Nottingham City and Nottinghamshire County

Nottingham City Council

A Health Needs Assessment of Young Offenders in Nottingham City

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SUMMARY OF KEY GAPS AND RECOMMENDATIONS

Overall, this health needs assessment has highlighted that there is a good process for identifying health needs of young offenders (YO) in Nottingham and a comprehensive pathway to specialist services to meet these needs. The specialist services seem to be appropriate in light of identified health needs and the services in place are being accessed by YO.

There are some potential gaps which may be preventing the health needs of YO from being adequately met in all circumstances. Gaps and recommendations have been summarised into the following 3 areas:

1. Service gaps
2. Health needs and equity of access to specialist services
3. Gaps in the identification of health needs/pathway gaps

A total of fifteen recommendations for consideration are given at the end of this report. In summary, priority gaps and recommendations are:

1. SERVICE GAPS

1. Lack of specialist smoking cessation service – Smoking has been identified as common amongst the YO population in Nottingham and it appears that this health need may not be adequately met.

   Explore options for increasing access to smoking cessation services for YO either through New Leaf or training of YOT staff/nurses and inclusion in the Nottingham City Health Model for YO.

2. No specific ways for identifying or meeting some nationally recognised health issues amongst YO including oral and respiratory health and chronic illnesses.

   Develop methods for identifying oral and respiratory health needs and ways to address these needs; integrate into the Nottingham City Health Model.

2. HEALTH NEEDS AND EQUITY OF ACCESS

1. The proportion of YO accessing all specialist health services tends to decline with age, and male YO appear to be less likely to access specialist health services than females which does not correspond to need.

   Identify and address reasons that may be preventing some older YO and male YO from accessing specialist health services.

2. Asian YO and female YO with substance misuse health needs may not be identified through the asset assessment.

   Investigate and address reasons that may be preventing Asian and female YO with substance misuse issues being identified through the asset assessment.

3. It appears that there is a significant number of YO identified as requiring a SQUIFA that are not having one.

   Confirm if there are insufficient SQUIFAs carried out, or if the discrepancy arises due to a recording/data issue and address as necessary.

3. IDENTIFICATION OF HEALTH NEEDS/PATHWAY GAPS

1. Lack of/inconsistent data from some YO specialist health services- This has limited the scale of assessment into the health needs of YO.

   Develop and agree standardised data collection from all YO specialist health services.

2. There are no specific criteria for referral to sexual health services - The 'Health role within case management model' does not clearly state when a referral for sexual health needs is required (i.e. specific score) and in which instances referral should be to the YOT nurse, and when to CASH.

   Develop a clear pathway/guidance for YOT Case Managers regarding when a client should be referred for sexual health advice, screening and treatment.

SECTION 1: INTRODUCTION

It is well established that young offenders (YO) are a vulnerable group, with complex psychosocial and physical health needs[1,2] and that they have greater health needs than their peers who are not offending. Their unmet health needs are also a contributing factor to their offending behaviour. Therefore YO can find themselves in a negative cycle which is difficult for them to break out of. Moreover, YO are more likely to come from deprived backgrounds, which also has inherent associated barriers to accessing health care[3].

Youth offences not only effect the individuals who are victims of those crimes but the offenders themselves are also affected; physically and mentally. The repercussions of these acts go on to affect these individual's future lives and also has a negative effect on the surrounding community and the society they live in.

There is now an increasing national and international body of evidence as to the health needs of young offenders. However, local information as to the health needs of young offenders that live within Nottingham has been limited. A Health Needs Assessment was therefore undertaken to capture this information.

1.1 Aim

The aim of this health needs assessment is to systematically assess the health needs of Young Offenders who are in contact with the Youth Offending Team in Nottingham City, primarily with regards to emotional well-being, substance misuse, sexual health and physical health.

1.2 Objectives

The objectives of this Health Needs Assessment are to:

- Review the national evidence, policy and guidance on the health needs of Young Offenders
- Identify patterns of local healthcare use, to include strengths, gaps and inequities in services.
- Identify future work required to:
    - Enhance the provision of health services and care
    - Improve health of young offenders
    - Reduce risk of re-offending
    - Reduce health inequalities experienced by Young offenders

SECTION 2: BACKGROUND

2.1 Policy Context

The Healthy Children, Safer Communities strategy was released in 2009 by the Government to promote the health and well being of individuals in contact with the Youth Justice System (YJS). The strategy[4] identified poor oral health, respiratory problems, smoking and sexually transmitted infections as four common examples of physical health needs of Young Offenders in England. The strategy identifies five key objectives to address the health and well being of individuals throughout the YJS:

1. Diversion from YJS.
2. Improve provision of primary and specialist health care services to YO.
3. Ensure courts and sentencers receive accurate information regarding health needs of YO and services available to meet these needs.
4. Promotion of health and well-being in secure estates.
5. Continuity of care and improved support when an individual's sentence is completed.

The work carried out in this strategy is directly related to several key previous publications (appendix 1).

The Youth Justice Board for England and Wales published 'Risk and Protective Factors' in 2005, which looked at factors which increased and decreased risk of youth crime and interventions to prevent youth crime[3]. Both physical and mental health are identified as factors which increase risk of offending and re-offending.

Actions Speak Louder was published in 2009, by the Healthcare Commission and Her Majesty's Inspectorate of probation[5]. Its aim was to review healthcare of young people who offend and those who are at risk of offending. The report found that the initial health assessment both for prevention work and YO in YOTs were frequently inadequate.

2.2 The Youth Justice System

The Criminal justice system in England defines a Youth Offender, also known as Juvenile Offender, as a person between the ages of 10 to 17 who has been cautioned or convicted for a criminal offence. The age at which a person becomes responsible for criminal activity in England is 10 years[6].

Ministry of Justice data for July 2010 to June 2011 shows Nottingham has one of the highest rates of first time entrants into the criminal justice system (FTE) in the country despite the huge reduction that has been seen locally since 2005/6[7]. According to the YJB, there were 529 YO entering the criminal justice system for the first time in Nottingham during 2010/11 (2,353 per 100,000 10-17 year population). It has been reported that each youth which is in the justice system costs £200,000 by the time they reach 16 years of age[8].

The YJS tries to help these individuals via targeted support, punishment or opportunities for reparation[8]. However, without helping to treat the underlying cause of their offending behaviour, YO are always at risk of re-offending.

2.3 Youth Offending Team

Youth Offending Teams (YOT) were set up following the Crime and Disorder Act 1998 in every local authority in England and Wales, and they play a key role in diverting YO from the YJS[5]. These multiagency teams include professionals from health, education, police, probation services, social services and drugs and alcohol misuse services. *Their main aim is to reduce the risk of offending and re-offending by providing support and counselling to YOs[5].* They provide support to YO throughout their sentences, whether it may be reparation plans, community service or secure estates. Access to a full range of universal services, including health, is just one of the YOT key activities. Poor health can be a risk factor for offending and identification and meeting these needs can be a protective factor from offending[4,5,9-11.]

SECTION 3: EPIDEMIOLOGICAL INFORMATION

SECTION 3: Summary Box

- There are an estimated 22,500 individuals aged 10 to 17 years in Nottingham City. The 10-19 year population is estimated to be 30,100.
- In 2010/11, approximately 1.6% of the Nottingham City population aged 10-19 years were clients of the YOT.
- From April 2008 to March 2011:
    - There were 1031 individuals referred to the Nottingham YOT. An average of 447 YO were on the YOT workload each year.
    - Males were 5.4 times more likely to be clients of the YOT than females.
    - Young people resident in the most deprived quintile are estimated to be 8 times more likely to become a YO than those living in the least deprived quintile
- In 2010/11:
    - 85% of the YOT client population were between 15 and 18 years of age.
    - Young people from the Black ethnic group were more than twice as likely to become a YOT client as their peers in the White ethnic group.
    - Young people in the Asian ethnic group are estimated to be 60% less likely to be a YOT client than those in the White Group.

3.1 Nottingham City population

According to mid-year 2010 population estimates, the population of Nottingham City is estimated to be 306,700 for 2011 with approximately 22,500 young people aged 10-17 years resident in Nottingham City.

As some individuals are still clients of the YOT up to the age of 19 years[1], it is deemed more appropriate to use the 10-19 year age group as the population of interest for this health needs assessment. The 10-19 year population of Nottingham City is estimated to be 30,100[2] with a female to male ratio of 1.06 (Table 1). This age group equates to approximately 10% of Nottingham City's total population.

Table 1: Nottingham City Population by Gender for 10-19 year olds

Total Nottingham population	Population aged 10-19 years	Number (%) Females Aged 10 -19	Number (%) Males Aged 10 -19
306,700	30,100	14,700 (48.8%)	15,500 (51.5%)

Nottingham's population is ethnically diverse. ONS population estimates suggest that 26% of those aged less than 16 years in Nottingham are from Black and Minority Ethnic (BME) groups. However, school census data (2011)[12] indicates that this is an underestimation and estimate 42% of children aged 5-13 years to be from BME groups (not White British). It is assumed that this is a more realistic estimate and has therefore been used in the analysis (Table 2).

Table 2: Proportion of young people (aged 10- 19 years) in each of the five broad Ethnic Groups in Nottingham City 2011

Ethnic group	Percentage of young people within group	Estimated number*[3]
White	61.7%	18,570
Mixed	10.7%	3,220
Asian	15.8%	4760
Black	8.9%	2680
Other	2.1%	630

* rounded to the nearest 10

3.2 Nottingham City YOT population

According to YOT data, between April 2008 and March 2011, 1031 unique individuals were referred to the YOT, with an average of 447 clients on the YOT workload each year. In 2010/11, approximately 1.6% (469 YO from population of 30,100) of the Nottingham City population aged 10-19 years were clients of the YOT (Table 3).

[1] If an individual commits an offence when they are below the age of 18 years they are referred to the YOT and depending on the length of their sentence, they may still be involved with the YOT when they turn 18 or beyond.
[2] The university student population aged 18-19 years have been subtracted from the ONS population estimates for these ages to ensure a representative population. The estimated student population has been derived from GP registrations at Cripps Health Centre, Radford and Sunrise Medical Practices (NHS Nottingham City Information Team)
[3] Assuming the ethnic breakdown of 10-19 years olds is the same as that for 5- 13 years olds

Table 3: Number of individuals in contact with the YOT (2008/9 – 2010/11)

Year	Number of individuals (client of the YOT in that year)
2008/09	534
2009/10	337
2010/11	469
Average per year	**447**

3.2.1 Nottingham YOT population by Gender

During 2008/9 and 2010/11, 873 males and 153 females were clients of the YOT. It is estimated that males are more than 5 times more likely to be a YO than females (Table 4).

Table 4: Number and rate of individuals referred to the Nottingham YOT by gender (2008/9 to 2010/11)

	10-19 year population	Number of individuals referred*	Rate per 1000 population	Risk ratio *(95% CI)*
Males	15,500	873	56.3	5.4 *(4.6 to 6.4)*
Females	14,700	153	10.4	1

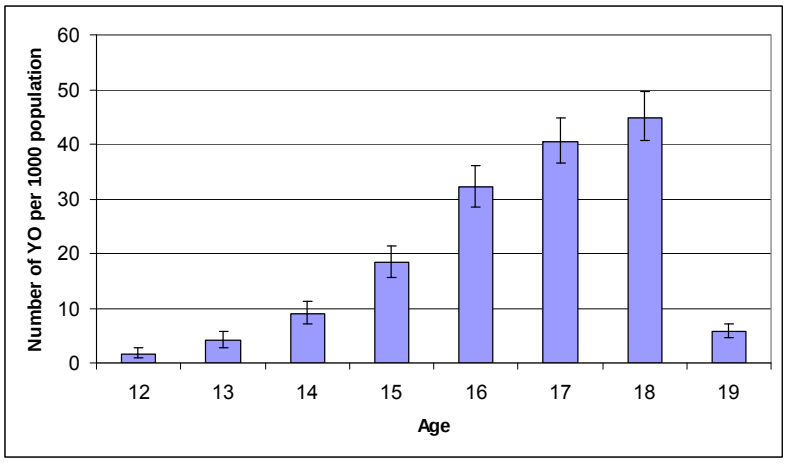
* Individuals have been counted once over the 3 year period.

3.2.2 Nottingham YOT population by Age

The rise in the rates of YO is apparent from the age of 14 years and peaks at 18 years of age (Figure 1). There were no YO under the age of 11 for males and none under the age of 13 for females. In 2010/11, 398 YO were aged between 15 and 18 years and this accounts for 85% of the YO population in that year.

The rate of YO per 1000 population is the highest in those aged 18 years (45 per 1000 population (95% CI 41 per 1000 to 50 per 1000 population).

Figure 1: Rate of YO per 1000 population by age in Nottingham City (2008/9 – 2010/11) with 95% confidence intervals



3.2.3 Nottingham YOT population by Ethnicity

Evidence shows people from BME groups are disproportionately represented in the Criminal Justice System[13] and that this is not simply the result of people from BME groups committing a disproportionate number of crimes. For example, findings from the Crime and Justice Survey suggest Black or Black British people between the ages of 10 and 25 years are no more or less likely to commit crime than their White counterparts. Nottingham YOT data suggests that young people from the Black ethnic group are more than 2 times increased risk of becoming a YOT client (RR 2.24 (95%CI 1.78 to 2.83)) than their peers in the White ethnic group (Table 5). It is unknown whether this is an accurate reflection of their involvement in crime or whether this could reflect disproportionate sentencing of Black young people.

Those from the Mixed group are estimated to be 23% more likely to be a YOT client than those from the White group, although this is not statistically significant, possibly due to small numbers (RR 1.23 (CI 0.94 – 1.62)). However, young people in the Asian ethnic group are estimated to be 60% less likely to be a YOT client than those in the White Group (RR 0.40 (CI 0.27 – 0.59)).

