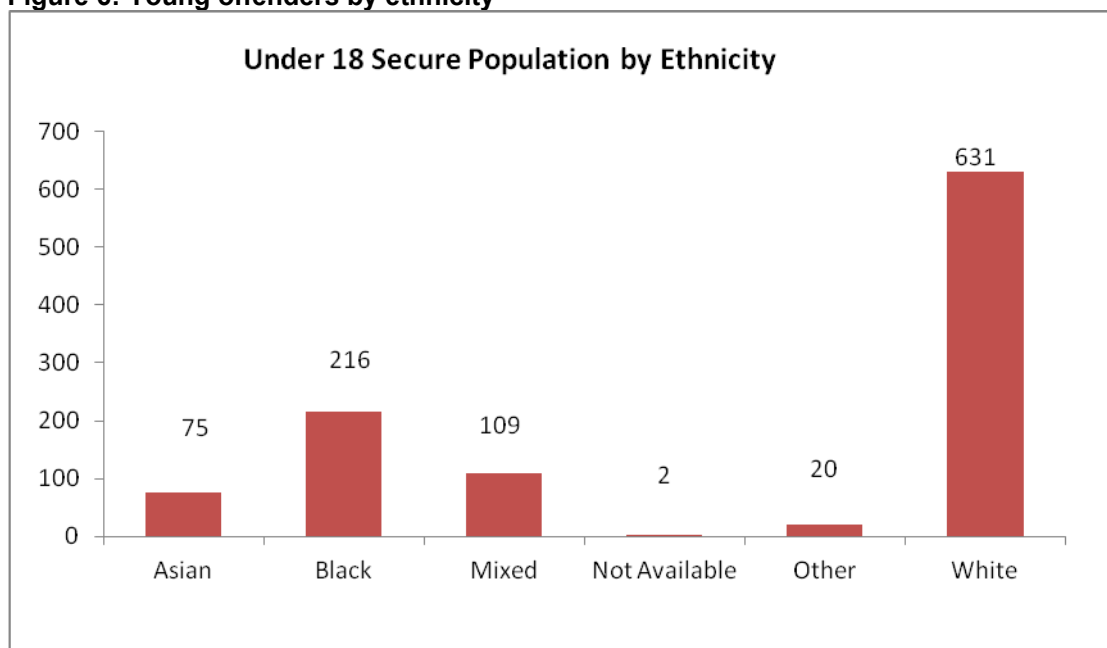


Source: Youth Justice Board 2014 Young Offenders Custody Report September 2014

Young offenders by ethnicity

2.12 Young offenders are predominantly white, however, black and minority ethnic groups are disproportionately represented (See Figure 6).

Figure 6: Young offenders by ethnicity



Source: Youth Justice Board 2014 Young Offenders Custody Report September 2014

3. The local picture – the youth justice system in Barking and Dagenham

3.1 In 2013, for every 100,000 10-17 year olds in the population of Barking and Dagenham, 463.1 received their first reprimand, warning or conviction. The England value is 440.9. The table below shows comparisons to national and regional data.

Table 1: Rates of young people aged 10-17 receiving their first reprimand, warning or conviction.

	First time entrants to the youth justice system (2010)	First time entrants to the youth justice system (2011)	First time entrants to the youth justice system (2012)	First time entrants to the youth justice system (2013)
Barking and Dagenham	957.2	817.6	517.3	463.1
London	983.1	795.9	591.3	458.2
England	901.7	725.6	556	440.9

