

# Turning young lives around:

*How health and justice services can respond to children with mental health problems and learning disabilities who offend*

A briefing paper by Robert Newman

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## Children who offend - the facts:

- 85,300 children were supervised by Youth Offending Teams in 2010/11, a reduction of 20% from 2009/10
- Around 25% of children who offend have very low IQs of less than 70
- 43% of children on community orders have emotional and mental health needs, and the prevalence amongst children in custody is much higher
- 60% of children who offend have communication difficulties and, of this group, around half have poor or very poor communication skills
- Around 33% of all children accessing local drug and substance misuse services are referred from the youth justice system
- 27% of children and young people who offend are not in full time education, training or employment at the end of their period of youth justice supervision.

## Who is this briefing for?

This briefing paper has been prepared for youth justice professionals and practitioners, local government directors of children's services and lead members, directors of public health, clinical commissioning groups and healthcare.

## Why is it useful?

This briefing paper will help to inform the development of Joint Health and Wellbeing Strategies. It will be of particular use to those involved in commissioning services, and for those concerned to ensure that the particular needs of children who offend, especially those with mental health problems and learning disabilities, are recognised and met.

## Summary

High numbers of children who offend have health, education and social care needs, which, if not met at an early age, can lead to a lifetime of declining health and worsening offending behaviour, with significant long term costs to the taxpayer, and to the victims of these crimes.

Despite considerable improvement in provision for children's mental health evidence shows that health and youth justice services are not working effectively together to respond to these children.

Reforms to health and social care in England, and the emphasis on localism, provide a chance to improve joint working between youth justice and healthcare services to make a real difference for children who offend.

Health and Wellbeing Boards, together with Clinical Commissioning Groups, will be responsible for shaping the future of health and social care provision for their local areas, a top priority of which is to tackle the health inequalities that children and young people who offend frequently experience.

This briefing paper seeks to encourage effective joint working between Health and Wellbeing Boards and youth justice services, in particular, to ensure that local strategies reflect the needs of children and young people who offend, especially those with mental health problems and learning disabilities. It outlines a practical action agenda and provides examples of good practice to help turn these young lives around.

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## Action agenda

### Action by Youth Offending Teams (YOTs) and YOT management boards:

- 1 Undertake a health and wellbeing needs assessment to produce reliable information on the support needs of children and young people who offend; use these data to inform your local Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS); see *Youth Justice Health and Wellbeing Needs Assessment Toolkit*: [www.chimat.org.uk/yj/hwbna](http://www.chimat.org.uk/yj/hwbna)
- 2 Agree a strategy to ensure matters relating to youth crime, the voices of children who offend and their health and wellbeing needs are reflected in your local authority JSNA and JHWS, and are represented at the Health and Wellbeing Board
- 3 Arrange to meet local Clinical Commissioning Groups (CCGs) to discuss the particular health and wellbeing needs of children who offend and those at risk of offending
- 4 Work with other YOTs and YOT management boards whose area is covered by the same Police and Crime Commissioner to influence your Commissioner's policy and funding decisions; see [www.justice.gov.uk/downloads/pcc/making-the-case-pcc-funding-template.ppt](http://www.justice.gov.uk/downloads/pcc/making-the-case-pcc-funding-template.ppt)
- 5 Work with local liaison and diversion pilots to highlight the health benefits of early interventions for children who offend or who are at risk of offending; see *Youth Justice Liaison Diversion Practical Toolkit*: [www.chimat.org.uk/yj/toolkit](http://www.chimat.org.uk/yj/toolkit)

### Action by Health and Wellbeing Boards:

- 6 Work with local youth justice services to ensure the particular health needs of children and young people who offend are reflected in your JSNA and JHWS (see [www.chimat.org.uk/yj/hwbna](http://www.chimat.org.uk/yj/hwbna)), and are represented on the Health and Wellbeing Board
- 7 Undertake an equality impact assessment to ensure that children under the supervision of youth justice staff and those identified as being at risk of offending are not marginalised, and that all services comply with the public sector equality duty
- 8 Clarify what arrangements have replaced Children's Trusts and, where necessary, set up children's committees to ensure the unique needs of children and, in particular, children who offend are taken account of. The focus of children's committees should be the planning and delivery of integrated services to deliver joined up care pathways, including timely access to Child and Adolescent Mental Health Services (CAMHS) and other specialist services, improving transitions from child to adult services and building on the lessons learned from Children's Trusts (see Annex 2: Engaging children and young people)
- 9 Review CAMHS to ensure they conform to the comprehensive CAMHS model; see [www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/@ps/documents/digitalasset/dh\\_110930.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_110930.pdf) and [www.chimat.org.uk/default.aspx?QN=CAMHSTOOL](http://www.chimat.org.uk/default.aspx?QN=CAMHSTOOL)

- 10 Ensure professional development for specialist health staff, and mental health and learning disability awareness training for specialist health staff and others working in the youth justice system.

**Action by Clinical Commissioning Groups:**

- 11 Work closely with, or consider delegating to, an expert group of local authority and NHS children's commissioners to commission services for children with mental health problems, learning disabilities and communication difficulties; such a group could agree a youth offending service commissioning plan, and manage aligned or pooled budgets
- 12 Ensure adequate resourcing of health and wellbeing services delivered in youth offending teams and an appropriate mix of specialist expertise to deliver commissioning objectives

**Action by the Department of Health:**

- 13 Prioritise the health needs of children who offend in forthcoming guidance on JSNAs and JHWSs
- 14 Deliver on the commitment made in *Healthy Children, Safer Communities*<sup>2</sup> to produce new guidance for commissioners on meeting the challenges of commissioning health services for children in the youth justice system, and ensure that the needs of children with mental health problems and learning disabilities are included in this guidance
- 15 Work with the Offender Health Collaborative<sup>3</sup> to ensure age-appropriate liaison and diversion services for children and young people

**Action by the Youth Justice Board (YJB):**

- 16 Monitor youth justice input into JSNAs and highlight where needs assessments fail to take account of the particular needs of children who offend

**Action by NICE:**

- 17 The NICE Quality Outcomes Indicator Programme and Commissioning Outcomes Framework should include indicators and outcomes relating to child and adolescent mental health

**Action by the Care Quality Commission (CQC):**

- 18 Youth justice inspection arrangements involving the CQC should assess the impact of NHS changes on the provision of health services to YOTs. CQC should continue to monitor how the health needs of children and young people who offend, or who are at risk of offending, are being met.

## Introduction

This briefing paper is about children and young people aged 10 to 17 years with mental health problems, learning disabilities and communication difficulties who offend and who are at risk of offending (hereafter referred to as ‘children who offend’ and ‘young offenders’). It seeks to inform local service managers and decision makers about the importance of improving health provision for this vulnerable, and often marginalised, group of children and to provide some pointers towards strategic improvement. The briefing paper should further stimulate debate locally about how professionals and practitioners concerned with children’s services – and with youth justice and health services in particular – can make best use of opportunities presented by NHS reforms and the increased focus on localism. The briefing paper outlines some of the challenges posed in achieving these objectives at a time of great change in the delivery of local authority and health services.

