Health Needs of Young Offenders in Nottinghamshire

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Executive summary

Introduction

Young people aged 10-17 who find themselves in contact with the Youth Justice Service (YJS) and accessing Youth Offending Services are known to experience poorer health and consequent increased complex health needs than young people in the wider non-offending population. Their health needs are often missed at an earlier stage, despite many of these young people being known to children's social care, and despite a sharp incline in offending behaviour during adolescence, health services and criminal justice responses often fail to reflect these changes (The Bradley Commission, 2014). With far more unmet needs, often compounded by a range of entrenched difficulties including school exclusion, social exclusion and unstable living conditions (DH, 2009a), offenders and reoffenders are at greater risk of not achieving good health outcomes and future economic stability. Poor self-reported health, low body mass index, and mental health disorder co-morbidities are much more common amongst this cohort, and medical interventions are vital to mitigate against worsening health outcomes.

This needs assessment considers the health and wellbeing of children and young people (CYP) who have come into contact with Nottinghamshire County Council's (NCC) YJS and local Youth Offending Teams (YOT), focusing on both the health needs of this cohort and targeted health service provision for those CYP who are on community-based orders in Nottinghamshire. This chapter endeavours to establish if provision of community health services across Nottinghamshire are sufficient to meet the health needs of this group; the chapter excludes an evaluation of custodial health provision.

Unmet need and gaps

- Scope for further research regarding the health needs of females within the cohort.
- Scope to establish if those young people who lack access to appropriate health care systems when entering the YJS are from a particular vulnerable group.
- Evidence suggests that there is a lack of early diagnosis amongst the cohort and the needs of young people are often not met by the current provision of universal services.
- Fragmented communications between community and custodial settings limit the streamlined transfer of health service delivery to young people.
- Excluded young people and looked after children often fail to access universal services and continued healthcare, becoming lost in the wider health system.
- There is a risk that the young offenders do not gain the relevant support to access targeted health services due to the limited capacity of the clinical nurse specialist.

Recommendations for consideration by commissioners

- Develop opportunities to undertake preventative work and engagement with groups including looked after children and excluded children, with regard to both health provision and wider social provision including alternative educational or employment provision.
- Develop an electronic information sharing system to enable the secure and efficient sharing of patient information between targeted community health services.
- Establish protocols for the sharing of information between community health services and custodial settings.
- Develop strategies to increase the capacity of the clinical nurse specialist to ensure that the physical health needs of young offenders are met.
- Develop a formal evaluation process for each of the services.

Full JSNA report

What do we know?

1) Who is at risk and why?

1.1. Facts and figures

Young offenders are considered a marginalised group who experience complex health needs greater than those young people in the wider non-offending population (Lader et al, 2000). A cross sectional study (Chitsabesan et al, 2006) concluded that young offenders experience a high level of need, particularly with regard to mental health, education/work and social relationships; one in ten of the 301 offenders studied experienced anxiety and post-traumatic stress disorder and had self-harmed, whilst one in five showed evidence of significant depressive symptoms. Risky health behaviours were also prevalent amongst this cohort, with 11 % demonstrating an alcohol problem and 20 %, a drug problem.

Despite high levels of physical and mental ill health however, there is a low usage of primary health care amongst this cohort, compared to high use of secondary health care (Lader et al, 2000) as CYP fail to readily access universal health service provision, often due to the social and environment context in which they live.

The national strategy *Healthy Lives, Brighter Future* (DH, 2009b) referenced a number of risk factors that affect young people who enter the criminal justice system, including

- Three-quarters have a history of temporary or permanent exclusion from school
- Approximately half have problems with peer and family relationships
- Two-thirds come from homes where the family structure has broken down
- A third have severe or complex mental health problems
- A quarter have learning disabilities and 30% have a physical disability, whilst over half have communication, speech, language and literacy problems.
- A third have been looked after by the Local Authority
- A high proportion have histories that include high levels of smoking, alcohol and illegal drug misuse and amongst this group, whilst high levels of health problems including sexually transmitted infections, dental health problems and blood-borne virus infections exist.

Such evidence of multiple disadvantages amongst this group enforces the need for a co-ordinated response by involved stakeholders. Failure to provide sufficient appropriate services can compound the development of serious consequences for the health, wellbeing and development of young people within this cohort.

What is the impact on health and wellbeing

With reduced access to universal health services and increased risk taking behaviour, it is not uncommon that CYP in contact with the YJS present with multiple health problems and vulnerabilities arising from a variety of social, psychological and economic factors that influence and enforce barriers to successful transition from and between services (The Bradley Commission, 2014). A number of physical and mental health problems are common amongst this group, many of which present as co-morbidities.

Physical ill health

Multiple physical health needs are often discovered when offenders undergo a physical health check (YJB, B310), and despite young people in custody having greater health problems than their peers, they receive less in the way of health promotion, screening, prevention and early intervention services (MacFarlane, 1997). There is generally little understanding of the physical health needs among young offenders although evidence of high substance use and risk taking behaviours, alongside common histories of neglect and social exclusion, would indicate high levels of health needs (Ryan and Tunnard, 2012). Self-reported physical health is used as an indicator and measure of the physical health needs of CYP entering the Criminal Justice System (CJS); a review found that 12% of 15 to 17 year old males and 30% of females reported a physical health problem on arrival to custody (Summerfield, 2011).

Common physical health problems include:

- A high prevalence of smoking (Galahas SMS Ltd, 2004), which draws a parallel to the most common health problem reported, respiratory problems (Lader et al, 2000)
- A high proportion of the cohort are not up to date with vaccinations due to a lack of utilisation of universal services
- High rates of sexually transmitted infections and early pregnancy amongst offending females (Lader et al, 2000)
- High rates of drug and alcohol dependence amongst the group (Galahad SMS Ltd, 2009)

Common physical health issues therefore include those related to a lack of exercise, poor diet, drug and alcohol use, smoking and sexual health, whilst there are also high levels of accident and emergency admissions, as individuals in the cohort often experience little previous interaction with universal services, therefore failing to manage their own health and presenting when in crisis.

Mental ill health

The incidence of mental-ill health amongst the general population has increased, and has been recognised as a pre-disposing factor to youth crime (Pitcher, 2004); high levels of mental ill health are therefore common among young offenders (YJB, B310) who are identified as a key group at risk of developing mental health difficulties in adulthood. Risk factors are believed to contribute to personal characteristics such of a lack of awareness of boundaries, limited mindfulness, poor coping mechanisms, symptoms of ADHD, ASD, anxiety, conduct and psychotic issues and a failure to access universal health services. Nationally, mental health service provision is considered to be failing to meet the mental health needs of young offenders as expertise and resources are lacking across all agencies involved (The Mental Health Foundation, 2002).

Dual diagnosis and co-morbidity

The Ministry of Justice Statistics Bulletin (2010) emphasised the prevalence of dual diagnosis and co-morbidities amongst young offenders, particularly mental health difficulties and associated increases in rates of risk taking behaviours (Pitcher, 2004). Lader er al (2000) found that 80% of 16-20 year old young offenders showed more than one of the following five mental health disorders, personality disorder, psychotic disorder, neurosis, hazardous drinking and drug dependence, whilst individuals with a dependence on drinking or drug taking were more likely to have a number of other disorders. 60% of young people in custody were found to have regularly used illegal drugs to relieve anxiety, stress and

depression or for other reasons linked to their emotional state, suggesting a link between mental health needs and substance misuse (YJB, 2009).

1.2. Groups most at risk

A number of predisposing risk factors exist in the development of both physical and mental health problems amongst young offenders, who are likely to have experienced a range of entrenched difficulties and compound disadvantages (Ryan and Tunnard, 2012). Non-school attendance and poor parenting are both factors associated with anti-social behaviour that are considered to lead to the early onset of drug taking (Pitcher, 2004) supporting further research that found that CYP in the CJS are more likely to have used both legal and illegal drugs and suffer from substance misuse problems (YJB, B310).

The Mental Health Foundation (2002) identified three main reasons for high rates of mental health disorders

- Predisposing risk factors
- Risky behaviours of the individual
- Interactions with the CJS causing anxiety and depression

Risky behaviours have been considered in section 1.1 particularly when considering the influence such behaviours have on physical and mental health. Pre-disposing risk factors consider the wider and more entrenched circumstances that influence the health of young offenders, and can be considered modifiable or fixed.