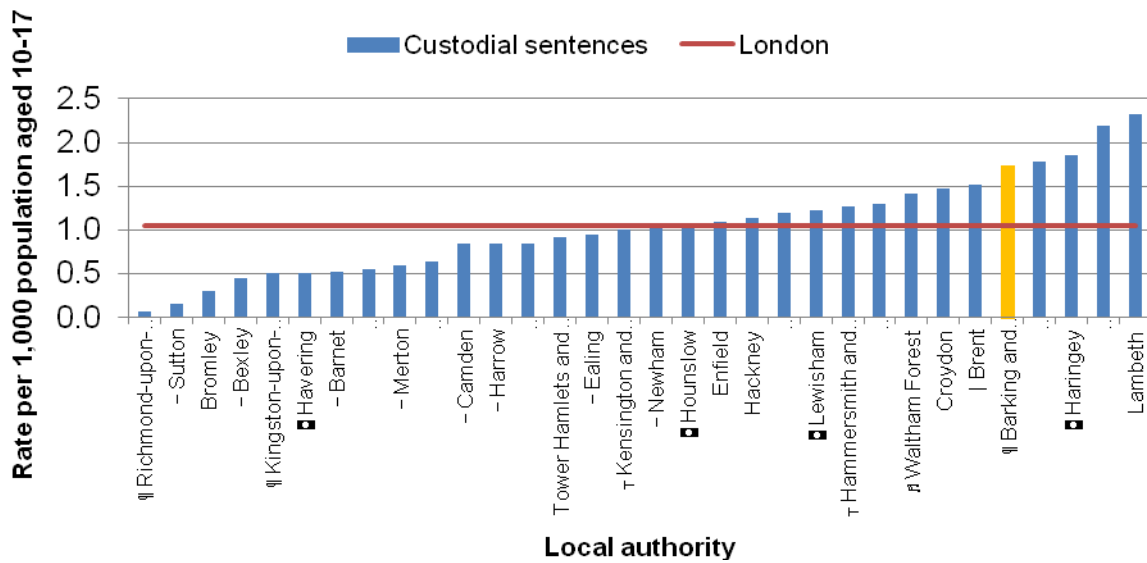
Source: Department for Education. Further information: www.education.gov.uk/rsgateway/DB/STR/d000895/index.shtml

Police custody

3.2 LBBD has the fifth highest rate of custodial sentences for youth offenders in London (See Figure 7)

Figure 7: Custodial sentences for youth offenders

Rate of custodial sentences for youth offenders, Barking and Dagenham and London, rate per 1,000 population aged 10-17 years, 2012/13



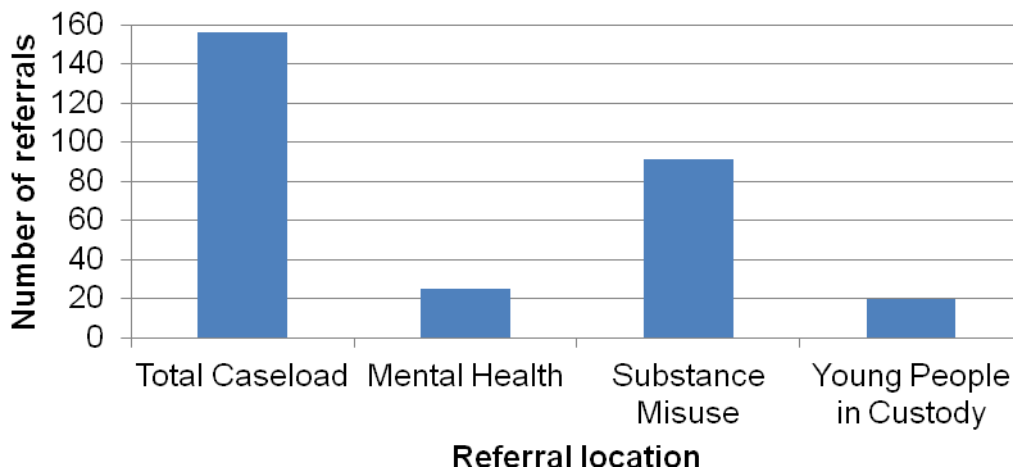
Source: Barking and Dagenham Youth Offending Service

Young offenders being managed by Youth Offending Services

3.3 Substance misuse made up the majority of referrals to the youth offender services, followed by mental health (See Figure 8)