Table 5: Youth Offenders by Ethnic Group in Nottingham with Risk Ratio (2010/11)

Ethnicity	**Nottingham City YOT population**	**Total population* (aged 10 - 19)**	**Rate per 1000 population**	**Risk Ratio** *(95% Confidence Interval)*
White	284	18750	15.1	1.00
Black or Black British	91	2680	34.0	2.24 *(1.78 to 2.83)*
Mixed	60	3220	18.6	1.23 *(0.94 to 1.62)*
Asian or Asian British	29	4760	6.1	0.40 *(0.27 to 0.59)*
Other	4	630	6.3	0.42 *(0.16 to 1.12)*

*using Nottingham City Council School Census Data for 2011

3.2.4 Nottingham YOT population by deprivation

YO are more likely to come from deprived backgrounds. In 2010, Nottingham City was ranked as the 20th most deprived area out of the 326 districts in England[14]. It is not surprising that the rate of YO in the population increases as the level of deprivation increases (Figures 2 and 3). Young people resident in the most deprived quintile of the City are estimated to be 8 times more likely to become a YO than those living in the least deprived quintile (RR 8.0 (95% CI 5.4 to 11.7)). Figure 3 illustrates visually how there are higher numbers of YOT clients from the more deprived areas of the City.

Analysis by deprivation should be interpreted with caution as the data used for this analysis uses the postcodes of YO when data was abstracted in May 2011, rather than their postcode at the time of the offence.

Figure 2: Rate of YO per 1000 population by local deprivation quintile in Nottingham City (2008/9 – 2010/11)

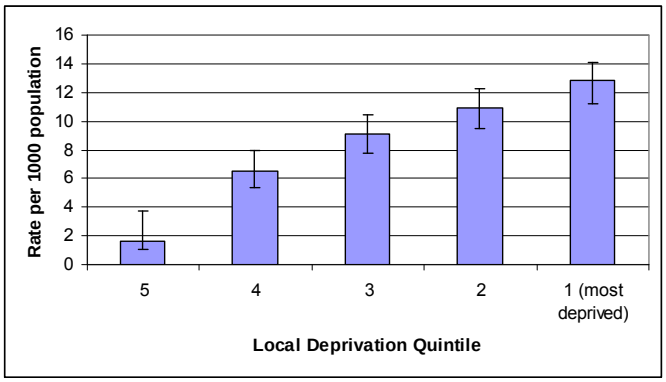
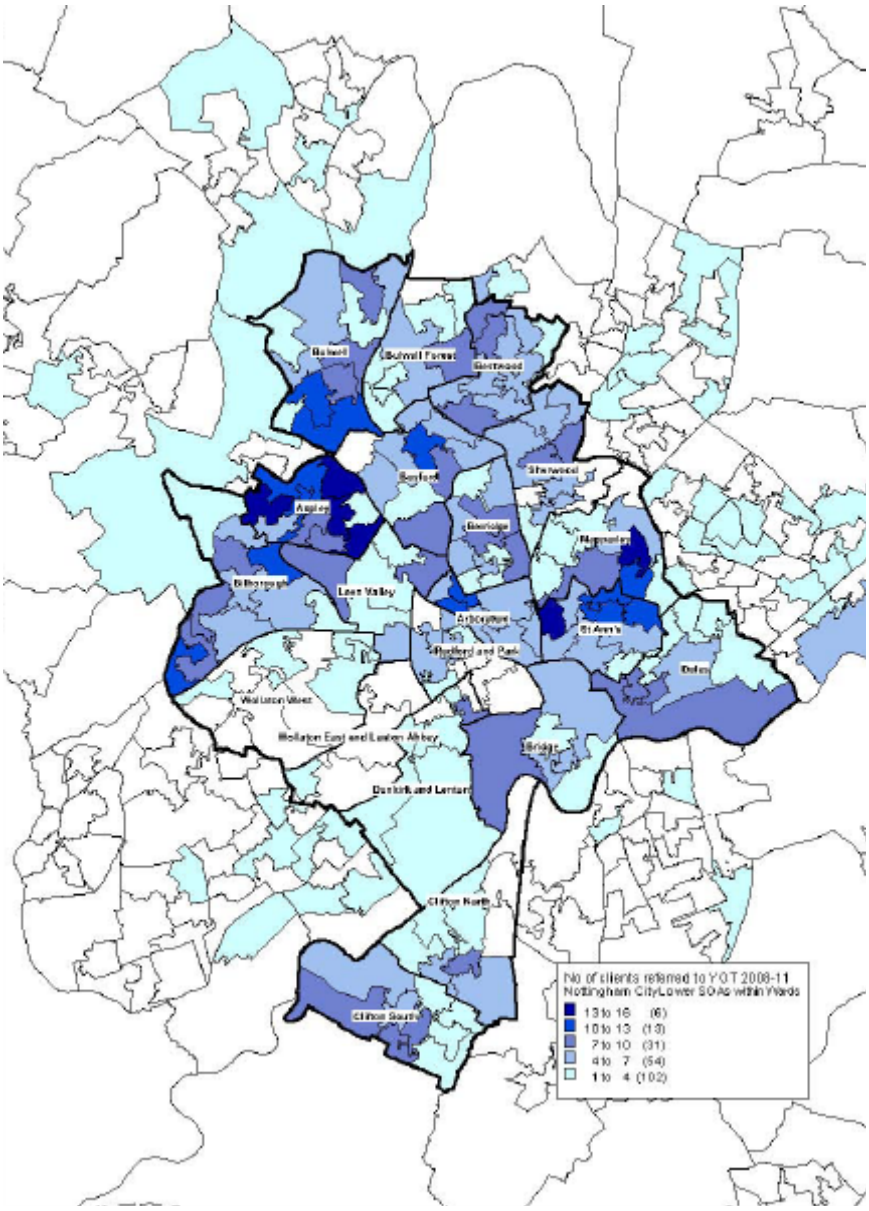


Figure 3: Number of YO referred to the Nottingham City YOT by super output area for 2008 to 2011.



SECTION 4: CURRENT HEALTH SERVICES AVAILABLE

4.1 Universal Health Services

All universal health services which are available for the general public are also available for YO. Some of the key universal services are:

1. **CAMHS** – The Child and Adolescent Mental Health Services is a specialised service provided by the Nottinghamshire Healthcare NHS Trust. CAMHS aim to improve the mental health of all children and young people up to the age of 18 years with severe and complex mental health problems and neurodevelopment problems.
2. **CASH** – Contraceptive and Sexual Health services. CASH services are for all ages and include thirteen outreach CASH sessions each week across 10 specific sites. Young people can also get access to contraception and sexual health services from GP practices, pharmacies, school Nurses, Base 51, the NHS walk-in Centre and the Health Shop.
3. **GUM** – Genitourinary medicine at the Nottingham City Hospital provides screening and treatment for sexually transmitted infections. GUM also provide peripheral clinics in a number of areas in addition to the core service at the City Hospital, for example at Mary Potter, Hyson Green, Clifton Cornerstone at Victoria Health Centre, the Walk in centre and at NEMS
4. **COMPASS** – This is a charity organisation which aims to support those with illicit drug and alcohol use related problems. Compass operates a young people's substance misuse service in Nottingham and has achieved 'You're Welcome' status which means they have a recognised standard for making their services available to young people. Services are available to anyone up to the age of 19 years, who are affected by their own or somebody else's substance misuse.
5. **Base 51** – This is a part charity and part limited company organisation, aimed at providing a range of services to people aged 12 to 25. They offer a range of services such as housing support, counselling, and rough sleepers support, as well as medical services. The Nurse Prescriber can be seen Monday to Friday; times of sessions vary from day to day, on a walk-in policy where no appointment is necessary. This service will be moving to NGY, My Place (multi-purpose youth activity centre for young people) in March 2012.
6. **Got it Covered** – This is a website developed by the Nottingham City Teenage Pregnancy Partnership, and is for young people living in Nottingham City aged from 13 to 19. It provides information about relationships, contraception and sexual health services. Support is also provided for young people who are parents or parents to be.
7. **W.A.M (What about me?)** – A service for children and young people, aged 5 to 19 years old, who are affected by parental substance misuse in Nottingham City and throughout the County.

4.2 Specialist Health Services

There are also specialist services which YO access through the YOT as per their individual needs. These services are:

1. **CASH Young People's Outreach** – based at the YOT, offers contraception and sexual health to YOT clients. The clinic runs twice a week every Wednesday from 2 pm to 5pm and Fridays 10am to 1pm.
2. **COMPASS** –provides a specialist service for YOT clients on statutory orders, providing Tier 2 and Tier 3 services[4]. Two workers are seconded to and based at the YOT. Unlike other health related referrals this contact is statutory and therefore once referred a clients' attendance is mandatory.
3. **Head 2 Head** – Part of **CAMHS**, it provides mental health assessment and intervention for YO who are referred by the YOT. They also provide detoxification for YO with substance misuse and take referrals of clients who have issues with both substance misuse and mental health or emotional problems. The aim of this service is to treat any underlying mental health issues which are perpetuating misuse of drugs. Head 2 Head is able to provide drug related advice and intervention but also liaise with Compass when caring for clients with dual diagnosis.
4. **YOT Nurses** – based at the YOT, provide physical and sexual health advice, sign post to services which are available to the general public and specialised services for YOT clients, manage clients in house or liaise with services to provide care for those YOT clients who refuse to be referred to services. YOT nurses also offer chlamydia screening and pregnancy testing to YOT clients.

SECTION 5: PATTERN OF HEALTH NEED AND USE

The literature would indicate that the most common health needs of YO in Nottingham are likely to be substance misuse, mental health, poor oral health, respiratory problems, smoking and sexually transmitted infections. Data from the four specialist health services has been used to assess the needs of YO in Nottingham in relation to some of these areas. However, analysis of all of these potential health needs was limited by the available data.

All YO who come into contact with the CJS undergo an asset assessment (appendix 2). This is a structured assessment tool used by YOT in England and Wales. It aims to look at the young person's offence or offences and identify a multitude of factors or circumstances - ranging from lack of educational attainment to mental health problems - which may have contributed to such behaviour. A YO's score on various sections of the asset determines whether a referral to a specialist health service is merited in accordance with the case management model (appendix 3). Asset data has been used to determine health needs amongst Nottingham's YO population.

Different levels of data were available from the four specialist services and so analysis varies in each section because of this. The Health Needs Assessment for

[4] Tier 2 interventions include group work, one off awareness sessions, 'drop-in' at the YOT and Tier 3 includes specialised compass assessment leading into structured 1:1 work including CBT, motivational interviewing, brief solutions focused therapy, harm reduction and family work.

Child and Adolescent Mental Health Services in Nottingham City PCT by Dr Eleanor Hayes and data from the Mental Health Care Trust was also utilised[15].

5.1 Overview of need

Overview of need: Summary

- In May 2011:
    - 88% of YOT clients required intervention and 66% needed enhanced or intensive support.
    - The mixed ethnic group were more likely to require enhanced or intensive level of intervention, and the Asian group the least likely to require the higher levels of intervention than the other ethnic groups
- During 2008/09 and 2010/11, the areas which YO were most likely to need further assessment or referral to specialist services were mental health followed by the YOT nurse.

The levels of interventions by the YOT are classified as Null, Standard, Enhanced and Intensive in ascending order, equating to ascending level of contact expected to be delivered to a YO respectively, dependant on a range of factors including the asset score given.

Information on the entire YOT workload in May 2011 was used to provide a snapshot of the levels of interventions required by YO at that time. In May 2011, there were 282 YO in contact with the YOT of which 88% required intervention (Table 6). The majority (66%) needed enhanced or intensive support indicating high levels of need in the YOT population.

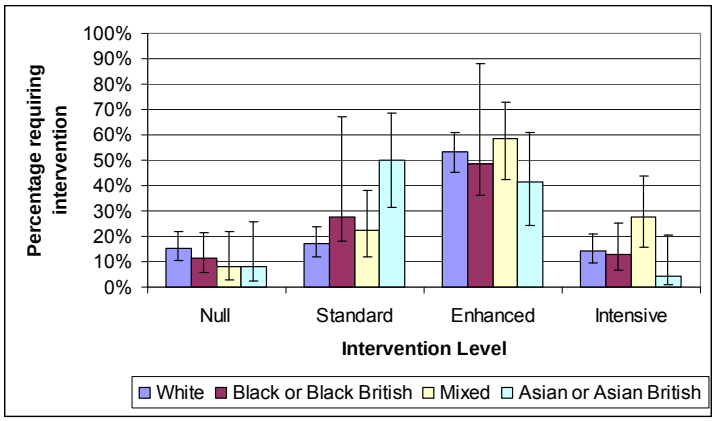
Table 6: Level of intervention needed by the YOT population (May 2011)

Level of intervention				
Null/None	Standard	Enhanced	Intensive	**Total**
35 (12%)	63 (22%)	143 (51%)	41 (15%)	**282 (100%)**

5.1.2: Level of intervention required by Ethnicity

It appears that the mixed ethnic group are more likely to require enhanced or intensive level of intervention and the Asian group is the least likely to require the higher levels of intervention than the other ethnic groups. However this is not statistically significant, so we cannot be confident of any true differences with these small numbers.

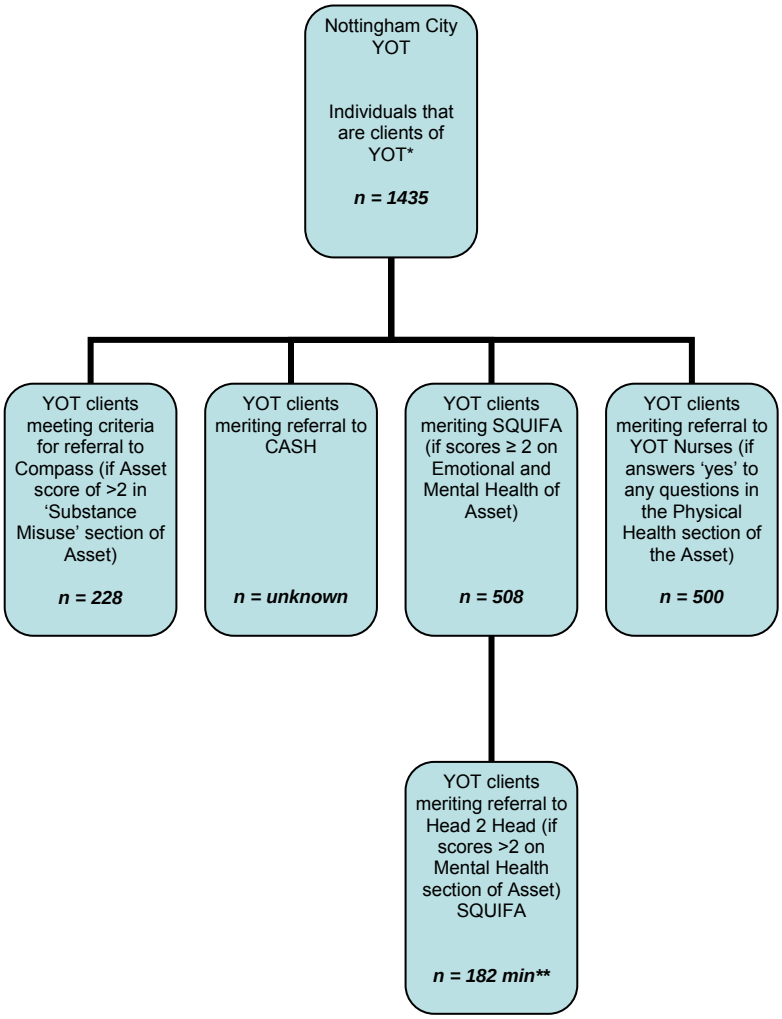
Figure 4: Level of intervention by Ethnicity of YOT population (May 2011)



* Other ethnic group was not included as there was only 1 YO in this group

According to asset data, it appears that the most common health need is mental health followed by physical health (Figure 5).