Modifiable risk factors:

Socio-economic context and lifestyle: poor backgrounds, restricted opportunities, stressful life experiences. CYP who are most at risk of offending are those from families who suffer socio-economic disadvantage and live in under resourced neighbourhoods, circumstances which are also likely to contribute to worse health outcomes of these children prior to offending (Pitcher, 2004). Despite overall reductions in reoffending, social environments increasingly influence drug use, mental health problems, and access to services, lifestyle factors and therefore the complexity of health needs.

Family networks: young people who have offended and have substance misuse problems are more likely to have experienced difficult life events such as familial problems, bereavements and abuse, leading to lower levels of psychological wellbeing and associated ill health (YJB, B310). Fragmented family relationships and parental poverty are common factors that have been identified amongst those CYP within the CJS who experience worse health (DH, 2009a).

Social exclusion: social exclusion is an underlying theme, particularly amongst the 16-18 age group; those young people with a background of severe social exclusion have an increased exposure of risk factors linked to youth offending and the development of mental health problems (Ryan and Tunnard, 2012). As a diverse group with diverse needs, this cohort has a general lack of understanding regarding the management of long term conditions, exacerbated by falling through gaps in the system, such as failing to re-register with a GP if they move or maintaining access to dentists and opticians once free provision ends once out of education. CYP in this cohort often feel as though they have little worth in

accessing services, having been marginalised by society and not having their opinions and circumstances considered in the delivery of services. Prejudice is considered a large barrier.

Community vs secure units: A cross sectional study concluded that young offenders in the community have far higher health needs than those in secure care (Chitsabesan et al, 2006), yet many of these needs are unmet.

Fixed risk factors:

Female young offenders: More than twice the number of 15 to 17 year old females in custody in 2010-2011 reported a physical health problem on arrival to custody than males, at a rate of 30%, compared to 12% respectively (Summerfield, 2011). Girls and young women in custody have greater mental health needs than boys, particularly in areas of depression, post-traumatic stress disorder and self-harm (Chitsabesan, 2006), whilst over a third of 17 year old girls in Youth Offender Institutes had engaged in self-harm in the previous month, more than double the rate for adult women in custody (Douglas and Plugge, 2006).

There is a clear overlap between the risk factors for the development of mental health problems and those for offending behaviour, whilst there are also clear barriers in the ability for young people to access services successfully. Colleagues within Nottinghamshire's Head2Head service and the Clinical Nurse Specialist confirm a number of these barriers and early experiences that influence access, including

- Poor early experiences of neglect and/or poverty
- Mental health problems
- Domestic violence
- Trauma
- Substance misuse

If the physical and mental health needs and substance misuse problems of young offenders do not receive due attention and are not met, there is a significant risk of re-offending and an increased risk of becoming an adult offender with even greater complexities of ill health.

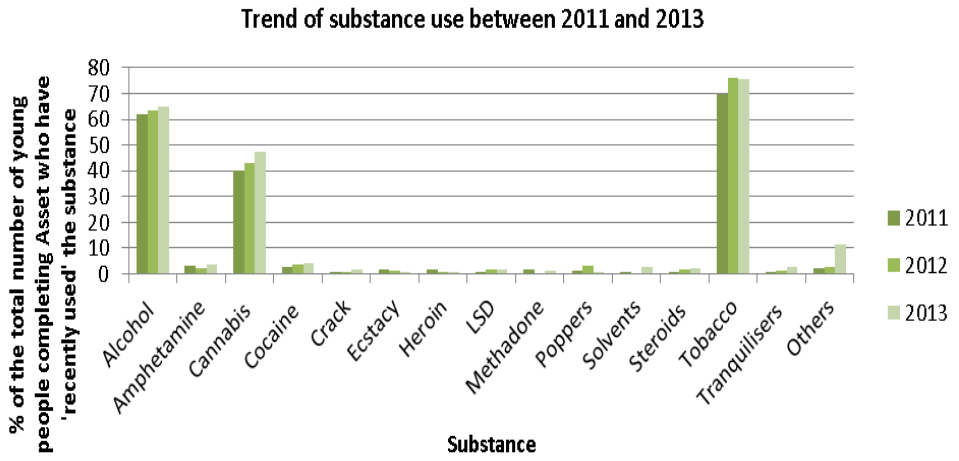
2) Size of the issue locally

2.1. What is the impact on health and wellbeing locally

Using data extracted from Asset questionnaires undertaken at the point of entry to NCC's YOTs, an overview of the self-reported health needs and ill health of individuals follows. Data obtained between 2011 and 2013 is analysed, providing an indication of possible local trends; and will discussed under the headings used within the Asset template.

Asset section 6. Substance Use

Figure 1: Substance use of young people entering the YJS between 2011 and 2013

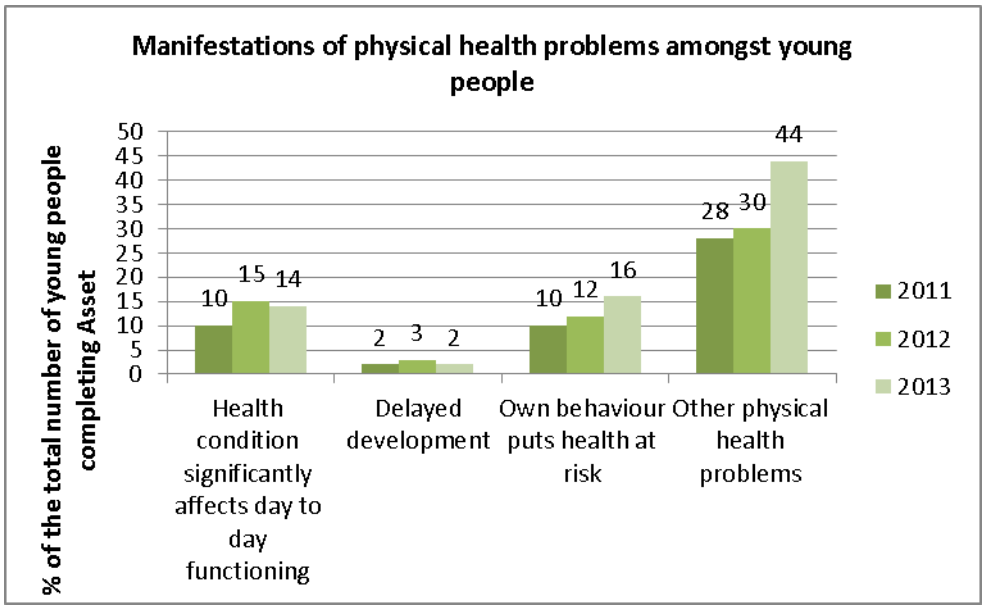


Source: Summary of Asset data, 2011-2013

The 'recent use' of a number of drugs, at the point of entering the YJS, has increased between 2011 and 2013 (Figure 1). Alcohol, cannabis and tobacco are evidently the substances most commonly used by the cohort, with data illustrating that use of the former two has steadily increased. Although levels of use are significantly lower, increased use of cocaine, steroids and tranquilisers is evident, alongside the rise in 'others' which may include legal highs, of which the prevalence of use is thought to have increased as a result of the clamp down on heroin (Blakemore, 2013).

Asset section 7: Physical health

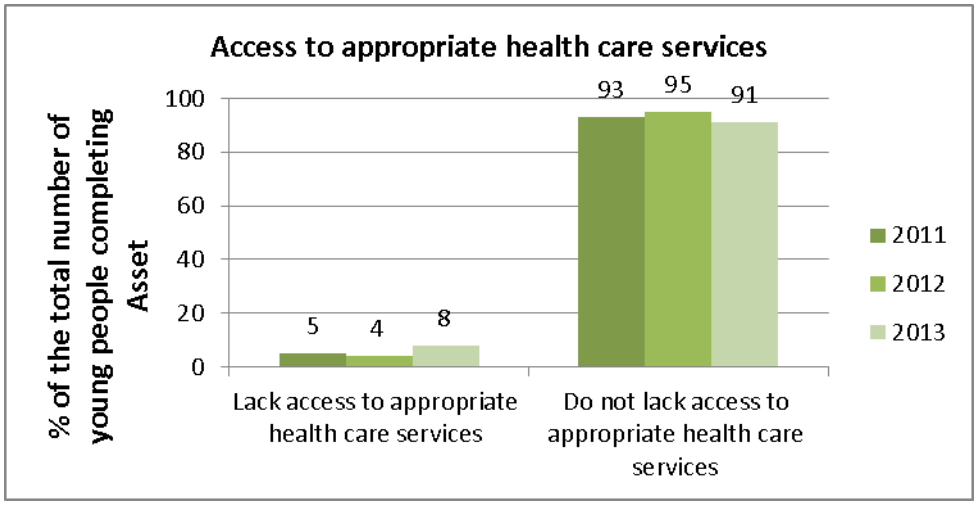
Figure 2: Physical health problems amongst young people entering the YJS between 2011 and 2013



Source: Summary of Asset data, 2011-2013

There is a rise in the proportion of CYP reporting that their own behaviour puts their health at risk (Figure 2), which corresponds with the increase in physical health problems and over half of CYP binge drinking, smoking, being obese and consuming a poor diet at the point of entering Nottinghamshire's YJS.

