HALTON, WARRINGTON, CHESHIRE WEST AND CHESTER

HEALTH AND WELL-BEING NEEDS ASSESSMENT OF YOUNG OFFENDERS ACROSS HALTON, WARRINGTON AND CHESHIRE WEST & CHESTER

The Centre for Public Innovation

May 2015 - FINAL

The Centre for Public Innovation is a Community Interest Company that provides research, training, support and advice in the fields of health, social care, criminal justice and community development.

Our mission is to improve the outcomes of public services for their users, with a particular emphasis on the most disadvantaged.
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1. Executive summary

Context

CPI was commissioned by the Youth Offending Service (YOS) Board health subgroup to undertake a health and well being needs assessment of its youth offender population to inform future commissioning for the young offender population across the Halton, Warrington, Cheshire West and Chester area. The scope of the health needs assessment was the youth offending population in the above geographical areas (including both males and females) between the ages of 10 and 18.

A total of 42 interviews were carried out with a range of professional stakeholders to determine their assessment of current healthcare provision. In addition 6 young people were interviewed. Quantitative analysis was carried out on records relating to a sample of 175 young people currently on the YOS caseload, giving a confidence level of 95%.

Current provision

Current arrangements for dedicated health provision are based upon the previous YOS delivery model and therefore resource availability differs in each geographical area. The expectation is to move to a model where there is greater parity of provision across the footprint thereby addressing inequality in provision and resource with particular reference to health provision.

All young people are given an initial health assessment using ASSET or Divert assessment tools. Each asks specific questions on physical, emotional and mental health screening, alongside substance use, speech, language and communication. This assessment contributes to the support offered.

Overview of YOS population

- Young people aged 16 to 17 are over-represented in the YOS population compared with the general population of young people in the area.
- Males are disproportionately over-represented in the YOS population (83% male) compared with all young people aged 10-18 in the area (50-52% male).
- The majority of young people involved with youth offending services were living in lower super output areas classified as ‘Disadvantaged Urban Communities’.
Epidemiology

- 6% of young offenders in the sample had a health condition that impacts on their daily functioning.
- A total of 4% of all cases in the sample were indicated to require some level of intervention in relation to physical health.
- 57% of young offenders in the sample were recorded as having some level of mental health need affecting their daily functioning; 17% had a formal diagnosis recorded. This compares to national prevalence estimates for young people of 11.5%.
- 23% of young people in the sample had a history of self-harm and/or suicide attempts.
- Of the recorded diagnosed conditions, ADHD was the most common.
- 40% of the young offenders in the sample were known to currently drink alcohol, and 43% to be using other substances.
- 21% of the sample were currently accommodated under a care order or were looked after children.
- Close to half of the sample had experienced abuse or neglect from parents or carers, including domestic violence (40%) or a major bereavement or trauma (27%).

Conclusions

1. The young offenders in the sample population had higher levels of health need compared to their peers who are not engaged with offending services in relation to several areas – mental health, learning difficulties, substance misuse and social issues.
2. Young offenders have high levels of co-morbidity – that is, the young people supported by the YOS have multiple health conditions (for instance simultaneous mental health and substance misuse needs) that need to be addressed. The population being served is therefore a particularly complex one to support as they may require interventions across multiple disciplines.
3. The health needs of young offenders interplay with a range of social factors – including family environment and housing – that further complicate and can exacerbate their physical and mental health needs.
4. Young offenders exhibit high levels of risk taking across a range of domains – risky health behaviours, risky sexual behaviours, high levels of alcohol consumption, substance misuse and so forth. It is likely that some of their health needs are partially accounted for by this underlying attitude to risk and poor decision-making. Helping young offenders make better and more informed choices will in turn impact on their wider health.
5. There was pronounced variation in the prevalence of physical and mental health conditions across the three YOS areas (Halton, Warrington, Cheshire West and Chester). It is likely that this is more a
function of the different ways in which health services are delivered (and therefore the extent to which health conditions are picked up) across the three areas than a measure of actual prevalence and need. That is, some health systems seem to be better placed to detect and respond to the health needs of young offenders than others.

6 Following on from Conclusion 5, it follows that there is not equitable access to healthcare across the three areas and that a young person’s experience of health provision is likely to vary in relation to where they live. Access to mental health services would appear to have the greatest levels of variation.

7 Young offenders on Youth Rehabilitation Orders (YROs) tended to be more likely overall to have identified needs in relation to substance misuse, mental health, and some social issues than those on Referral Orders and on the Diversion Programme. This may be due to this being a more complex cohort of young offenders, or it may be attributable to differences in assessment and recording.

