

# ACTIONS SPEAK **LOUDER**

A second review of healthcare in the community  
for young people who offend



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# Foreword

This report by the Healthcare Commission and Her Majesty's Inspectorate of Probation follows our review published in October 2006, and evaluates the last phase of a five-year inspection cycle that began in September 2003. It highlights the changes that have taken place in healthcare in the community for children and young people who had been involved, or were likely to become involved, in offending behaviour since the first phase of the inspection cycle. It also makes recommendations to help the organisations involved make further improvements.

The majority of children and young people who have offended, or who are likely to, have more health needs than those who have not offended. These needs span a range of physical, emotional and mental health areas and substance misuse problems, and are potentially linked to crime. They have to be recognised and addressed in order to increase the likelihood of making the lives of these children and young people better and free of crime.

Our report looks at how much health services contribute to addressing health needs through their involvement in youth offending work in their local areas. It is primarily based on the inspections we carried out in the last phase of the programme (phase 4) and focuses on youth offending teams in England. Healthcare Inspectorate Wales has been responsible for the contribution to inspections in Wales since April 2008.

It was very disappointing for us to find that insufficient progress has been made in many key elements over the course of this cycle of inspections, and following our previous review report. The patchy nature of the improvements we have identified simply reinforces our continuing concerns about health inequalities in this field.

We hope that our recommendations will help partners within the Government, NHS trusts and youth offending management boards to work together more effectively to improve services for this vulnerable group of children and young people.

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Chief Executive  
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# Summary

Youth offending teams (YOT)<sup>1</sup> were established in every local authority in England and Wales, following the Crime and Disorder Act 1998. They are statutory bodies that include representatives from health, education, police, and probation services, social services and drugs and alcohol misuse services. Each YOT has a manager who is responsible for coordinating the work of the youth justice services. YOTs are critical in assessing the needs of children and young people under their supervision and directing them to help in addressing their offending behaviour. Healthcare organisations (chiefly primary care trusts) are expected to make specific and significant contributions towards the effective assessment of the health needs of children and young people, and the provision of appropriate and accessible services to meet those needs. The Healthcare Commission is a key partner in the five-year inspection programme of YOTs, which is led by Her Majesty's Inspectorate of Probation.

We highlighted in 2006 that, of the YOT partners, healthcare organisations received the second highest number of recommendations for improvement as a result of our joint inspections. In this report, we review progress against some of these issues and make robust recommendations for improvement. The purpose of our inspections is to help improve the nature and quality of the services that children and young people receive, so, in this report, we are focusing on those aspects that we found needed to improve. We also highlight some examples of good practice, which are taken from published reports in the last phase of the inspection programme.

<sup>1</sup> In this report we will generally refer to YOTs, although more recently the term youth offending service (YOS) is being increasingly used to describe the provision offered to those children and young people who offend or may be likely to offend.

## Key findings

Insufficient progress has been made in the provision of healthcare to YOTs between the first and the last phase of our five-year inspection programme. Services for substance misuse, for example, were more established in YOTs and were providing a consistent and timely service to those who have offended. But although health services provided a good standard of information about substance misuse to children and young people, they did not always carry out the prevention work necessary. Where there are gaps in the resources of health services, it is often prevention work that gets reduced, despite this being a key factor in positively influencing the behaviour of future potential offenders.

### Health assessments

We found that the nature and quality of initial health assessments, both in prevention work and in relation to those who have offended, were too frequently inadequate. Health staff have not provided people who work in YOTs with sufficient training and updates to enable them to carry out timely, consistent and accurate initial assessments. This can prevent children and young people from being referred to health specialists for further assessment, which means that their needs remain unmet. Even when the YOT made a referral, we found that specialist services did not always respond and provide the requested assessments. We did find examples of good assessments, referrals and appropriate interventions taking place, but they were not sufficiently widespread.

### Court work

Court work was not well served by health services. Packages of support for people on bail very rarely contained health interventions. Only a third of court reports represented individuals' health needs accurately, and they rarely contained a health report as a supplement, or addendum. Although we found examples of health staff liaising well with magistrates and other court officials, and offering them excellent training, this was not common.

### Transitions between the community and custody

We found problems relating to when young people transfer between the community and custodial settings. Staff in the two settings were not routinely exchanging information, and their lack of contact often meant that they were unable to engage appropriately with young people at points of transition. However, our inspections found that individuals who misused substances received better support than before, particularly from teams who provide resettlement and aftercare services.

### Management boards

Health service managers' commitment and involvement in the management boards of YOTs has improved, although their attendance could still be erratic.

Health service managers and YOTs' management boards are certainly beginning to challenge the outcomes of health interventions more robustly, although this encouraging development is generally still at an early stage. There was a significant lack of widespread monitoring and evaluation of health services provided to YOTs, which prevents interventions from being tailored to meet the needs of children and young people.

### **Funding and resources**

Resourcing for YOTs by health services has increased in some areas, but was still inadequate in nearly half of the YOTs inspected for this review. The national average for this financial contribution has also fallen significantly since our first review.

Although the provision of healthcare within YOTs has improved, to some extent, since our initial review, 10% of YOTs still had no mental health worker on site and 30% did not have a resource for general health nursing. The most recent Youth Justice Board figures (December 2008) indicated that 24 YOTs had no health worker on site, despite this being a statutory expectation. Although universal services, such as child and adolescent mental health services, GPs, opticians and dentists, had contingency plans in place to support some of these YOTs, this was hampered by staff vacancies. Our inspectors have seen improvements in relation to the links and provision of health services from outside the YOT, but there are still some problems, particularly with the access and support that child and adolescent mental health services gave to 16–18 year olds. One positive finding from our inspections was that the availability of support for those with substance misuse problems has increased and was more consistently applied throughout the country.

What is clear from our review is that the statutory requirement that this vulnerable group of children and young people should receive a consistent level of healthcare remained unmet. There were gaps in provision and clear inequalities across a range of local authorities. Consequently, core health standards (Ref. 1) were not met. It is important, for example, to make sure that children and young people who have offended, or who are likely to offend, are safeguarded through accurate, consistent assessments of their health needs. Equally important is the need for professionals to ensure that they exchange information effectively with each other.

## Recommendations

### **Primary care trusts (PCTs), YOT managers, court services, drug and alcohol teams and mental health trusts working with YOTs should ensure that:**

- Preventative services are improved so that children and young people's health needs are accurately assessed and appropriate interventions are provided.
- Health services, in conjunction with YOTs, carry out thorough assessments of generic health needs within youth offending services.
- YOT staff, who have been trained well, carry out initial assessments of health needs, using recognised assessment tools. Referrals to specialist health workers need to be carried out consistently where required.
- Court services are encouraged to consider health needs more consistently by receiving training and also through health information being included in packages of support for people on bail and in pre-sentence reports where required.
- Health services have appropriate, and sufficiently senior, representatives on youth offending management boards. These should include people from all health agencies involved in the YOT, including substance misuse services.

### **PCTs working with YOTs should ensure that:**

- Sufficient resources are provided to identify and meet specific health needs, including the provision of health workers in YOTs as appropriate to the size of the YOT.

### **PCTs, mental health trusts, the Youth Justice Board and YOTs should ensure that:**

- YOT health workers and staff in secure establishments communicate with each other effectively to ensure that children and young people experience positive health transitions between different environments.

### **Child and adolescent mental health services (CAMHS) working with YOTs should ensure that:**

- All children and young people up to the age of 18 who require appropriate intervention can receive access and support from CAMHS, including clear pathways for referrals.
- Transitions from child-centred to adult-oriented mental health services take place with care and sensitivity.

### **Management boards of YOTs and PCTs should ensure that:**

- Service level agreements and relevant protocols are in place between health services and YOTs.
- Protocols for sharing information between health services and YOTs are introduced as a matter of urgency where these do not exist.

- The contribution of health services to the aims and objectives of YOTs is consistently monitored and evaluated.

**The Department of Health, the Department for Children, Schools and Families, the Ministry of Justice and the Youth Justice Board should ensure that:**

- There is a consistent framework and explicit standards for health services to improve health outcomes and contribute effectively to a reduction in youth offending.
- Assessment tools are reviewed to ensure that they are fit for purpose and can be used consistently.
- Analyses of health needs are carried out in each YOT and that there are sufficient resources provided to meet identified needs either directly or through access to, and support from, universal services.
- There are clearer measures of performance about access to health services and how those services contribute to the work of YOTs.

**Strategic health authorities should ensure that they:**

- Demonstrate oversight and performance management of the health services' contribution to youth offending services.

**The Care Quality Commission should ensure that:**

- It continues the contribution of the Healthcare Commission to inspections of YOTs in order to monitor improvement against the recommendations in this report.

# Introduction

“The risk factors for youth offending and substance abuse overlap to a very large degree with those for educational underachievement, young parenthood, and adolescent mental health problems. Action taken to address these risk factors (and to increase levels of protection) therefore helps to prevent a range of negative outcomes. Moreover, because these outcomes are closely related (anti-social behaviour is strongly correlated with heavy alcohol consumption, for example, and vice versa), this broad based approach to prevention offers the greatest prospect of securing lasting reductions in offending behaviour.”