Figure 5: Summary of pathways to services for YO and the number of YO identified as meriting need for 2008-2011.



*YO counted once each year they are clients of the YOT
** This is a minimum because there will be some YO who scored 2 on the mental health section of asset and dependant on the result of the SQUIFA would then be referred to Head 2 Head. Those scoring 3 or 4 are automatically referred directly to Head 2 Head.

Table 7: Number of clients identified by Nottingham City YOT who merit referral vs. number of clients reported to have been referred to services for further assessment (2010-2011)

	Number of YOT clients identified for referral	Number of clients reported to have been referred or received further assessment
Compass	82	95
SQUIFA	173	20
Head 2 Head	57 minimum	48
CASH	unknown	189
YOT Nurses	158	93

5.2 Characteristics of YOT clients in services

5.2.1 Substance Misuse and access to Compass

Substance Misuse: Summary

During 2008/9 and 2010/11:

- 228 (16%) YO met the referral criteria for Compass and approximately one in five YO entered into treatment for substance misuse.
- A total of 663 young people entered into treatment for substance misuse with Compass of which 313 (47%) were YOT referrals.
- YO were significantly more likely to enter into treatment with Compass for substance misuse than other 10-19 year olds in Nottingham.
- Males and female YO are equally likely to meet referral criteria for Compass and enter into treatment for substance misuse.
- Females may be more likely to self-refer to Compass or be referred through other routes than males, as almost double the amount of female YO enter treatment than merit referral through the asset assessment.
- YO aged 14-17 years were more likely to enter into treatment for substance misuse than other age groups. Fewer YO aged 18-19 years entered into treatment than expected according to need.
- YO in the White, Black and Mixed ethnic groups appear to have similar likelihood of meeting referral criteria for Compass. Those in the Asian and Other groups appear to be less likely to meet referral criteria than these 3 groups.
- YO in the White ethnic group appear to be the most likely to enter into treatment with Compass and those in the Asian group the least likely.
- Asian YO and female YO with substance misuse issues may not be being picked up through the asset assessment.
- Three quarters of those accessing Compass used cannabis as their primary drug of choice. The next most common drug used was alcohol.
- 643 (62%) clients reported current use of tobacco. This represents a significant health need that is not being met.

Nationally, there is evidence of a significantly increased propensity to misuse substances amongst certain vulnerable groups including youth offenders[16]. In addition to the harmful effects of substance misuse in relation to physical and mental health, it also has a negative impact on children and young people in relation to sexual health and teenage pregnancy; failing in education, employment and training; and involvement anti-social and criminal activity.

During 2008/9 and 2010/11, 228 (16%) YO met the referral criteria for Compass, and 313 (22%) entered into treatment (Table 7). As more YO enter treatment than are referred, it can be assumed that some YO self-refer to Compass or are referred by other services.

During this same time period, a total of 663 young residents of Nottingham entered into treatment with Compass, of which 313 (47%) were YOT referrals (Table 8). This is the largest single referral source into treatment. Proportionately, YO were 55 times more likely to enter into treatment with Compass for substance misuse than other 10-19 year olds in Nottingham (RR 55.38 (CI 48 to 63.9)). The need in the general population is not known and greater awareness of Compass amongst the YO population may have contributed to the increased access amongst this group. However, it is safe to assume that the YO population are at increased risk of substance misuse than the general population.

Table 7: Number of YO meeting referral criteria and numbers entering treatment for substance misuse with Compass (2008/9 to 2010/11)

	YO population	Number (%) meeting referral criteria	Number YO entering treatment (individuals counted once per year)	% YO who meet criteria accessing Compass	% total YO population entering treatment
2008/9	534	84 (16%)	115	137%	22%
2009/10	432	62 (14%)	103	166%	24%
2010/11	469	82 (17%)	95	116%	20%
Total	**1435***	**228 (16%)**	**313****	**137%**	**22%**

*total population can include same person twice if individual remains under supervision of the YOT for more than one year

** If a YO ends treatment and then re-enters treatment in another year during this 3 year period they will be counted more than once in the total

Table 8: Number and percentage of Compass clients that are YO (2008/9 to 2010/11)

Total number of 10-19 yr population entering into treatment	**Number YO entering treatment** (individuals counted once per year)	**% entering treatment who are YO**
204	115	56%
249	103	41%
210	95	45%
663*	**313****	**47%**

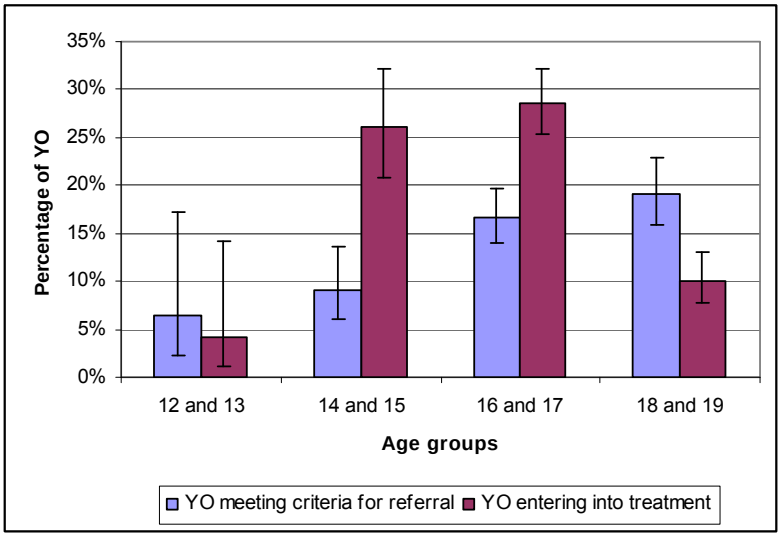
Three quarters of those accessing Compass used cannabis as their primary drug of choice. The next most common drug used was alcohol; almost one in 5 (19%), used alcohol as their primary drug of choice and 27% used it as their secondary drug of choice. The use of cocaine, amphetamines, solvents, crack and ecstasy are also recorded. Data over the past 3 years indicate that use of cocaine and ecstasy may be decreasing.

643 (62%) YOT clients reported current use of tobacco in their asset assessment. This is significantly higher than the Nottingham smoking prevalence which is 32%[17]. The New Leaf smoking cessation service does not provide a specialist service for the YOT, although it is available universally to anyone over the age of 12 years. YO are given advice and help with regards to smoking from the YOT Nurses and their GPs, although it appears that referral to New Leaf is not part of the referral pathway. Compass works with clients on smoking, when this is part of harm reduction around cannabis. However, it appears that this is a significant health need that may not be sufficiently met.

Substance Misuse and access to Compass by age, gender and ethnicity

It appears that substance misuse needs increase as age increases, with those aged 16 and above being significantly more likely to meet referral criteria for Compass than the younger age groups. Interestingly, significantly more YO aged 14 to 17 years enter into treatment with Compass than are shown to merit referral from the asset. However it appears that some YO aged 18-19 years who merit referral to Compass are not entering treatment as 19% (CI 16% to 23%) met referral criteria whilst 10% (8% to 13%) entered into treatment (Figure 6).

Figure 6: YO population that met referral criteria for Compass and population that entered treatment by age (2008/9 – 2010/11)



*each individual entering into treatment is counted once per year. However if a YO accessed Compass in more than one year, they are counted again.

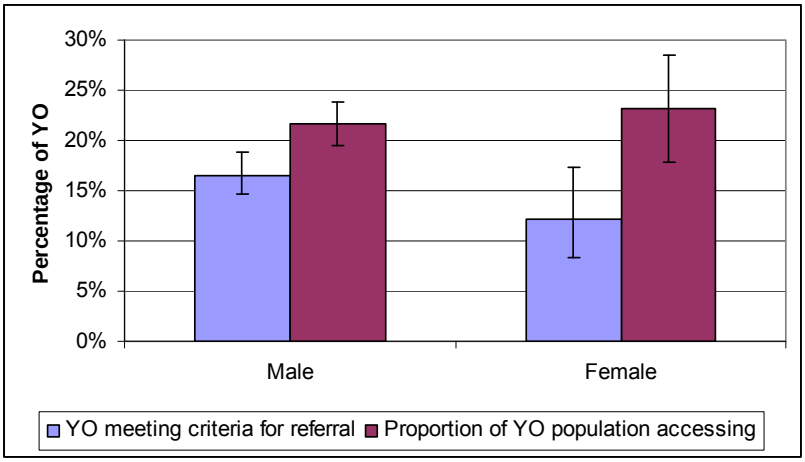
More than one in four YO (26% (95% CI 21% to 31%)) aged 14 -15 years and 29% (95% CI 25% to 32%) of 16 and 17 years olds entered into treatment with Compass during 2008/9 and 2010/11 indicating that substance misuse is a significant health issue amongst this population.

Although more male than female YO meet referral criteria and enter into treatment with Compass, proportionally, the likelihood of males and females meeting referral criteria and entering treatment is very similar with no statistically significant difference (Figure 7). However, it appears that females may be more likely to self-refer or be referred through other routes than males, as almost double the amount of female YO enter treatment than merit referral through the asset (Table 9). This indicates that females with substance misuse issues may not be adequately identified through the asset assessment.

Table 9: Number and percentage of YO meeting referral criteria and entering treatment with Compass (2008/09 to 2010/11)

Gender	YO population	Number YO meeting referral criteria	% YO meeting criteria for referral (95% CI)	Number YO entering treatment	Proportion of YO entering treatment (95% CI)
Male	1231	204	17% *(15% - 19%)*	267	22% *(19% to 24%)*
Female	198	24	12% *(8% to 17%)*	46	23% *(18% to 30%)*

Figure 7: Percentage of the YO meeting referral criteria and entering treatment with Compass by Gender (2008/9 to 2010/11)



The proportion of YO in the White, Black and Mixed ethnic groups who meet the referral criteria for Compass appears to be very similar. Those in the Asian and Other groups appear to be less likely to meet referral criteria than the other 3 groups (Figure 8).

However YO in the White ethnic group appear to be the most likely to enter into treatment. It is interesting that none of the YO in the Asian group met the referral criteria for Compass, yet 14% (CI 8% to 25%) entered into treatment with Compass (Table 10). Although the numbers are small, this is a statistically significant finding which suggests that Asian YO with substance misuse issues may not be being picked up through the asset assessment.

Figure 8: Percentage of YO meeting referral criteria and entering treatment with Compass by ethnicity (2008/09 to 2010/11)

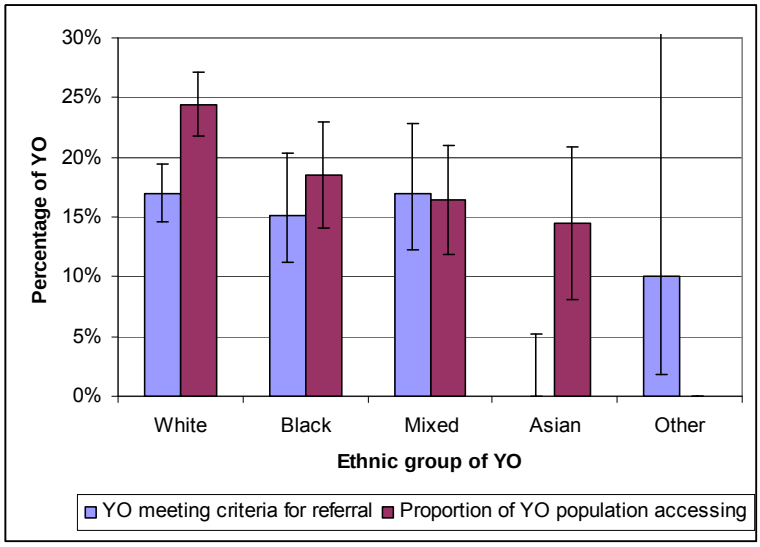


Table 10: Number of YO meriting referral to Compass and number and percentage accessing the service (2008/09 – 2010/11)

Ethnicity	YO population	Number (%) YO meriting referral	Number (%) YO accessing Compass
White	922	156 (17%)	225 (24%)
Black	237	36 (15%)	44 (19%)
Mixed	195	33 (17%)	32 (16%)
Asian	69	0 (0%)	10 (14%)
Other	10	1 (10%)	0 (0%)

5.2.2 Sexual Health and access to CASH Young People's Outreach Services (based at the YOT)

Sexual Health: Summary

- The asset data does not allow for the identification of YO who merited sexual health services.
- During 2010/11
    - It appears that YO were nearly 5 times more likely to access specialist CASH outreach at the YOT than the general population access Core CASH services.
    - 40% of the YOT population accessed CASH outreach services.
    - Although more male YO use CASH outreach than females YO, as a proportion females were significantly more likely to access CASH than males.
    - It appears that as a proportion, the YO aged 12-13 years are the most likely to access specialist CASH outreach services and those aged 18-19 years accessed CASH significantly less than the younger age groups.
    - YO in the Mixed ethnic group are significantly more likely to access CASH outreach at the YOT than the White, Black and Asian groups
- YO may have increased sexual health needs at a younger age than the general population.