Figure 8: Youth offender referrals

Youth offenders service, referrals in Barking and Dagenham, 2013/14

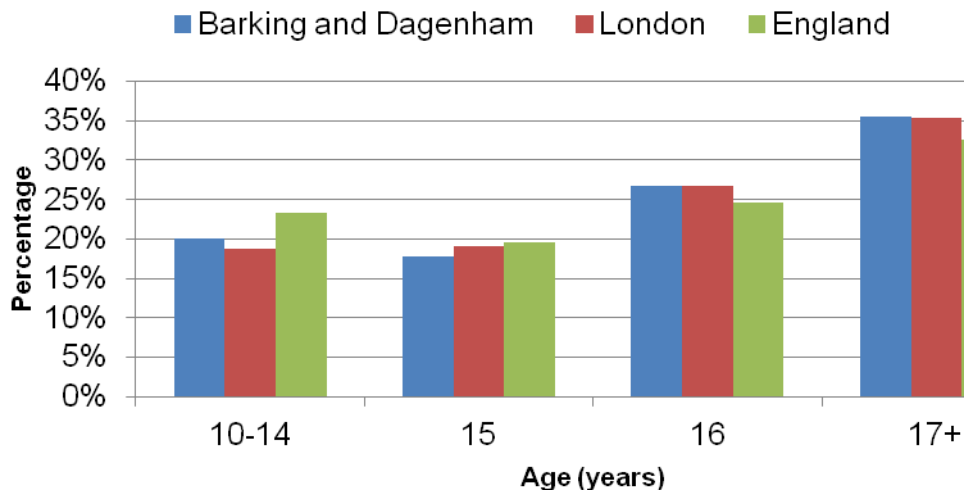


Source: Barking and Dagenham Youth Offending Service

3.4 Almost 36% of referrals are amongst youths over 17 years, about 20% are amongst children aged from 10 to 14 years (See Figure 9).

Figure 9: Age profile of youth offenders

Age profile of youth offenders, Barking and Dagenham, London and England, percentage of all youth offenders, 2012/13

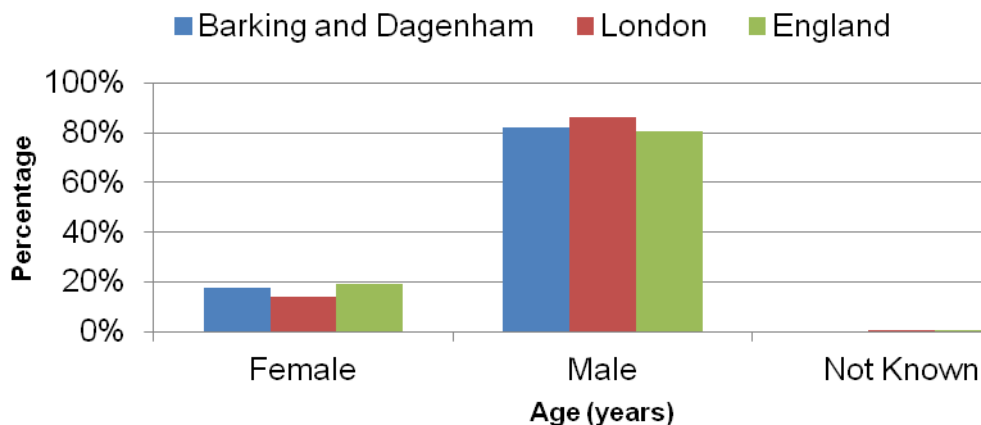


Source: Ministry of Justice

3.5 The majority of offenders in LBBDD are male which is similar to both the London and England picture (See Figure 10).

Figure 10: Gender profile of youth offenders

Gender profile of youth offenders, Barking and Dagenham, London and England, percentage of all youth offenders, 2012/13

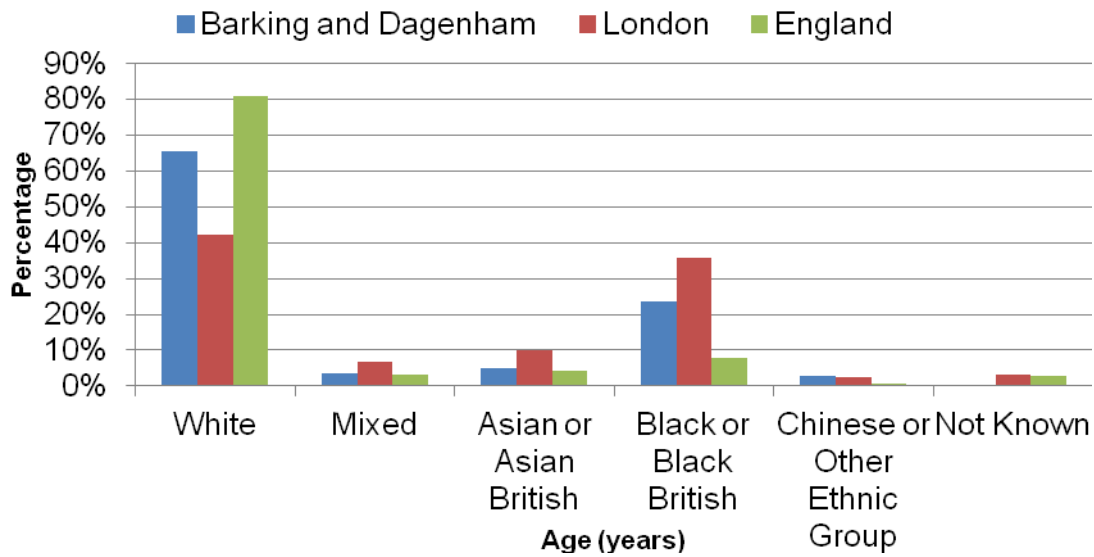


Source: Ministry of Justice

3.6 The majority of youth offenders in LBBDD are amongst the white population (See Figure 11). The proportions of offenders are dissimilar to both London and England.