*(Risk and protective factors, Youth Justice Board, 2005)*

In October 2006, the Healthcare Commission and Her Majesty's Inspectorate of Probation (HMI Probation) jointly published a review of healthcare in the community for children and young people who offend. This document looked at the role and contribution made by healthcare organisations to the work of youth offending teams (YOTs) during the first phase of a five-year programme of inspection led by HMI Probation.

YOTs were established in 1998 under the Crime and Disorder Act in order to divert and prevent children and young people from engaging in offending behaviour<sup>2</sup>. The agencies that are expected to contribute to these teams include social services, education, health, the police and probation, so that a variety of needs can be met.

Our first report analysed the findings from the inspections of the first 50 YOTs in England and Wales between September 2003 and April 2006. We identified specific needs for this vulnerable group, which included emotional and mental health needs, substance misuse problems and having learning difficulties and disabilities. The review was prompted by the fact that health services, at that time, were receiving more recommendations in inspection reports than any other agency, apart from the police.

A number of explicit recommendations were made in the 2006 report including the need for:

- Primary care trusts (PCTs) to ensure that they fulfilled their statutory duty to provide at least one healthcare worker to their local YOT.
- PCTs to ensure their representation on YOTs' management boards.
- YOTs and healthcare services to increase the use of protocols and service level agreements between themselves.
- Local healthcare organisations to improve their provision of services to YOTs.
- YOTs and health services to share information better.
- Health services to assess health needs better.
- Health services to improve the evaluation of services.

This new report is primarily based on an analysis of the findings of the last phase of the five-year inspection cycle (phase 4 – April 2007 to September 2008). This covers about the last 50 inspections carried out. We have assessed the progress that has been made between the two reviews and highlighted the issues that remain. We have also made further recommendations for improving the contribution provided by health services to YOTs.

<sup>2</sup> See Appendix C of the Crime and Disorder Act 1998 (extract). This emphasised the partnership nature of both the operational and strategic structures, of which health formed a very important part.

## Health services and youth offending

It may be useful, at this point, to demonstrate how health services can be involved in the pathway of children and young people who are believed by different agencies to be likely to offend. Health workers in schools or early years facilities can, for example, identify initial issues and intervene to support families before possible escalation. Children's services can also identify early needs for intervention and employ a lead health professional through the use of the CAF process (Common Assessment Framework). Early intervention will generally be with primary health services in the community, but sometimes there is access to specialist health workers within YOTs. Health services and YOT health workers are likely to be directly involved, where this is seen to be appropriate, once children and young people are involved with anti-social behaviour, or when they begin to offend.

An assessment of health needs and possible interventions can again take place when a child or young person is charged and then remanded on bail or in custody. Court reports, prior to sentence, should also contain relevant health information to assist magistrates in sentencing. A community order or a custodial sentence may also involve external health services (substance misuse, psychological or psychiatric services, for example) and YOT health workers in order to meet health needs, particularly where these are clearly linked to offending behaviour. The YOT health practitioner, indeed, should be the key link worker for transitions between the community and custody, or other secure environments, and also central to the release process in appropriate circumstances.

There have been a limited number of explicit expectations or standards on healthcare services in relation to youth offending services and this has contributed to developments being made inconsistently. The Crime and Disorder Act 1998 placed a duty on the former health authorities to cooperate in the establishment of YOTs. It set the expectation that this cooperation would be fulfilled through authorities participating in the steering group, and contributing to the funding and the provision of at least one health worker. Subsequent inter-departmental guidance (Ref. 2) clarified a number of aspects, including the role of healthcare staff and how information should be shared. A great degree of flexibility, however, remains in relation to the development of individual frameworks delivering health interventions.

The responsibilities outlined have now, effectively, been transferred from health authorities to PCTs. Indeed, a number of inspections highlighted the negative effect that successive health reorganisations had on continued and consistent involvement with YOTs. The complexity of commissioning arrangements and changes in responsibility was sharply highlighted in inspections, where some health representatives on YOTs' management boards had no clear idea of the expectations on them in relation to those children and young people who are involved with YOTs. Similarly, the increasing focus on youth offending in, for example, the Improving Health, Supporting Justice consultation and strategy, and the Youth Crime Action Plan was not generally well understood.

The few explicit measures collated by the Youth Justice Board (YJB), in addition to the funding contribution and the provision of health workers, effectively relate to the timeliness of health referrals and interventions with both mental health and substance misuse cases<sup>3</sup>. There is, however, an issue with the figures gathered, since there was no widespread understanding of the criteria used for measurement in relation to mental health. Inspectors found that one service would understand a 'formal assessment' as the point that a specialist child and adolescent mental health (CAMHS) worker looked at a referral form, whereas another service would understand the formal assessment as beginning when the young person was seen by a CAMHS worker. The reliability of this measure was therefore questionable, given the variety of interpretations, particularly in relation to mental health assessments and interventions. These explicit health performance measures no longer exist and although the new local area agreement national indicator set contains YJB standards, there are none that relate directly to health services within YOTs.

### **The aim of this review**

This report follows up the preliminary assessment of the extent to which healthcare organisations have been successful in meeting their responsibilities. It allows us to look at the health aspects of the whole five-year inspection cycle and to judge how well healthcare organisations have contributed to youth offending services at both a strategic and operational level. We are also able to identify good practice and to make further recommendations.

### **The nature of inspections**

Although our inspection methodology has changed during the course of the five-year inspection cycle, in all the phases each YOT was judged against a set of criteria that outlined the inspectorate's expectations of how it should operate. Throughout, the inspection remained targeted on the delivery of services to those children and young people who were either likely to offend or who had already offended, but the number of cases in the sample increased and the inspection tools were more sharply focused.

<sup>3</sup>The YJB target for CAMHS was to ensure that 100% of young people assessed by ASSET (and the mental health assessment tool) as manifesting acute mental health difficulties are referred for a formal assessment by CAMHS within five working days and nonacute concerns are referred within 15 working days. With substance misuse, the expectation was clearer on receiving a formal assessment within five working days and intervention and treatment, where necessary, within 10 working days.

Health inspectors, during this final phase, looked at a range of random cases (now including prevention, community order and custodial cases), examined files<sup>4</sup> and interrogated key workers and case managers. They also continued to evaluate evidence provided in advance, as well as supplementary information, and discussed issues with health workers and health managers before contributing to the final inspection report. Health information in inspection reports was also analysed in relation to core health standards and contributed to the verification of the self-reported annual health check. Probation inspectors undertook interviews with service users, and information from this exercise will be described in a report covering the whole five years of the programme, published by Her Majesty's Inspectorate of Probation in March 2009.

For this review, the inspection reports from 2007 and 2008 were analysed with a small number of re-inspections from the same period. Additional information was also collated from our experiences of inspecting YOTs over the final phase. Some of the combined statistics from the health aspects of all the case management inspections<sup>5</sup> carried out by health, education and probation inspectors have also been considered. Our findings in this and the previous review provide a comprehensive overview of the health-related issues affecting youth offending services, and this report includes some significant recommendations for improvement.

<sup>4</sup> This was from a total of 189 case files having been examined in inspections.

<sup>5</sup> This was from a total of 3,370 case files having been examined in inspections.

# Findings

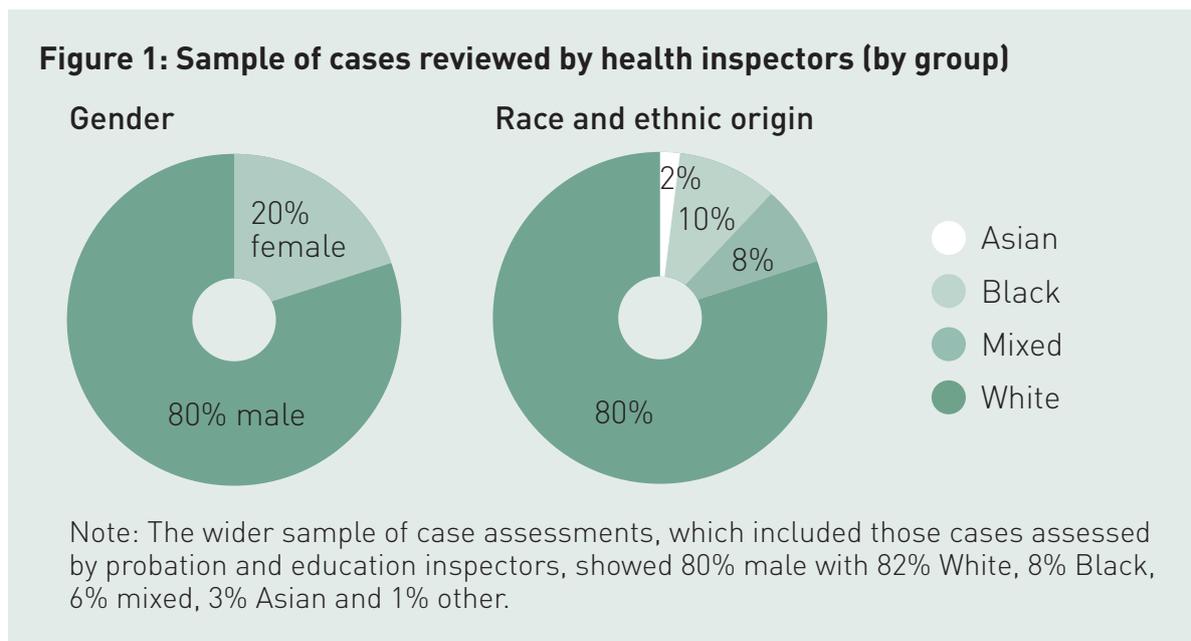
Our findings follow the format used in the phase 4 inspection reports. They will be broken down into:

- Work in the courts.
- Work with children and young people in the community.
- Work with children and young people subject to custodial sentences.
- Victims and restorative justice.
- Management and leadership.