There have been advances over the last decade in healthcare provision for children who offend. There is evidence, however, that much more remains to be done. A common theme of this research is the failure of local services to work effectively together, resulting in many children with complex health and social care needs slipping through the net. A more joined up approach between health and youth justice services would make the most of the time these children spend under the supervision of youth justice services, to address their health needs and to help turn their lives around. The *Healthy Children, Safer Communities*<sup>4</sup> strategy, published in 2010, is a step in the right direction, but implementation will be a challenge during the period of instability caused by wider health reforms.

In recent years the shift in offender health policy for children and adults has been towards improving access to mainstream services, as opposed to creating specific and dedicated services for offenders. This has been especially so for children who offend, of whom around 97% are subject to community supervision.

The thematic focus of this briefing paper is mental health, learning disability and communication difficulties. While not attempting to look in any detail at physical health, health education or drug and substance misuse, it is acknowledged there is considerable overlap, and often interdependency, and that children’s support needs will often be complex, rarely corresponding to the artificial boundaries constructed for the purposes of strategic planning and service commissioning.

Extracts from interviews with children with mental health problems and learning disabilities are included at points throughout the text to illustrate the real life stories at the heart of these discussions. These extracts are taken from interviews with children and young people participating in the *Raising your Game* project.

## **Children and young people who offend**

Slightly more than 85,000 children were under the supervision of youth justice services in the year ending 2011. This is a small minority of children, and getting smaller each year – the 2010/11 figures being around 20% less than in the previous year. However, this smaller group may be more challenging to work with, as shown in the higher predicted rate of reoffending.<sup>5</sup>

All children who come into contact with youth justice services are vulnerable by virtue of their young age and developmental immaturity. Many, however, are doubly vulnerable – that is, they are disadvantaged socially, educationally, and also because they experience a range of impairments and emotional difficulties. It is well established that children who offend have more complex health and support needs than other children of their age.<sup>6</sup> The health and wellbeing needs of these children tend to be particularly severe by the time they are at risk of receiving a community sentence, and even more so when they receive a custodial sentence.<sup>7</sup>

If these children are not helped at an early age, they can be sentenced to a lifetime of declining health and worsening offending behaviour, with significant long term costs to the taxpayer, and to the victims of these crimes. Brief contacts with the youth justice system are only one element of state intervention in the lives of these children and their families; the role of schools, social care and health services are all critical determinants of improving outcomes.

### **Mental health and wellbeing**

Evidence from the UK<sup>8</sup> and international studies<sup>9</sup> shows that between a third and a half of children in custody have a diagnosable mental health disorder such as depression, which is particularly prevalent in girls. A review of joint inspections undertaken by the Healthcare Commission and HM Inspectorate of Probation<sup>10</sup> in 2009 found 43% of children on community orders to have emotional and mental health needs.

### **Learning disability**

An assessment, in 2005, of children who offend found that 23% had an IQ of under 70 ('extremely low') and 36% had an IQ of 70-79.<sup>11</sup> More recently, according to the Department of Health, over a quarter of children in the youth justice system have a learning disability, while more than three-quarters have serious difficulties with literacy.<sup>12</sup>

### **Communication difficulties**

Research studies consistently show high numbers of children in the youth justice system with speech, language and communication difficulties. It is generally acknowledged that around 60% of such children have a communication disability and, of this group, around half have poor or very poor communication skills,<sup>13</sup> resulting in an increased likelihood that the child will not understand, or be able to participate effectively in verbally mediated interventions.

### **Victimisation**

Over half of children and young people who offend have themselves been victims of crime.<sup>14</sup>

## Drug and Substance Misuse

Over a third of all children accessing local drug and substance misuse services are referred from the youth justice system.<sup>15</sup> This is indicative of the numbers of children entering the youth justice system with a multiplicity of often low level, complex and interlocking needs, many of whom would fall below the threshold for access to specialist help.

## Children in care

Children who are, or who have been, in care are over-represented among the offender population. Research shows that 42% of children on custodial sentences had been 'held in care', while 17% were on the child protection register.<sup>16</sup> A more recent review, published in 2009, found that 22% of children aged under 14 years had been living in care at the time of their arrest, and a further 6% were on the child protection register.<sup>17</sup> This compares with around 1% of children within the general population who are in the care of the local authority.

### Ronnie:

Ronnie, aged 16 years, is currently awaiting sentence on a firearms offence and has been told to expect a custodial sentence. Ronnie has recently taken an overdose and put a knife to his head; he also has drink and drug misuse problems. Ronnie missed a lot of school, completing only about two years of secondary education. He tells his story:

*I was at the hotel I was living in and this person, he is like 43 and has schizophrenia, he lost the plot and put the gun to my head. And I know what he is like, he is like mental and I was scared. I knew the gun wasn't real, but he sort of knocked me out. He hit someone with a dumbbell, and then I was in a room; he left the hotel and the police came. I had the gun down my waist band... They came over to me and put me on the floor.*

*I have got a YOT worker for five days a week; I can see someone from CAMHS regularly and someone [from the drug and alcohol misuse project] for checks. I have one off appointments. I can go when I want to if I feel there is something wrong with me; I can get hold of them when I need to. They are putting me on 'watch and wait' to see how I do and after my court case they will get in touch with me. I don't want to go to prison. I am really nervous about that. I am seeing someone about my drinking – I have cut it down a bit now. If I have money, I drink a bottle of brandy, [strong lager], and a bit of vodka and maybe a bit of cider. I started drinking when I was 13 or 14.*

*I used to just hang around on street corners with my friends in the city centre a lot; drinking and smoking. I don't hang around on the street corners anymore; I haven't got time for that. I want to see what happens about the court case and then I just want to change my life.*

*The worst age of my life is 16; it's supposed to be the best years of your life. It is hard to concentrate on anything else.*

## The challenge for youth offending services

The success of the YOT model has been widely acknowledged as an effective way of providing children who offend with the right mix of care, supervision and rehabilitation.<sup>18</sup> But fourteen years after their creation, YOTs face many challenges in adapting to shifting dynamics in local authority services and a new kind of relationship with central government, against a backdrop of spending cuts. Whilst nobody would claim that recent successes – such as falls in youth crime, reductions in first time entrants to the youth justice system and fewer children in custody – have been achieved solely through the efforts of YOTs, it is clear that the reformed youth justice system, an increasingly child centred culture and a strong voluntary sector lobby<sup>19</sup> have come together to produce these outcomes.

As youth crime continues to fall, YOTs may become vulnerable to spending cuts by cash strapped local authorities. Funding reductions to YOTs, in the order of 20% over the next three years, are already having an impact, with the loss of many key personnel including those in specialist posts such as health and education. This creates pressure to concentrate on the ‘core business’ so reducing resourcing in areas such as prevention, particularly for smaller authorities where managers have less room for manoeuvre. It remains to be seen whether the capacity of YOTs to prioritise prevention activity will be further undermined by the consolidation of all prevention resources into the government’s early intervention fund.