Figure 3: % of young people entering the YJS who have access to appropriate health services

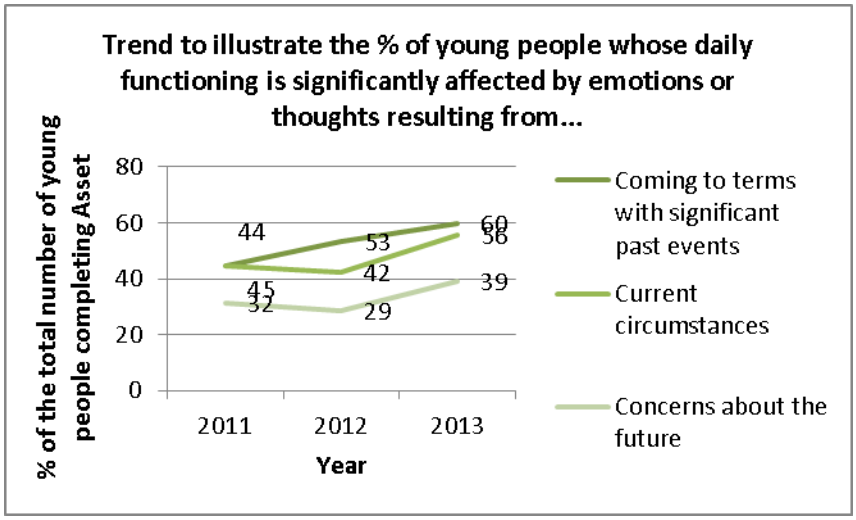


Source: Summary of Asset data, 2011-2013

The majority of young people entering the YJS consider themselves to have access to appropriate health care services (Figure 3), with less than ten percent considering themselves to lack access. This appears to contradict the national picture that young people entering the YJS have experienced a previous lack of access to health care services.

Asset section 8: Emotional and mental health

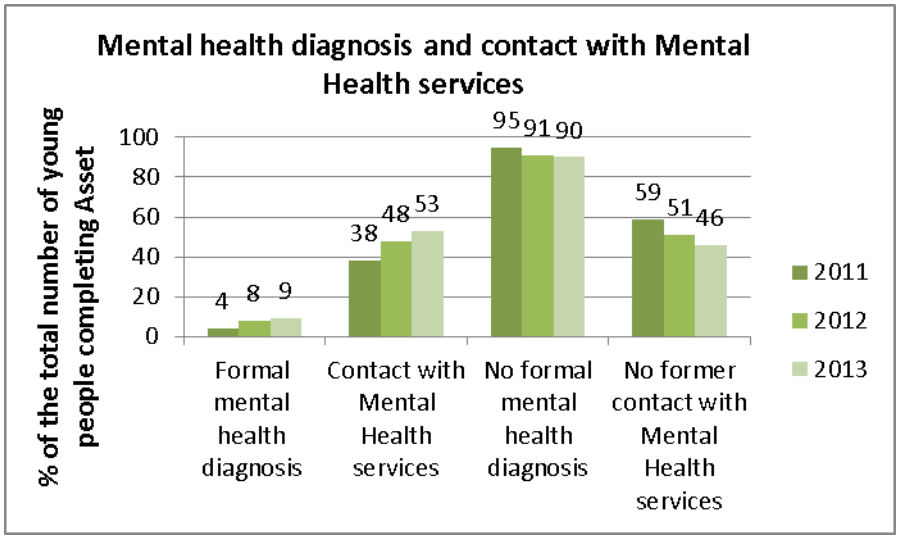
Figure 4: Young people entering the YJS whose daily function is affected by their emotional and mental health



Source: Summary of Asset data, 2011-2013

There has been a steady increase in the proportion of young people entering the local YJS who consider their daily functioning to be significantly affected by past, current and future concerns (Figure 4). This demonstrates the increased mental health needs of young people amongst this cohort in recent years.

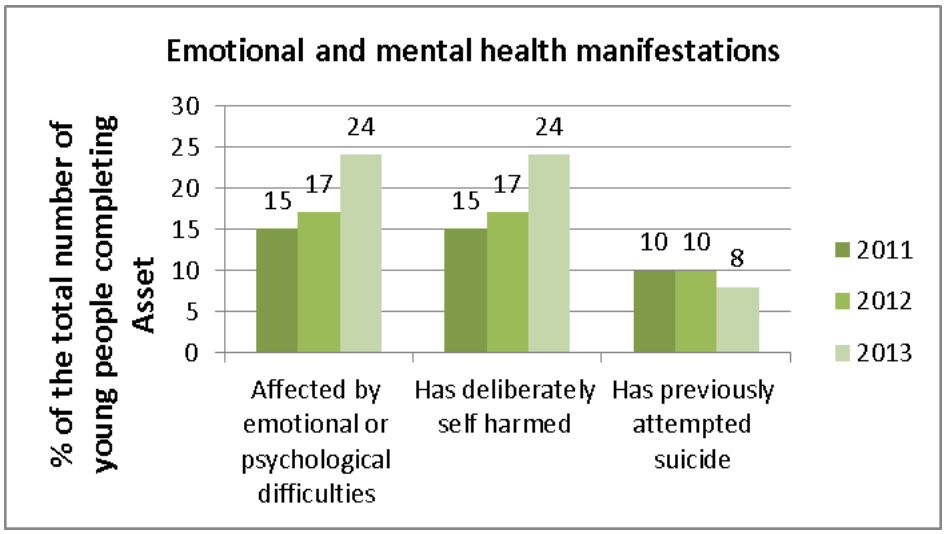
Figure 5: Mental health diagnosis and contact with mental health services of young people entering the YJS



Source: Summary of Asset data, 2011-2013

Figure 5 illustrates an increased demand upon formal mental health services by young people within this cohort as increasing numbers are making contact with mental health services and obtaining formal mental health diagnoses.

Figure 6: Emotional and mental health manifestations experience by young people entering the YJS



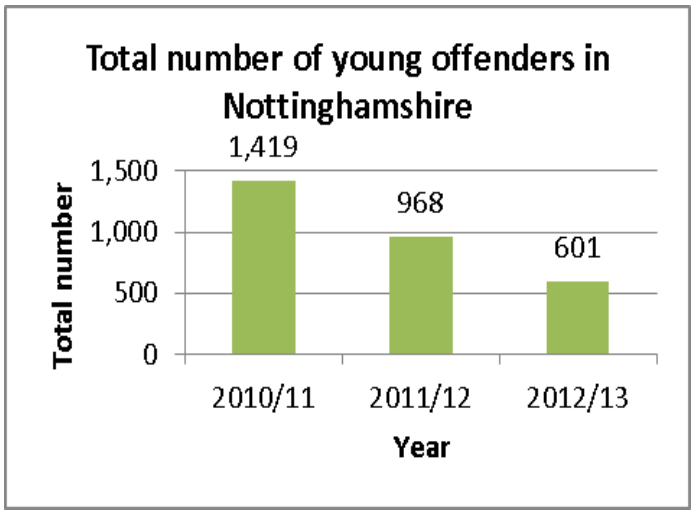
Source: Summary of Asset data, 2011-2013

An increased percentage of young people self-report that they are affected by emotional or psychological difficulties or have self-harmed (Figure 6), drawing a parallel to the increased contact made by young offenders with formal mental health services.