Since we believe strongly in the importance of positive improvement through inspection, we include good practice in this report, alongside comments on areas that would benefit from further change and improvement.

## Contextual data from our case assessments

The majority of cases our health inspectors looked at were white males (figure 1) although specific inspections did highlight some difficulties in designing appropriate interventions with females, particularly in relation to alcohol and drug misuse.



There have been good examples of interventions designed to meet the specific needs of minority groups.

### Good practice from inspection reports

“A young Muslim girl, who was referred for a health review to the youth offending service nurse, disclosed having unprotected sexual intercourse. Good, sensitive, effective and coordinated work took place between the nurse, social worker and the young person in investigating the background to this issue while protecting and supporting the young girl.”

“The health workers aimed to provide a service that addressed individual and diverse needs. They were active in supporting young women with appropriate sexual health advice, and were involved in the sexual exploitation strategic group, linking with the local safeguarding children board.”

“There was proactive identification of general health needs and good liaison with GPs and general paediatrics, with access to a specialist black and minority ethnic worker, needle exchange and smoking cessation services.”

A total of 61% of children and young people whose cases were reviewed by health inspectors were in full-time education and 35% were unemployed or ‘other’ (figure 2). Clearly there is a significant issue here in terms of economic wellbeing for those children and young people who have offended or who are likely to, which needs to be more fully addressed.<sup>6</sup>

**Figure 2: Sample of cases reviewed by health inspectors (by occupation)**



Note: Figures for the wider sample of cases showed 58% in full-time education or training with 6% in employment and 27% unemployed or ‘other’. The remaining percentage relates to part-time education or training. The number of cases reviewed by health inspectors used in this analysis numbered 189.

<sup>6</sup> This will be analysed further in a report on phase 4 inspections by Ofsted and HMI Probation, expected in early 2009.

Of the children and young people whose cases our health inspectors looked at, nearly a quarter were assessed as having some form of disability. Half of those related to a learning disability, a fifth had a physical impairment and the rest had a disability linked to their mental health or emotional state. In the total number of cases reviewed by both health inspectors and Her Majesty's Inspectorate of Probation inspectors in phase 4, 17% were assessed as having a disability with a quarter of those exhibiting issues linked to their mental health or emotional state.<sup>7</sup> A considerable number of children and young people displaying offending behaviour therefore have identifiable health issues. The overall number, however, may be higher, since we also found that many health needs were not being reliably assessed or, in the case of physical health, too often ignored.

There is still a significant percentage of children and young people who are 'looked-after'<sup>8</sup> who come into contact with YOTs. Twelve per cent of all the children and young people (from a random sample) whose cases were investigated were either accommodated and maintained via a care order, or remanded in local authority accommodation.

In phase 4, we also considered what the nature of the original offence was of the young people whose cases we examined. The highest percentage of the total (30%) related to violence against the person, and the second highest (16%) involved theft and handling stolen goods. Specific drug offences amounted to 4% of the total while criminal damage was 10% overall. For those children and young people with custodial sentences, the majority who had been released into the community on community supervision had conditions, or an intensive supervision and surveillance programme, attached to that order.

## Prevention

In all cases relating to prevention in phase 4, there was evidence of specific physical health needs (scoring above 3 using the YJB 'Onset'<sup>9</sup>) in 15% of the cases. There was additional evidence of emotional and mental health needs in 50% of the cases and evidence of substance misuse needs in 15% of cases (out of 554 prevention cases providing relevant data for this analysis). Less than half of these cases were subsequently referred to mainstream health services.

The percentage of cases where there was evidence of an intervention being delivered in relation to physical health only amounted to 9%; for emotional and mental health, the percentage was 26%; and for substance misuse, the percentage

<sup>7</sup> This was from a total of 3,370 cases having been examined in inspections.

<sup>8</sup> Those children and young people who are accommodated by a local authority.

<sup>9</sup> Onset is a YJB assessment tool used for those who may offend – the YJB indicates that an assessment score of 3 or more should lead to a referral for a more thorough assessment by a specialist health worker. The scale is 0-4 where 0 is not associated with the likelihood of offending and 4 is very strongly associated with the likelihood of offending.

only amounted to 7% of the total. Inspectors assessed over a quarter of cases as not having the relevant support by preventative services to enable these young people to access local health services.

We can see from the evidence about preventative services that, even where health needs existed, they were not being sufficiently well assessed or referred on for specialist assessment. Of those referred, a very low number actually received an intervention to meet physical health or substance misuse needs, while only a quarter received an intervention, at an early stage, in relation to emotional and mental health problems.

## Community orders

For those children and young people who had offended and were subject to community orders, there was evidence of physical health needs (scoring 2 or more on 'Asset' assessments<sup>10</sup>) in 11% of cases. There was evidence of emotional and mental health needs in 43% of the cases and substance misuse needs in 49% of cases.<sup>11</sup> The percentage of those cases referred for specialist health assessments within the YOT amounted to 39% for those with physical health needs, 52% for those with emotional and mental health needs and 69% for those with substance misuse needs. Only half of those referrals, however, used the health assessment tool recommended by the Youth Justice Board (YJB)<sup>12</sup>, with some using their own assessment tools and others referring cases on without a proper assessment being carried out.

Predictably, evidence of an intervention being delivered for young people who were subject to community orders is higher than for prevention cases – 36% for those with physical health needs, 37% for emotional and mental health needs and 58% for those misusing substances. Seventy-seven per cent of cases were assessed by inspectors as having had sufficient support from the YOT in accessing local services where this was required. This is certainly better, in terms of interventions, than for prevention cases but nevertheless, it still means that nearly a quarter of cases have been assessed as not having had sufficient support to access services. There was also a considerable difference between those with substance misuse needs who had received an intervention, compared with those who were seen to have other health needs.

One important finding gathered from those cases on community orders is the assessment of whether a child or young person was 'a risk to themselves' either

<sup>10</sup> Asset is an assessment tool used for those who have offended – the YJB indicates that an assessment score of 2 or more should lead to a referral for a more thorough assessment by a specialist health worker. The scale is 0-4 where 0 is not associated with the likelihood of further offending and 4 is very strongly associated with the likelihood of further offending.

<sup>11</sup> The number of cases providing relevant data for this specific analysis was 2,118.

<sup>12</sup> SQIFA and SIFA – assessment tools used respectively by case managers and health specialists.

at present or in the past. Over 50% were seen to be 'at risk' either through self-harm, drug misuse or alcohol misuse. Twenty-four per cent were seen to be at risk through sexual behaviour, with 66% from being reckless or wilfully disregarding their own health and safety. Again, a high number of cases have specific needs, despite the fact that the risks may, or may not, be seen to directly relate to the offending behaviour that has led to the community sentence. With both prevention and community orders, it is clear that the poor assessment of health needs and the lack of targeted interventions, where individuals are considered to be at risk of harm to themselves, can mean that those vulnerable children and young people are not adequately safeguarded.

## Custody

In relation to those children and young people who are subject to custodial sentences, 74% of secure establishments had received an up-to-date core Asset assessment that included a vulnerability assessment including known health needs.<sup>13</sup> One worrying aspect here, however, was that only 11% of cases had relevant health and education plans that were sent to the secure establishment within 24 hours, as required by the YJB. More generally, there have been improvements in information exchange over time following the introduction of the electronic yellow envelope<sup>14</sup>, although actions resulting from the exchange of information have not necessarily been recorded on file. The provision of relevant health plans and other health information needs to link more readily with this electronic system.

Around half of the custodial cases had joint work, involving both community agencies and custodial staff, delivered to plan and achieved within reasonable timescales, to address physical health and emotional and mental health needs. Positively, over 70% of those young people with alcohol and substance misuse needs had joint work delivered to plan and achieved within reasonable timescales, having had those needs identified in the Asset assessment. The percentage of custodial cases seen as being a risk to themselves was also, understandably, higher than those on community orders.

## Work in the courts

Since the relevant legislation is nearly ten years old, we might expect to see that health workers and health services contribute well to packages of support for people on bail and the pre-sentence reports (PSRs) offered to courts. We might also expect courts to be well aware of health services offered in their area and how this might contribute to the reduction of offending behaviour. At the very least, we would

<sup>13</sup> The number of custodial cases providing relevant data for this analysis was 698.

<sup>14</sup> The electronic yellow envelope (EYE) is the exchange of information electronically between the YOT and the secure establishment.

expect to see relevant health information being considered during the sentencing process. This was disappointingly not the case in too many areas.