With two thirds of the money spent on youth justice going into custodial provision, there is even more pressure to devolve the accountability for custody funding to local authorities. To that end, four local authority clusters have been piloting this arrangement and, from December 2012, the budget for custodial remand will be devolved to local authorities.

Local services are responding to these pressures using a variety of approaches such as mergers and consolidation in order to create greater efficiencies across geographical boundaries. The breaking up of Children’s Trusts will also have an impact on the way YOTs are managed and funded with the management of the YOT increasingly being undertaken by a senior manager with a range of other responsibilities within the authority.

### Adam:

Adam, aged 17 years, lives in bed and breakfast accommodation. Previous health assessments resulted in a range of diagnoses including ADHD and mental health issues. A more recent assessment by CAMHS, undertaken following a referral from youth offending services, identified autism spectrum disorder and a need for emotional support following significant emotional abuse during early childhood and bereavement, following the death of his mother. Adam also has alcohol and drug misuse problems. Adam tells his story:

*I’ve been in hotels for about six months. Before that I was with my aunt but it all broke down following an allegation my step mum made... my step mum has some issues [Adam was accused of abusing a child].*

*I’ve got ASD – autism spectrum disorder. I’ve got social services support and the YOS [youth offending service] including AJ here [YOS CAMHS worker] and another*



worker who deals with my case. AJ is the main person who deals with my diagnosis, he managed to reduce the diagnosis from a list like that [Adam opens his arms out wide]. Before that I was diagnosed with Aspergers, ADHD, autism, bi-polar and alcohol and drug misuse issues, oh and depression. Over the years they said I had all that but the recent assessment said I don't have any of that just ASD.

I hated school; every day I did a walkabout and staff had to get their cars out or call the police. I was disobedient at school, I just hated it. It just wasn't my thing, I don't like boarding schools.

JB [the school counsellor] helped me, I tried to see him every day; what I did, he even noticed. If I went to a lesson I didn't like I would walk out and go and see him.

I took lots of medication but it was just knocking me out, I'd take it and like an hour later I'd be doing my work at school and I'd then fall asleep on my desk. They just gave me medication. They were supposed to check my blood levels every two or three weeks but they didn't do that for two years.

On June 14th 2007 I was kicking off really badly, I was restrained from 10pm to 2am in the morning, and on that same date my mum was in a car accident and was killed. I didn't find that out until 7am the next morning after 6 hours sleep.

Would you say you have received more help or less help since you've been in touch with youth offending services?

More help and it has made me realise that what I have been doing, well I have to change my ways, it isn't really good. They have made me do paperwork – how would it feel if it was you it was done to – would I like it? Doing that a couple of times has made me think, 'no it isn't nice', so I've stopped now....it has made me realise; my fiancé has a baby on the way so I need to make sure I don't get to prison so I can look after this baby and be there for him until he grows up.

Thinking about the future, Adam explained:

I'd like to get my own place, my own car, wife and children and a decent job.... I've looked into going to college but with moves and stuff I lost my college place. I could pick it up again; my attendance was good but when I got homeless and have been moving about it stopped. I might go in the future but I don't know.

## **The vision of integration**

Youth Offending Teams (YOTs) were created as multi-agency organisations to facilitate holistic service provision. Despite this, there is much evidence that children in need of specialist assessment and intervention are often not referred to such services, or accepted by them, and that youth justice, health and wider children's services frequently fail to work together to deliver timely and joined up support for these children.

The National CAMHS Review (2008<sup>20</sup>) identified children in the youth justice system as particularly vulnerable and made recommendations to improve outcomes for this group through better collaboration:

*This spotlight on mental health and psychological wellbeing will be especially important over the next three to five years to show how all the pieces of this complex jigsaw fit together and how everyone can play their part. This will be a challenge, given the other priorities that local areas have to address. Nonetheless we believe this is a priority worth focusing on, given the impact that poor mental health has on children, their families, friends and also their communities.*

In 2009 the Healthcare Commission and HM Inspectorate of Probation published *Actions Speak Louder, A Second Review of Healthcare in the Community for Young People who Offend*.<sup>21</sup> The Review identified that resourcing for healthcare was inadequate in almost half of the YOTs it inspected and there was:

*... a lack of commitment by, primarily, a significant minority of PCTs to the functioning of their multi-agency YOT, which can affect strategic direction, oversight and accountability.*

The Review also expressed concerns about health input into court work, assessment and transitions from custody to the community, and concluded that:

*... the statutory requirement that this vulnerable group of children and young people should receive a consistent level of healthcare remained unmet.*

The Review called for YOTs to undertake analyses of health need amongst their populations so that adequate resources could be made available for the provision of universal services.

The need for better informed and more joined up planning for offender health was further emphasised by the Bradley Report (2009):

*A minimum dataset should be developed, for collection by Criminal Justice Mental Health Teams, to provide improved information to assess need, plan and performance manage services, and inform commissioning decisions.*<sup>22</sup>

In the face of this evidence of considerable disjuncture between health and youth justice services, the fact that many children entering the youth justice system will have their healthcare needs assessed, and be appropriately referred for treatment for perhaps the first time in their lives, should not be lost sight of. That said, such activity frequently happens as a result of the resourcefulness and commitment on the part of individual youth justice and health staff working together, rather than any properly integrated planning and commissioning.

Prison Reform Trust research<sup>23</sup> with youth justice managers revealed some of the problems YOTs face in accessing mainstream services for children who offend. These included:

- insufficient input from specialist health staff
- high thresholds for access to mental health and learning disability services
- poor transition planning for the older age group (16 and 17 year olds).

The subsequent report recommended, amongst other things:

- flexible models of healthcare delivery that suit the particular characteristics of the youth justice cohort
- the specific inclusion of children who offend in all relevant commissioned services
- service level agreements and referral protocols between youth justice services and health providers.

More recently, the third review of health care in the community for young offenders, undertaken by the Care Quality Commission, reported welcome progress on a number of fronts. However, ‘YOTs confirmed continuing difficulties in terms of CAMHS involvement’.<sup>24</sup> In 2011 the Office of the Children’s Commissioner<sup>25</sup> highlighted how a lack of integrated working in the community can have a deleterious effect on transitions both into and out of custody.

### **Child and adolescent mental health services (CAMHS) and youth justice services**

Following the CAMHS Review in 2008,<sup>26</sup> the government published its response outlining how the delivery of CAMHS would be transformed and resources provided to support the reform process. This publication<sup>27</sup> provided a blueprint for local service provision across the three domains of service delivery – universal, targeted and specialist. The response emphasised the importance of improving local and regional governance as a prerequisite for improving the integration of services.<sup>28</sup>

The importance of integrated service provision with clear care pathways is vital in the youth justice system where mental health problems in children who offend may be identified for the first time, but with a limited window of opportunity to assess need, plan for and deliver an appropriate intervention. However, the government’s 2010 CAMHS stock-take,<sup>29</sup> found:

- inconsistencies in commissioning particularly around transitions to adult care
- inadequate multi-agency working and packages of care for children with complex needs
- concern about sustainability, workforce development programmes and responsiveness in the face of financial cuts
- that the structure of the JSNA does not encourage full analysis of the support needs of children who offend to inform the Children’s Plan.