2.2. Trends and projections

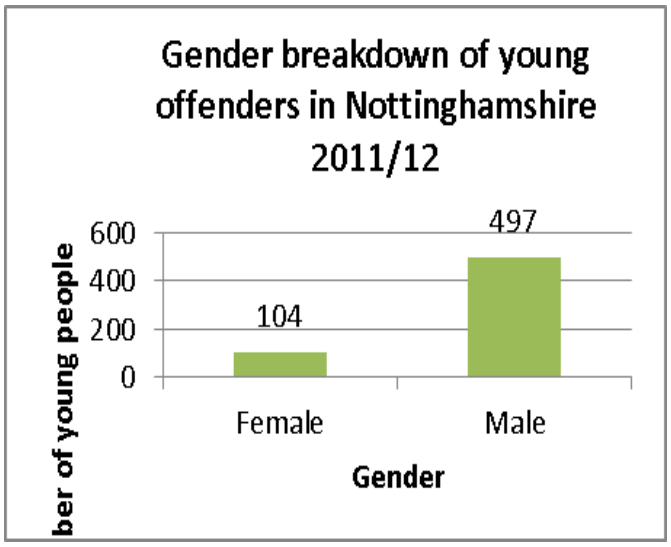
The total number of young offenders in Nottinghamshire fell between 2010/11 and 2012/13 (Figure 7); in 2011/12 just over three quarters of these were male (Figure 8), whilst three quarters were over the age of 15 (Figure 9). 94% of those young offenders in 2011/12 were white (Figure 10). There are demonstrably prominent characteristic groups within the young offender cohort in Nottinghamshire.

Figure 7: Trend of young offenders in Nottinghamshire



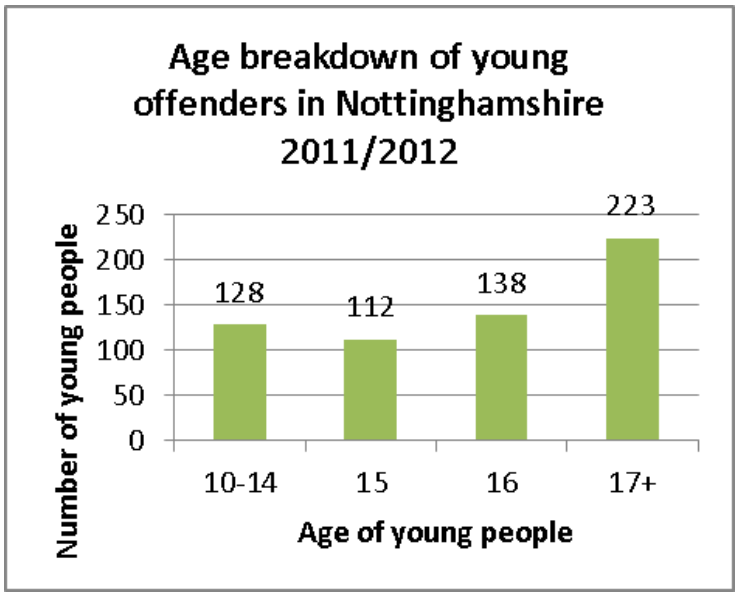
Source: Youth Justice Statistics, 2012-13, Ministry of Justice, 2014

Figure 8: Gender of young offenders in Nottinghamshire



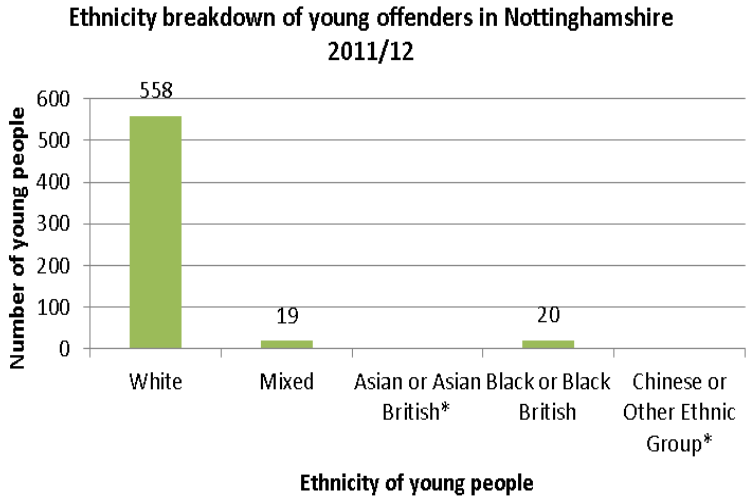
Source: Youth Justice Statistics, 2012-13, Ministry of Justice, 2014

Figure 9: Age of young offenders in Nottinghamshire



Source: Youth Justice Statistics, 2012-13, Ministry of Justice, 2014

Figure 10: Ethnicity of young offenders in Nottinghamshire

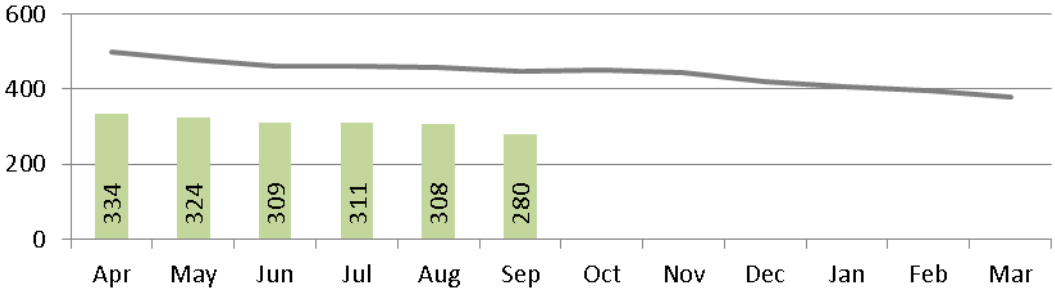


*Numbers below 5 and suppressed

Source: Youth Justice Statistics, 2012-13, Ministry of Justice, 2014

Asset section 6. Substance Use

Figure 11: Number of young offenders in Nottinghamshire specialist substance misuse community services

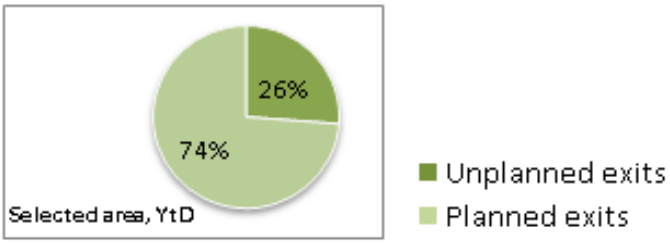


NB Data refers to both Head2Head and FaceIt

Source: YP Quarterly Local Assurance Report 2013/14, Public Health England

Figure 11 illustrates the number of youth offenders in Nottinghamshire in specialist substance misuse community services on a rolling 12 months basis for 2013/14. The grey line represents the figures for the same period in 2012/13, and therefore demonstrates a reduction in numbers using these services. The Targeted Support Operations Manager was asked to provide an narrative to accompany this trend in data: *'In relation to the overall reduction in numbers of young people accessing community based specialist substance misuse services, I think the answer may lie in some of the operational changes that have occurred since the FACE IT service was integrated into Targeted Support. For example FACE IT previously operated a Freephone number providing advice for people who didn't want ongoing support and this is no longer operational. They also offered an acupuncture service which is no longer available. So both of these changes will have had an impact on numbers. This is likely to account for some of the shortfall. In addition we want to explore how we can make the service accessible through some of the drop in sessions run by Targeted Support.'* However, this reduction in service use will also correspond with reduction in the overall number of new entries into the YJS (Figure 7).