We examined 130 cases where the child or young person had gone through the court process and, while a PSR was written prior to sentence in 85% of cases, an appropriate health component was included in only 68% of cases – this means including relevant evidence from the Asset assessment. More worryingly, only 48% of those reports were considered by the inspectors to be balanced, verified and factually accurate and only 58% were seen to have addressed diversity issues sufficiently. Although there are good examples, PSRs simply did not routinely include information on the health of the individual, even where there were clear indications of health issues contained on file.

Sometimes, it is suggested that there is not a sufficiently direct relationship between a health issue and a specific offence. Although this argument may have more weight in an Asset assessment, it is surely less credible where the court has to consider factors about a young person's health when it is carrying out sentencing. Indeed, where the emotional and mental health or the substance misuse component of PSRs did not reflect the range of issues identified in either the Asset or in the separate health file, this has left children and young people vulnerable to safeguarding issues and their health needs not being met. It has also increased the potential for children and young people to cause harm to others where violence has been a feature of the offending behaviour.

### **Good practice from inspection reports**

**“Practitioners within a health team had lists of all children and young people who had scheduled court and panel sentencing appearances, which enabled them to prioritise and contribute to PSRs appropriately. Health workers were also accessible for informing pre-sentence processes effectively. Court reports covering child and adolescent mental health services (CAMHS) and substance misuse issues were timely and appropriately informed.”**

**“Staff working in health and substance misuse services provided good information for inclusion within PSRs and also offered relevant addenda as appropriate.”**

One YOT not only had health practitioners contributing to training for court magistrates, but also had their substance misuse service offering a presence in court in order to provide 'stand-down' reports (reports created during a break in proceedings) and packages of support for people on bail. This level of support, however, was highly unusual. In general, packages of support for people on bail that

involve health interventions were very rarely used and, although 'stand-down' reports were used to speed up the court sentencing process, there was usually no time, or opportunity, to find out about health needs.

Contributions by health workers to the ongoing training of magistrates were more common, particularly in relation to developing a greater understanding of the causes, effects and treatment of substance misuse. Where this training has been provided, benefits have included:

- A greater awareness of what support can be provided.
- Sentencing that has included more specific health components.
- Sentencing that has benefited from good health information.

There were too many occasions, however, where health information from Asset was not included in the PSR and where no relevant health report was submitted as a supplement, or addendum.

### **Good practice from inspection reports**

**"The health workers had done some useful training with courts about mental health assessment reports to highlight the options available to courts other than the use of psychiatric reports."**

## **Work with children and young people in the community**

There were wide variations between YOTs in the quality of assessment that enables them to identify the health needs of children and young people who are likely to offend. The first review made a specific recommendation that:

"Managers of youth offending teams, their healthcare workers and their substance misuse workers should ensure that: the assessment and referral processes for health and substance misuse issues are sufficiently robust and efficient".

Tools used to assess individuals for preventative and other services were not used consistently by workers within YOTs<sup>15</sup>. These are:

- Onset (for prevention work) and CAF (Common Assessment Framework).
- Asset (for community and custodial work).
- SQIFA (screening questionnaire interview for adolescents) and SIFA (screening interview for adolescents) (to more directly assess health needs).

<sup>15</sup>This assessment should be carried out in line with YJB Key Elements of Effective Practice.

Local variations have been developed not only of the forms being used, but also of the specific criteria being used for onward referrals.

One recent independent review of London YOTs found that “a wide range of assessment tools is used with the most common being a standard CAMHS assessment”. This study also found that “there are widely differing views about the usefulness of SQIFA and a general impression that Asset is inadequate for mental health referral.” (Ref. 3) The lack of consistency and confidence in the tools being used does not help with continuity of care or the relationships between, and contribution by, partner agencies.

Despite there being even more variations in the assessment forms for substance misuse services, a child or young person was far more likely to be assessed by a specialist in that field and was therefore more likely to receive an appropriate intervention in community and custodial work. However, assessments of mental or emotional health were often not well understood by YOT case managers, and there were too many inconsistencies in cases that led to specialist referrals. In one example, SQIFA was not consistently being used as a screening tool to assess the emotional and mental health needs of children and young people. In this instance, SQIFA had not been used where a need had been identified in six out of eight relevant cases inspected. Clearly, if YOTs have issues with the recommended assessment framework, this needs to be tackled so that thorough, useful and consistent methods are being used to assess needs.

The best current examples in preventative work offer a holistic assessment at the point of engagement with a child or young person, which allows the service to pinpoint the most visible health needs to address. Well-informed YOT key workers either carried out this assessment or, through clear and specific criteria, a referral was made to a health specialist to complete the assessment. There were also specific offending services where a health practitioner (for example, a seconded school nurse) offered an assessment to all children and young people coming into contact with the YOT before predominantly using universal health services (such as a GP) to address needs.

### Good practice from inspection reports

“Children and young people who were referred to the youth offending service were screened for their health needs as part of the Onset assessment and referred to specialist workers where appropriate.”

“All children and young people at risk of offending who were referred to both the youth inclusion programme (YIP)<sup>16</sup> and youth inclusion and support panels (YISP) had full access to the mental health and physical health screening and advice available through the youth offending service. This included a full-time drugs advisor and mental health and health workers provided by CAMHS and the primary care trust.”

“Holistic health assessments regularly resulted in access to teenage pregnancy services, condom distribution by the YOT, smoking cessation, parenting support, priority GP and dental access and diabetes recognition. In addition, domestic violence, epilepsy, nutritional needs, bereavement counselling, public health issues, bullying, anger management and immunisation were also addressed.”

Too often, however, YOTs missed children or young people’s health issues because they did not make good initial assessments. A quarter of initial assessments (using Onset) in cases examined were not judged by inspectors to have been of sufficient quality in relation to identified health issues. This explains why a similar percentage was judged not to have full attention paid to the methods likely to be most effective with the child or young person. A third of cases did not actively assess, at an early stage, diversity issues, factors that could discriminate against or disadvantage young people, or other individual needs. Even where YOTs were making accurate assessments of the range of health needs, there often remained a shortfall in the cases of children or young people who were then appropriately referred for specialist assessment.

Clearly, without a thorough and accurate assessment of needs, proper consideration of the capacity of health services to meet needs cannot be undertaken. Where health resources were low, or even non-existent, for preventative services within a YOT, it created a ‘no-win’ situation. Practitioners did not assess health needs, since a service couldn’t be provided and health services indicated that no clear need was apparent, due to the lack of referrals. Consequently, direct services were not provided.

Good and productive work in prevention is key to deterring children and young people from offending, and health services need to do as much as they can to assist

<sup>16</sup> The Youth Justice Board’s evaluation of youth inclusion programmes revealed that 25,000 young people had benefited from the support these programmes offered over a three-year period – *YJBulletin*, 25 November 2008.

with meeting their needs at the earliest possible stage. If health workers within a YOT are unable to offer interventions in prevention, as was uncovered in some of our inspections, then clear and useful links must be made with local universal health services to ensure children and young people likely to offend can access health services and be supported in doing so.

We have seen very good prevention work being carried out, particularly in relation to health workers providing useful information on, for example, sexual health and substance misuse. There was also some good partnership working, particularly between YOT workers, health staff, youth services and schools. Gaps remained, however, and the contextual information highlights the fact that health needs in preventative work were too frequently not met.

### **Good practice from inspection reports**

**“The YISP process had good multi-agency support and input from managers and practitioners. Appropriate health service practitioners were participating in the YISP, for example, including school nurses and CAMHS personnel.”**

**“The prevention team had access to the range of health services provided directly to the youth offending service and had also made good links with community resources.”**

Assessment tools need to be well understood and consistently used by both YOT case managers and by specialist health workers to make sure that the range of health inequalities are reduced in different areas of the country. Again, we found good examples of physical health being well assessed but these were in the minority. There were also further examples of health practitioners training staff on initial health assessments within certain YOTs, which led both to greater accuracy and more consistency. Generally, this level of engagement also leads to better liaison between YOT case managers and health practitioners and can enhance the level of information sharing, both before and after referrals.

Pathways for referrals between initial assessments and health interventions, whether this is within or outside the YOT, were not sufficiently clear in a number of areas. This situation was sometimes complicated when a dual diagnosis was potentially required. We found examples of joint needs, in relation to both mental health and substance misuse, where only a single intervention was pursued. Even where both areas of need were worked on in sequence, and there were clear links between the two, we found examples of information not being exchanged sufficiently well and outcomes suffering as a result, despite the availability of good practice. (Ref. 4)

## Physical health

Potential physical health needs of children and young people who offend, or who might offend, were very often poorly assessed, or even ignored, and consequently interventions were frequently very limited. For example, inspectors found high-scoring assessments of substance misuse that had a zero score on physical health, despite there being clear indications that the child or young person's physical health was suffering as a direct result of the abuse. Another example was where a young person was assessed as having clear emotional problems which related to his offending behaviour and, again, physical health was not seen as an issue. A simple reading of his case file, however, indicated that his self-image was heavily affected by his obesity.