Ironing out these difficulties and delivering the vision of an integrated and effective CAMHS will be a major challenge for Clinical Commissioning Groups as the new NHS structures evolve. The number of 16 to 17 year olds unable to access either children’s or adult services is still a major concern; as is the high threshold for acceptance of CAMHS referrals, which excludes many children with lower level, multiple and often complex mental health needs and learning disabilities. Similarly challenging will be the marrying up of local priorities with nationally determined outcome measures such as those set out in

the recently published draft Commissioning Outcomes Framework being developed by NICE,<sup>30</sup> and the ongoing NICE Quality Outcomes Indicator Programme.

### **YOT health provision and the role of the YOT health worker**

The Crime and Disorder Act 1998 introduced the duty on health authorities to contribute to the newly established youth offending teams. Whilst cementing health as part of the YOT partnership, the Act itself wasn't prescriptive about what form health input into the YOT should take, and a variety of approaches evolved. The larger YOTs tended to develop quite complex health staffing arrangements with a range of secondments and agreements with different specialist health services. In smaller YOTs the generic health worker typically acted as a conduit with a signposting role, acting as a bridge between youth justice and health.

A detailed insight into the way health authorities and YOTs were working together to shape health input was provided by the Centre for Mental Health in 2010.<sup>31</sup> Its survey found a wide variety of models and concluded that:

*Health provision does not have to be based full time in YOTs but appears to work best when there is a regular and systematic presence of health and mental health workers in these settings. Regular attendance allows YOT health practitioners access to consultation and advice and facilitates confident management of cases. It is important that any health presence in the YOT also has very strong links to a broad range of local mainstream services.*

The value of staff with expertise in mental health, learning disability and communication difficulty being available to the YOT isn't just about the direct support they can provide to the children on YOT caseloads. They also play a vital role in raising health awareness in generic YOT staff and other professions working with the YOT, such as police and court staff. This, in turn, increases the capability of youth justice services to recognise and work more effectively with children with such impairments including, for example, ensuring timely referrals for more specialist assessments and better data collection to inform future service planning and delivery.

#### **Jessie:**

Jessie is 17 years old. Her mother and step father asked her to leave the family home after her last offence. She is living with different family members and has her name down to go into the local Foyer; she is under the care of the social services '16 plus team'. She has been referred to CAMHS because of Obsessive Compulsive Disorder type behaviours and anger problems but has not received a formal diagnosis. Jessie tells her story:

*The first real bad thing was at this party and girls from the school where I got bullied were there. I was drunk and my anger just came out. All that anger from when they bullied me was like all out ... I started fighting with one girl and then the other came to help her and so I was fighting her as well and I really hurt them both. And then just to finish it off, I was stupid I took my shoe off and I whacked them in the head with the high heel, both of them.*

*I was arrested for ABH; I got searched and got sent to the cell. They took me upstairs for an interview and showed me photos and showed what I had done which was really horrible. I didn't feel bad. I felt scared like I could have killed them but I really felt I had got them back for how much they had hurt me.*

*Since then I've been arrested a few times ... for burglary with intent and common assault.... Then I got arrested when I had a fight with one of my friends, well she was meant to be my friend and I was so angry, people wind me up so easily and I was so angry with her, I like broke her door and stuff... then I found that breaking in somebody's door can be classed as burglary with intent. It was the YOT worker who gave me the advice. Even when I had intimidated a witness I hadn't had a solicitor, it was only after I got referred to the YOT that I found out it was a good idea to have one..... My dad came to the court but he is a drug addict and forgot to take his methadone and stuff so he was like a bit shaky.*

*The YOS [youth offending service] wanted to assess me to see if I had anything wrong because I am a bit obsessive with things like cleaning and stuff. I love AJ [YOS CAMHS worker]. They [social services] don't give you much help. They give you some money and that is it. They put me in a B&B [bed and breakfast] and I didn't want to be there.*

Would you say you have received more help or less help since you've been in touch with youth offending services?

*I have loads more because if I didn't have my YOT worker and then was homeless, who would have helped me through it? It would have been harder.*

Do you think there is any help you could have had when you were younger to stop you getting into trouble in the first place?

*I don't know – I suppose if my mum had gone for help because I was so naughty. My mum says I was like naughty since I was born. If she had gone for help then maybe she could have coped more. She tried her best. School just gave up on me.*

### **Action agenda:**

- Health and Wellbeing Boards should:
  - Work with local youth justice services to ensure the particular health needs of children and young people who offend are reflected in the JSNA and JHWS (see [www.chimat.org.uk/yj/hwbna](http://www.chimat.org.uk/yj/hwbna)), and are represented on the Health and Wellbeing Board
  - Undertake an equality impact assessment to ensure that children under the supervision of youth justice services and those identified as being at risk of offending are not marginalised, and that all services comply with the public sector equality duty

- Review CAMHS to ensure they conform to the comprehensive CAMHS model; see [www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/@ps/documents/digitalasset/dh\\_110930.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_110930.pdf) and [www.chimat.org.uk/default.aspx?QN=CAMHSTOOL](http://www.chimat.org.uk/default.aspx?QN=CAMHSTOOL)
- Ensure professional development for specialist health staff, and mental health and learning disability awareness training for specialist health staff and others working in the youth justice system
- Clinical Commissioning Groups should ensure adequate resourcing of health and wellbeing services delivered in youth offending teams and an appropriate mix of specialist expertise to deliver commissioning objectives
- The NICE Quality Outcomes Indicator Programme and Commissioning Outcomes Framework should include indicators and outcomes relating to child and adolescent mental health.

### **Planning and resourcing YOT health provision**

Levels of health resourcing per capita vary tremendously between YOTs and this is likely to continue with the increased focus on localism. The youth justice planning process, agreed by the YOT management board, is the main vehicle for deciding multi-agency inputs into the YOT and agreeing the strategy for deploying resources. The relationship between youth justice plans and other local planning processes, primarily the JSNA, is a major determinant of successful integrated working. However, it is fair to say that youth justice services have frequently not engaged in such planning processes or assessments, possibly due to a lack of awareness of their potential significance.

The requirement for local authorities and primary care trusts to draw up a JSNA was set out in the Local Government and Public Involvement Act 2007. Its purpose was to improve partnership working between local authorities, communities and the NHS to ensure better foundations for commissioning health and social care provision. The Local Government Association published an overview in 2009, *Joint Strategic Needs Assessment – Progress so Far*.<sup>32</sup> Although the overview found good progress had been made in bringing multi agency partners together, there were major concerns that the process was cumbersome and resource intensive. At its best, the JSNA process was seen to be producing well founded plans that brought together partners who previously hadn't been engaged in the wider debate about health and wellbeing; while at its worst, it was seen as another vehicle through which local battles about priorities were re-enacted.

An unpublished report produced by the Youth Justice Board (YJB) in July 2011<sup>33</sup> found alarmingly low levels of information in JSNAs about youth crime or about the health needs of children who offend. Using a representative sample of 20 local authorities, the YJB analysed the content of their JSNAs using a 'sufficiency test' to determine how much, if

any, information relating to youth offending and the health needs of young offenders was present. In only 25% of the JSNAs sampled were there deemed to be 'significant' youth justice related content and in only 10% was this deemed to be sufficient to influence the commissioning process and properly shape the required health input into YOTs.