Figure 12: Planned and unplanned exits from Nottinghamshire specialist substance misuse community services, 2013/2014



NB Data refers to both Head2Head and FaceIt

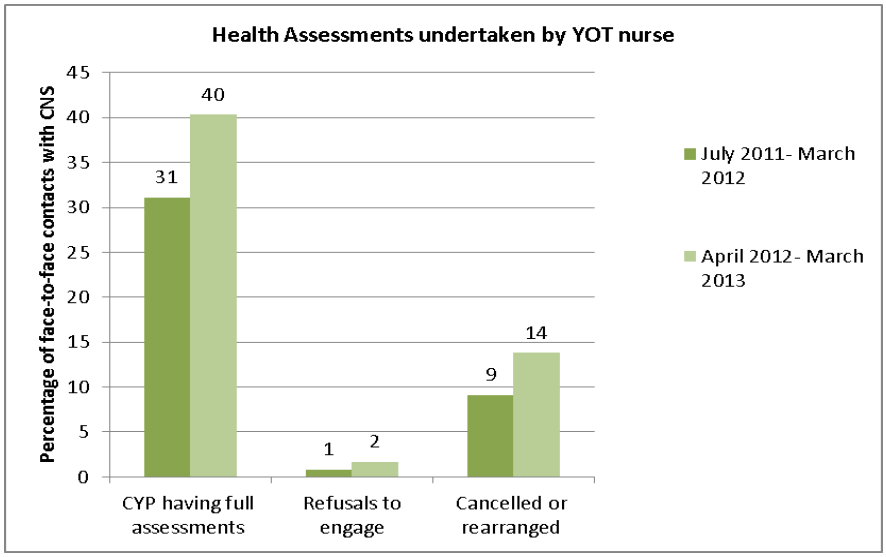
Source: YP Quarterly Local Assurance Report 2013/14, Public Health England

Just over a quarter of exits from specialist substance misuse community services are unplanned (Figure 12). Once again, the Targeted Support Operations Manager was asked to provide a narrative to accompany this trend in data: *'The primary reason for the dip in planned exits from treatment are around some staffing difficulties. The Nottinghamshire Healthcare Trust Substance Misuse staff were not up to capacity for parts of this year so this has impacted on the ability of the service to handle all exits in a planned manner. The issues are being addressed with the current provider and the service is being re-tendered at present with a new contract start date of October 2014.'*

The most common age groups in the specialist substance misuse community services are those individuals aged 15, 16 and 17; together these age groups account for 90% of all young people in specialist services, loosely reflecting both the local and national pattern of youth offending by age (Young people by region 2011-12; Youth Justice Statistics regional data).

Asset section 7: Physical health

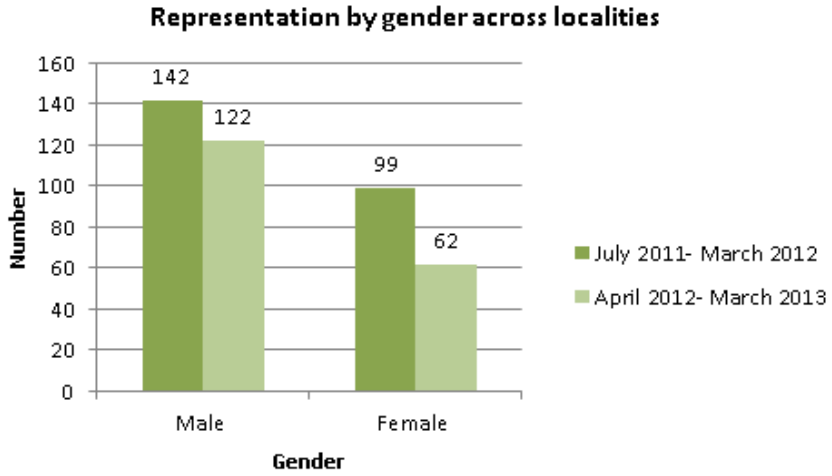
Figure 13: Health assessments undertaken by Clinical Nurse Specialist (CNS)



Source: Summary of Asset data, 2011-2013

Between July 2011 and March 2012, there were 241 face-to-face contacts with the CNS following referral, of these 31% had full assessments and 9% were cancelled or rearranged. Between April 2012 and March 2013, there were 181 face-to-face contacts with the CNS, following referral, of these 40% had full assessment and 14% were cancelled or rearranged (Figure 13). The reduction in the number of face-to-face contacts corresponds with the reduction in the overall number of new entries into the YJS (Figure 7). Clients from Mansfield and Ashfield accounted for 54% of the total in the 2011-2012 period, and 48% in 2012-2013.

Figure 14: Gender of young people accessing the CNS



Source: Summary of Asset data, 2011-2013

The proportion of male and female contacts with the CNS illustrates that a higher proportion of females within the youth offending cohort in Nottinghamshire has a physical health problem than males (2011-12, 42% female, 58% male and 2012-13, 34% female, 66% male) (figure 14); despite females making up just 17.3% of the youth offending cohort (figure 8), they account for around 62% of the CNS assessments. These findings reflect national evidence that females are over twice as likely to report a physical health problem, than males (Summerfield, 2011), which is likely to be a reflection that females has a much higher level of health need, combined with a lack of uptake by males.

3) Targets and performance

CNS: Physical health concerns

The CNS works to the targets and key performance indicators of their original job description and service specification. They also work to the Commissioning for Quality and Innovation (CQUIN) targets for health partnerships, which includes steps to go smoke-free and A&E follow-ups.

Objectives included in the CNS' service specification include:

- All entrants and re-entrants to YOS who have a Youth Justice order or final warning status or who are released from custody have access to a detailed Health Assessment and health promotion advice, which in turn promotes their use of mainstream services including registration with a GP and re-entry to school, further education and training or employment (DH 2009 section 5.54). *The CNS provided clarification that access to a detailed Health Assessment is provided if the young person is referred by their case manager following identification on Asset or a Health Screening Checklist. Other services, usually agencies involved such as Looked After Children teams and targeted support, also refer young people for a health review. All young people who have a health assessment are automatically flagged by the CNS so the yearly review health assessment can be initiated, which is incorporated into the care plan to case managers are aware when an assessment is due; alternatively, the service may be offered by the GP or school nurse if necessary.*

- Evaluation following health assessment will demonstrate increased uptake of universal services, including GP registration and access, with uptake of appropriate services to meet identified health needs.
- Where indicated a health delivery plan will be agreed as part of the Health Assessment process to support access to early intervention and treatment that may be of benefit (DH 2009 section 5.54)
- Young people who need support for transition into adult health provision effective negotiation of an appropriate, coordinated package to meet individual needs, enabling a safe and effective transition to appropriate adult provision (DH 2009 section 5.54). *The CNS clarified that transition to school nurse, GP or other service is supported at closure of an order and on an individual needs led basis. Depending on who is involved, transition occurs as early as 15/16, although generally services should be supporting children and young people until at least the age of 18 unless they have a disability.*

CAMHS: Emotional health and wellbeing concerns

Head2Head do not work to any specific targets

Substance Misuse Workers: Substance misuse problems

The SMS reports on measures including planned exists (see figure 12) and timeliness of interventions

The health of young offenders can also be contextualised within the wider remit of health, and measured against a number of local and national performance indicators:

Health and Wellbeing Strategy for Nottinghamshire 2014-2017[1]

- Work together to keep children and young people safe
- Improve children and young people's outcomes through the integrated commissioning of services
- Provide children and young people with the early help support that they need

(the above are also priorities of the Nottinghamshire Children, Young People and Families Plan 2014-2016)

- Improve services to reduce drug and alcohol misuse
- Improving access to primary care doctors and nurses

NHS Outcomes Framework 2014-2016[2]

Domain 1: Preventing people from dying prematurely

11ii – Potential Years of Life lost (PYLL) from causes considered amenable to healthcare: Children and Young People

[1] http://www.nottinghamshire.gov.uk/caring/yourhealth/developing-health-services/health-and-wellbeing-board/strategy/

[2] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/256457/At_a_glance_NHS_OF.pdf

Public Health Outcomes Framework[3]

Wider Determinants of Health

1.04 - First time entrants to the youth justice system

1.13i - Re-offending levels - percentage of offenders who re-offend

1.13ii - Re-offending levels - average number of re-offences per offender

4) Current activity, service provision and assets

4.1. Young Offenders in the community

The formal YJS commences when a child or young person aged 10 to 18 has committed an offence and receives a reprimand or warning, or is charged to appear in court. Despite this, many young offenders who are not in the formal YJS will be in contact with police and/ or the YOTs.

The National Youth Justice Board (YJB) was created by the Crime and Disorder Act 1998, and has responsibility to ensure the health needs of CYP under the age of 18 are taken into consideration and addressed effectively (Pitcher, 2004). The YJB has set clear priorities for health within the Youth Justice Framework, in order to see a reduction in the number of young people involved within the YJS who regularly misuse drugs, solvents or alcohol. These priorities also include having set time limits for the commencement of assessments by CAMHS and specifying that every young person referred to YOT undergo an assessment of substance needs to ensure the appropriate delivery of services (YJB, 2004).

When young people enter the YJS, an Asset questionnaire is undertaken with each individual, scoring their risk of re-offending; this is undertaken at the start of the process and reviewed on a three monthly basis as a minimum. The questionnaire assesses physical health, emotional mental health and substance misuse, based on self-reporting, and is used to tailor individual packages. The pathway has been developed to ensure that once assessed by the YOT, the young person will be referred seamlessly to the follow up service following the health screening checklist which initially establishes a health need before seeking more detail.