YOTs that develop links with, for example, GPs, opticians, sexual health workers, speech therapists and dentists can help support the various physical health needs of those children or young people who offend. Even advice and support in relation to the benefits of a good diet can have an impact on offending behaviour. Research published in 2002 described the positive effect of young offenders taking dietary supplements, with 40% fewer violent offences being committed and a 25% reduction in offending. The author of the study (Bernard Gesch) wrote that:

“We tend to forget that humans are physical as well as psychological beings and putting poor fuel into the brain seems significantly to affect social behaviour”.  
(Ref. 5)

The link between diet and some behavioural and learning problems is only one area where physical needs may be seen to have an impact on a child or young person. For example, inspectors found a case of a young person who had offended, who was unable to comply with the parameters of a community order because he had an autistic spectrum disorder. An assessment resulted in the programme being redesigned to meet his needs. Physical needs, in short, should not be underestimated, since they can have a significant part to play in a positive assessment.

### Good practice from inspection reports

“The physical health work with children and young people who have a score of 2 or more on the relevant section of Asset, which was undertaken by the nurse was exceptional. The physical health worker offered a wide range of advice and assistance to children and young people and their case managers.”

## Substance misuse

Despite there being some gaps in the provision of preventative work from substance misuse services (and some elements supported only by short-term funding), virtually all YOTs experienced direct provision of support for tackling substance misuse needs for those children and young people who had offended. The funding stream here is clear and specific, and has allowed this valuable service to grow. Fewer vacancies, and shortfalls, were in evidence in comparison to the last review and substance misuse workers were generally well qualified and experienced, and offered a wide range of interventions. The best services:

- Contributed effectively to both YIPs and YISPs.
- Were involved in substance misuse education within schools and youth centres.
- Trained YOT workers and case managers to become more clearly aware of substance misuse issues and to refer on appropriately.
- Had clear pathways for referrals.
- Offered comprehensive and timely specialist assessments.
- Were able to engage well with children and young people.
- Offered a wide range of good interventions.
- Evaluated their services thoroughly.

Four of the 50 YOTs that were inspected in this last phase, however, were only able to demonstrate that, between them, one-fifth, one-quarter, one-third and a half of those children and young people for whom a substance misuse need was identified, were able to access appropriate services. This example continues to highlight the fact that many of those in need of a specific health intervention within the YOT were not receiving it. However, we have also found specific YOTs where considerable progress has been made towards specialist assessments taking place for all children and young people who come into contact with the YOT.

### Good practice from inspection reports

**“All young people referred to the youth offending service were screened for substance misuse followed by specialist assessment and intervention where required.”**

**“Early intervention for substance misuse problems was available through a service provider who sat on the YISP. The substance misuse workers were also actively involved in carrying out drugs education as part of the Healthy Schools programme.”**

**“Service users expressed dissatisfaction with the reality of some of the DVDs used in work around substance misuse. As a result, the team worked with young people and produced a DVD that they felt was more representative of the issues they faced.”**

We found good examples of substance misuse workers engaging positively and imaginatively with children and young people, and making comprehensive interventions at the right time. In general, relationships between substance misuse workers and their YOT colleagues was good and information sharing, in practice, has improved, even where a specific policy is not in existence.

### **Good practice from inspection reports**

**“There was evidence of skilled and sensitive work to promote the disclosure of drug misuse issues in individual cases.”**

## **Emotional and mental health**

Emotional and mental health services for children and young people who have offended, were still inconsistent in different parts of the country. Although the percentage of YOTs who have health workers in their teams has improved, one in 10 of those inspected still did not meet this explicit requirement. The mental health knowledge of YOT practitioners could also be patchy. We accept that, in some cases, clear attempts had been made to recruit without success, but this overall situation remains very worrying. Even where it is difficult to attract the right calibre of person, more could be done to shore up the deficit through secondment or temporary appointment, for example.

Where there are gaps, YOTs could still improve the service children and young people receive by, for example, ensuring that clear pathways for referrals to universal services exist, and providing additional training so that case managers can identify and support the tackling of health issues. It is clear from our inspections that where a YOT did not have a health worker within their team, health needs were not being fully recognised, assessed, supported or met. Where there were health workers on site in a YOT, there were still a few instances where they were carrying more generic caseloads, which could affect their ability to meet specifically identified health needs.

### Good practice from inspection reports

“To ensure a consistent mental health service, a system of supportive crisis and contingency plans were in place for weekends and staff holidays.

Health staff in the YOT, alongside other specialist mental health workers from CAMHS, provided YOT staff with a training programme on mental health issues and how to use the YOT mental health screening tool. The seconded staff were a point of contact for CAMHS staff regarding all issues relating to criminal justice. They also advised and supported YOT practitioners who had concerns regarding children and young people’s emotional wellbeing.”

We still found examples of thresholds for admission into adult mental health services being too high and older children (principally 16 to 18 year olds) having problems in accessing services. One unfortunate example of this was a YOT where emotional and mental health services were not available to young people aged 17 and above, unless they had previously been known to CAMHS.

While links with CAMHS generally have improved, the best support was particularly noticeable where the health worker in the YOT was seconded from CAMHS and continued to have clinical supervision from that service. Working protocols between the YOT and CAMHS, however, could often be conspicuous by their absence. Notable instances included the lack of a confidentiality protocol, which caused particular difficulties between a YOT and CAMHS in exchanging information and inputting relevant information onto the YOT IT system. Clear strategies, service level agreements and protocols do not only reflect a good multi-agency commitment to vulnerable children and young people but also result in improved access and intervention in relation to all levels of CAMHS.

### Good practice from inspection reports

“The employment of the psychologist within the YOT meant that it had excellent links with CAMHS. The psychologist and other CAMHS staff had provided YOT case managers with mental health awareness training. The co-location of the seconded health worker and the psychologist within the YOT meant that caseworkers had ready, formal and informal access to advice and support from the two specialist workers. This also led to a reduced need to refer children and young people to external specialist services, with much of the work being undertaken by the seconded health worker, or by case workers supported by the psychologist.”

We also found a lack of good quality needs assessments within a YOT area and insufficient evaluation of interventions by health workers and health services. Again, there were good examples where these have been carried out and have led to the delivery of much improved and better directed services but there were too many YOTs where this was not the case.

## Work with children and young people subject to custodial sentences<sup>17</sup>

Investigation into the health aspects of children and young people who are subject to custodial sentences, and their community component, is an area that was not reported on in the original review, since few inspections in the initial phases contained evidence of it. Phase 4 of the inspection cycle included assessments of custodial cases by health inspectors and the gathering of additional evidence in this area. There were specific aspects that have arisen in those inspections and require some degree of scrutiny.

The transition of children and young people between the community and the secure environment is often the core element that influences whether children or young people think they are treated well, or not. Other direct and linked issues, such as the exchange of information, attendance at planning meetings and links with universal services also need to be considered.

### Good practice from inspection reports

**“For those children and young people for whom there were vulnerability concerns, the YOT had an agreed safeguarding system with the mental health team at the young offenders’ institution. This process was monitored by the YOT’s seconded health and substance misuse workers. They alerted staff in the young offenders’ institution of the potential risks in the case and a custodial health assessment was completed upon admission. The process was repeated during the resettlement period and YOT health workers could ‘fast-track’ into appropriate community-based health service interventions.”**

It is critical that any children or young person’s health needs that are identified are communicated swiftly and effectively to any secure environment to ensure that attempts are made to meet their needs during a sentence. It is also important that custodial institutions maintain a dialogue and provide information to the local YOT to ensure consistency and continuity of support. This maximises the possibility of positive change, but it does not happen in all places. Equally, the views of YOT

<sup>17</sup> This section relates to those subject to custodial sentences but specifically concentrates on the community phases of these sentences and the impact of transitions.

health workers should be considered at initial planning meetings and within the training plan reviews.

Four of the YOTs inspected in phase 4 had not routinely sent health plans or Asset health assessments to custodial establishments. An additional four had no health views represented in the initial training plan and, as an example, one of those YOTs only had a health representative at one in nine initial planning meetings, while another two had only three out of 10 and three out of 14 representatives. This contrasts sharply with those where health needs were well assessed and communicated. In these YOTs, their health workers communicated regularly with the custodial establishment and good interventions continued immediately after release, and in the community phase of the sentence.

### Good practice from inspection reports

**“The health needs of young people receiving custodial sentences were communicated effectively to the custodial establishments and the YOT workers showed real commitment to supporting children and young people who had any special needs while in custody.”**

**“A particular strength noted in almost every case was the involvement of both the education worker, and a focus on consistently addressing any substance misuse needs through the training plan meetings.”**

Ten per cent of YOTs inspected did not provide sufficient and appropriate health provision to children and young people, following release from a secure environment. This was more pronounced in relation to meeting identified emotional and mental health needs – in one YOT, a fifth of cases where there was an identifiable mental health need had not received support. If there was insufficient involvement and communication between the local health worker and a child or young person in the latter stages of their custodial sentence, this appeared to reduce the likelihood that the child or young person would engage with services on release.

Resettlement and Aftercare Provision (RAP), established towards the end of 2004, allowed additional support to be offered in 59 YOT areas to improve services for children and young people with custodial sentences who have substance misuse problems<sup>18</sup>. RAP focuses primarily on effective care during custody and resettlement for children and young people and can provide up to 25 hours of support and activities. Where this service was in place, and attached to YOTs, feedback from YOT workers and other health workers was almost universally positive. Although there were occasions where there could have been a better evaluation of the impact of their work, the service generally offered an effective and responsive approach.