Recommendations

1. Use findings from current health needs assessment to inform the development of wider health inequality proxy measures to help develop the cost-avoidance measures as this will then provide an informed view of how the scheme has impacted upon health and access to provision. In addition it would be useful to measure changes in any identified mental health needs and other vulnerabilities (over a three month contact period).

2. Use findings of presenting and emerging need to inform whether this warrants investment into health provision which would support specialist intervention at point of entry to the system within the Diversion Team.

3. If provision cannot be met by a dedicated health worker then appropriately trained and supported YOT staff could carry out the assessment function and refer appropriately to universal and/or specialist services. Using an agreed holistic health assessment tool.

4. Review pathway in place with Five Borough Partnership to ensure it serves the level of need and throughput and is consistent in providing consultation to YOS officers. Community CAMHS services in Halton and Warrington should also adopt an assertive outreach approach to maximise engagement and reduce delay.
5. Explore whether resources are available to support a generic health role which combines both physical and mental health needs to serve Halton and Warrington. In determining the best model, commissioners and YOTs should be aware of the range of different YOT health commissioning models available and make decisions taking into account a needs assessment of all vulnerable young people in the area, an audit of what other services (voluntary and statutory) are available in the locality, the extent of difficulties faced in accessing local specialist services and the evidence base.

6. There is a need for more dedicated specialists for young offenders with learning disabilities and other developmental needs to be aligned with the YOS including the Diversion Scheme to assist in identifying young people with learning disabilities and other developmental disabilities.

7. Clarity and awareness is needed of the local ASD Pathways and what is available to the YOS staff, young people and their carers. This would help to co-ordinate involvement between the YOS and appropriate agencies and promote partnership with parents and young people.

8. The YOS, in partnership with children's services departments should provide preventive services for pre-teenage children that address common risk factors for care and crime and promote resilience.

9. Youth offending teams should work in close collaboration with looked after children teams to offer advice and preventive services / appropriate interventions for looked after children at risk of offending / re-offending.

10. The YOS should ensure training for its staff regarding the impact of abuse and neglect on looked after children in relation to offending, care placements and pathways.

11. Housing policy does not appear at present to reflect the needs of young people which often require an immediate response to acute need on a short-term basis. Additionally, the YOS lack access to short term emergency accommodation that could, in the first instance, act as a stop gap. The housing needs of young people with whom the YOS comes into contact need to be fed into housing/homeless forums in order to determine how these needs can best be met.
12. The availability of dedicated and specialist assistance to help young people to cope on a day to day basis with their living arrangements and to advocate for them if they get into difficulties is an area of support that some local authorities are already investing in, for example through floating support, but which needs further consideration with regard to young people and should be specifically available for all 16 and 17 year olds living independently. Those who have had fractured family relationships and move in and out of home are in effect trying to make the transition to independent living.
2. Aims and objectives

2.1 Introduction
CPI was commissioned by the Youth Offending Service (YOS) Board health subgroup to undertake a health and well being needs assessment of its youth offender population.

2.2 Purpose and scope of the HNA
A thorough evidence base is required to inform future commissioning for the young offender population across the Halton, Warrington, Cheshire West and Chester area. The scope of the health needs assessment was the youth offending population in the above geographical areas (including both males and females) between the ages of 10 and 18.

2.3 Methodology and data sources used

2.3.1 Methodology
Interviews were conducted during February and March 2015 with a range of stakeholders including representatives from:

- Local Safeguarding Children's Board
- School Nursing
- Youth Service
- Clinical Commissioning Group (CCG)
- Local authority strategic commissioning
- Custody health; and
- Child and Adolescent Mental Health Services (CAMHS)

In addition interviews were carried out with managers, case managers, education staff, substance misuse and CAMHS staff from within the YOS. In total 42 individuals were spoken to.

Issues explored with stakeholders included:
How are physical and mental health needs of young offenders identified?

What are the levels of threshold used which trigger referral for intervention from a health professional?

How confident/equipped do generic YOS staff feel able to identify health problems?

What healthcare provision is available across the young offender pathway in custodial and community settings?

Quality of relationships and information sharing between YOS and external providers/Case Managers.

Level of need in relation to: Physical health conditions, Mental health, Behavioural, Disability, Finance and Relationships.

Wider health related needs such as accommodation and education, training and employment needs.

A small group of young people on current YOS orders were also interviewed to ascertain their views on health needs and services they had received, in total 6 young people participated, having given informed consent.

2.3.2 Data sources

Types of interventions provided by the Youth Offending Service (YOS) in Halton, Warrington and Cheshire West and Chester include statutory orders and Diversion Programme interventions. The two most common statutory orders, and most commonly referred to in this document, are:

- Referral Orders (RO) and
- Youth Rehabilitation Orders (YRO).