Figure 11: Ethnicity profile of youth offenders

Ethnicity profile of youth offenders, Barking and Dagenham, London and England, percentage of all youth offenders, 2012/13



Source: Ministry of Justice

Teenage pregnancy

- 3.7 National data suggests there is a higher engagement in crime by male children of adolescent mothers (Maynard, 1997). Estimates also suggest that around 39% of young women under the age of 21 in prison are mothers, and 25% of young men are fathers (NICE 2007).
- 3.8 Table 2 below shows the trend in teenage conception rates in Barking and Dagenham since 2002-2004, while the table shows the under 18 conception rate per 1,000 females aged 15-17 years in Barking and Dagenham compared to national and regional data. In 2002 there were 73.2 conceptions per 1,000 female population aged 15-17 compared to 54.6 in 1998. Over the same period the average rate in England decreased from 42.1 to 41.0 per 1,000 female population aged 15-17.

Table 2: Under 18 conception rate (per 1,000 females aged 15-17 years)

	Under 18 conception rate (per 1,000 females aged 15-17 years) (2012)
Barking and Dagenham	35.4
London	25.9
England	27.7

Source: Department for Education. Further information: www.education.gov.uk/childrenandyoungpeople/healthandwellbeing/teenagepregnancy/a0064898/under-18-and-under-16-conception-statistics

Risky health behaviours

- 3.9 Evidence suggests substantially higher rates of smoking, alcohol and substance misuse amongst young offenders. Smoking rates amongst young offenders in national and regional surveys are over 80% which is three times higher than the rates within the general population (Home Office, 2005). A Scottish NHS study showed that nearly 80% of 16-24 year-olds in prison identified themselves as a smoker (Taulbut and Gordon, 2008). A further study in 2004 looking at substance misuse amongst young offenders found that 84% were regular smokers at the time of their arrest (Youth Justice Board, 2004). If the 80% prevalence is applied to young offenders in LBBD just over 370 young offenders will be actively smoking.
- 3.10 The evidence suggests alcohol dependence and alcohol misuse are commonplace amongst offenders, and are often contributing factors in criminal activity. In 2006, data collated from the Offender Analysis System (OAS) revealed that 37% of offenders had both a problem with alcohol and/or were binge drinkers, 32% exhibited violent behaviour because of their alcohol misuse and 38% had a criminogenic need relating to alcohol (National Offender Management Service, 2006) i.e. alcohol was a factor in their criminal behaviour. In 2009, figures from the National Health Service showed that 32% of 16-24 year-olds reported drinking over 6/8 units (the maximum recommended level for females/males) in one drinking session in the previous week compared to just 20% of all adults (NHS, 2010). The 2007 evidence suggests that 40% get drunk daily and 49% weekly, applied to the LBBD case load this equates to 185 of young people entering the YJS drinking daily.
- 3.11 Substance misuse of drugs describes a range of behaviours, the 2007 Arrestee Survey found a substantially higher rate of drug use amongst young offenders, with 69% of newly arrested 17-24 year-olds in 2006 compared to 38% of arrestees aged 35yrs (Boreham et al, 2007). Young offenders are more likely to be using cannabis and ecstasy than using heroin or crack cocaine (Ministry of Justice, 2008). If this pattern is replicated in LBBD then an estimated 319 entrants to the YJS will be using drugs and require support and intervention.

Speech, language and communication needs

- 3.12 Over half of children and young people in custody in the YJS have difficulties with speech, language and communication (HM Government, 2009). Estimates of prevalence of speech impairment from the Royal College of Speech and Language Therapists suggests that LBBD has 535 children aged 12-14 years with a speech impairment¹.