<sup>18</sup>This resource is also now being used to supplement work with community orders.

Sometimes, the additional capacity which RAP could offer led to innovative arrangements being made to meet identified needs. For example, one RAP worker delivered practical assistance to address both substance misuse needs and accommodation issues in conjunction with a case manager. Another case was where a volunteer mentoring service was offered to those leaving custody.

### Good practice from inspection reports

“RAP workers responded creatively to address some of the wider issues around substance misuse. Awareness of diversity was high and programmes adapted to meet these needs. The workers had made effective links with other health practitioners to ensure that services were integrated.”

## Victims and restorative justice

There is either no information or very little information about healthcare relating directly to victims and restorative justice. Health inspectors were rarely able to find any involvement of health workers in this area of a YOT's work. This is not to say, however, that health should not be considered, since restorative justice can involve activities that deal with physical and environmental problems – and can promote health in a more general way.

## Management and leadership

Management and leadership is critical to successful partnership working and is fundamental to successfully identifying and meeting health needs. A number of aspects relating to the management of health services and youth offending were seen as requiring attention in the first review document. These included the following:

- The representation, attendance and contribution of health representatives on youth offending management boards.
- The provision of health workers, and the level of their qualifications, within YOTs.
- The existence of protocols and service level agreements between YOTs and health services.
- The level and accessibility of healthcare services in general, and CAMHS in particular.
- The existence of policies in relation to sharing information and keeping records.
- The monitoring and evaluation of health needs and the impact of interventions.

### Management board membership

In our last review, it was well publicised that one in six YOTs did not have a healthcare representative on their management board. In phase 4, this has fallen considerably, with only two YOTs not explicitly meeting this expectation. Actual attendance by the health representative, however, was still an issue and 16% of the YOTs inspected under this review pinpointed issues in this respect. The degree of contribution by the health representative also varied and was found to be insufficient in 12% of YOTs. For example, despite good attendance at board meetings, some minutes have not demonstrated any contributions by health representatives.

Inspections also showed that changing health representatives could lead to a lack of consistency and continuity, although this was sometimes explained as resulting from significant changes in the composition of PCTs. Overall, however, these issues demonstrated 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 first review report also recommended that the 'drug action team and/or local children and young person's substance misuse service should ensure that they had representation on the management board of the youth offending team'. It also recommended that there should be 'specific policies on the sharing of information for substance misuse workers'.

Unfortunately, neither of those recommendations has, as yet, made a significant impact, since representation on the board and policies on the sharing of information between substance misuse workers and the YOT are still rare.

#### Good practice from inspection reports

"The service director of CAMHS and a public health consultant from the PCT, along with the head of service for the drug action team, had recently joined the reorganised management board."

"The health sector provided an appropriate level of funding for the youth offending service through the CAMHS and substance misuse commissioning budgets. Despite great pressures on funding, they have actively worked with other agencies to resolve financial difficulties and sustain the resource allocation."

In the best examples, where boards contained active and committed health representatives, there were strong and shared views of governance, meaningful performance targets, and a high level of scrutiny. In a very few YOTs, the health representative was not of sufficient seniority to effectively influence decisions within their own agency.

### **Service level agreements, protocols and information exchange**

One recommendation from the first review related to the lack of development of protocols and service level agreements between YOTs and healthcare organisations. One-third of YOTs either had no agreement, or they were inadequate in some respect. This review of phase 4 inspections shows that finding again. Just under a third of YOTs still had either no service level agreement, just a draft version, or the existing agreement was assessed as simply inadequate. Without good protocols and service level agreements, there can be a lack of clarity and focus between health services, health workers and colleagues within a YOT.

One particular issue linked to the general lack of protocols related to the exchange of information. Significant problems in joint working between YOT and health workers were highlighted in the earlier review report and it was stated that these problems were “exacerbated by the lack of adequate procedures for the sharing of information that affected many youth offending teams”.

It is still the case that 20% of YOTs were assessed as having inadequate processes and procedures relating to confidentiality between YOTs and health services, including those health workers within YOTs. Health files were often kept separate from the main YOT file, because of perceived confidentiality issues, and were inaccessible by YOT managers, while relevant health information was not consistently supplied to case managers electronically. This meant that YOT managers and case managers did not always have the most up-to-date information when reviewing the accuracy of assessments and the interventions being delivered.

The lack of relevant information can have potentially much worse repercussions – for example, health information regarding a previous attempt at suicide by a young person was not conveyed to a custodial establishment, because the information had not been passed automatically to the case manager. This had implications for the degree of supervision of the young person in the custodial establishment. It is simply unacceptable for relevant health information not to be shared with YOT workers, particularly where information sharing has been seen as an ongoing issue in partnership working for many years. Clear updated guidance has now been issued by the Department of Health in this respect. (Ref. 4)

#### **Good practice from inspection reports**

**“There were no concerns either with matters of confidentiality or information sharing as far as health workers were concerned. A protocol was in place for this. They kept their own health records and formed judgements about what information they needed to share. Children and young people signed a confidentiality agreement at the outset.”**

## Funding and resources

One aspect raised by the YJB in *Sustaining the Success* was the inadequacy of the average funding contribution to YOTs by PCTs. (Ref. 6) At that time, the average contribution was 5.8% of an overall YOT budget and the YJB stated that this needed to be increased. Currently, only seven YOTs exceed the 5.8% contribution. Using this as a crude benchmark during our inspections, but also taking into account how well needs are identified and met, resources provided by PCTs were seen to be inadequate in nearly half of the YOTs. Significantly, the average level of contribution for England and Wales has also decreased to 3.4% according to the YJB<sup>19</sup> so the degree of financial commitment by health to the YOTs has to be questionable. Improvements are vital to both identify and meet the health needs of those children and young people who are either likely to offend or who have offended.

As demonstrated earlier in this report, there were still problems with the resourcing of YOTs with health workers. Health staff who were in post, however, were generally well qualified and experienced, particularly in relation to substance misuse posts. Existing staff were generally well supported, with good levels of both clinical supervision and line management within the YOT. Relationships between on-site health workers and case managers within the YOT were often seen to be very positive and mutually supportive.

### Good practice from inspection reports

**“The health staff seconded to the YOT had the appropriate skills and experience for the roles undertaken. All health staff had received appropriate child protection training and were subject to enhanced Criminal Records Bureau checks. There were robust arrangements for professional supervision and for joint meetings between the line managers in the YOT and the managers in the seconding organisations.”**

Where there were long-term vacancies for health workers, lengthy sickness absences or simply gaps in the service, contingency plans and temporary solutions were all too rare. The biggest difficulty for health services appeared to be finding health workers experienced in emotional and mental health work, who were willing to work within a YOT. Ten per cent of YOTs still had no mental health worker on-site, although this constitutes an improvement on a third of YOTs having no mental health worker at the time of the original review. One example from an inspection indicated that the lack of two mental health workers in the YOT had made a significant impact on the service’s ability to meet health needs, with only 19% of cases being referred to a specialist where 60% showed evidence of a need.

<sup>19</sup> Figures submitted by the YJB to the Healthcare Commission (2008).

An absence of health workers also clearly affects the degree of training and ongoing support necessary for YOT caseworkers to understand, assess and refer health needs satisfactorily. The lack of resources in general health nursing, which was found in 30% of YOTs in this review, has meant that appropriate interventions have not been delivered to meet the physical health needs of children and young people, including many elements that would promote a healthy lifestyle.

Where there are gaps in direct provision, it becomes even more important for universal services to provide a sufficient bridge, and for a possible fast-tracking system to be in place in order to ensure that identified needs are met. Where there have been issues with thresholds and the extent of universal provision, particularly in mental health, needs that are potentially linked to crime remained unmet in this vulnerable group.

### **Monitoring and evaluation**

The extent of evaluation of healthcare within YOTs was also problematic, since many YOTs have no clear idea of the impact of their health provision. There was, indeed, little evidence of the systematic evaluation of either the effectiveness of health services on offending behaviour, or their link to the overall performance of the YOT. Targeted monitoring and outcome measures, including service users' feedback, need to improve and become more reliable and consistent so that health services can understand, and learn from, achievements or shortcomings in their work with YOTs.

Where monitoring and evaluation has been carried out effectively, often directly related to the standard key performance indicators, good use has been made of the potential to influence performance improvement. When Asset is accurately completed, for example, this electronically based assessment system can offer a range of 'wizards' (individually designed reports), which identify the most common and high-scoring needs. This can influence resource allocation and then ascertain changes or trends over time.

#### **Good practice from inspection reports**

**“Data was used to improve service outcomes for children and young people in a range of ways. The psychologist in the YOT also undertook an audit of mental health needs within the YOT, which was used to inform the decision to secure the continued specialist input to the team.”**

**“The head of youth offending service held monthly meetings with the local PCT and CAMHS, where monthly performance information was discussed.”**

# Conclusions

One of the fundamental issues for health and youth offending services to consider is the nature and quality of assessments, both for those who have offended and for those who might do. If these are not carried out promptly and accurately, important factors that can be linked to crime can be missed, minimised or ignored. If an initial Asset assessment is not thoroughly completed, and lacks the necessary specialist supplementary health assessments, this can impact on the nature both of sentencing and intervention. The section about court work in this report demonstrates, for example, that a third of the reports presented to court did not have an accurate representation of health needs, which could be relevant during sentencing. Where health needs are not being assessed, this also limits the ability of the youth offending team (YOT) case manager to offer packages of support for people on bail, which include health.