A Referral Order ‘refers the young offender to a Youth Offending Team and places the young person under their supervision for a period of 3–12 months’ and will include a Referral Order Contract agreed with the young person and their parent/carer to prevent further offending. This may include a letter of apology to the victims, community service, sessional training programmes, or advice and support.
A Youth Rehabilitation Order is ‘a generic community order’, often with requirements imposed by the court, such as a curfew (with electronic tag), activity or exclusion requirements, supervision by the YOS, or drug treatment attendance\(^1\).

The Diversion Programme is a scheme aimed at first-time entrants into the criminal justice system and includes assessment, referral/s to appropriate interventions and support. ‘The key aim of the project is to divert children and young people with specific health needs or learning difficulties away from the Youth Justice System, by providing appropriate and professional support at the earliest stage’\(^2\).

Participation in statutory orders is mandated by the courts; participation in the Diversion Programme, while beneficial, is voluntary.

A review of case records for young offenders undergoing both statutory orders and Diversion Programme interventions (primarily focusing on assessment documents) was carried out to investigate the recorded health needs of young offenders (male and female, aged 10-18) in contact with the youth offending service across Halton, Warrington and Cheshire West and Chester.

The current caseload (rather than historical records) was selected to include in analysis so as to align with results from interviews with young offenders currently being supported by the service. Since including all 240 current cases would not have been practical within time constraints, a sample was defined, stratified by area (so a representative proportion of the sample would be from each area) and cases were randomly selected using a random number generator.

The final sample numbers are outlined in Table 1.

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Table 1: Sample numbers in each area

<table>
<thead>
<tr>
<th>Area of Residence</th>
<th>Cases in Final Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cheshire West and Chester</td>
<td>92</td>
</tr>
<tr>
<td>Halton</td>
<td>36</td>
</tr>
<tr>
<td>Warrington</td>
<td>47</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>175</strong></td>
</tr>
</tbody>
</table>

These numbers gave an overall statistical confidence level of 95% with a confidence interval of +/-3.86.

It should be noted that some young people may have been included twice in the sample due to having two types of ongoing order (both a statutory Referral Order or Youth Rehabilitation Order and a Diversion Programme intervention).

National and local data from various sources was gathered to enable comparison of prevalence with that found in the YOS data. These sources included data on young people in general, such as census and population data from the Office for National Statistics, data from the National Child and Maternal Health Intelligence Network (CHIMAT) and data regarding the physical health, mental health, substance use and social needs of young people from a variety of academic research, national strategies and local publications. Data regarding the health and wellbeing needs of young offenders nationally was also included where appropriate and available to add context.

An online survey was used to gather the views of stakeholders regarding the health and wellbeing needs of young offenders as well as strengths, limitations and potential improvements to current health and wellbeing provision for this group.
2.4 Data Limitations

The assessment documents used in the review differed depending on the young offender’s order.

For young offenders on statutory orders such as Youth Rehabilitation Orders (YRO) or Referral Orders (RO) this consisted of an ASSET assessment. ASSET is ‘a common, structured, assessment tool used across the youth justice system in England and Wales. The purpose of an ASSET Assessment for making a comprehensive and holistic assessment; identifying the needs of a young person; identifying factors contributing to offending behaviour; identifying risk and vulnerability and identifying positive factors as well as problems.’ ASSET includes detailed sections covering assessment of mental health, substance misuse and social variables. Physical health is also assessed (although in less detail).

For those on Diversion Orders the assessment template is different and less detailed, with notably fewer ‘prompts’ in the form of questions and tick-boxes, such that in many cases it was not clear whether a particular need was not present or that the question had not been asked. For this reason some of the information available regarding a young person’s health was different depending on the type of order they were subject to.

Assessment documents are updated or added to at case review or when a case is being closed. Where possible the most recent assessment document available was used in order to capture any changes or improvements from the start to review / end of order. However, since the cases used were those on the current caseload (so as to align more closely with interview findings) only a few orders had progressed to review stage and very few were at the point of closure, so it was rare that any change was documented.

A total of 246 client records were initially thought to be available as a snapshot of all those in contact with the YOS across all three areas (Halton, Warrington and Cheshire West and Chester) as of January 2015. During the course of the case review, 6 cases (4 from Cheshire West and Chester and 2 from Warrington) were found to be duplicates or cases that were no longer live but had not been closed on the system; these were removed from the case list, reducing the total number of cases available from 246 to 240.