Autistic Spectrum Disorders

- 3.13 A study in South East London, (Baird et al, 2006) estimated the prevalence of childhood autism at 38.9 per 10,000 and that of other ASDs at 77.2 per 10,000. This made the total prevalence of all ASDs 116.1 per 10,000 or approximately 1%. If the prevalence rate found in Baird's study were applied to the population aged 5



¹ For more details, please see www.rcslt.org/speech_and_language_therapy/commissioning/sli_plus_intro.

to 16 years of Barking and Dagenham this would give an estimate of approximately 293.0 children.

Learning disability

- 3.14 It is estimated that 25 to 30 per cent of children and young people in the YJS have learning disabilities, and that this rises to around 50 per cent of those in custody (HM Government, 2009).
- 3.15 Estimating the prevalence of learning disability is problematic and should be treated with caution. One general population study (Emerson and Hatton, 2004) estimated that 2% of the total population has a learning disability, and the researchers calculated age related prevalence as follows: 5 to 9 years - 0.96%; 10 to 14 years - 2.26%; and 15 to 19 years - 2.67%.
- 3.16 The estimated total number of children with a learning disability in Barking and Dagenham are shown in the table below.

Estimated total number of children with a learning disability

	Barking and Dagenham
 Ages 10 to 14 (2010)	268
 Ages 15 to 19 (2010)	315

Source: Estimates based on ONS population data

Children with a learning disability who suffer from a mental health problem

- 3.17 On the basis of a 40% prevalence of mental health problems associated with learning disability (Foundation for People with Learning Disabilities, 2002), in Barking and Dagenham the number of children with both a learning disability and a mental health problem might be expected to be as follows: 10 to 14 years - 107; and 15 to 19 years - 126.

Looked after children

- 3.18 Evidence suggests that there is considerable overlap between children who are in contact with children's social care services and those in the YJS (Ryan and Tunnard, 2012). In Barking and Dagenham there were 410 looked after children on 31 March 2011, of whom 65 were in residential care.

4. Literature review

- 4.1 Young people in the YJS generally suffer from worse health than other children of a similar age, particularly in terms of mental health problems, learning difficulties, addictions and speech and language problems.

Ethnicity of young people in the YJS

- 4.2 While the majority of children and young people in contact with the YJS are white, children from some minority groups are over-represented nationally. This is particularly noticeable for young people in custody (Ref). In addition, a larger proportion of children from Black and Minority Ethnic (BME) groups have post-traumatic stress disorder than other children, in both community and custody settings (Harrington, et al, 2005).

Mental health of young people in the YJS

- 4.3 One of the key objectives in the Government's 'No Health without Mental Health' (HMG, 2011) is to, 'Improve early recognition and intervention for mental health problems in children and young people, including those in or at risk of moving into the youth justice system'. Self-harm is an issue of concern particularly those in the secure estate (DoH, 2009). Of prisoners, aged 16-20 years, around 85% show signs of a personality disorder and 10% exhibit signs of psychotic illness (Mental Health Foundation, 2007). There is a particularly high prevalence of depression and self-harm among young women in custody (Douglas and Plugge, 2006). About 30% of adolescents who self harm report previous episodes that have not been mentioned previously or to a medical professional. Self-harm is a risk factor for suicide and Hawley et al found that characteristics of those who self-harm are similar to those who commit suicide. The following factors seem to indicate a risk:

- violent method of self-harm;
- multiple previous episodes of self-harm;
- apathy, hopelessness, and insomnia;
- being an older teenage male;
- substance misuse; and
- previous admission to a psychiatric hospital.

Models of service provision to address the needs of youth offenders

- 4.4 A review undertaken in 2010 of YOT services identified several models of provision (Khan and Wilson, 2010). These included six different models as shown below:

The lone health practitioner model

- 4.5 Practitioners tended to be located full time in the YOT with low level linkage to local health teams.

The foot in-foot out model

- 4.6 The health practitioner typically had a presence in the YOT team as well as good systematic clinical and operational links with a specific local health team.

The virtual locality health team model

- 4.7 Health workers are located in the YOT and also have strong operational and clinical links with a specific health team outside the YOT; in addition they have developed systematic linkage, networks and joint working practices with broader health and mental health workers in the local area.

Outreach consultative model

- 4.8 We found some examples of an outreach consultative mental health model. This type of service not only provided direct services to very high risk and/or to vulnerable young people in the region or locality, it also provided supervision and clinical and telephone support to health workers in YOTs, in custodial settings, in specialist CAMHS as well as others throughout an area or region.