Any concerns raised during this initial questionnaire can form a basis for the following referrals:

- Physical health concerns to the Clinical Nurse Specialist (CNS) (County Health Partnerships- Nottinghamshire Healthcare NHS Trust)
- Emotional health and wellbeing concerns to Head2Head (Nottinghamshire Healthcare NHS Trust)
- Substance misuse problems referred to substance misuse workers (Targeted Support and Youth Justice Substance Misuse Service (SMS)- Nottinghamshire Healthcare NHS Trust)

Each provide a comprehensive health service, tailor made to the specific needs of CYP entering the YJS across Nottinghamshire County.

[3] http://www.phoutcomes.info/public-health-outcomes-framework

Physical health concerns: Clinical Nurse Specialist

The role: Resulting from an inspection of Inspectorate of Probation in 2008 alongside a Health Needs Assessment undertaken by Nottinghamshire Public Health and Youth Offending Service, the current CNS post was commissioned and recruited to in 2010. Sitting with Health Partnerships, the CNS works closely with primary and secondary health care providers to enable the CYP to have their health needs met holistically.

The post is pivotal in the provision of a specialist health assessment service which aims to address the negative health consequences of young offenders, with a detailed care plan to address their health needs. Nottinghamshire's service provision is a lone practitioner model, one CNS provides support to the YJS and deals with any concerns that the YOT may have regarding individual young people, following an initial assessment.

Young people are referred to the CNS, but can choose not to engage if they wish. The aim of the CNS, their service and partnership work it entails is to improve and encourage healthier lifestyles amongst the cohort, they work with an estimated 360 plus children across the whole county (CNS Annual report, 2012-2013).

The role of the CNS encapsulates a number of areas including

- Educating the child/ young person/ parent around routine vaccinations and advising them of the vaccinations that are missing
- Home visits, accompanied health service visits or surgery meetings if any risk elements are established
- Providing liaison and training to the YOT Case Managers on the vaccination schedule and identifying those CYP that are outstanding
- Supporting CYP to access universal services to have these administered often through the provision of accompanied health appointments
- Ensure that the young people are registered with a dentist, GP and optician and are referred to other services as required
- Responding to queries from the Multi Agency Safeguarding Hub (MASH) in an attempt to bridge the gap with regard to safeguarding
- Consideration of Accident and Emergency attendance and liaison, ensuring that cases are both followed up and fed into risk reviews

Much of the work undertaken by the CNS is specific to educating and raising awareness of the individual, encouraging ownership for health and being self-sufficient and confident in accessing universal services such as smoking cessation.

Referral and assessment process: YOT case managers screen each young person who enters the YJS using a health screening checklist (Asset) which endeavours to identify any self-reported ongoing health needs, individuals who have not accessed health services in the previous two years or are not registered with GP, dentist or optician, and those who are not in education, training or employment. Section 7 of the Asset survey specifically considers physical health needs; a yes marker following assessment sees the young person offered a referral for a further health assessment with the CNS. If they take up the offer of this further assessment, generic referrals are received securely via Asset by the CNS.

Appointments are made within 28 days of referral or two weeks in an urgent case. The first meeting, to undertake the health assessment and develop a care plan, is arranged and subsequent meetings are negotiated and arranged later. Families are able to attend meetings but young people often attend on their own, and are generally considered to be receptive and engaging.

The comprehensive health assessment is approximately an hour in length and endeavours to ensure and promote continued access to quality healthcare. The young person is involved in the assessment process and development of a care plan to establish what they do and do not want, agreements surrounding confidentiality and sharing of information. Time frames and expected outcomes are also established at the initial meeting, which are reviewed at later meetings and are dependent on the needs and risks of the young person.

Outcomes of assessment: Considering the health assessment and care plan, the CNS will refer the young person, as appropriate, to a variety of health services including New Leaf, CASH and GUM, dieticians, paediatrics, vaccination teams, drug and alcohol teams and CAMHS. The CNS appreciates that issues such as sleeping problems, diet and exercise are often rooted in emotional and mental health problems, so will refer appropriately to primary and secondary care services that will meet their needs, providing further assessment and specialised advice. With the permission of the individual, care plans are shared with the individual, their parent/ carer, Case Manager and other partners including GP, Health Visitor/ School Nurse, Head2Head and SMS if involved. Individual health assessments are reviewed every 12 months, and at the end of each order, a tripartite meeting is undertaken between the CNS, young person and GP with whom they are registered or school nurse; this provides an opportunity to undertake a 'handover' process

Partnership and engagement: The CNS attends monthly YOT meetings to keep abreast of new developments within the YJS, whilst consultation opportunities are available between staff from the various teams involved, including the SMS and Head2Head team meetings. Such forums provide an opportunity for the appropriate sharing of information, discussions regarding interventions, supervision of particular cases whilst also facilitating the joint assessment of referrals. This also seeks to remove duplication of assessment, and provide an opportunity for consultation.

The CNS endeavours to ensure that relevant information is shared with custodial sentences, feeding in relevant information specific to vaccinations and medication; this is considered vital as the two electronic systems do not talk, due to closed records and issues regarding timely communication. Custody notifications are received by the CNS via the YOT, which she will follow up with a call the custodial setting to discuss meeting the young person's health needs transitionally.

Head2head, CAMHS: Emotional health and wellbeing concerns

The role: The provision of Head2Head runs parallel to and is well linked to the YOT, who are the services primary referrer. The service provides a targeted and specialist CAMHS service across the county and there is believed to be an even spread of referrals from across the county, although perhaps less from Broxtowe, Gedling and Rushcliffe (BGR). A duty system is in place that ensures appropriate levels of staff are available to answer queries from the YOTs and establish individual case histories; duty workers also screen each referral to establish the urgency of that individual referral. Staff provide consultation, advice and support, to the young person but also YOTs, supporting them to address issues presented by young people with whom they engage, and attempt to avoid unnecessary referrals and promote experiences of seamless services.

Referral and assessment process: YOT case managers screen each young person who enters the YJS using Asset; section 8 specifically focuses on emotional and mental health, and if a score of two or more is obtained for this section, the mental health screening questionnaire interview for adolescents (SQIFA) is undertaken by the YOT case manager. If a score or three or four is achieved by the young person, the full screening interview for adolescents (SIFA) is undertaken in order to provide support and make appropriate referrals to appropriate levels of CAMHS services. Referrals are made to the Head2Head team as a whole from the YOTs, via secure mail to the team administrator, before being allocated to an individual workers based on their skill set and availability. This demonstrates the service's approach to meeting the needs of the young person using an assertive outreach model. Urgent assessment is undertaken if required and immediate referrals are made without the completion of the Screening Pathway.

The assessment process commences immediately as does liaison with the SMS. Allocation of initial assessments and meetings are arranges one day per week for non-urgent cases, whilst those young people involved in urgent referrals are seen immediately to ensure a care plan is developed and put in place as soon as possible.

The Head2Head staff member will meet individuals in a number of settings in an attempt to encourage engagement particularly as they are often from hard to reach families on the periphery of services and may have had a poor experience of CAMHs services previously. With a wide skill set, the team is able to develop a package and plan to meet the needs of the young person, which is developed as an individualised process, working with the young person who is encouraged to be fully involved and a part of the development of their care plan. The individual care plans are initially developed as a digital plan which enables agreement between the worker and young person, both saving time but enabling the young person to agree a plan that they have helped develop.

Outcomes of the assessment: Despite this being a specialist service, every effort is made to ensure that it is also a time limited service that does not remain involved throughout the length of the order unlike the YOTs if there are no continued mental health needs. The individuals are therefore assessed with a view to ceasing their service use. Every effort is made to ensure that the young people are not worked with in isolation, but that surrounding support mechanisms exist and are utilised.

Partnership and engagement: Head2Head staffs believe that the experience and low turnover of the YOTs is a positive characteristic of the teams, who are able to maintain knowledge and good levels of case management. They also consider it a positive move that the looked after children (LAC) team and YOTs are co-located, to promote good communication, particularly as many of individuals within this group experience comorbidities.

Assessments and individual care plans are disseminated to the relevant YOT as the referrer and GPs alongside any other partners involved in the care plan with the young person's consent. Such information is not shared if the young person withholds consent, although this is rarely the case. The assessment is considered to take a global approach, which focuses on mental health primarily, but also physical health and safeguarding, and must therefore consider interventions and potential engagement with health practitioners.