The asset includes Sexual Health under its Physical Health section. However, there is no question which investigated sexual health specifically making identification of YO who had sexual health needs difficult.

However data from CASH (outreach at the YOT) for 2010 to 2011 shows that there were 189 new Nottingham City YOT clients and 227 returning clients. As 40% of all YO in 2010/11 accessed CASH, it can be assumed that this is a significant health need (Table 11).

Table 11: Number and percentage of YO accessing CASH (2010/11)

YO population	Number YO accessing CASH YOT outreach (first time contacts only)	Percentage of YO population accessing CASH outreach services ***(95% CI)***
469	189	40% *(36% to 45%)*

When compared with the general population, it appears that YO are nearly 5 times more likely to access CASH outreach at the YOT than the general population (aged 10-19 years) access core CASH services. This could indicate increased sexual health needs amongst the YO population, although YO may be more aware of CASH than the general population and this may also contribute to increased access by YO.

Table 12: Comparison of YO and the general population aged 10-19 years and access to CASH (2010/11)

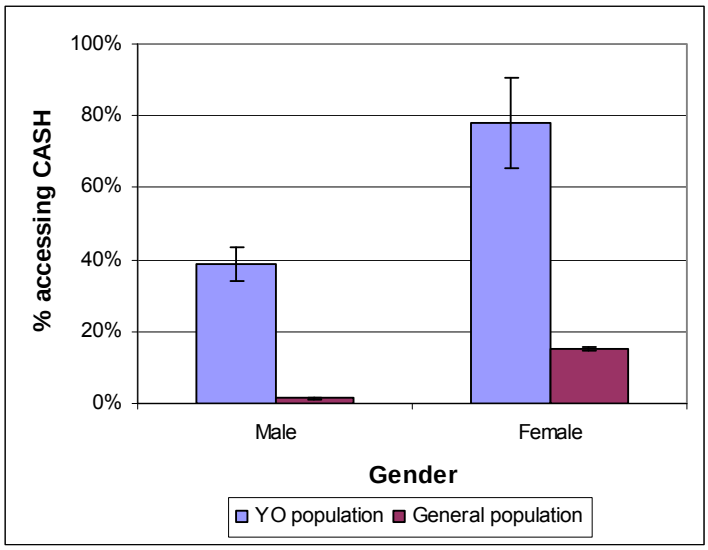
Percentage of YO accessing CASH outreach	Percentage of general population accessing Core CASH Services	Risk Ratio ***(95% CI)***
40%	8%	4.85 *(4.3 to 5.5)*

Sexual Health and access to CASH (YOT outreach service) by age, gender and ethnicity

According to CASH data, 201 new clients[5] attended the outreach clinics based at YOT during 2010/11 of which 158 (79%) were male and 43 (21%) female. As a proportion, females were more than twice as likely to access CASH as males (RR 2.02 (95% CI 1.68 to 2.44)). Females are also more likely to access CASH in the general 10-19 year population although the difference is more marked in the general population, as females are estimated to be 10 times more likely to access CASH than males.

[5] Includes those accessing CASH for the first time and also first visits in that financial year

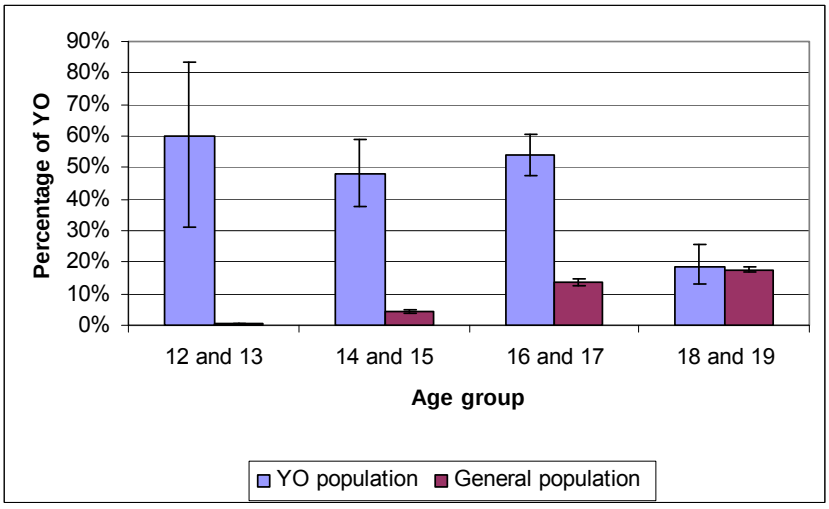
Figure 9: Percentage of male and female YO accessing CASH Outreach at the YOT (2010/11)



Amongst the YO population, the proportion accessing CASH, appears to be highest in the 12 -13 year age group. However actual numbers in this age group are small and this is not statistically significantly higher than those aged 14 – 17 years so we cannot be confident of any true difference (Figure 9). As a proportion, those aged 18-19 years accessed CASH significantly less than the younger age groups. This merits further investigation. One explanation could be that older YO get their health needs met in mainstream services.

A different pattern of access is found in the general population which has the lowest proportion accessing CASH amongst the youngest age groups and access increases with age. This indicates that YO may have increased sexual health needs at a younger age than the general population (Figure 10) and that sexual health needs becomes more similar to the general population as YO get older.

Figure 10: Percentage of YO and the general population accessing CASH outreach at the YOT by age (2010/11)



Data was not available to analyse access to CASH by ethnicity.

5.2.3 Physical health and access to YOT Nurses

Physical Health: Summary:

- During 2008/09 and 2010/11, more than one in three YO were assessed as having physical health needs and requiring a referral to the YOT nurse.
- Approximately half of those eligible for a referral accessed the YOT nurse.
- The proportion of YO that meet referral criteria and go on to access the YOT nurse appears to decline from age 16 years
- Male YO may be at particular risk of not getting their physical health needs adequately met.
- YO in the White ethnic group appear to be the most likely to meet referral criteria for the YOT nurse
- The proportion accessing the nurse was below what would be expected for all ethnic groups, and was lowest amongst the Black YO in which only 39% of those that met referral criteria accessed the service

During 2008/09 and 2010/11, 500 (35%) of YOT population met the referral criteria for the YOT nurse and 246 (49%) of these accessed the nurse (Table 13). This data suggests that a significant number of YO may not be having their physical health needs met.

Table 13: Number of YO meeting referral criteria for YOT nurse and number accessing the service (2008/09 to 2010/11)

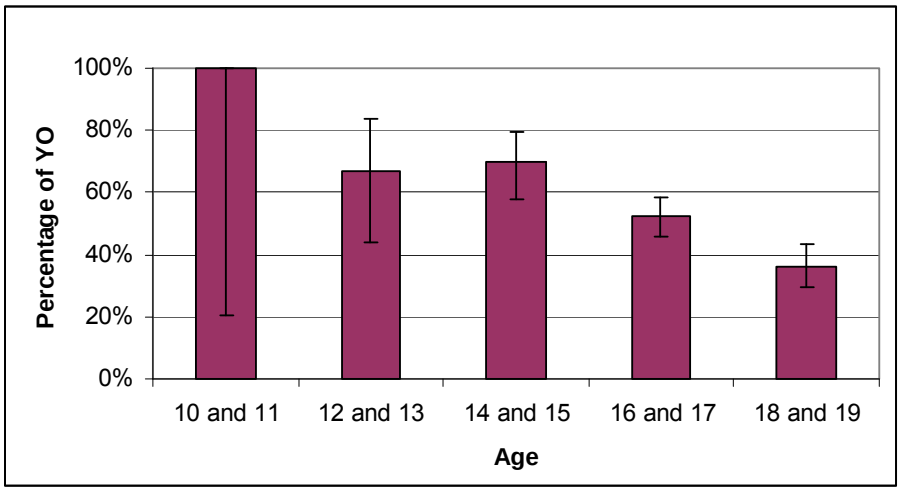
Year	YO population	Number (%) meeting referral criteria	Number YO having nurse contact*	% of YO that meet referral criteria and accessed nurse
2008/9	534	189 (35%)	58 (11%)	31%
2009/10	432	153 (35%)	95 (22%)	62%
2010/11	469	158 (34%)	93 (20%)	59%
Total	**1435**	**500 (35%)**	**246 (17%)**	**49%**

** Counted if YO has at least one contact with nurse*

Physical Health and access to YOT nurses by age, gender and ethnicity

All age groups had a similar likelihood of meeting the referral criteria for the YOT nurse. However the proportion accessing the service appears to decline from age 16 years (Figure 11)

Figure 11: Percentage of YO who met referral criteria for YOT nurse that accessed the service by age (2008/09 to 2010/11)



It appears that females are more likely to meet the referral criteria for the YOT nurse than males, although this is not statistically significant. 417 (35% (CI 32% to 37%)) male YO and 82 (41% (35% to 48%)) female YO met the referral criteria for the YOT nurse. Females that met the criteria were significantly more likely to access the nurse (Figure 12) than males. This could indicate that male YO may be at particular risk of not getting their physical health needs adequately met. However, YO could also be accessing other providers for general health support such as their GP and therefore getting their physical health needs met through alternative routes.

Figure 12: Percentage of YO who met referral criteria for YOT nurse that accessed the service by gender (2008/09 to 2010/11)

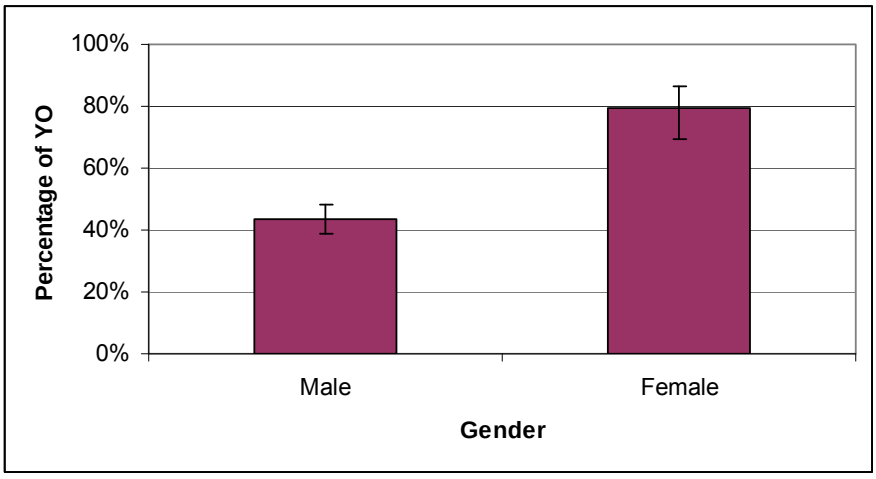
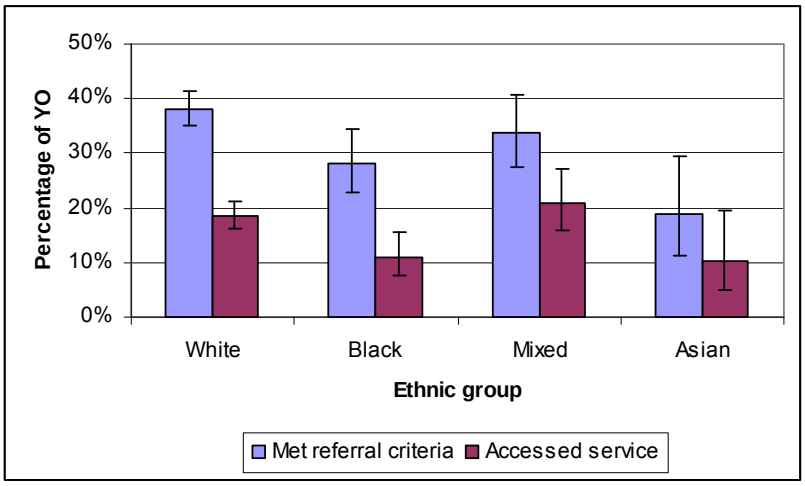


Figure 13: Percentage of YO who met referral criteria for YOT nurse and the proportion that accessed the service by ethnicity (2008/09 to 2010/11)



- Other ethnic group was omitted as no YO from this group met the referral criteria

YO in the White ethnic group were significantly more likely to meet the referral criteria for the YOT nurse than YO in the Black, Asian and Other ethnic groups. In terms of access however, those in the Mixed group were the most likely to access the nurse (Figure 13). The proportion accessing the nurse was below what would be expected for all ethnic groups, and was lowest amongst the Black YO in which only 39% (CI 28% to 51%) that met referral criteria for the nurse accessed the service (Table 14).

Table 14: Proportion of those meeting YOT nurse referral criteria that accessed the service by ethnicity (2008/09 to 2010/11)

Ethnicity	YO population	Number YO meeting criteria for YOT nurse	Number (% of those eligible) accessing nurse (95% CI)
White	922	352	170 (48%) *(43% to 54%)*
Black	237	67	26 (39%) *(28% to 51%)*
Mixed	195	66	41(62%) *(50% to 73%)*
Asian	69	13	7 (54%) *(29% to 77%)*

It was not possible to identity reasons for referral to the YOT nurse. Therefore the prevalence of chronic conditions could not be investigated and is currently unknown for the Nottingham City YOT client population.

5.2.4 Emotional and Mental Health and access to CAMHS – Head to Head

Emotional and Mental Health: Summary

- During 2009/10 and 2010/11:
  - 508 (35%) YO met criteria for a SQUIFA, whereas only 68 are reported to have had this assessment.
  - 178 YO accessed Head 2 Head, which is 12% of the YO population
  - During 2009 and 2011, the YO population were more than 5 times more likely to access Head 2 Head than the general population were to access all other Child and Adolescent Mental Health Services.
  - Data suggests that males with identified mental health needs are not accessing services so their needs may not be being met.
  - The younger YO (10-14 years) were nearly twice as likely to access Head 2 Head as the older YO (15-19 years). This does not correspond to need, indicating access issues for older YO.
  - It appears that YO from the Mixed ethnic group were the most likely to meet referral criteria for mental health services and are significantly more likely to access them than the white YO.