The internal YOT health team

- 4.9 In some areas, a team of health practitioners have been pulled together in a YOT. Often this type of team has an internally located YOT health manager.

The external YOT health one-stop-shop

- 4.10 Some YOTs had no health presence in the YOT but young people's needs were served through being referred to an external resource specifically commissioned for vulnerable young people in the area.
- 4.11 Each of these models demonstrated strengths and weaknesses. Health practitioners voiced the greatest concerns about the lone practitioner approach. Many workers described feeling professionally isolated and facing persistent struggles with accessing mainstream and specialist health and mental health provision for children and young people in contact with the YOT. Lone health practitioners often ended up working directly with young people and did not always fulfil the originally intended role of being a bridge to mainstream services.

Most effective interventions

- 4.12 There is now strong evidence that the most effective way to reduce both crime and poor outcomes for children is to work with families whose children are at the highest risk, at the earliest point possible, particularly where children are showing early signs of behavioural problems (Fergusson, Horwood and Ridder, 2005). Poor parenting and family dysfunction explains up to 30– 40% of problematic behaviour in children (Patterson, DeBaryshe and Ramsey, 1989), indicating a need to focus predominantly on strengthening parenting skills (Scott, 2008) and on building the child's resilience (Alperstein & Raman, 2003). Parenting interventions offer the best chance of change at this early stage, with consequent reductions in crime and multiple adverse outcomes and improved life chances as these young people mature (Sainsbury Centre for Mental Health, 2009).

5. Current Service Model to address the health of youth offenders in LBB

- 5.1 A report was written in 2012 that outlines the health input to the YOS being via a range of funding mechanisms and fluctuation in provision and style of input from 2006.
- 5.2 The YOS team in LBB in 2011 included a full time psychologist, filled by a locum, which replaced the previous two FTE psychologists. Varney (2012) commented that 'there is no structured physical health input provided'. Furthermore, there were two

dedicated YOS Drug and Alcohol workers who are provided through Drug and Alcohol Treatment contracts.

- 5.3 CQC Inspection and local review of health provision for young offenders identified gaps in the provision of support to YOT by community & mental health services.
- 5.4 The service specification for health provision to both youth offending teams and to young people at risk of offending was developed following an ONEL wide review of health provision which was informed by a needs assessment.
- 5.5 The contract variation for health provision to YOS was agreed with the North East London Foundation Trust (NELFT) in 12/13.
- 5.6 Although no additional investment was identified in respect of the remodelled service it was agreed that benefits would be derived through closer working and integration of health professionals with responsibility for vulnerable children across mental health and community health services.
- 5.7 NELFT is commissioned by B&D CCG and Havering CCG to provide the health input into the Youth Offending Service in line with the revised service specification.
- 5.8 The overall aim of the service is to ensure access to integrated health provision for this vulnerable group of young people.
- 5.9 Particular focus on early intervention, prevention and active management of chronic conditions.
- 5.10 The health provision originally comprised 2 WTE clinical mental health specialists (CAMHS) one for each borough (Havering and Barking and Dagenham), a clinical psychologist 0.9 WTE (B&D only) and input from school nursing - regular fortnightly clinic at YOT. Following discussions with YOT, public health and NELFT in 2013/14 – and in the light of identified issues around general health and prevention input it was agreed that the clinical mental health specialist role be changed to a broader health promotion worker.
- 5.11 The contract is monitored as part of CCG NELFT contracting arrangements and a revised suite of KPIs was agreed in discussion with PH, YOT and NELFT below

KPIs	Measurement - comments
Number of ASSET assessments undertaken by YOS worker with completed health section	Number of new ASSET assessments completed in the relevant quarter with completed health section
Number of ASSET assessments reviewed by health worker within 72 hours	Number of new ASSET assessments completed in the relevant quarter with completed health section reviewed within 72 hours by health worker
Number of CYP receiving second tier general health assessment and screening	Number of CYP receiving second tier general health assessment and screening in relevant quarter following completion of ASSET assessment/health review.
Number of CYP who access mental health/physical health care following general health assessment	Number of CYP who access mental health/physical health care following general health assessment in relevant quarter.
Number of CYP stepped up to tier 3 CAMHs	Number of CYP who are stepped up to tier 3 CAMHS in relevant quarter.
Number of CYP smoking at general health assessment	Number of CYP smoking at general health assessment for reporting quarter in question.
Number of CYP in service for over 6 months smoking	Number of CYP on health caseload smoking after 6 months for reporting quarter in question. <i>NB this will not report changes in same cohort but should overtime provide indication of changes in smoking status for CYP with general health interventions</i>