It is therefore likely that the low levels of engagement between youth justice services and the JSNA planning process has had a detrimental impact on the planning and provision of health services for children who offend, possibly compounded by limited local information on the health needs of this group. For example, a recent report by the Prison Reform Trust<sup>34</sup> found that few YOTs were adequately identifying and recording the particular health needs of children under their supervision, with the possible exception of mental health problems.

The JSNA will continue to be the main tool for local strategic health planning. The Department of Health has published draft guidance on JSNAs<sup>35</sup> foreshadowing the statutory guidance expected later this year or early 2013. The draft guidance stresses the need for integrated services, particularly to meet the needs of the most vulnerable and those with poor health outcomes. It refers to the important role of the new directors of public health in local strategic planning to ensure better integration across local services and cites reducing crime and reoffending as an example of how alignment with other parts of the local system can produce long term health benefits. Transition of local public health functions to the new directors of public health will, it is hoped, ensure better integration across local services, overseen by Public Health England.

The refreshed JSNA planning process presents a significant opportunity for youth justice services to ensure the inclusion of offender health data in local planning processes. This will be challenging, particularly where competition for scarce resources is fierce in the face of other pressing local priorities such as tackling obesity, substance misuse and chronic physical illness. There is also a risk that YOT managers and management boards won't be sufficiently engaged with the process. It is clear from previous experience that enabling youth justice services to influence local strategic planning for health is a considerable challenge, and also indications that this is a wider problem for children's services more generally.

In its response to the public health white paper the Association of Directors of Children's Services and its adult counterpart identified this problem of potential marginalisation:

*We remain concerned that, at times, the needs and stories of children and young people .... can be lost in the accumulation of information and evidence as part of the JSNA. We strongly suggest that in any efforts to build a local evidence base through the JSNA, and in the efforts of Public Health England to build a national evidence base, full attention is given to the lives and needs of children and young people.*<sup>36</sup>

The intentions of government to improve integration through the new health delivery structure are welcomed; however, the risk remains that marginalised groups, such as children who offend, will continue to find it hard to access services. YOT management boards need to take a wider view of the health and social care needs of the YOT client group and, in particular, should address how the work of the YOT can add value to outcomes being pursued by other local boards, such as safeguarding.

The shift towards localism presents both opportunities and risks; opportunities to identify local solutions and to enhance integration, but also the risk of fragmented services and a national patchwork of provision. It is crucial therefore that youth justice services are proactive in engaging fully with the evolving health delivery landscape in their local area and, in particular, with the new Health and Wellbeing Board.

#### **Action agenda:**

- YOTs and YOT management boards should:
  - Undertake a health and wellbeing needs assessment to produce reliable information on the support needs of children and young people who offend; use these data to inform your local Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS); see *Youth Justice Health and Well-being Needs Assessment Toolkit*: [www.chimat.org.uk/yj/hwbna](http://www.chimat.org.uk/yj/hwbna)
  - Agree a strategy to ensure matters relating to youth crime, the voices of children who offend and their health and wellbeing needs are reflected in your local authority JSNA and JHWS, and are represented at the Health and Wellbeing Board
- The Department of Health should prioritise the health needs of children who offend in forthcoming guidance on JSNAs and JHWS
- The YJB should monitor youth justice input into JSNAs and highlight where needs assessments fail to take account of the particular needs of children who offend.

### **The future landscape of health delivery**

The Health and Social Care Act 2012 introduces major changes to local health and social care commissioning. Primary Care Trusts (PCTs) are being abolished and from April 2013 responsibility for commissioning health services will be transferred to Clinical Commissioning Groups (CCGs) and the NHS Commissioning Board, with local authorities assuming responsibility for public health improvement. Under the Act, Health and Wellbeing Boards will be established in every local authority area from April 2013, and many boards have been operating in a non-statutory role from April 2012.

Since the publication of the government's plans for health reform, opposition has been voiced<sup>37</sup> about the ability of local services to undertake such wide ranging reforms at a time when budgets are being cut and local services are being reconfigured to cope with the economic downturn.



In July 2011, YoungMinds published a briefing, which was based on survey results from 55 local health trusts and councils. The briefing warns of the dangers of disbanding specialist teams and reducing funding to already overstretched CAMHS, as well as the likely impact this will have on the ability of CAMHS to deliver early interventions. The briefing points out the longer term economic consequences of such short term financial cuts in mental health, increasing the risk of problems becoming ‘more serious and entrenched’.<sup>38</sup> This is of considerable relevance to children who come to the attention of youth justice services with emerging mental health problems and learning disabilities, which could, with the right intervention, be addressed – with the added benefit of reducing the risks of a wide range of longer term negative health and social outcomes as well as entrenched offending.

The role of the Care Quality Commission (CQC) is important in helping to monitor how the health needs of children and young people who offend, or are at risk of offending, are being met. The benefit of inspections of these specialised health services, by CQC, is demonstrated, in part, by progress made between the last two reviews of health care in the community for young offenders.<sup>39</sup> Given the changes to health service structures, it is important to ensure that progress made is consolidated and that any residual concerns are addressed. The CQC has recently worked alongside HMI Probation in a YOT inspection programme, the overall findings from which will be published shortly.

### **Health and Wellbeing Boards**

Health and Wellbeing Boards have a core statutory membership, including directors of children’s services, adult social services and public health, elected members, representatives from Clinical Commissioning Groups that fall within the local authority area, and local Healthwatch organisations. Although Health and Wellbeing Boards can appoint non-statutory members, there is no guarantee that there will be any direct representation of youth offending services or of justice services more generally.

Health and Wellbeing Boards will undertake JSNAs and JHWSs, which, together, will drive local commissioning policies and practice. JSNAs and JHWSs are the main mechanisms through which Health and Wellbeing Boards will engage with local partners, including youth justice.

Whilst largely welcomed for their potential to integrate the work of health and local authority children’s services, the concept of the Health and Wellbeing Board has been criticised by a number of professional bodies such as the Association of Directors of Children’s Services,<sup>40</sup> the Association of Directors of Adult Social Services, the Royal College of Paediatrics and Child Health (RCPCH) and the NHS Confederation.<sup>41</sup> The main drift of their criticisms is that the Boards have ambiguous governance structures, a confusing mixture of local and national direction and inadequate statutory powers over commissioning plans and JSNAs.

The implications of this for youth offending services are profound and local arrangements will differ depending, for example, on the effectiveness of partnership working between health and youth justice, the relationship between the YOT and children’s services, the size of the YOT, and the seniority and commitment of health representation on the YOT management board. Where there is a close alignment between children’s services and

youth justice, for example, where the YOT is part of the children's services directorate, it can be assumed that representation will be through the director of children's services. However, if the YOT is part of the community safety structure within the local authority, as many are, this could be more problematic.