SQUIFA assessment

A score of 2 or more in section 8 of the Assess Core profile would indicate the completion of a mental health screening questionnaire interview for adolescents (SQUIFA) in line with national guidance[18.] SQUIFA is scored out of 4; if a client scores 3 or more then a referral to Head 2 Head is made where a more thorough assessment is made. The outcome of this screening process was not available, i.e. SQUIFA scores.

From 2008/09 and 2010/11, Nottingham City YOT data identified 508 clients who qualified for further assessment, and 68 were recorded as having a SQUIFA (Table 15).

Table 15: Number of YO who met criteria for SQUIFA and Head 2 Head and the number accessing

Year	Number requiring SQUIFA	Number that had SQUIFA	Minimum number meeting criteria for referral to Head 2 Head	Number accessing Head 2 Head
2008-2009	189	19	68	45
2009-2010	146	29	57	55
2010-2011	173	20	57	78
TOTAL	**508**	**68**	**182**	**178**

In 2008/09, it appears that not all YO that met referral criteria for Head 2 Head accessed the service. However during 2009/10 and 2010/11 access appears to be as expected.

Data suggests that there are some YO who merit further assessment (SQUIFA) that are not having these needs met. However, there could be several explanations for this apparent gap:

- YO scoring 3 or 4 are referred directly to Head 2 Head and perhaps in this instance a SQUIFA is not carried out.
- Lack of reporting that a SQUIFA has been completed onto the asset form.
- Clients not participating in the SQUIFA.
- Clients who volunteer mental health or emotional problems under the care of other services, such as Nottingham City YOT nurses, CASH and Compass:
    - Not being assessed further with the SQUIFA.
    - Not being referred for further assessment.
    - Not being assessed further despite referral for further assessment.
    - No direct referral being made to CAMHS by these services.

The Health Needs Assessment for Child and Adolescent Mental Health Services in Nottingham City PCT also identified the following possibilities for these discrepancies:

- YOT case managers not making referrals despite identified need.
- YO who are already known to Head 2 Head may not be referred for further assessment, i.e. SQUIFA, however they are still identified by the asset as having need.

Access to Head 2 Head

During 2008/9 and 2010/11, 178 YO accessed Head 2 Head, which is 12% (95% CI 11% to 14%) of the YO population. It is estimated that the YO population were more than 5.5 times (RR 5.5 (CI 4.8 to 6.4)) more likely to access Head 2 Head than the general Nottingham population aged 10-19 years were to access all other Child and Adolescent Mental Health Services.

Nottingham City YOT clients referred to CAMHS may have been provided with mental health services from services other than the Head 2 Head specialist YO service, so this is likely to be an underestimation of the true use of mental health services by YO.

Emotional and Mental Health and access to CAMHS – Head to Head by age, gender and ethnicity

Mental Health Care Trust data for Nottingham City was used to analyse access to Head 2 Head by age, gender and ethnicity. This data does not include all YO that accessed Head 2 Head and so should be interpreted with some caution.

Female YO were estimated to be 45% less likely (RR 0.55 (CI 0.28 to 1.1) to meet referral criteria for Head 2 Head than male YO, although statistical significance cannot be identified due to small numbers. However, data suggests that females may be slightly more likely to access Head 2 Head than males (13% compared to 9%) (Table 16). Again no statistically significant difference could be found possibly due to small numbers. This may indicate that males with identified mental health needs are not accessing services and their needs are not being met.

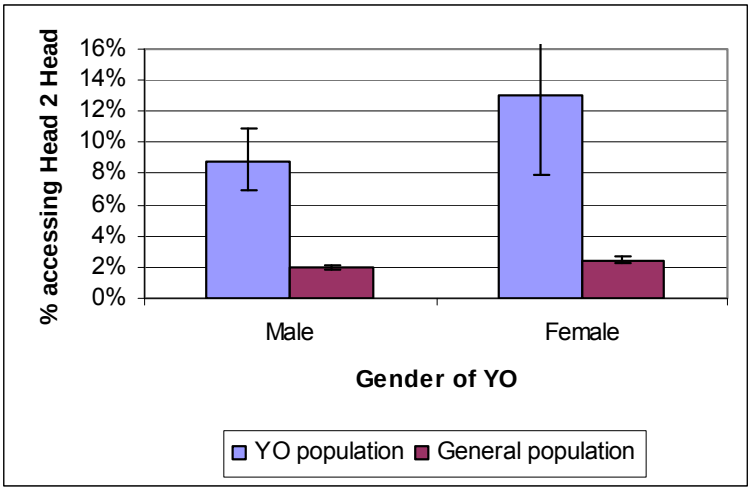
Table 16: YO requiring referral and access to Head 2 Head by gender (2009/10 - 2010/11)

Gender	YO population	Number (%) meriting direct referral*	Number (%) YO accessing Head 2 Head	Risk ratio meeting referral criteria (95% CI)	Risk ratio for access (95% CI)
Male	787	106 (13%)	69 (9%)	1	1
Female	108	8 (7%)	14 (13%)	0.55 (0.28 to 1.10)	1.48 (0.86 to 2.53)

* scored 3 or 4 on mental health section of asset

Females in the general population also appear to be slightly more likely to access CAMHS than males. (2.5% compared to 2%), although the difference is smaller than amongst the YOT population (Figure 14)

Figure 14: Percentage of YO accessing Head 2 Head by Gender (2009/10 – 2010/11)



Data suggests that the younger age group are 84% (RR 1.84 (CI 1.11 to 3.05)) more likely to access Head 2 Head than the older age group. This does not appear to correspond to need (Figures 15 and 16) and suggests that older YO may not be getting their mental needs met. Perhaps older YO may be more reluctant to access mental services due to perceived stigma and they may also have more autonomy on whether to attend or not.

Figure 15: Percentage of YO meeting direct referral criteria for Head 2 Head by age (2009/10 and 2010/11)

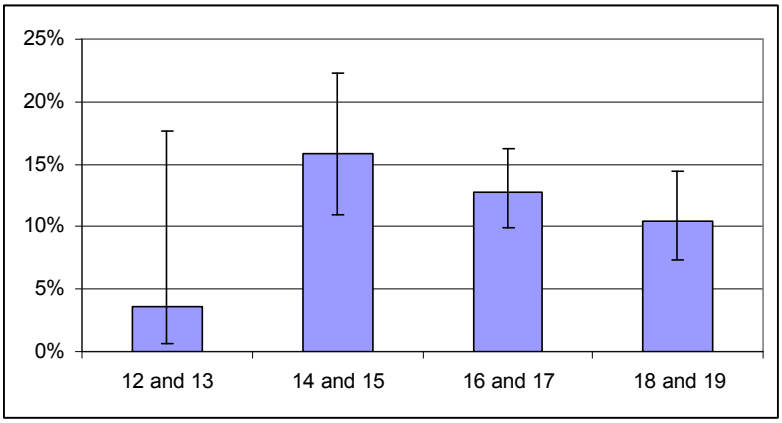
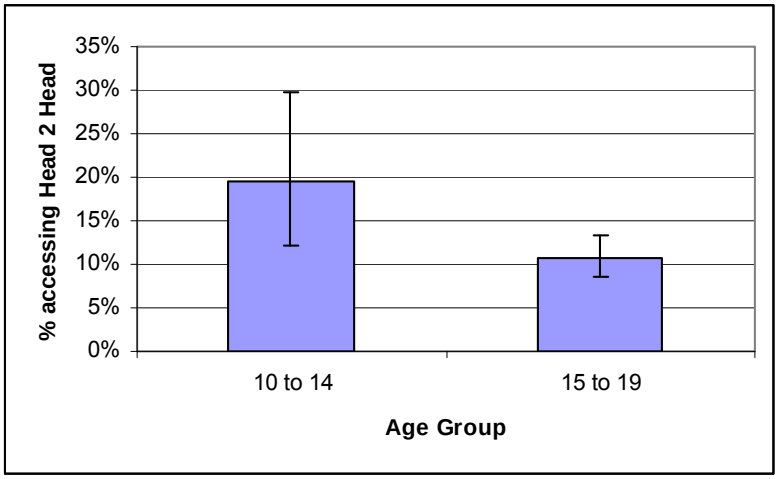
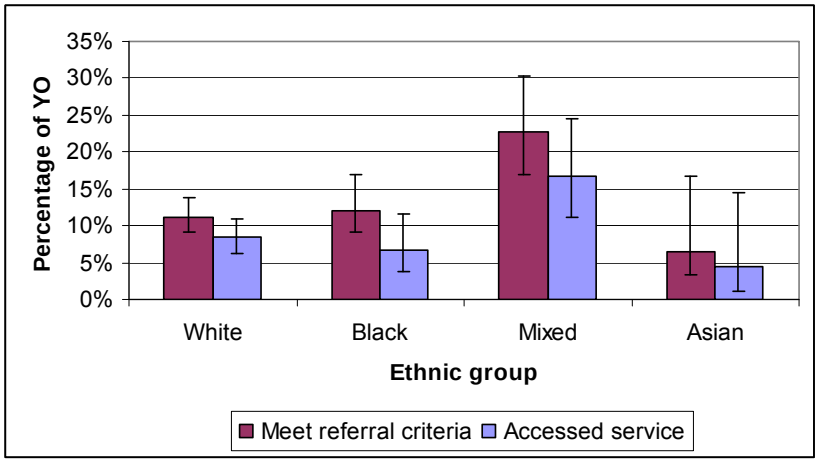


Figure 16: Percentage of YO accessing Head 2 Head by age group (2009/10 – 2010/11



It appears that YO from the Mixed ethnic group were more likely to meet referral criteria for mental health services and are significantly more likely to access them than the white YO.

Figure 17: Percentage of YO meeting referral criteria and accessing Head 2 Head by Ethnicity (2009/10 – 2010/11)



SECTION 6: CORPORATE VIEWS

SECTION 6: Summary

- There is clear pathway for referral to Compass from the YOT.
- YOT clients are reported to welcome the provision of CASH outreach clinics at the YOT and report that having the service at the YOT increases the likelihood of them accessing it.
- There is no named person from Head 2 Head based at the YOT. There are conflicting views about whether this would be beneficial in terms of access and quality of care.
- The number of referrals received by Head 2 Head is felt to be lower than would be expected.
- There is a perception that some YOT clients with mental health needs are managed in-house or are referred to other services rather than to Head 2 Head.
- YOT nurses manage some clients in-house with regards to mental health (if Tier 1 or 2)
- Many clients refuse referral to mental health services by the YOT nurse due to the perceived stigma.

Views and opinions of some of the professionals with regards to the services provided for the Nottingham City YOT client population are summarised below. Views of the professionals from the services were gathered through interview, phone or email correspondence.

COMPASS
Compass has two full-time staff based at the YOT where they see YO. They also provide weekly drop-in sessions for clients and staff consultation. They provide regular training sessions to YOT staff. There is a clear pathway for referral.

CASH
Contraception and sexual health specialists from CASH hold an out-reach clinic twice a week at the YOT. Attendance by YOT clients elsewhere was not popular and clients have been reported to welcome the provision of this service at the YOT. YO are referred directly by the YOT nurse and case managers, although many YO access the service opportunistically.

CAMHS
A specialist service called *Head 2 Head* is offered to YO by CAMHS. CAMHS has multiple professionals with specialist interests in different areas such as substance misuse and sexual abuse. This is an out-reach service and currently there is no named person based at the YOT. They feel that having a named person attend regularly would considerably narrow down the available sub-specialist input they can offer to the YOT client population reducing the quality of service offered.

CAMHS also provides a dual diagnosis service for YOT clients with substance misuse. They accept referrals from other services as well as self-referrals. They also provide training to staff in other services. Issues raised by CAMHS were:

- The amount of referrals they currently get are under-representative of the need for the YOT client population.
- They feel that the reason for this could be the in-house management of clients with mental health issues and inappropriate referral of clients to other services when the actual underlying problem creating the health need referral to a different service is psychological e.g. referral to Compass when the reason for substance misuse is psychological.

YOT Nurses

Currently there are 2 YOT Nurses for Nottingham City who are based at the YOT. They help clients identify health needs and access services and at times they accompany clients to these services such as the GP. Nurses offer C-card service (condoms), chlamydia screening and morning after pill on site. As well as providing advice, they also do health promotion.

Where they are unable to meet the needs of the client they then refer the client to specialist services. They are able to refer to Compass directly but they always inform the Case Manager of the client. They also refer to CAMHS Head 2 Head but report that the stigma of mental health services amongst clients is a barrier for this referral and this is the most common reason a client refuses a referral to this service. Nurses feel that having Head 2 Head based at the YOT would help to address this.

Nurses are trained to provide mental health advice and in such circumstances they try to manage these clients in-house. They use CAMHS classification of Tiers 1 to 4 with these clients; clients who are 1-2 are dealt with in-house. If they are 3-4 they would either be referred to CAMHS or would be discussed with CAMHS. Issues raised by the YOT Nurses were:

- There is a stigma amongst the Nottingham City YOT clients regarding referral to CAMHS Head 2 Head which makes referral difficult.
- There is no practical means for them to gather data regarding their clients for this Health Needs Assessment on their current system.

The YOT Nurses have recently started using a Health Information Sharing Tool (HIST) form with each new referral. The HIST form covers areas such as social history, substance use and mental health, immunisation history and physical health. Overall, the HIST form seems to offer a more thorough assessment of the health needs of YOT clients.

SECTION 7: COMPARATIVE ASSESSMENT

SECTION 7: Summary

- There is a lot of emphasis on mental health provision across all comparison areas and many have CAMHS Nurses based at the YOT.
- Derby, Manchester and Leicester YOT do not have any YOT Nurses and delegate their sexual health and physical health service provision amongst other professionals.
- Manchester and Leicester YOT do not provide any input regarding physical health needs of their clients.
- All areas provide substance misuse services. The majority are provided by outside services that are based at the YOT, except for Manchester City which provides Tier 1 intervention in-house by YOT staff and refers any other higher needs.
- Smoking cessation support varies across the areas.
- Manchester City YOT is currently looking into providing speech and language services to help YO better communicate with the YOT. Salford YOT is already providing this service.
- In summary, the Nottingham City YOT seems well equipped when compared to these areas with regards to the services provided. The main differences in Nottingham are:
    - not having CAMHS based at the YOT
    - not providing speech and language therapy
    - not having clear pathway for smoking cessation support

Regional and deprivation related comparisons were made with other cities regarding Nottingham City and the health services provided to YO. This included Derby, Leicester, Manchester, Hastings and Salford.