- 5.12 There have been ongoing issues around recruitment and retention to the health promotion post and recent issues with clinical psychology cover. These are being picked up with the provider.
- 5.13 All young people are assessed using that standardised Asset tool which includes a section for assessment of physical and emotional health but there is no training or standardised methodology for case workers conducting the assessment to gather the requisite information. The Asset assessment is sometimes also done in the presence of parents so this may inhibit disclosure, particularly those of risky behaviours.
- 5.14 Historically the LBBY YOS health support has varied and at times has included two full time psychologists, a full time community psychiatric nurse and intermittent support from one of the nurses in the looked after children's health team.
- 5.15 Funding sources are unclear and there is some opacity in what is commissioned as part of the CAMHS provision and as part of the general children's health budget provisions.

- 5.16 The national framework for the child health programme includes provision for young offenders, amongst other vulnerable groups, as part of the general contracting framework, however there is no evidence locally on engagement between these services and the YOS in a proactive way.

Qualitative interviews with youth offending team

- 5.17 As part of the report by Varney (2012) semi-structured interviews were conducted with a sample of the Barking and Dagenham youth offending team to gain a better understanding of the current process for identifying and supporting health needs of young offenders.
- 5.18 The interviews highlighted the following key themes:
- There has been some variation in the model and approach to the YOS health service over the last few years and moved from a mixed model of intermittent health visitor support, two full time psychologists and a community psychiatric nurse to now a fixed term locum full time psychologist with no physical health support. The current capacity is felt to be inadequate to meet the needs of the young people and families attending the service.
 - The process of assessment has varied as well, the current model is based on using the Asset tool which is implemented by the case worker with the young person and only if a health issue is identified is a referral made to the YOS Health worker for further assessment and support.
 - There has been no local review of whether the Asset tool implemented in this way is an appropriate screening tool for health risk or need and there is an appetite to do local research to review differences between Asset only and Asset Plus a formal health assessment as a model.
 - There does not appear to be a structured training programme for staff working in and with the YOS, and this was a gap raised by several individuals in interviews. A lack of structured training has led to a variation in staff understanding of health issues, referrals and follow-up processes.
 - Concerns were raised about capacity and location of YOS health support because of the potential challenges in attendance amongst users for off-site providers, there is a strong sense that health services need to come to the YOS location not be an offsite provision.
 - Gaps were identified around how integrated the YOS is with other providers and although current staff are working hard to build relationships with children's centres and parenting programmes, there could be more integration with children's services to maximise support for young offenders and for their parents.
 - Anger management was often used as language to describe a more complex set of issues reflecting both educational and family situations where young people lack higher skills for expression and although there was some provision from health it lacked the family dimension because of capacity.
 - There is a high level of cannabis and alcohol use amongst the client group but limited support service available to address this. There was also a sense that in the wider community and amongst service providers, cannabis was not viewed as a significant health issue.
 - There is a strong desire to work more with parents in a multi-disciplinary way and find ways to engage parents and support young people to disclose to parents constructively, this requires specialist skills and support for staff and involvement of psychologists with capacity to undertake family group therapy.

- Concerns were raised about how health could better support the small numbers of offenders where sexual offenses were involved, there was also discussion about the different thresholds for concern and action between agencies which has also been highlighted as an area for action at the Children's Trust. There is national best practice in this area and a structured assessment tool (AIM), which is used effectively elsewhere but requires more capacity to deliver locally and specific training.

5.19 The interviewees were asked to consider the potential for cross-borough provision of a specialist YOS health service, which prompted the following comments:

- Support for more specialist support and input, especially around family therapy, sex offenses and professionals who are used to working with teenagers.
- Concern that attendance is an issue with clients so there is a need for at least 3 days a week onsite presence to support opportunistic interventions as well as programmed activities.
- Need for work which is holistic, encompassing physical and mental health needs and building relationships with mainstream providers, especially GPs.

6. What is the evidence that we are making a difference?

6.1 According to the current management changes have been implemented since 2011 and there is far more integration with other services. The need for more family work has been addressed and this now takes place.

6.2 The review of Asset assessment has been undertaken and LBBB will be changing to Asset Plus, which is far more appropriate for a health and strengths based assessment.