The effectiveness of the new Healthwatch organisations in mitigating any potentially marginalising consequences of the reforms is, as yet, untested. For example, it is unclear how the voices of vulnerable children, especially children who offend, will be effectively represented, or how YOTs may be able to work with Healthwatch to ensure an inclusive approach is taken.

The ability to identify health needs and set local cross cutting priorities to address the health needs of any service user group will be crucial as Health and Wellbeing Boards establish themselves. The JSNA and the JHWS are crucial in ensuring the health needs of children who offend are met and the wider benefits of properly addressing such needs are fully represented in local priority setting discussions.

#### **Action agenda:**

- Youth justice inspection arrangements involving the CQC should assess the impact of NHS changes on the provision of health services to YOTs. CQC should continue to monitor how the health needs of children and young people who offend, or are at risk of offending, are being met.
- Health and Wellbeing Boards should clarify what arrangements have replaced Children's Trusts and, where necessary, set up children's committees to ensure the unique needs of children and, in particular, children who offend are taken account of. The focus of children's committees should be the planning and delivery of integrated services to deliver joined up care pathways, including timely access to CAMHS and other specialist services, improving transitions from child to adult services and building on the lessons learned from Children's Trusts (see Annex 2: Engaging children and young people).

#### **Clinical Commissioning Groups (CCGs)**

Duties relevant to youth justice placed on PCTs under the Crime and Disorder Act 1998 have been amended by the Health and Social Care Act 2012, which makes CCGs responsible. It is, as yet, unclear how these changes will be reflected in health representation on YOT management boards and in the budget for provision of YOT based health services.

CCGs will have statutory representation on Health and Wellbeing Boards. They will commission most services on behalf of patients, including treatment services for children and CAMHS, and early diagnosis as part of community health and outpatient services.

Each CCG will be responsible for, amongst other things:

- managing their budget and deciding how best to use resources to meet their patients' healthcare needs
- deciding commissioning priorities to reflect local need, supported by the NHS Commissioning Board's national framework of quality standards
- deciding which aspects of commissioning activity to undertake themselves and which require collaboration with other consortia.

A number of concerns have been voiced about the ability of CCGs to commission services for groups of patients which may not have traditionally been referred through General Practitioners (GPs). Concerns about the potentially negative impact of the health reforms on children's health more generally have been expressed by the NHS Confederation and the Royal College of Paediatrics and Child Health.<sup>42</sup>

Many conditions prevalent amongst children who offend such as mental health problems, learning disability and communication difficulties are not currently the core business of GPs, a theme reiterated by Jean Gross, the outgoing Communication Champion in her final report.<sup>43</sup> Additionally, low awareness amongst GPs of conduct disorder, ADHD and the high proportion of family and parenting problems reported as the reason for consultation, are outlined in a survey of GPs conducted for *Family Lives*.<sup>44</sup>

It is vital therefore that children's and youth justice services develop a joint approach to ensure that CCGs are made aware of the health needs of children and young people and, in particular, those who offend and who are at risk of offending. Further, the importance of integrated commissioning, to ensure that those under the supervision of the YOT receive timely and appropriate assessment and interventions, should be emphasised.

**Zac:**

Zac, aged 11 years, has received warnings for criminal damage and struggles to control his anger. He has a strong sense of guilt about family problems, including bereavement, emotional difficulties with his mother and a difficult relationship with his dad, as well as problems in school, where he has experienced serious bullying. He has recently been diagnosed with attention deficit hyperactive disorder (ADHD), for which he is on prescription medication.

Zac explained that although he did receive some support at school to control his anger, it didn't really help:

*Like they say to 'think before you do something' and stuff like that. If you are in the playground and you get into a bit of a row with somebody, you don't usually – I don't know if this sounds a bit stupid – but you don't think before you act usually and like getting told that TIME AFTER TIME AFTER TIME does get on my nerves because I've been told that so many times and it don't work. I met an education psychologist. I saw her once. It was meant to be an ongoing thing but she never came back.*

Zac added that he gets upset if his friends ‘don’t want to play’ with him and that he ‘bottles things up inside’. He explained that he would like somebody ‘like a social worker’ to visit him at home, somebody who would:

*Just like, play .... I’m not dissing my mum and dad or anything but we don’t get to play board games much so to play board games with someone would be good. Something like that.*

#### **Action agenda:**

- CCGs should work closely with, or consider delegating to, an expert group of local authority and NHS children’s commissioners to commission services for children with mental health problems, learning disabilities and communication difficulties; such a group could agree a youth offending service commissioning plan, and manage aligned or pooled budgets
- YOTs and YOT management boards should arrange to meet with local CCGs to discuss the particular health and wellbeing needs of children who offend and those at risk of offending
- The Department of Health should deliver on its commitment made in *Healthy Children, Safer Communities* to produce new guidance for commissioners on meeting the challenges of commissioning health services for children and young people in the youth justice system.

### **Liaison and diversion services**

The establishment of liaison and diversion services to provide support for vulnerable suspects and defendants was recommended in the Reed Review (1992). However, services have been patchy and, in the main, concentrated on adult defendants with mental health problems.

In recent years Youth Justice Liaison and Diversion (YJLD) services have been piloted, which created opportunities to reduce further the number of children being inappropriately dealt with in the youth justice system and to promote a wider range of preventive outcomes for children at high risk of offending. Indeed the case for the universal application of such services where children are concerned is compelling, especially as a means of ensuring those with mental health problems and learning disabilities are appropriately referred into therapeutic pathways. However, a recent evaluation<sup>45</sup> of six YJLD pilots proved inconclusive due to the small size of the cohort and difficulties in establishing matched comparator groups. Although the evaluation found no significant reductions in reoffending, it does identify a significant slowing down in the rate of reoffending and some promising health improvements.

Following Lord Bradley's review,<sup>46</sup> and work by the *Care not Custody* coalition led by the National Federation of Women's Institutes and the Prison Reform Trust, the government made a commitment to establish liaison and diversion services across England by 2014. A major role for liaison and diversion services will be to assist criminal justice staff – and police custody officers in particular – to identify suspects and defendants with mental health problems, learning disabilities and other impairments and support needs, and to provide information on appropriate interventions and referral routes for specialist services.

Under this new arrangement, liaison and diversion services for children and adults will be brought together under one overall provision and a model is currently being developed by the Offender Health Collaborative,<sup>47</sup> on behalf of the Department of Health. There are obvious advantages to one overall provision such as bridging the transition gap frequently experienced between children's and adult services. However it will be important to ensure that the different and particular needs of children who offend are prioritised and properly addressed.

#### **Youth Justice Liaison and Diversion (YJLD) point of arrest scheme:**

James was referred to the YJLD after being bailed by the police for an alleged offence of shop lifting. Prior to this referral, James had received a Reprimand and a Final Warning.

The YJLD worker visited James and his family at home and completed an assessment that identified possible problems with cannabis use, negative peer influences and anger management. James expressed fears about what would happen if he really 'lost it'.

The YJLD worker arranged for the mental health specialist attached to the YJLD to visit James at home to assess his needs in greater detail. The assessment led to a referral to Child and Adolescent Mental Health Services (CAMHS) for suspected attention deficit hyperactivity disorder (ADHD). While waiting for his appointment with CAMHS James received support from the YJLD worker; he met youth offending service prevention workers to address his offending behaviour and substance misuse workers to address his use of cannabis.