Derby

- A Mental Health Nurse is based at the YOT who screens for mental health and physical health related problems. This Nurse is provided by CAMHS.
- There are no generic YOT Nurses for physical health only.
- There is a Substance Misuse Worker from 'ADDACTION' (UK based charity helping people affected by drug and alcohol problems) who is based at the YOT and screens for substance misuse related problems.
- Both the Mental Health Nurse and the Substance Misuse Worker contribute to sexual health screening of YO at the Derby City YOT.
- There is no specific smoking cessation service for YO. There is a service in Derby City known as 'Fresh Start' which is equivalent to New Leaf in Nottingham City. Fresh Start provides service to schools and so the service are available to those aged under 16 years. Derby City YOT directs their clients to Fresh Start for smoking cessation advice.

Leicester

- Used to have a YOT Nurse who screened for mental, physical and sexual health problems but currently they do not have a Nurse.
- Full-time substance misuse workers are based at the YOT.
- A named Community Psychiatric Nurse (CPN) from CAMHS provides mental health input. The CPN is not based at the YOT but attends the YOT to provide this service.
- Some of the Case Managers are trained in providing sexual health advice.
- The YOT investigates whether the YO are registered with a GP but accessing services with regards to their physical health needs are deemed the responsibility of the YO and the parents of YO, and therefore the Leicester City YOT does not have any further input.
- Their YOT Nurse was trained in providing smoking cessation service to their YO, but currently they direct their clients to GPs and Health Clinics. There are no specific services with regards to this.
- The Leicester City YOT aims to work closely with universal services which are available to the general public to meet the needs of their clients. They try to involve their clients with services based at their own communities to try to integrate them back into that community.

Manchester

- Used to have YOT Nurses, who had generic health backgrounds and used to provide health services regarding health screening, GP registration, immunisations, sexual health advice and services and health advice and promotion.
- Felt their mental health service was poor and they could not meet the high demand of mental health needs of their clients. Therefore they replaced their YOT Nurses with 2 Mental Health Nurses from CAMHS who only provide mental health screening and services.
- Outside agencies are used for all other health needs of their clients.
- Their physical health service provision is currently under review. They provide no service in this area at this time and are in the process of deciding whether the responsibility for physical health should be with the YO and their parents rather than the YOT.
- Some of the Workers at the YOT are trained in providing smoking cessation and sexual health advice.
- Invite external services to run group sessions at the YOT sites regarding sexual health. For any other sexual health needs YO are directed to GUM and other external clinics.
- Manage Tier 1 substance misuse needs in-house and clients with higher needs are referred to 'Eclypse' (drugs and alcohol misuse service in Manchester) who provide an out-reach service.
- Manchester City YOT is currently looking into providing speech and language services, as they have come across evidence from Leeds that YO have difficulty understanding what is being communicated to them and this is having a detrimental impact on the YOT meeting their particular needs. This is not a service which is aimed at those from different ethnic backgrounds whose first language is not English but to all YO facing difficulty communicating with the YOT.

Hastings

- Has a full time psychologist based at the YOT.
- A YOT Nurse provides sexual health, general health advice and promotion, and assists with GP registration of YO.

- There is an under 19's substance misuse service which YO are referred to but this service is not specific for YO. There is no specific smoking cessation service offered.

Salford

- A YOT Nurse carries out physical health assessments, mental health assessments using the SQUIFA, sexual health screening and treatment up to tier 3 including Chlamydia screening and treatment.
- Nurse offers emergency contraception, gives out condoms, depot contraceptive injections and implants, immunisations, wounds care, smoking cessation advice and treatment.
- Nurse is an independent and supplementary prescriber and will treat physical conditions within her remit e.g. impetigo.
- Any physical health problems the nurse cannot address are referred to a doctor.
- A Clinical Psychologist from CHAMS is based at the YOT for mental health input
- A Substance Misuse and Alcohol Worker are based at the YOT.
- A part-time Speech and Language Therapist is based at the YOT half the week.

SECTION 8: GAP ANALYSIS AND RECOMMENDATION

Overall, it appears that there is a good process for identifying health needs of YO in Nottingham and a comprehensive pathway to specialist services to meet these needs. The specialist services seem to be appropriate in light of identified health needs and the services in place are being accessed by YO.

This health needs assessment has identified some possible gaps and potential areas of unmet health needs for Nottingham City YOT clients. These are summarised below, along with recommendations for consideration.

8.1 Potential gaps

Service gaps

1. Lack of specialist smoking cessation service – Smoking has been identified as common amongst the YO population in Nottingham and it appears that this health need may not be adequately met.

2. Currently there are no specific ways for identifying or meeting some nationally recognised health issues amongst YO including oral and respiratory health and chronic illnesses.

3. Lack of Speech and Language service provision in Nottingham City - Currently, this service is not provided for YO in Nottingham City. Other comparator cities have found this beneficial in improving communication with YO.

Health needs and equity of access

1. Males, living in deprived areas of Nottingham City, especially those in the Black ethnic group are at particular risk of becoming a YO. This further increases their risk of poor mental and physical health.

2. Cannabis, alcohol and tobacco are the most common substances reported to be used by YO.

3. YO may have increased sexual health needs at a younger age than their non-offending peers.

4. YO are four times more likely to access mental health services, five time more likely to access CASH, and 55 times more likely to access Compass than their non-offending peers.

5. The proportion of YO accessing all specialist health services tends to decline with age, which does not correspond to need. However this may be due to other factors such as YO accessing universal services.

6. It appears that more YO meet referral criteria for the YOT nurse than access them.

7. Male YO appear to be less likely to access specialist health services than female YO, which does not correspond to need.

8. Asian YO and female YO with substance misuse issues may not be identified through the asset assessment.

9. Some YO aged 18-19 years who meet the referral criteria for Compass are not accessing the specialist service.

10. Some YO may not be having their mental health needs met as they are reluctant to be referred to mental health services because of perceived stigma of accessing these services. It appears that this may be more apparent for those aged 15-19 years.

11. It appears that there is a significant number of YO identified as requiring a SQUIFA that did not have one.

<u>Identification of needs/pathway gaps</u>

1. Lack of/inconsistent data from YO specialist services- This has limited the scale of assessment into the health needs of YO.

2. Local pathway of managing mental health needs may not be fully adhered to – it is perceived that some YO are being managed in-house or referred to alternative services when their mental health needs may be best met by CAMHS.

3. There are no specific criteria for referral to sexual health services - The 'Health role within case management model' does not clearly state when a referral for sexual health needs is required (i.e. specific score) and in which instances referral should be to the YOT nurse, and when to CASH.

4. There are no specialist YOT services or pathways for chronic health needs of YO e.g. asthma, diabetes - Chronic health needs of YO may not be identified or managed appropriately.

8.2 Recommendations and considerations for action

Service gaps

1. Continue to provide specialist health services for YO in the areas of substance misuse, mental health, physical health and sexual health.

2. Explore options for increasing access to smoking cessation services for YO either through New Leaf or training of YOT staff/nurses and inclusion in the Nottingham City Health Model for YO.

3. Develop methods for identifying oral and respiratory health needs and ways to address these needs; integrate into the Nottingham City Health Model.

4. Further investigate the need and potential benefits of a speech and language service.

Health needs and equity of access

1. Explore reasons for the apparent gap between the numbers of YO meriting referral to YOT nurses and the numbers accessing them, and address any access barriers.

2. Identify and address reasons that may be preventing some male YO from accessing specialist health services.

3. Investigate and address reasons that may be preventing Asian and female YO with substance misuse issues being identified through the asset assessment.

4. Identify whether YO aged 18-19 years are having their substance misuse health needs met via mainstream services. If this is not the case, identify and address access issues as required.

5. Explore ways to address the stigma that many YO feel when referred to mental health services to ensure this does not act as a barrier to access.

6. Confirm if there are insufficient SQUIFAs carried out, or if the discrepancy arises due to a recording/data issue and address as necessary.

7. Conduct Health Equity Audits for all YO specialist health services to confirm possible inequities identified in this assessment and address as required.

Identification of needs/pathway gaps

1. Develop and agree standardised data collection from all YO specialist health services.

2. All partners to review and agree the local mental health pathway for YO to ensure the mental health needs of YO are consistently and adequately met.

3. Develop a clear pathway/guidance for YOT Case Managers regarding when a client should be referred for sexual health advice (including contraception, pregnancy testing support and emergency contraception), screening and treatment.

4. Include the identification of chronic diseases and pathway of referral into the Nottingham City Health Model.

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APPENDIX 1

Policy context

- United Nations Convention 1989, the Rights of the Child. The concept of Children's rights originates back to early 1920's.[19]
- The Children Acts 1989 and 2004, England, ensure welfare of children and protect children from harm. The 2004 act aims to further improve children's lives and give legal emphasis to the Every Child Matters: Change for Children, a national framework for local change programmes to help build local services to meet the needs of children. Other legislation related to the Children's acts is:
    - The Children and Young Person Act 2008[20].
    - Protection of Children Act 1999[21].
    - Safeguarding Vulnerable Groups Act 2006[22]
    - The Childcare Act 2006[23].
- The Human Rights act 1998[24]
- Youth Crime Action Plan 2008, a cross government analysis of needs in order to better manage youth crime by enforcement and punishment, prevention and support[25].
- Healthy Lives, Brighter Futures. Published by Department of Health in 2009[26]
- Children's Plan: Building Brighter Futures, published in 2007 by the department of children, schools and families[27]
- Lord Bradley's review of adults in the criminal justice system with mental health problems or learning disabilities, published in 2009.[10]

Appendix 2

3 CORE PROFILE

Asset Core Profile

YOUTH JUSTICE BOARD

Additional information on answering the questions marked by asterisks on this form is given in the guidance notes.

Personal details

Surname _____ First name(s) _____

Other names _____ Gender: Male / Female Date of birth _____

*Unique ID _____ *Police National Computer number _____

*Address _____

_____ *Postcode _____

Phone numbers (home, mobile, work) _____

***Ethnic classification (2001 census)** Information not obtainable ☐

White	British ☐	Irish ☐	Other White ☐				
Black/Black British	Caribbean ☐	African ☐	Other Black ☐				
Asian/Asian British	Indian ☐	Pakistani ☐	Bangladeshi ☐	Other Asian ☐			
Mixed	White/Black Caribbean ☐	White/Black African ☐	White/Asian ☐	Other Mixed ☐			
Chinese/Other ethnic group	Chinese ☐	Any other ☐					

Preferred language (other than English) _____

Information used for assessment (Please tick all that apply.)

Interview	☐	Crown Prosecution Service	☐	General practitioner	☐
Case record	☐	Solicitor	☐	Mental health service	☐
Family/carer	☐	Previous convictions	☐	Other health service	☐
School	☐	Residential home/hostel	☐	Drug/alcohol service	☐
Social Services Department	☐	Housing association	☐	Young Offender Institution	☐
Victim	☐	Local education authority	☐	Secure unit	☐
Police	☐	Careers guidance service	☐	Voluntary organisation	☐
		*Common Assessment Framework	☐	Lead Professional	☐

Other (e.g. club, religious organisation, local youth projects) _____

Give details of any particular difficulties in obtaining information.

Specify any significant pieces of information still to be obtained.

Assessment completed by _____ Date completed _____

1

Offence details

		*Seriousness score (1-8)
*Primary index offence		
Additional offences		

Outline of current offence(s)

*Case stage

Referral Order	☐	Pre-sentence report	☐	Post-sentence	☐		
Mid-Detention and Training Order	☐	*Review	☐	End order	☐	*Other	☐

*Victim/s (Please tick all that apply.)

*Specific, targeted victim	☐	*Vulnerable victim	☐	*Repeat victim	☐
Victim not known to him/her	☐	Racially motivated offence	☐		

Details

Offence analysis

Please use the framework below to describe and analyse the young person's offending behaviour regarding current offences.

***Actions and intentions**

- What was the offence?
- Where, when, and with whom was it committed?
- What methods were used?
- What degree of planning was involved?
- Were any weapons used?
- What was the value of money or property stolen?
- Were alcohol and/or drugs used at the time of the offence?
- Was it a group offence? If so, was the young person a leader or follower?
- What were the intentions of the young person?
- What were the differences between their intentions and their actions?
- Was the victim targeted/random/groomed/particularly vulnerable?
- Were there any other aggravating or mitigating factors?

***Outcomes and consequences**

- What is the impact on the victim – in the immediate and the longer term?
- What are the consequences for the young person (e.g. reaction to arrest and detention, response from family)?

***Reasons and motives**

- What were the young person's personal and social circumstances at the time?
- What were the young person's motives?
- What were the young person's attitudes?
- Does the young person have any particular attitudes/beliefs which might have influenced the offence (e.g. a belief that certain types of behaviour are justified, racial motivation, triggers, disinhibitors)?

***Patterns of offending behaviour**

- Are there any similarities or differences with previous behaviour?
- Has there been an increase/decrease in seriousness and/or frequency?
- Does the young person show a specialisation/diversity of offences?
- Are there any gaps in offending patterns?
- Has the young person made previous attempts to desist?

Analysis and evidence

Criminal history

Age at first Reprimand/Caution	10 ☐	11 ☐	12 ☐	13 ☐	14 ☐	15 ☐	16 ☐	17 ☐	N/A ☐	Don't know ☐
Age at first conviction	10 ☐	11 ☐	12 ☐	13 ☐	14 ☐	15 ☐	16 ☐	17 ☐	N/A ☐	Don't know ☐
Number of previous convictions	10+ ☐	8-9 ☐	6-7 ☐	5 ☐	4 ☐	3 ☐	2 ☐	1 ☐	0 ☐	Don't know ☐
Previous custodial sentences							2+ ☐	1 ☐	0 ☐	Don't know ☐

*Time since last conviction or pre-court disposal	Up to… 3 months ☐	6 months ☐	12 months ☐	1 year + ☐	N/A ☐	Don't know ☐

Previous disposals

Please indicate whether the young person has ever received any of the following disposals.