The team works with families and carers where viable and appropriate, and encourage strong relationships with the young people and partner services based on trust, collaboration and integration. Wider systems, including school settings and working with learning mentors, are accessed to encourage positive outcomes, whilst engagement with families occurs on an individual basis, and the service is able to deliver a range of family interventions if they chose to engage with the support available. Partners involved, including YOTs, the CNS and SMS, are all considered to share the same core values and ethos as Head2Head colleagues, and despite not being co-located, there is a high level of integrated and collaborative working and care for the young people. The three health providers talk, share information regarding the young person and attempt to avoid duplication in order to establish and meet goals set for individual young people.

Similarly to the CNS, the Head2Head service is able to inform custodial settings of individual needs if issues are known to exist when entering a custodial setting from community. The team is also informed of any young people with emotional and mental health needs released from custodial settings into the community, by the YOTs.

Regular formal meetings and reviews, alongside ongoing informal conversations occur between the service and NCC commissioners which are considered to be built into the service provision.

Substance Misuse Workers: Substance misuse problems

The most recent Young Persons Substance Misuse Needs Assessment for Nottinghamshire was undertaken by Nottingham Trent University on behalf of NCC in March 2013. The full report can be accessed at www.nottinghamshire.gov.uk/caring/childrenstrust. The following discussion will draw on some of the findings from this needs assessment.

The role: SMS specifications must be developed locally and identify needs of young people, in order to improve their outcomes. Nottinghamshire's SMS structure corresponds with that of the YOT provision and eight/ nine full time equivalent staff currently straddles targeted support and youth justice, providing a holistic service and attempting to address underlying issues, undertaking broader thinking around areas. The SMS also pick up more complex cases or individuals with specific requirements as part of their order. Individual young people are worked with on an individual basis and have a named substance misuse worker; the worker-young person relationship is based on confidentiality and consent, unless any safeguarding issues are or become evident. SMS workers are responsible for:

- Undertaking a comprehensive assessment interview with those individuals referred
- Increasing the young person's understanding of substances and the effects of substance misuse
- Working to any plan to address or stop substance use
- Considering other issues including behaviour and schools problems, working with relevant partners to address the issue appropriately.

Referral and assessment process: The majority of referrals to substance misuse services are made from criminal justice agencies such as the YOTs across Nottinghamshire county (Barnard et al, 2013). Referrals are either made on an individual basis through the Early Help Unit or following the YJS assessment process and completion of the Asset assessment. Young people are referred to a substance misuse worker following an Asset assessment score of two or more in Section 6, if their offence is associated with substance misuse or if they wish to address substance misuse which is not directly linked to their offending. Following referral, a holistic individual assessment, Chat Plus, is undertaken and saved on Care Works.

Partnership and engagement: There is a move towards locality working and there is an increased focus on working closely with partners, particularly as many work within the same service area. Due to the holistic approach taken in working with individuals, efforts are made to involve parents and carers and relevant partners when developing each young person's plan. Part of a case manager's role and responsibility is to explore the involvement of other partners, and such partnership is considered to have been promoted by the colocation of workers and management meetings, for example Early Help Implementation meetings.

5) Evidence of what works

There would appear to be a number of strengths associated with the provision of and transition of young offenders to appropriate health services in Nottinghamshire. Referrals from the YOTs following the completion of the Asset assessment forms would appear streamlined and timely in their nature.

Partnership working between the various services seems to be valued by each service and colocation and forums such as management meetings are considered strengths, enabling the sharing of information and development of shared and more holistic care plans for individual young people. The integration of the three health providers and the YOTs has ensured the maximisation of consultation opportunities between these core services, but also at a wider scale with LAC teams, secure establishments and primary, secondary and community health colleagues.

The services appear to share the same ethos and drive to improve opportunities for those young people that are referred to their services, understanding the barriers to services and social difficulties many of these individuals have experienced previously. Each therefore involves the young people in the development of their individual care plans to encourage continued engagement and ownership of their improved health.

There is evidence that each of the services undertakes continued monitoring and self-evaluation of progress, the CNS via an annual report and Head2Head through continued evaluation.

Clinical nurse specialist: Services provided by the CNS, including drop in sessions, have been widely advertised in each locality; contact details and targeted information has been made available via leaflets and promotion by other teams. The role of the CNS includes supporting young people to access universal services and to take responsibility for their own health through education and awareness; registration to services including GPs, dentists and optometrists demonstrates a level of success.

Head2Head: The service has experienced some self-re-referral of previous service users, who express their positive experiences and ease at re-accessing the service. Many had built a good relationship with their worker and due to a low staff turnover amongst the team, are able to request the worker with whom they would like to work with, avoiding the need to rebuild the worker-service user relationship.

SMS: The 2013 JSNA undertaken by Nottingham Trent identified a number of service strengths including the well-kept recording and running records of contact with individuals, accurate, timely and evidenced multi-disciplinary approach, well recorded and comprehensive care plans that are tailored to individuals needs and stage of recovery (Barnard et al, 2013).

Despite apparent successes amongst each of the three targeted community services, and discrete annual or ongoing evaluations of each, there would appear a need to develop a formal evaluation process for each of the services.

6) What is on the horizon?

At a national level the Healthy Children, Safer Communities strategy (DH, 2009a), Youth Crime Action Plan (HM Government, 2009) and Healthy Lives, Brighter Future (DH, 2009b) were developed in order to bring about the necessary changes to improve the health and wellbeing of those children and young people in contact with the youth justice system. However, there is no recent update or strategy available to consider needs going forward.

At a local level, the Nottinghamshire Youth Justice Plan is currently under development and will be going to committee for approval in May 2014, whilst each service was able to identify areas of development which can be found below:

Clinical nurse specialist: The CNS identifies a number of priority areas in her 2012-2013 annual report which include:

- The continued development of service provision to support the ability to increase the number of CYP to access a health assessment
- Continued improvement of communications across agencies whilst building links with each of the locality teams and specialist health providers within the YJS
- Continue to work within the 'You're Welcome' criteria
- Further work to re-integrate young people into school nursing or transition into adult services
- Further enabling of health, social care and criminal justice service personnel to better identify health needs of this vulnerable cohort of young people

In order to achieve these priority areas, it has been identified that

- Staff will be trained on pathway use and the referral pathway will be reinforced, whilst these pathways will experience continued development
- Relationships with other health providers and case managers will continue to be built
- Feedback will continue to be requested from service users, informing the development of services
- Professionals will access further training to support them in identifying health needs more appropriately.

The CNS also hopes to continue to report on A&E attendance of the CYP with whom she engages, many of whom have attendances of more than three per year, in order to demonstrate that her role to educate, support and improve risk management, is able to play a part in reducing this costly access to services.

Head2Head: Plans to reconfigure the CAMHS service are considered a major threat to the Head2Head service and therefore the provision of the service to young offenders with emotional or mental health needs. There is a lack of confidence and certainty that the service could continue to be delivered as an independent service due to the need to meet the variable mental health needs of service users. It is recognised that a service that is able to provide targeted and specialist services in a flexible way, which can deal with the inherent variability of demand, is required.

SMS: The SMS is part of a wider retendering process for a package of public health services including obesity and drug and alcohol services; it is hoped that the new tender will provide further stability and improve the experience of young people. Staff recruited in the new tender will sit within targeted support and have an increased focus on LAC, with one staff member working with this particular focus across the county whilst the remaining staff will work on a district basis. The current delivery will change and will provide an opportunity to re-scope and influence the provision of the service, whilst staff will continue to work directly with young people, support cessation alongside harm reduction and minimisation. There are

plans to increasingly distinguish between more specialist treatments alongside the up skilling of other colleagues, whilst it is also recognised that the holistic assessment currently used is quite lengthy and there is scope to slim-line this as part of the tender and for its inclusion as an additional part of the Early Help Assessment Form.

School Nursing: following a review of school nursing services, the service is due to be reconfigured to enable a public health nursing service to work with 5-19 year olds in a range of settings. The service will have specific targets to work with vulnerable groups such as young offenders. The service will therefore be provided to enhance the Clinical Nurse Specialist role by supporting health promotion and public health nursing interventions with this group.

7) Local Views

Clinical Nurse Specialist: A feedback form is used by the CNS to gain feedback from the young people with whom she works, at the end of their assessment. In addition a service user assessment is undertaken independently by Nottingham Healthcare Trust during a survey week once a month; the Trust encourages the use of their Patient Opinion Website. Feedback from both, are fed back into the service although the CNS considers these two methods of engagement to be less user friendly.