The YJLD worker attended the first CAMHS appointment with James and his mother.

James engaged well with the support offered and, influenced by this, the police took no further action. Since then, James has not reoffended, his cannabis use has decreased and he has not been involved in any anti-social behaviour.

Material provided by the Centre for Mental Health.

### Action agenda:

- YOTs and YOT management boards should work with local liaison and diversion pilots to highlight the health benefits of early interventions for children who offend or who are at risk of offending; see *Youth Justice Liaison Diversion Practical Toolkit*: [www.chimat.org.uk/yj/toolkit](http://www.chimat.org.uk/yj/toolkit)
- The Department of Health should work with the Offender Health Collaborative to ensure age-appropriate liaison and diversion services for children and young people.

## Police and Crime Commissioners

The government's plans for Police and Crime Commissioners (PCCs) were published in Police Reform and Social Responsibility Bill (2010).<sup>48</sup> The intention is to improve the accountability of the police by having a locally elected, highly visible figure to hold chief constables to account and give local people a voice in influencing police and crime strategy. Following elections in November 2012, their powers will include:

- Appointing their area chief constable
- Setting out a five-year police and crime plan
- Determining local policing priorities, in consultation with the chief constable
- Commissioning policing services from the chief constable (or other providers), in consultation with the chief constable.

It is difficult to envisage exactly what impact PCCs will have, but according to the Home Office:

*PCCs will be a significantly more visible and able advocate of the public voice as well as representing better value for money than their overly bureaucratic counterpart currently in place.*<sup>49</sup>

Bodies such as the Association of Chief Police Officers (ACPO) have given the idea a lukewarm reception,<sup>50</sup> with concerns about dilution of accountability and political interference in the operational decisions of the chief constable.

It is equally difficult to predict what impact they might have on youth justice and health services locally. But it is clear that PCCs will be elected on promises to deal with pressing local issues and priorities so it is highly probable that youth crime and antisocial behaviour will feature in the plans.

PCCs will have the budget for drug and substance misuse services and some youth crime prevention work, estimated to be around 13% of the funding currently going to YOTs. So decisions about how this will be used locally will be under their influence. Given the historically high proportion of all children and young person's drug and substance misuse

referrals coming from YOTs (around a third) and the vital role of prevention services in heading off children destined to enter the youth justice system, this is a significant change.

Although chief constables will seek to maintain their operational independence, PCCs will influence how policing will be approached in line with local public opinion. It is therefore likely, for example, that PCCs will influence the extent to which a police force uses restorative justice approaches in favour of putting low level (young) offenders through the justice system; and will have a view on the extent to which liaison and diversion is used to ensure offenders, including children and young people, with mental health problems and learning disabilities are dealt with outside the criminal justice system.

The Youth Justice Board has helpfully produced an information pack to help YOTs and their partners develop a business case to take to PCCs, once elected, to try and secure funding for targeted prevention and early intervention; see [www.justice.gov.uk/downloads/pcc/making-the-case-pcc-funding-template.ppt](http://www.justice.gov.uk/downloads/pcc/making-the-case-pcc-funding-template.ppt)

**Action agenda:**

- YOTs and YOT management boards whose area is covered by the same PCC should work together to influence their Commissioner's policy and funding decisions; see [www.justice.gov.uk/downloads/pcc/making-the-case-pcc-funding-template.ppt](http://www.justice.gov.uk/downloads/pcc/making-the-case-pcc-funding-template.ppt)

## **ANNEX 1**

### **Examples of good practice**

#### **Exemplar 1:**

#### **Nottinghamshire – a comprehensive approach to meeting the health needs of young people who offend**

**Source: Laurence Jones, YOT manager**

Through the documentation produced by a number of different agencies in Nottinghamshire over the last two years it is possible to identify a constant thread from the highest level policy documents to those which directly drive operations. This demonstrates the use of joint commissioning based on comprehensive needs assessment, supporting integrated services funded where necessary by pooled budgets. There is also evidence in these documents of a clear read-across between the JSNA, the CAMHS Strategy and the Youth Crime Strategy:

#### **Nottinghamshire County Joint Strategic Needs Assessment – children and young people – September 2010**

[www.nottinghamshire.gov.uk/home/youandyourcommunity/factsaboutnotts.htm#jsna](http://www.nottinghamshire.gov.uk/home/youandyourcommunity/factsaboutnotts.htm#jsna)

Section 5.1 gives a very comprehensive coverage of youth justice issues with some key messages for planners based on local priorities. The section contains key data on offending and reoffending levels, types of offences, age, gender and ethnicity break down of young offenders by crime and disorder reduction partnership area. The predominant health and substance misuse issues are described, including references to mental health, depression and behavioural disorders.

This represents an excellent foundation of evidence to influence commissioning decisions.

#### **Nottinghamshire County CAMHS Strategy 2011-2013**

[www.nottinghamshire.gov.uk/home/learningandwork/childrenstrust/childrenyoungpeopleandfamiliesplan/improvechildrenandyoungpeoplesemoionalwellbeing.htm](http://www.nottinghamshire.gov.uk/home/learningandwork/childrenstrust/childrenyoungpeopleandfamiliesplan/improvechildrenandyoungpeoplesemoionalwellbeing.htm)

Outlines a joint commissioning approach to CAMHS. The Nottinghamshire CAMHS joint commissioning group reports to the Health and Wellbeing Board via the Children's Trust executive. The Strategy describes an 'Inclusive approach to vulnerability' and applies a broad descriptor of 'vulnerable children and young people' as an inclusive statement. It acknowledges that children and young people may present with a number of vulnerabilities which may include: looked after children, young offenders/ those at risk of offending, children and young people who have learning and or physical disability etc.

The need to retain a culture of integration across the range of providers of CAMHS is emphasised as a prerequisite of integrated delivery, especially in the



current climate of NHS organisational change. The Commissioning Group/Partnership needs to reflect new commissioning arrangements and have strong engagement from school commissioners, clinical commissioning groups and adult services. It describes a commitment to the joint commissioning and delivery of an integrated, whole system CAMHS, across Nottinghamshire, with the development of aligned/pooled budgets with clear commissioner responsibilities.

### **Nottinghamshire Youth Crime Strategy 2010 – 2013**

[www.nottinghamshire.gov.uk/item6nottsyouthcrimestrategy20102013.pdf](http://www.nottinghamshire.gov.uk/item6nottsyouthcrimestrategy20102013.pdf)

#### ***'Improving the health outcomes of young people who offend***

*A comprehensive assessment of health needs amongst young people who offend was carried out by Public Health in 2009. An Action Plan and Commissioning Plan have been set up to address these areas of need. Key to success is the improvement of health assessments and the sharing of information. Our strategy will be to move increasingly towards key information available to the YOS and key health professionals located on a single accessible information system. The quality of health assessment will be improved by additional specialist expertise in the YOS, commissioned by the Primary Care Trusts (PCTs), DAAT or the YOS itself, and specific ongoing health training for all staff.*

*The formulation of a YOS Health Forum will bring together key managers to coordinate all of the strands of work.'*

### **Health Needs Assessment – Nottinghamshire Youth Offending Service – May 2009**

This corporate health needs assessment was initiated at the request of the Youth Offending Service in Nottinghamshire. The purpose was to establish the health needs of the young people in its care, provide key findings and subsequent recommendations to shape future service provision.