	Date/s		Date/s
Final Warning		Supervision Order	
Referral Order		Community Punishment Order	
Reparation Order		Community Rehabilitation Order	
Action Plan Order		*Other disposals, e.g. fine	
ASBO			

Have there been any instances of failing to complete or comply with previous disposals? Yes ☐ No ☐ Don't know ☐ N/A ☐

Details (Please explain reasons for any 'Don't know' responses.)

	Yes	No	Don't know
Is the young person's name on the sex offenders' register?	☐	☐	☐
***Any other previous contact with Yot?** (e.g. YISP, YIP, Splash, ABC, referral for Child Safety Order)	☐	☐	☐

Details (This does not include the information recorded above about previous disposals.)

Care history and 'looked after' status

Please indicate whether any of the following apply to the young person.	Current	Previous	Never	Don't know
Accommodated by voluntary agreement with parents (s20 Children Act 1989)	☐	☐	☐	☐
Subject to a care order (s31 Children Act 1989)	☐	☐	☐	☐
Remand to local authority accommodation (s23(1) Children and Young Person's Act 1969)	☐	☐	☐	☐

If the young person is 16 or 17 and you have ticked a 'current' or 'previous' box above:

	Yes	No	Don't know
*Is s/he an 'eligible child' (still in care and looked after for at least 13 weeks since the age of 14)?	☐	☐	☐
*(If 'No') Is s/he a 'relevant child' (has left care but was looked after for at least 13 weeks from the age of 14, and for some time while 16 or 17)?	☐	☐	☐

Other social services contact	Current	Previous	Never	Don't know
His/her name has been placed on the child protection register	☐	☐	☐	☐
*Any other referrals to or contact with social services	☐	☐	☐	☐
Any social services involvement with siblings	☐	☐	☐	☐

Details (Please explain reasons for any 'Don't know' responses and outline any aspects of the young person's care history which you consider relevant.)

1. Living arrangements

***Who has the young person been mostly living with over the last six months?**

Mother	☐	Grandparent/s	☐	Friend/s	☐
Father	☐	Other family	☐	Residents of home or institution	☐
Step-parent	☐	By self	☐		
Foster carer/s	☐	Partner	☐	Other/s	☐
Sibling/s	☐	Own child(ren)	☐		

If his/her *current* living arrangements are different, please specify below.

Please indicate whether any of the following apply to the young person.	Yes	No	Don't know
*No fixed abode	☐	☐	☐
*Unsuitable, does not meet his/her needs (e.g. overcrowded, lacks basic amenities)	☐	☐	☐
Deprived household (e.g. dependent on benefits, entitlement to free school meals)	☐	☐	☐
*Living with known offender/s	☐	☐	☐
Absconding or staying away (e.g. ever reported as missing person)	☐	☐	☐
*Disorganised/chaotic (e.g. different people coming and going)	☐	☐	☐
*Other problems (e.g. uncertainty over length of stay)	☐	☐	☐

Evidence (Please explain reasons for any 'Don't know' responses.)

***Rate the extent to which the young person's living arrangements are associated with the likelihood of further offending.**

0	1	2	3	4

(0 = not associated, 4 = very strongly associated)

2. Family and personal relationships

Which family members or carers has the young person been in contact with over the last six months?

Birth mother	☐	Grandparent/s	☐	Other significant adults (e.g. neighbour, family friend)	☐
Birth father	☐	Sibling/s	☐		
Adoptive parent/s	☐	Partner	☐		
Step-parent	☐	Own child(ren)	☐	Other/s	☐
Foster carer/s	☐	Other family	☐		

Please indicate whether any of the following apply to the young person.

	Yes	No	Don't know
*Evidence of family members or carers with whom the young person has been in contact over the last six months being involved in criminal activity	☐	☐	☐
*Evidence of family members or carers with whom the young person has been in contact over the last six months being involved in heavy alcohol misuse	☐	☐	☐
*Evidence of family members or carers with whom the young person has been in contact over the last six months being involved in drug or solvent misuse	☐	☐	☐
*Significant adults fail to communicate with or show care/interest in the young person	☐	☐	☐
Inconsistent supervision and boundary setting	☐	☐	☐
*Experience of abuse (i.e. physical, sexual, emotional, neglect)	☐	☐	☐
*Witnessing other violence in family context	☐	☐	☐
*Significant bereavement or loss	☐	☐	☐
*Difficulties with care of his/her own children N/A	☐	☐	☐
Other problems (e.g. parent with physical/mental health problem, loss of contact, acrimonious divorce of parents, other stress/tension)	☐	☐	☐

Evidence (Please explain reasons for any 'Don't know' responses.)

***Rate the extent to which the young person's family and personal relationships are associated with the likelihood of further offending.**

0	1	2	3	4

(0 = not associated, 4 = very strongly associated)

3. Education, training and employment

Engagement in education, training or employment (ETE)

***Is the young person of compulsory school age?** Yes ☐ No ☐

Which of the following best describe his/her current ETE situation?
(Tick as many as apply.)

Mainstream school	☐	Work experience	☐	College/further education	☐
Special school	☐	Full time work	☐	Other training course	☐
Pupil referral unit	☐	Part time work	☐	Unable to work (e.g. incapacity)	☐
Other specialist unit	☐	Casual/temporary work	☐	Looking after family	☐
Community home with education	☐	Unemployed	☐	Nothing currently arranged	☐
		New Deal	☐	Other	☐
Home tuition	☐	Pre-employment/lifeskills training	☐		

***How many hours of ETE are arranged each week?** _____ **hours**

***How many hours of ETE is she/he currently engaged in/receiving per week?** ___ **hours**

***Is there evidence of non-attendance?** (Please tick relevant reasons and give details below.) Yes ☐ No ☐

Permanent exclusion ☐ Fixed-term exclusion ☐ Family issues ☐ Illness ☐

Other non-attendance (specify) _____

Evidence (Please explain reasons for any 'Don't know' responses.)

Educational attainment

		Yes	No	Don't know
Does s/he have any educational qualifications?		☐	☐	☐
Does s/he have vocational/practical qualifications?		☐	☐	☐
*Have special needs (SEN) been identified?		☐	☐	☐
If 'yes', does s/he have a statement of SEN?	N/A	☐	☐	☐
Does s/he have difficulties with literacy?		☐	☐	☐
Does s/he have difficulties with numeracy?		☐	☐	☐
Does s/he have difficulties caused by a severe lack of English (or Welsh, if applicable) language skills?		☐	☐	☐

Evidence (Please explain reasons for any 'Don't know' responses.)

Other factors relating to engagement in ETE	Yes	No	Don't know
Negative attitudes towards ETE	☐	☐	☐
Lack of attachment to current ETE provision (e.g. wants to leave, cannot see benefits of learning)	☐	☐	☐
*Bullied	☐	☐	☐
*Bullies others	☐	☐	☐
Poor relationships with most teachers/tutors/employers/colleagues	☐	☐	☐
Negative parental/carer attitudes towards education/training or employment	☐	☐	☐
Other problems (e.g. frequent changes of school/educational placement, school is unchallenging/boring, disability, lack of stable address meaning difficulties securing work, no money to buy books/tools/equipment).	☐	☐	☐

Evidence (Please explain reasons for any 'Don't know' responses.)

***Rate the extent to which the young person's education, training and employment is associated with the likelihood of further offending.**

0	1	2	3	4

(0 = not associated, 4 = very strongly associated)

4. Neighbourhood

***Please give a brief description of the neighbourhood in which the young person spends most of their time.**

Please indicate whether any of the following are a problem in the neighbourhood.

	Yes	No	Don't know
*Obvious signs of drug dealing and/or usage	☐	☐	☐
Isolated location/lack of accessible transport	☐	☐	☐
*Lack of age-appropriate facilities (e.g. youth clubs, sports facilities)	☐	☐	☐
Racial or ethnic tensions	☐	☐	☐
Other problems (e.g. lack of amenities such as shops or post office, opportunities to sell stolen goods, red-light district, tension between police and local community)	☐	☐	☐

Evidence (Please explain reasons for any 'Don't know' responses.)

***Rate the extent to which the young person's neighbourhood is associated with the likelihood of further offending.**

(0 = not associated, 4 = very strongly associated)

0	1	2	3	4

5. Lifestyle

Please indicate whether the following are characteristic of the young person's lifestyle.	Yes	No	Don't know
*Lack of age-appropriate friendships	☐	☐	☐
*Associating with predominantly pro-criminal peers	☐	☐	☐
*Lack of non-criminal friends	☐	☐	☐
Has nothing much to do in spare time	☐	☐	☐
*Participation in reckless activity	☐	☐	☐
*Inadequate legitimate personal income	☐	☐	☐
Other problems (e.g. gambling, staying out late at night, loneliness)	☐	☐	☐

Evidence (Please explain reasons for any 'Don't know' responses.)

*Rate the extent to which the young person's lifestyle is associated with the likelihood of further offending.

(0 = not associated, 4 = very strongly associated)

0	1	2	3	4

6. Substance use

Please answer the questions below to give details of substance use (based on the information currently available).

	*Ever used	*Recent use	Age at first use	Not known to have used
Tobacco	☐	☐	☐	☐
Alcohol (Please specify types of alcohol in evidence box.)	☐	☐	☐	☐
Solvents (glue, gas and volatile substances e.g. petrol, lighter fuel)	☐	☐	☐	☐
Cannabis	☐	☐	☐	☐
Ecstasy	☐	☐	☐	☐
Amphetamines	☐	☐	☐	☐
LSD	☐	☐	☐	☐
Poppers	☐	☐	☐	☐
Cocaine	☐	☐	☐	☐
Crack	☐	☐	☐	☐
Heroin	☐	☐	☐	☐
Methadone (obtained legally or illegally – specify in evidence box)	☐	☐	☐	☐
Tranquilisers	☐	☐	☐	☐
Steroids	☐	☐	☐	☐
Other (Please specify in evidence box.)	☐	☐	☐	☐

Please indicate whether any of the following apply to the young person.

	Yes	No	Don't know
*Practices which put him/her at particular risk (e.g. injecting, sharing equipment, poly-drug use)	☐	☐	☐
*Sees substance use as positive and/or essential to life	☐	☐	☐
*Noticeably detrimental effect on education, relationships, daily functioning	☐	☐	☐
Offending to obtain money for substances	☐	☐	☐
Other links to offending (e.g. offending while under influence, possessing/supplying illegal drugs, obtaining substances by deception)	☐	☐	☐

Evidence (Please explain reasons for any 'Don't know' responses.)

***Rate the extent to which the young person's substance use is associated with the likelihood of further offending.**

0	1	2	3	4

(0 = not associated, 4 = very strongly associated)

7. Physical health

Please indicate whether any of the following apply to the young person.	Yes	No	Don't know
*Health condition which significantly affects everyday life functioning	☐	☐	☐
*Physical immaturity/delayed development	☐	☐	☐
*Problems caused by not being registered with GP	☐	☐	☐
*Lack of access to other appropriate health care services (e.g. dentist)	☐	☐	☐
*Health put at risk through his/her own behaviour (e.g. hard drug use, unsafe sex, prostitution)	☐	☐	☐
Other problems (prescribed medication, binge drinking, obesity, poor diet, smoking, hyperactivity, early or late physical maturation)	☐	☐	☐

Evidence (Please explain reasons for any 'Don't know' responses.)

*Rate the extent to which the young person's physical health is associated with the likelihood of further offending.

0	1	2	3	4

(0 = not associated, 4 = very strongly associated)

8. Emotional and mental health

Is the young person's daily functioning significantly affected by emotions or thoughts resulting from the following?

	Yes	No	Don't know
*Coming to terms with significant past event/s (e.g. feelings of anger, sadness, grief, bitterness)	☐	☐	☐
*Current circumstances (e.g. feelings of frustration, stress, sadness, worry/anxiety)	☐	☐	☐
*Concerns about the future (e.g. feelings of worry/anxiety, fear, uncertainty)	☐	☐	☐

Evidence (Please explain reasons for any 'Don't know' responses.)

	Yes	No	Don't know
***Has there been any formal diagnosis of mental illness?**	☐	☐	☐
***Any other contact with, or referrals to, mental health services?**	☐	☐	☐

Evidence (Please explain reasons for any 'Don't know' responses.)

***Are there indications that any of the following apply to the young person?**

	Yes	No	Don't know
*S/he is affected by other emotional or psychological difficulties (e.g. phobias, eating or sleep disorders, suicidal feelings not yet acted out, obsessive compulsive disorder, hypochondria).	☐	☐	☐
*S/he has deliberately harmed her/himself.	☐	☐	☐
*S/he has previously attempted suicide.	☐	☐	☐

Details (Specify type of illness, medication, whether she/he co-operates with treatment etc. Please explain reasons for any 'Don't know' responses.)

***Rate the extent to which the young person's emotional and mental health is associated with the likelihood of further offending.**

0	1	2	3	4

(0 = not associated, 4 = very strongly associated)

9. Perception of self and others

Please indicate whether any of the following apply to the young person.	Yes	No	Don't know
*S/he has difficulties with self-identity.	☐	☐	☐
*S/he has inappropriate self-esteem (e.g. too high or too low).	☐	☐	☐
*S/he has a general mistrust of others.	☐	☐	☐
Sees him/herself as a victim of discrimination or unfair treatment (e.g. in the home, school, community, prison).	☐	☐	☐
*S/he displays discriminatory attitudes towards others (e.g. race, ethnicity, religion, gender, age, class, disability, sexuality).	☐	☐	☐
*S/he perceives him/herself as having a criminal identity.	☐	☐	☐

Evidence (Please explain reasons for any 'Don't know' responses.)

*Rate the extent to which the young person's perception of self and others is associated with the likelihood of further offending.