Feedback illustrates that young people consider the service good-excellent (40% rated the service excellent and 60% good in 2011-2012), that they feel consulted about their care and treatment options available and appreciate the support received from and role of their Case Managers. Recurring themes include:

- Receiving useful information
- Service being approachable and friendly
- Service being good and very helpful

Direct quotes referred to in the CNS annual review include:

- *'I have valued the support to attend medical appointments and speak to the doctors for me'*
- *'Brilliant'*
- *'Learned how to protect myself and others from STIs'*
- *'The service is great and useful that would help a lot with young people like myself'*
- *'Was able to talk about and see contraception options available to me'*

Previous feedback and suggested improvements have shaped the service, for example the timing of appointments, which now means that each individual is able to indicate on their referral form their preferred time, date and time for their initial appointment.

The number of completed and returned feedback forms increased from three in 2010-2011 to 40 in 2011-2012. Despite this, the CNS identified in her 2012-2013 annual report the need to further develop service user feedback opportunities, improving the timeliness of feedback.

Head2Head: It is recognised that obtaining patient feedback is challenging but there is currently a piece of work that is asking young people specific questions regarding their experience of the service, in an attempt to obtain information that could influence the service design. Little information has been collected as yet but there is an understanding that there is a general appreciation and happiness with the service.

SMS: A needs assessment of young people was undertaken in 2013 to establish views and experience of current service provision, to inform the new tendering of the service; the results have encouraged the inclusion of a focus to combine specialist and up-skilled staff within the service going forward. Feedback from YP and their parents/carers are gathered but are considered quite general and it is therefore recognised that there is a need to further embed the collection of timely data.

What does this tell us?

8) Unmet needs and service gaps

8.1. What are the key inequalities

The geography of Nottinghamshire is considered challenging due to the unequal need across the county, with higher need and demand in the northern districts of Nottinghamshire. However, as the cohort are known and closely scrutinised, we can be relatively confident that there is no unmet need. The locality based model and service provision of the CNS, Head2Head and the SMS, alongside the locality based model of the YOTs, aim to mitigate any inequalities to meet the health needs of the young offenders across the county. Although there are more young people who come into contact with Nottinghamshire's YJS from Mansfield and Ashfield when compared with the southern localities, access to health services once in the system is equal regardless of the district in which the individual resides.

However, universal and targeted services across the county are not considered to provide an equitable service, for example CASH outreach through the SEXions team, which is available only in the north of the county, as well as opportunities for walk-in and vaccination services. In addition school nursing services have not traditionally worked with this group in the past unless they are attending school, however as most young offenders have poor attendance at school and face greater poor health outcomes, further work is required to target this group specifically.

8.2. What are the gaps in service

Across the three services there are a number of specific and non-specific wider gaps that have been identified. These are summarised below:

- Each of the services is able to illustrate the highly complex needs amongst the young people in the young offender cohort who access their services. However, there would appear to be failings in early diagnosis, for example a failure to identify speech disorders or autism prior to the individual's initial contact with the YOTs. This lack of early intervention implies a need for the development of policies to encourage more streamlined and effective services.
- An increase in targeting within or addition to universal services, such as school nursing, as current provision is deemed ineffective amongst this particular cohort. There is an apparent need for a specialised team of health professionals who are able to support those young people who have been excluded, live independently or are looked after; this is strengthened by the acknowledgment that young people prefer to hear from and speak to health professionals as opposed to family members or teachers when discussing health issues.
- Assessment tools used across the health services are inconsistent. Although the Chat Plus health assessment used by the YOTs provides some consistency across custodial and community orders, community services including Head2Head and the SMS use different assessment tools.
- Although communications and transitional work with Wetherby Young Offenders Institution are considered good, with a pro-forma being provided as a discharge summary evidencing the needs of an individual yet to be met, further improvements to communications between custodial and community settings are required;

community health services find that they often have to chase up health summaries from custodial settings following the discharge of young people into the community.

- **CNS:** requests for health assessments have continued to increase steadily and the capacity of the CNS and the lone practitioner model in which she works is stretched. The CNS is currently unable to make time to see everyone and accompany young people to their health appointments as requested by the young people, particularly when accessing services for the first time. She therefore feels that this lack of capacity must be addressed rapidly to ensure that all young people are able to have their health needs met holistically. However, she also recognises that this issue has been considered in the pathway and the CNS believes there is scope to integrate appropriate teams in order to develop a health team specifically for young offenders, rather than the current provision of services operating from different systems with evident gaps, particularly with regard to data sharing.

- **CNS:** Concerns were raised with regard to older adolescent out-of or excluded-from school as evidence suggest that these individuals are missing out and failing to access universal services and continued healthcare. These individuals, often with entrenched issues and risk taking behaviours, are therefore lost in the wider health system. The CNS would therefore like to see the service develop so as to ensure LAC, excluded young people and hard to reach groups are targeted and captured by the service; it is recognised that gaps exist due to the assumption that everyone can read and write and a lack of follow up.

- **Head2Head:** There are concerns regarding the wider provision of CAMHS tiers 2 and 3 services. A bottle neck in provision has seen that young people out of their order find themselves experiencing long waiting times to be seen by these services.

- **SMS:** A flux in staffing is recognised to have been experienced by the team in the final months of the existing contracts due to a level of instabilities within the service. This has had a knock on effect on to the young people accessing the service and it is hoped that the new tender will provide further stability, improving experience of the service.

8.3. What are the gaps in monitoring

The SMS recognises that there has, in the past, been an awareness of trends and changes in service use, which has been somewhat lacking recently, again due to the flux in staffing experienced, and whilst there is an understanding that there has been a drop in planned exits, there is a need to refocus in the future

9) Knowledge gaps

As local evidence indicates that female young offenders are proportionately more likely to experience physical health problems, there is scope for further research to establish how ‘girl friendly’ provision is.

Further research could be undertaken to establish if those young people entering the YJS and stating that they lack access to appropriate health care services are from a particular vulnerable group. Targeted work could then be undertaken if appropriate, to support these young

What should we do next?

10) Recommendations for consideration by commissioners

- Develop opportunities to undertake preventative work and engagement with groups including looked after children and excluded children, with regard to both health provision and wider social provision including alternative educational or employment provision. The Tender Specification for the Young People's Substance misuse service includes some specific work with LAC population.
- Commission a public health nursing service for 5-19 year olds to replace the current model of school nursing, with targets to engage young offenders as a key priority group.
- Develop an electronic information sharing system to enable the secure and efficient sharing of patient information between targeted community health services
- Establish protocols for the sharing of information between community health services and custodial settings.
- Develop strategies to increase the capacity of the clinical nurse specialist to ensure that the physical health needs of young offenders are met.
- Develop a formal evaluation process for each of the services.

A number of recommendations have also been highlighted by colleagues within those health services that work with young offenders and through the analysis of these services. A number were made in the 2013 JSNA of substance misuse treatment services, which consider:

- The use of electronic support and social media tools (i.e. apps) for substance misuse treatment, advice and information.
- Undertake further exploration of dual diagnosis and co-morbidity of substance misuse and mental health difficulties.
- Develop the maintenance of external facing electronic information, ensuring such information is up to date.
- Further review of programmes to specifically address substance misuse issues amongst looked after children.
- Review aftercare and longitudinal support for those engaging with substance misuse services, assessing recovery.

The CNS also included various recommendations in her 2012-2013 annual report, including a need to:

- Consider tailored educational provision
- Work closely with partnerships and organisations to ensure health needs are addressed.
- Young offenders are involved in the design, delivery and evaluation of services.

- Youth Offending Teams to help children and young people access appropriate mainstream health services.
- The CNS identifies a need and desire to work to develop a national uniform healthcare assessment tool, to which all services will uniformly work towards in the future.

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Glossary of abbreviations

A&E	Accident and Emergency
ADHD	Attention Deficit Hyperactivity Disorder
ASD	Autism Spectrum Disorder
CAMHS	Children and Adolescent Mental Health Service
CASH	Contraception and Sexual Health services
CYP	Children and Young People
CJS	Criminal Justice System
CNS	Clinical Nurse Specialist
DH	Department of Health
GUM	Genitourinary Medicine
LAC	Looked after children
NCC	Nottinghamshire County Council
SMS	Substance Misuse Service
YJB	Youth Justice Board
YJS	Youth Justice Service
YOT	Youth Offending Team

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