7. What is the perspective of the public on the support available to them?

7.1 The current report has not been able to undertake an in-depth assessment of the perspectives of the public on the support available to them and this would help the commissioning and ongoing development of services.

7.2 More information is needed from the perspectives of the youth offenders in LBBB.

8. Conclusions

8.1 The findings from this report reinforces the need for a coherent health presence as part of the initial assessment of all young people coming into contact with the YOS. There is also a clear need for robust referral pathways with agreed outcomes and follow-up developed in partnership with the young people and the youth offending team.

8.2 There is clear evidence of health needs amongst young offenders and much of this is currently un-identified or unmet in the current provision. The scale and complexity of the caseload suggests that commissioners may want to commission via a two-borough approach that would allow and the need for local provision linked to local YOT services. Such a solution may be beneficial, especially where there is already collaboration between youth justice and children's services.

8.3 The driver for this current piece of work is the over-arching partnership objective to improve outcomes and opportunities for vulnerable children and young people.

9. Recommendations

9.1 Children's Services to provide a further report on the support needed and available for those that fall in between troubles families and offending.

9.2 NHS Barking and Dagenham Clinical Commissioning Group need to have regard for the adequate provision of health services to support Youth Offending Services with a clear set of outcomes and activity expectations across the breadth of the youth justice system.

9.3 All young offenders should have an annual health check encompassing physical, mental health, emotional health and health risk behaviours. The findings and the agreed health outcomes plan agreed with the client should form part of the overall YOS care and support planning records.

9.4 YOS Health Services need to be commissioned with adequate resource and a clear set of outcomes and activity expectations across the breadth of the youth justice system.

9.5 Significant work is needed to educate the wider health community about the needs of young offenders and develop a clear coherent pathway and transition plans for youth offenders; this work could be led by a GP clinical champion who has a special interest in adolescent medicine and the criminal justice system.

9.6 Workforce development planning and training programmes for both health and social care staff should include explicit education on youth justice for all front line professionals. There should also be specific training additional training support on health risk assessment and understanding of the NHS for YOS professionals.

10. Mandatory Implications

10.1 Joint Strategic Needs Assessment

The JSNA has a sub section dedicated to the health of young offenders. This sub section JSNA is up dated annually in conjunction with Community Safety Partnership Strategic assessment.

10.2 Health and Wellbeing Strategy

Children and young people in the youth justice system are at high risk of multiple health inequalities and poor life chances and as such are a key target group for health services charged with narrowing the gap in outcomes between the highest and lowest achieving children. Barriers to progress include higher than average:

- Mental health vulnerabilities,
- Levels of learning disabilities,
- Levels of speech and communication needs,
- Health inequalities,
- Rates of problematic drug and alcohol use.

Research indicates that these young people are less likely to have their needs identified early in primary care or school settings. We also know that their needs remain under identified and supported after entry into the Youth Justice System.

At this point there is no need to change the focus of the Health and Wellbeing Strategy as a result of this report.

10.3 Integration

One of the outcomes we want to achieve for our Joint Health and Wellbeing Strategy is to improve health and wellbeing outcomes through integrated services. The report's recommendations are underpinned for the need for effective integration of services and partnership working.

10.4 Financial Implications

There are no immediate financial implications directly arising from this report.

[Completed by Roger Hampson Group Manager Finance (Adults and Community Services)]

10.5 Legal Implications

There are no legal implications for the following reasons. The programme is being implemented in accordance with DOH Guidance. In accordance with the Guidance key recommendations for the service is to be implemented. Contracts are being strengthened with partner agencies so that the services can be introduced. KPI have been identified and measurement of outcomes devised to address how these will be met. Lastly National Guidance have been interpreted to address issues local to LBBD.

[Completed by Dawn Pele Adult Care Lawyer Legal and Democratic Services]

10.6 Risk Management

The management of risk should efforts to address health and offending in the youth justice system need to build on a firm foundation of non-stigmatising identification and intervention with children as early as possible, using evidence-based parenting approaches, to prevent multiple adverse outcomes and reduce risks of re-offending.

Health, children's (and some adult) services outside the youth justice system should take primary responsibility for these children and young people's outcomes at this earlier stage in their pathway by linking families up with engaging, cost-effective and proven family based interventions.

10.7. Non-mandatory Implications

- Crime and disorder
- Safeguarding
- Property/assets
- Customer impact
- Contractual issues
- Staffing issues

Background Papers used in the preparation of the Report: None

List of Appendices: None