The health needs assessment was conducted using data from the Youth Offending Service database ASSET, Children and Adolescent Mental Health Service (CAMHS), Face It (drug and alcohol service) and baseline data from the Joint Strategic Needs Assessment were to identify areas of health need, good practice and any gaps in the provision or uptake of health services.

It took into account the views of service users and their parents as well as a variety of YOS and health practitioners. This was supported by quantitative data covering offending statistics and information on specific health needs such as physical health, addictions, ADHD, ASD and sexual health.

The needs assessment was used by the YOS management board to influence commissioning decisions

## **Health Commissioning Plan within Nottinghamshire County Youth offending Service (YOS) (July 2009)**

The YOS commissioning plan sets out the agreed commissioning objectives, desired outcomes, what will be commissioned and from whom and how its effectiveness will be monitored and measured.

### **Exemplar 2:**

#### **Hampshire YOT health provision**

##### **Source: Ian Langley, YOT manager**

Hampshire YOT has been recently formed following the disaggregation of Wessex YOT into its four constituent authorities, Southampton, Portsmouth, Isle of Wight and Hampshire. Under previous arrangements healthcare input was provided by two NHS regions, Hampshire and Solent. Now it will come solely from Hants NHS region which has boundaries coterminous with the YOT. The YOT is divided into four geographically determined operational areas and each has its own full time mental health worker supported by generic YOT health workers. They cover the whole range of referral, assessment and court work and are managed by a health team leader who divides her time equally between youth justice and safeguarding. The YOT is also involved in delivering the young people's substance misuse contract in the county.

Ian Langley regards the working relationship between his service and health as good and is satisfied with the specialist staff he has available to him. Health input into the YOT is commissioned through Hampshire's Joint Children's Commissioning Team which is a collaboration between NHS Hampshire and Hampshire County Council, responsible for:

- Children with complex needs
- Safeguarding children, including forensic services
- Palliative care and end of life care
- Child and Adolescent Mental Health Services including healthcare provision for young offenders and young people with learning disabilities
- Early intervention and prevention

These resources are however enhanced by the provision of a forensic psychiatric team provided by the South Central Specialised Commissioning Group, consisting of two part time consultant psychiatrists supported by a mental health nurse. They also provide the forensic input into Swanwick Lodge secure children's home which is located in the county. The value in having this specialist capacity is that complex cases can be dealt with more quickly, the forensic team can input into pre-sentence reports where mental health may have been a salient factor. An agreement with the courts means that the forensic service can be called upon to provide input rather than commissioning a full psychiatric report, thereby reducing delays and costs. Further added value is provided by the 'Bluebird Unit', a secure adolescent mental health facility located in the county.

The newly configured Hampshire YOT management board will have senior health input from NHS Hampshire's children's partnership manager who is directly involved in commissioning and therefore well positioned to influence health commissioning decisions in relation to the YOT. They are forming a health sub committee and will shortly undertake a YOT health needs assessment in preparation for the round of strategic planning to inform the JSNA and the health and wellbeing plan. The one area of unmet need identified by the YOT manager is speech, language and communication where there is currently no provision available to the YOT.

Ian Langley is optimistic that due to the pre-existing robust relationship between youth justice, children's services and health in Hampshire, making the transition into the new health structures shouldn't be too problematic although he acknowledges the lack of any clear guidance from the centre about how YOTs should be approaching these challenges.

### **Exemplar 3:**

**A guide for commissioners of children's, young people's and maternal health and wellbeing services commissioned by the north west children, young people and maternal health board (June 2010)**

**Source: Nicola Ellis Primary Health Care Lead, Regional Offender Health Team, NHS North West.**

### **Case Study 24:**

*What works to improve health outcomes for young people in the youth justice system?*

#### ***Why was improvement needed?***

*The national report, Actions Speak Louder, on the quality of health provision within youth offending teams (YOTs) was critical of the partnership working, levels of cooperation and investment in health services in the youth justice arena. The health and wellbeing issues of children and young people in the youth justice system are well known.*

#### ***What was done?***

*The North West Regional Youth Offender Health Team and the North West Youth Justice Board agreed to develop a framework, including a performance audit tool, to examine the issues raised in Actions Speak Louder.*

*The tool was developed with youth offending team (YOT) nurses, heads of service and operational managers. It provides all partner agencies with a framework to address the health issues posed by children and young people within the community youth justice arena, whether they are offending or at risk of offending.*

**What difference did it make?**

*The audit tool provides YOT managers with clear guidance about expectations of their health partners, and gives health services a clear guide to their role within youth justice. Commissioners can use the findings from the tool for contract monitoring, gap analysis and reinvestment. It also sets out the expectations from provider services that can use the outcomes from the audit for service improvement.*

**What next?**

*The tool and guidance has been circulated and audits will take place from early 2011, with the findings shared regionally and nationally with the Youth Justice Board. The tool has been recommended for inclusion in forthcoming commissioning guidance to support implementation of the Healthy Children, Safer Communities Strategy.'*

## ANNEX 2

### Engaging children and young people

Involving children and young people in the commissioning, delivery and evaluation of their health services ensures that these services are best placed to meet their needs. Children and young people are the experts when it comes to ensuring high quality services that are accessible and work well for them, so their involvement should be a key part of service design and delivery.

Structures of meaningful involvement:

- At an individual level – ensuring children and young people have the opportunity to be part of decisions around the care/support/treatment; shared decision making
- At an organisational level – children and young people participating in staff recruitment and selection, staff training and the development of policies and procedures.
- At a strategic level – children and young people participating in the planning and development of future services.

Giving children and young people the opportunity to participate in this way requires careful thought and consideration to ensure their involvement is meaningful and does not fall into the trap of being tokenistic. It can be helpful to consider these points:

- The first step in involving children and young people is making information, choices and decisions ‘accessible’
- Research existing practice in your local area. Most local authorities have participation workers and structures such as Youth Councils – they may be able to give you advice and support and there may be opportunities for collaboration
- Start small – choose one or two areas to focus on with clearly assigned staff lead, tasks and desired outcomes
- Focus on purpose and outcomes – aim to develop participation structures/practices which are meaningful to service users and to the service
- Be honest with young people about the limits to their involvement and set realistic expectations
- Be flexible – meaningful participation takes many forms and careful thought needs to be given to the most appropriate method of engagement.

To hear what young people have to say about their participation, see:

[www.youtube.com/watch?v=KPjsH8v0CTo&list=UUBrcD2CYLBN8v9c7fxRqQAw&index=16&feature=plcp](https://www.youtube.com/watch?v=KPjsH8v0CTo&list=UUBrcD2CYLBN8v9c7fxRqQAw&index=16&feature=plcp)

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