Substantial numbers of children and young people who are likely to offend or who have offended, did not have their generic health needs well assessed and therefore cannot be referred on to receive appropriate interventions. This situation can be made worse where young people place themselves at risk and this has often not been taken into account.

We found too many situations where health needs, including diversity issues, were clearly present in case file information, but which had not been adequately assessed and considered in relation to interventions. This was particularly true for those with physical health needs, where often these needs are simply ignored. Sometimes the lack of a thorough initial health assessment was due to case managers being poorly trained in primary health screening; otherwise it was simply because a YOT was not using recognised assessment tools. Where all children and young people attending a YOT are subject to accurate and consistent universal screening for health issues (by a specialist), which includes checks for physical health, emotional and mental health and substance misuse, they are much more likely to receive appropriate advice and assistance.

Inspectors found effective audits and performance reviews within YOTs, for example, in Asset completion, where findings were used to inform future practice – but these were exceptions.

Pathways for referrals from initial assessments to interventions, whether these are within or outside the YOT, were not clear enough. Additionally, work with cases requiring a dual diagnosis was not sufficiently consistent. Health interventions with victims and the use of aspects of healthcare within restorative justice were underdeveloped.

The extent of health interventions was limited in a number of YOT areas, because there were gaps in provision. This included lengthy vacancies for health workers and insufficient commitment from primary care trusts (PCTs). This has led to health needs not being fully, or properly assessed, and/or being referred on.

Although the quantity of health provision has improved since the time of our first review, too many PCTs are still not meeting their statutory duty to provide at least one health worker to a YOT. Universal health services have again improved, but we are still seeing examples of needs not being met within child and adolescent mental health services – particularly for the older age range. This can be critical where essential support is needed to bridge the transition to adult services.

Inspections found problems in communication between community settings and secure environments for custodial cases. Health provision in the community following a release from custody can also be problematic. The situation is much improved, however, where good liaison and communication takes place between the local YOT and the establishment, both at the beginning of a sentence and prior to release. If a child or young person is engaged with a community-based health worker before release, there is a much stronger likelihood that good links will continue afterwards. One generally positive aspect relating to custody is the introduction and use of resettlement and aftercare project workers, who are providing good, ongoing support to those who misuse substances.

We found that health services were represented more than before at management board meetings, although there were some continuing problems with their levels of attendance and contribution. Substance misuse services, however, are much less well represented at that level. Consistent, functional and up-to-date service level agreements and protocols were only found at the best YOTs, so this area requires an increased focus by PCTs. We were particularly concerned with the lack of information-sharing protocols between YOTs and health services, which allows the misunderstandings and confusion to continue.

Resources provided by health services to the YOTs remained inadequate in nearly half of the YOTs evaluated for this review and the national average for this financial contribution has fallen. This is worrying since we also found, as detailed above, that health needs are not consistently being identified and met. Gaps in provision are clearly affecting the ability of YOTs to deliver appropriate interventions.

Although health services are beginning to look more at outcomes from their work within YOTs, and their increased representation on management boards is contributing to this improvement, the lack of widespread evaluation means that the usefulness of health interventions in contributing to reducing offending behaviour cannot be measured.

The findings in a small number of initial inspections of YOTs led to re-inspections. Our recommendations about health have led to specific improvements in almost all cases. However, one YOT, where health provision deteriorated, had to be pursued more rigorously through local Healthcare Commission operational teams and the relevant strategic health authority (SHA). An explicit health action plan was requested, and provided, and progress is being followed up. It is also notable that evidence suggests that SHAs are not universally aware of their responsibilities in relation to the health provision within YOTs.

## Next steps

As we stated in our first report, children and young people who have offended or are likely to offend, often have greater health needs than the general youth population. These health needs can contribute strongly to offending behaviour, whether they are overt or not. It is therefore very important for health services to meet these needs as much as possible in order to reduce, or assist in reducing, offending behaviour and to maximise the possibility of positive change in a young person's life.

Although Her Majesty's Inspectorate of Probation will continue to inspect and report on youth offending teams, the methodology is changing and the contribution by the Healthcare Commission (or the Care Quality Commission which will take over this responsibility from April 2009) is likely to alter accordingly. The replacement system of youth offending inspections will involve two component parts; the first will be a three-year cycle of core case inspections and the second will be a programme of thematic inspections. It is anticipated that the Care Quality Commission will contribute to the former on a risk-assessed basis, but will be fully involved in both the development of the methodology and in the execution of the latter thematic inspections.

It is clearly vitally important for both the Care Quality Commission and HMI Probation to monitor and evaluate the progress made following this report and the recommendations it contains. The inspectorates also need to ensure that recommendations made to individual YOTs in inspection reports have been acted on appropriately, and where this has not been done, to follow this up with remedial action.

## Appendix A

### About the Healthcare Commission, Her Majesty's Inspectorate of Probation and joint inspections

#### Healthcare Commission

The Healthcare Commission works to promote improvements in the quality of healthcare and public health in England and Wales.

In England, we assess and report on the performance of healthcare organisations in the NHS and independent sector, to ensure that they are providing a high standard of care. We also encourage them to continually improve their services and the way they work.

In Wales, the Healthcare Commission's role is more limited. It relates mainly to national reviews that include Wales and to our yearly report on the state of healthcare.

The Healthcare Commission aims to:

- Safeguard patients and promote continuous improvement in healthcare services for patients, carers and the public.
- Promote the rights of everyone to have access to healthcare services and the opportunity to improve their health.
- Be independent, fair and open in our decision making, and consultative about our processes.

On 1 April 2009, the Care Quality Commission, the new independent regulator of health, mental health and adult social care, will take over the Healthcare Commission's work in England. Healthcare Inspectorate Wales will become responsible for carrying out our activities relating to Wales.

**[www.healthcarecommission.org.uk](http://www.healthcarecommission.org.uk)**

## Her Majesty's Inspectorate of Probation

HMI Probation is an independent Inspectorate, funded by the Ministry of Justice and reporting directly to the Secretary of State. Our purpose is to:

- Report to the Secretary of State on the effectiveness of work with individual offenders, children and young people aimed at reducing reoffending and protecting the public, whoever undertakes this work under the auspices of the National Offender Management Service or the Youth Justice Board.
- Report on the effectiveness of the arrangements for this work, working with other Inspectorates as necessary.
- Contribute to improved performance by the organisations whose work we inspect.
- Contribute to sound policy and effective service delivery, especially in public protection, by providing advice and disseminating good practice, based on inspection findings, to Ministers, officials, managers and practitioners.
- Promote actively race equality and wider diversity issues, especially in the organisations whose work we inspect.
- Contribute to the overall effectiveness of the criminal justice system, particularly through joint work with other inspectorates.

HMI Probation aims to achieve its purpose and to meet the Government's principles for inspection in the public sector by:

- Working in an honest, professional, fair and polite way.
- Reporting and publishing inspection findings and recommendations for improvement in good time and to a good standard.
- Promoting race equality and wider attention to diversity in all aspects of our work, including within our own employment practices and organisational processes.
- For the organisations whose work we are inspecting, keeping to a minimum the amount of extra work arising as a result of the inspection process.

**[www.inspectorates.justice.gov.uk/hmiprobation](http://www.inspectorates.justice.gov.uk/hmiprobation)**

## Joint inspection arrangements

The joint YOT inspection programme began in September 2003 and is the first full inspection programme to examine the work of the YOTs. It has been implemented over four phases, covering all YOTs in England and Wales over a five year period. From September 2005, the findings in England have contributed to the Joint Area Reviews of children's services (led by Ofsted) and the Corporate Assessment of local authority services (led by the Audit Commission).

## Appendix B

### Additional reading

- 1 *Key Elements of Effective Practice*, Youth Justice Board (YJB), 2008.
- 2 Joint Inspection of Youth Offending Team Reports, Her Majesty's Inspectorate of Probation (HMIP), 2008.
- 3 *The YOT health practitioner – Identifying and sharing good mental health practice*, NACRO, 2007.
- 4 *Joint Inspection of Youth Offending Teams – Annual Report 2006/2007*, HMIP, 2007.
- 5 *Her Majesty's Inspectorate of Probation Annual Report 2007-08*, HMIP, 2008.
- 6 *'Let's Talk About It' – A review of healthcare in the community for young people who offend*, Healthcare Commission, 2006.
- 7 *Improving Health, Supporting Justice: A Consultation Document*, Department of Health (DH), 2007.
- 8 *Sainsbury Centre for Mental Health – Annual Review 2007*, 2007.
- 9 *Effective mental healthcare for offenders: the need for a fresh approach*, NACRO, 2007.
- 10 *Confidentiality: Protecting and Providing Information*, General Medical Council, 2004.
- 11 *National Standards for Youth Justice Services*, YJB/Home Office, 2004.
- 12 *Risk and protective factors*, YJB, 2005.