0	1	2	3	4

(0 = not associated, 4 = very strongly associated)

10. Thinking and behaviour

***Are the young person's actions characterised by any of the following?**

	Yes	No	Don't know
*Lack of understanding of consequences (e.g. immediate and longer term outcomes, direct and indirect consequences, proximal and distal consequences)	☐	☐	☐
*Impulsiveness	☐	☐	☐
*Need for excitement (easily bored)	☐	☐	☐
*Giving in easily to pressure from others (lack of assertiveness)	☐	☐	☐
Poor control of temper	☐	☐	☐
*Inappropriate social and communication skills	☐	☐	☐

***Does the young person display any of the following types of behaviour?**

	Yes	No	Don't know
*Destruction of property	☐	☐	☐
*Aggression towards others (e.g. verbal, physical)	☐	☐	☐
*Sexually inappropriate behaviour	☐	☐	☐
*Attempts to manipulate/control others	☐	☐	☐

Evidence (Please explain reasons for any 'Don't know' responses.)

***Rate the extent to which the young person's thinking and behaviour is associated with the likelihood of further offending.**

0	1	2	3	4

(0 = not associated, 4 = very strongly associated)

11. Attitudes to offending

*Please indicate whether the young person displays any of the following attitudes.	Yes	No	Don't know
*Denial of the seriousness of his/her behaviour	☐	☐	☐
*Reluctance to accept any responsibility for involvement in most recent offence/s	☐	☐	☐
*Lack of understanding of the effect of his/her behaviour on victims (if victimless, on society)	☐	☐	☐
*Lack of remorse	☐	☐	☐
*Lack of understanding about the effects of his/her behaviour on family/carers	☐	☐	☐
*A belief that certain types of offences are acceptable	☐	☐	☐
*A belief that certain people/groups are acceptable 'targets' of offending behaviour	☐	☐	☐
*S/he thinks that further offending is inevitable	☐	☐	☐

Evidence (Please explain reasons for any 'Don't know' responses.)

*Rate the extent to which the young person's attitudes to offending is associated with the likelihood of further offending.

0	1	2	3	4

(0 = not associated, 4 = very strongly associated)

12. Motivation to change

Please indicate whether the young person displays any of the following attitudes.	Yes	No	Don't know
*Has an appropriate understanding of the problematic aspects of his/her own behaviour	☐	☐	☐
Shows real evidence of wanting to deal with problems in his/her life	☐	☐	☐
*Understands the consequences for him/herself of further offending	☐	☐	☐
*Has identified clear reasons or incentives for him/her to avoid further offending	☐	☐	☐
*Shows real evidence of wanting to stop offending	☐	☐	☐
Will receive positive support from family, friends or others during any intervention	☐	☐	☐
Is willing to co-operate with others (family, Yot, other agencies) to achieve change	☐	☐	☐

Evidence (Please explain reasons for any 'Don't know' responses.)

*Rate the extent to which the young person's motivation to change is associated with the likelihood of further offending.
(0 = not associated, 4 = very strongly associated)

0	1	2	3	4

Summary of dynamic risk factors

	Rating
1. Living arrangements	
2. Family and personal relationships	
3. Education, training and employment	
4. Neighbourhood	
5. Lifestyle	
6. Substance use	

	Rating
7. Physical health	
8. Emotional and mental health	
9. Perception of self and others	
10. Thinking and behaviour	
11. Attitudes to offending	
12. Motivation to change	
Total score from sections 1-12 (max. 48)	

Any other relevant information

Positive factors

Please tick the relevant boxes to indicate the presence of positive factors in the young person's life. If, for any question, there do not seem to be any positives (or you are unsure) please leave that particular box blank. Use the evidence boxes to explain what impact the different factors may have on the likelihood of reoffending.

Individual factors

	Current (or potential)
Education/training/work experience that enhances confidence and self-esteem (e.g. good at certain subjects, demonstrates practical skills, recognition of achievements)	☐
Has obtained qualifications that will help him/her to obtain employment	☐
Has some friends who are not involved in offending, model positive social behaviour etc.	☐
Positive and constructive things to do in his/her spare time	☐

Evidence

	Current (or potential)
A sense of self-efficacy (e.g. that she/he can take action to change things, displays optimism)	☐
A goal, ambition, sense of direction or something to 'aim at' in life	☐
Opportunities for 'turning points' (e.g. change of school, moving to a new area, new social opportunities)	☐
Resilience (e.g. copes well with difficulties, knows where to seek help, seems to spring back quickly from adversity)	☐
Has engaged well with previous interventions (e.g. from YISP, YIP, Positive Activities or other initiatives, interventions by other agencies)	☐

Evidence

Family factors

	Current (or potential)
Strong, stable relationship with at least one parent or other family member	☐
Parent/s or carers who value education/training/employment	☐
Family members or carers who model pro-social behaviour and norms	☐

Evidence

Community factors

	Current (or potential)
Professional help/support, e.g. receiving support/counselling, other agency involvement with family	☐
School is interested in the young person's progress, keen to get involved and help	☐
Strong, stable relationship with an adult outside of the family home (e.g. teacher, youth club leader, neighbour)	☐
Community offers opportunities for the young person to get involved with activities (e.g. youth centre, sports facilities that caters for the young person's interests, other interest groups)	☐
If applicable, young person receives strong support from cultural and ethnic communities	☐

Evidence

Any other positive factors that can be identified (e.g. stable accommodation, good transport links)

Details

Indicators of vulnerability

This section focuses on the possibility of harm being caused to the young person.

The first three questions should be completed in all cases; the last two, regarding previous custodial sentences and current concerns about vulnerability in custody, are not always required, but can be used where a young person is likely to receive a custodial sentence and there are concerns about his or her vulnerability within a secure establishment.

***Is there evidence that s/he is likely to be vulnerable as a result of the following?**

	Yes	No	Don't know
The behaviour of other people (e.g. bullying, abuse, neglect, intimidation, exploitation)	☐	☐	☐
Other events or circumstances (e.g. separation, anniversary of loss, change of care arrangements)	☐	☐	☐
His/her own behaviour (e.g. risk taking, ignorance, drugs, acting out, inappropriate response to stress)	☐	☐	☐

Evidence (Please explain reasons for any 'Don't know' responses.)

***Are there indications that s/he is at risk of self-harm or suicide?** Yes ☐ No ☐ Don't know ☐

Evidence (Please explain reasons for any 'Don't know' responses.)

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***Are there any protective factors that may reduce his/her vulnerability?** Yes ☐ No ☐ Don't know ☐

Evidence (Please explain reasons for any 'Don't know' responses.)

Are there any known problems during previous custodial sentences? Yes ☐ No ☐ Don't know ☐

If yes, please specify (i.e. self-harm, attempted suicide, or victim of bullying) and provide details

Are there any current concerns about vulnerability if s/he were to go to custody? Yes ☐ No ☐ Don't know ☐

If yes, please specify the nature of the problems, and circumstances in which they are likely to occur

Indicators of risk of serious harm to others

This section focuses on the possibility of the young person causing serious harm to other people. Serious harm is defined as 'death or injury (either physical or psychological) that is life threatening and/or traumatic and from which recovery is expected to be difficult, incomplete or impossible'.

***Do any of the following apply to the young person in relation to the current offence/s?**	Yes	No	Don't know
S/he has been convicted of a serious specified offence	☐	☐	☐
S/he is being sentenced in the Crown Court for a specified offence	☐	☐	☐
A Youth Court has specifically requested that the pre-sentence report risk assessment should contribute to the court's assessment of 'dangerousness', in order to determine whether to remit the case to the Crown Court for sentencing	☐	☐	☐
***Has the young person ever been assessed as presenting 'a risk to children'?**	☐	☐	☐

If you have answered 'yes' to either of the questions above, you must complete the full *Risk of Serious Harm* form. If none of these cases applies, please complete the questions below. Take account of known offences and other behaviour that may not have resulted in a conviction (e.g. behaviour within the family, at school, in institutions, towards staff). If you answer 'yes' to either of the questions, you must go on to complete the full *Risk of Serious Harm* form.

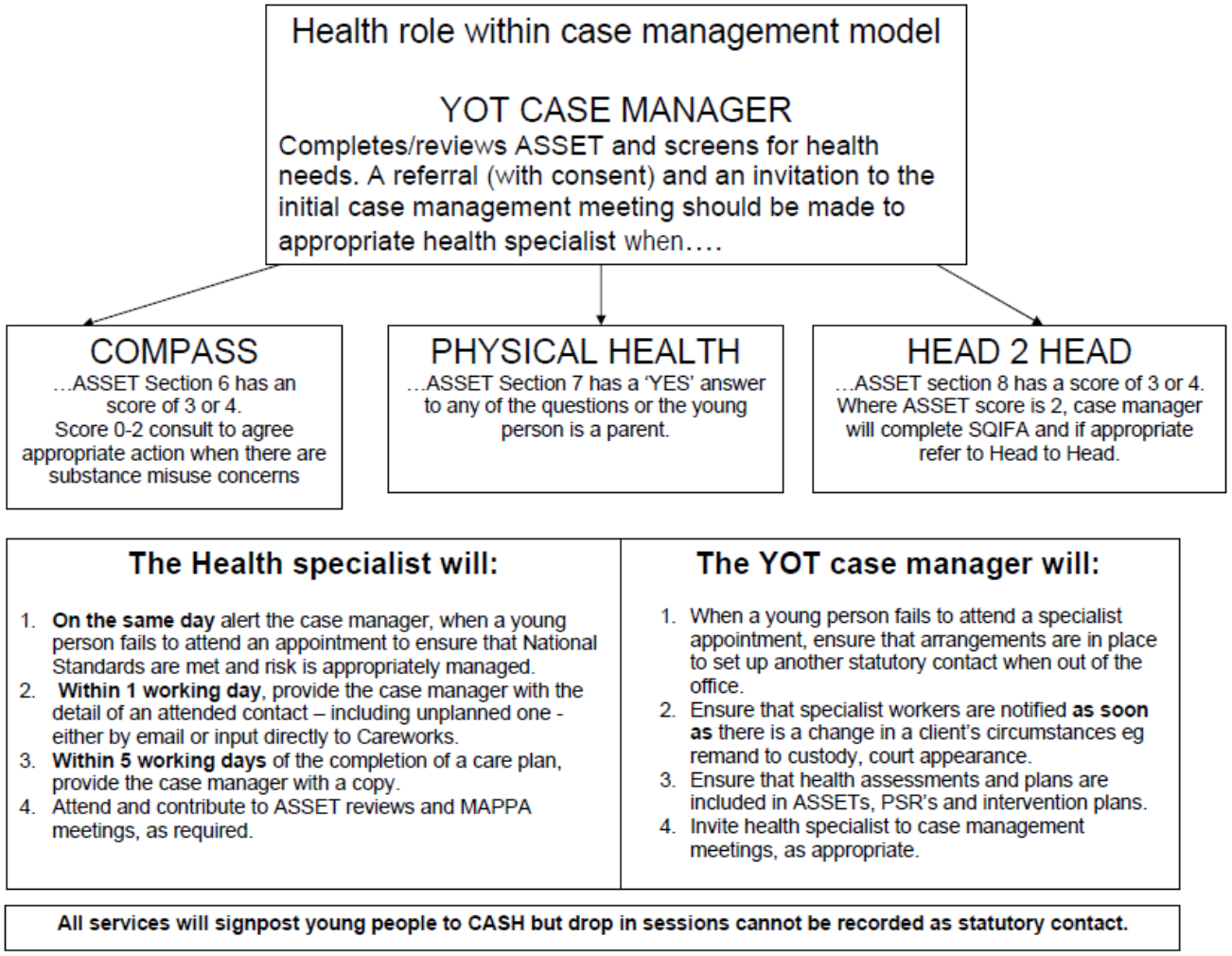
***Is there any evidence of the following?**	Yes	No	Don't know
*Behaviour by the young person which resulted in actual serious harm being caused	☐	☐	☐
*Behaviour which indicates that s/he was intending or preparing to cause serious harm	☐	☐	☐
*Other (e.g. reckless or unintentional) behaviour that was very likely to have caused serious harm	☐	☐	☐

Do any of the following indicate that there may be a risk of serious harm?	Yes	No	Don't know
*Other features of his/her offending (e.g. unduly sophisticated methods, use of weapons, targeting)	☐	☐	☐
*His/her attitudes and motives (e.g. driven by desires for revenge, control or by discriminatory beliefs)	☐	☐	☐
*Current interests or activities (e.g. fascination with military paraphernalia, networks/associates)	☐	☐	☐

***Do any of the following cause significant concern?**	Yes	No	Don't know
*Any other disconcerting or disturbing behaviour by the young person (e.g. cruelty to animals)	☐	☐	☐
*Young person has said, indicated or threatened that s/he might cause serious harm to others	☐	☐	☐
*Others (e.g. family, school) have expressed concern that the young person might cause serious harm to others	☐	☐	☐
*Any other intuitive or 'gut' feelings about possible harmful behaviour	☐	☐	☐

Details (Where there are 'don't know' responses, specify what additional information is needed in order to make a judgement.)

APPENDIX 3


Health role within case management model
YOT CASE MANAGER
Completes/reviews ASSET and screens for health needs. A referral (with consent) and an invitation to the initial case management meeting should be made to appropriate health specialist when….
COMPASS
…ASSET Section 6 has an score of 3 or 4.
Score 0-2 consult to agree appropriate action when there are substance misuse concerns
PHYSICAL HEALTH
…ASSET Section 7 has a 'YES' answer to any of the questions or the young person is a parent.
HEAD 2 HEAD
…ASSET section 8 has a score of 3 or 4.
Where ASSET score is 2, case manager will complete SQIFA and if appropriate refer to Head to Head.
The Health specialist will:
1. On the same day alert the case manager, when a young person fails to attend an appointment to ensure that National Standards are met and risk is appropriately managed.
2. Within 1 working day, provide the case manager with the detail of an attended contact – including unplanned one - either by email or input directly to Careworks.
3. Within 5 working days of the completion of a care plan, provide the case manager with a copy.
4. Attend and contribute to ASSET reviews and MAPPA meetings, as required.
The YOT case manager will:
1. When a young person fails to attend a specialist appointment, ensure that arrangements are in place to set up another statutory contact when out of the office.
2. Ensure that specialist workers are notified as soon as there is a change in a client's circumstances eg remand to custody, court appearance.
3. Ensure that health assessments and plans are included in ASSETs, PSR's and intervention plans.
4. Invite health specialist to case management meetings, as appropriate.
All services will signpost young people to CASH but drop in sessions cannot be recorded as statutory contact.