## Appendix C

### Glossary

<b>Asset</b>	Assessment tool for those who have offended
<b>CAF</b>	Common Assessment Framework
<b>CAMHS</b>	Child and adolescent mental health services
<b>HMIP</b>	Her Majesty's Inspectorate of Probation
<b>Looked after children</b>	Children accommodated by the local authority
<b>Ofsted</b>	Office for Standards in Education, Children's Services and Skills
<b>Onset</b>	Assessment tool for those at risk of offending
<b>PCT</b>	Primary care trust
<b>PSR</b>	Pre-sentence report
<b>RAP</b>	Resettlement and aftercare programme
<b>SHA</b>	Strategic health authority
<b>SIFA</b>	Screening interview for adolescents
<b>SQIFA</b>	Screening questionnaire interview for adolescents
<b>YIP</b>	Youth inclusion programme
<b>YISP</b>	Youth inclusion and support panels
<b>YJB</b>	Youth Justice Board
<b>YOT/YOS</b>	Youth offending team / youth offending service

## Appendix D

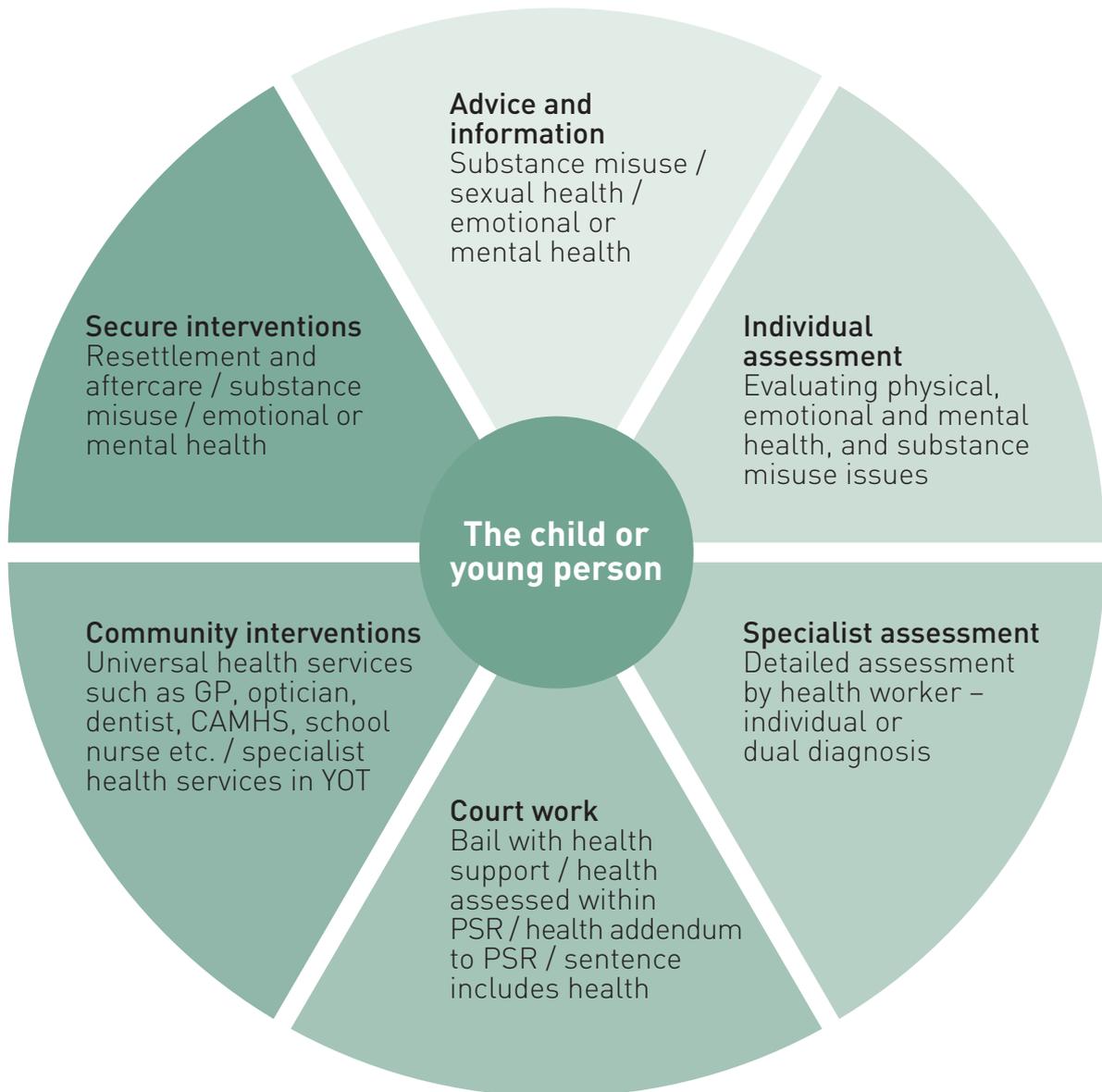
### Crime and Disorder Act 1998 (extract)

#### **Youth offending teams**

- (1)** Subject to subsection (2) below, it shall be the duty of each local authority, acting in cooperation with the persons and bodies mentioned in subsection (3) below, to establish for their area one or more youth offending teams.
- (2)** Two (or more) local authorities acting together may establish one or more youth offending teams for both (or all) their areas; and where they do so—
  - (a)** any reference in the following provisions of this section (except subsection (4)(b)) to, or to the area of, the local authority or a particular local authority shall be construed accordingly, and
  - (b)** the reference in subsection (4)(b) to the local authority shall be construed as a reference to one of the authorities.
- (3)** It shall be the duty of—
  - (a)** every chief officer of police any part of whose police area lies within the local authority's area; and
  - (b)** every probation committee or health authority any part of whose area lies within that area, to co-operate in the discharge by the local authority of their duty under subsection (1) above.
- (4)** The local authority and every person or body mentioned in subsection (3) above shall have power to make payments towards expenditure incurred by, or for purposes connected with, youth offending teams—
  - (a)** by making the payments directly; or
  - (b)** by contributing to a fund, established and maintained by the local authority, out of which the payments may be made.
- (5)** A youth offending team shall include at least one of each of the following, namely—
  - (a)** a probation officer;
  - (b)** a social worker of a local authority social services department;
  - (c)** a police officer;
  - (d)** a person nominated by a health authority any part of whose area lies within the local authority's area;
  - (e)** a person nominated by the chief education officer appointed by the local authority under section 532 of the [1996 c. 56.] Education Act 1996.
- (6)** A youth offending team may also include such other persons as the local authority thinks appropriate after consulting the persons and bodies mentioned in subsection (3) above.
- (7)** It shall be the duty of the youth offending team or teams established by a particular local authority—
  - (a)** to co-ordinate the provision of youth justice services for all those in the authority's area who need them; and
  - (b)** to carry out such functions as are assigned to the team or teams in the youth justice plan formulated by the authority under section 40(1) below.

## Appendix E

Examples of possible health involvement with those children or young people who have offended or are likely to offend



## Appendix F

### Description of youth offending teams

(abstract from the Home Office website)

The youth offending team or service (YOT or YOS) has a critical role in terms of tackling young people's anti-social behaviour (ASB). Their role extends beyond managing those who have offended and includes the prevention of and diversion from offending and becoming involved in ASB. However, it is important to remember that young people are more likely to be victims of ASB than perpetrators of it.

The Crime and Disorder Act (1998) placed a statutory requirement to establish multi-agency YOTs in metropolitan, unitary and county council local government areas: there are 157 YOTs in England and Wales. Previously social services departments' youth justice division supervised young offenders. The legislation also made changes to the management of the youth justice system, including the court disposals for young people.

YOT staff typically include social workers, education welfare officers, Connexions staff, police officers, probation officers and health and substance misuse workers. YOTs' work and performance is overseen by the non-departmental government body the Youth Justice Board (YJB).

The YJB's aims and objectives are:

- Confronting young offenders with the consequences of their offending.
- Establishing punishments proportionate to the seriousness and persistence of offending.
- Encouraging reparation to victims by young offenders.
- Reinforcing parents' responsibilities.
- Swift administration of justice.
- Interventions that target particular factors which put a young person at risk of offending.

YOTs undertake the following roles:

- Assessment: assessing the risk and protective factors in a young person's life that relate to their offending behaviour, to enable effective interventions to be implemented.
- Providing support to young people on police and court bail.
- Providing support to young people in the court setting.
- Supervising and managing the cases of young offenders.
- Providing support to young people who have been released into the community from custody.
- Early intervention and preventative work, both in terms of criminality and ASB.
- Strategic planning and performance monitoring – YOTs must report on their performance in a number of key areas to the YJB on a quarterly basis.

## References

- 1 *Standards for Better Health*, Department of Health, 2004 (updated 2007-2008).
- 2 Inter-departmental circular on establishing youth offending teams, December 1998.
- 3 *London Youth Offending Teams Mental Health Mapping*, The Health and Social Care Advisory Service, 2008.
- 4 *When To Share Information – best practice guidance for everyone working in the youth justice system*, Department of Health, 2008.
- 5 *Influence of supplementary vitamins, minerals and essential fatty acids on the antisocial behaviour of young adult prisoners*, Benton and Gesch, British Journal of Psychiatry, 2002.
- 6 *Sustaining the Success – extending the guidance*, Youth Justice Board, 2004.

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