3 http://trixresources.proceduresonline.com/nat_key/keywords/asset_assessment.html
In addition, due to an ongoing transfer of Cheshire West and Chester cases being moved onto the same computer system as Halton and Warrington, a number of Cheshire West and Chester cases were not available to view. These were excluded by necessity, and this resulted in the Cheshire West and Chester sample being slightly smaller than planned. This also meant it was impossible to achieve a random sample for Cheshire West and Chester, as all available Cheshire West and Chester cases had to be included. It was apparent that some YOS staff members had a larger ‘backlog’ of cases yet to be entered than others; it is not clear whether this will have affected the results (that is whether young people with certain needs are more likely to be allocated to certain practitioners).

The intended and final sample numbers are outlined below at Table 2.

**Table 2: Sample numbers in each area**

<table>
<thead>
<tr>
<th>Health Needs Assessment Sampling</th>
<th>Total Cases</th>
<th>Initial (Intended) Sample</th>
<th>Cases in Final Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cheshire West and Chester</td>
<td>129</td>
<td>100</td>
<td>92</td>
</tr>
<tr>
<td>Halton</td>
<td>48</td>
<td>37</td>
<td>36</td>
</tr>
<tr>
<td>Warrington</td>
<td>63</td>
<td>49</td>
<td>47</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>240</strong></td>
<td><strong>186</strong></td>
<td><strong>175</strong></td>
</tr>
</tbody>
</table>

The sample as a whole is representative of the YOS client population as at January 2015, with a confidence level of 95% and confidence interval of +/-3.86. This means that, for example, if 50% of the sample were reported to have mental health problems, it is possible to be 95% certain that the prevalence of mental health problems within the whole current client population lies between 46.14% and 53.86% (3.86 either side of 50%).

The relatively small numbers involved when comparing between Halton, Warrington and Cheshire West and Chester, or between young offenders on difference types of order, mean results should be

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4 While some cases were found to have been incorrectly transferred (should not have still been ‘live’ on the system) during the review, it was impossible to know whether those not yet input onto the system should be live or not. Thus there may in reality be fewer total cases than stated here. A data cleansing exercise to determine the actual total number of Cheshire West Divert cases was planned but had not yet been completed at the time of writing.
interpreted with caution. The 95% confidence intervals for all health and wellbeing prevalence figures are presented in tables in Appendix 3. All health and wellbeing prevalence figures quoted in the report should be interpreted in conjunction with their confidence intervals.

Due to the very small numbers presented in some instances, for data protection reasons, figures where case (client) numbers were less than 5 have been suppressed.
3. Policy context

In 2010-2012 a review was carried out of the then Halton and Warrington Youth Offending Team and Cheshire Youth Offending Service, by the respective partner organisations and their management boards. The review resulted in the establishment of Cheshire West, Halton and Warrington Youth Offending Service (CWHYOS) which came into existence on the 1st October 2012.

A new partnership agreement was adopted in December 2012 and the current Chair is the Director of Children Services at both Halton and Cheshire West and Chester. The Chair's position rotates between the three local authorities and the Executive Director for the Families and Wellbeing directorate in Warrington will take over for the period 2016-2017. The primary motive for the new partnership was to improve services and outcomes for children, young people, victims and communities in an age of diminishing resources.

A Youth Justice Strategic Plan is in place for 2014-2017. The Strategic Plan links to the Children and Young People’s Plans in all three local authority areas as well as the relevant Community Safety Plans and the Cheshire Criminal Justice Board plan. The Youth Justice Strategic Plan also links to the plans of the three Local Safeguarding Children Boards (LSCB) and that of the Police and Crime Commissioner.

The strategic landscape within which CWHYOS operates is set out diagrammatically below.
Figure 1: Strategic landscape

CWHYOS Strategic Position

Note on organisations represented.5

MAPPA: Multi-Agency Public Protection Arrangements (management of violent and sexual offenders)
MARAC: Multi-Agency Risk Assessment Conferences (part of coordinated community response to domestic abuse)
IOM-Navigate: The NAVIGATE scheme brings together key partners: Police, probation, youth offending teams, employment, health, housing and drug and alcohol agencies to work in partnership with Cheshire’s most prolific and repeat offenders so as to change their behaviour and lifestyle.
PCC: Police and Crime Commissioner
CSP: Community Safety Partnership
CWHWYOS has five focus areas, with an ambition to maintain and, where possible, improve existing service outcomes:

1. Reduce first time entrants to the Youth Justice System
2. Reduce use of custody
3. Reduce reoffending
4. Reduce numbers of young offenders who are not in employment, education or training, and
5. Improve the accommodation outcomes for young people subject to youth offending supervision.

The local strategic environment is complex but its importance was recognised by all partners in their desire to maintain a YOS that would be compatible with the original Youth Offending Team (YOT) model and with Youth Justice Board (YJB) guidance on Modern YOT Partnerships (October 2013).

The Head of YOS Services is well placed within the local authority strategic framework and is a member of the three relevant Safeguarding Children Boards, Children’s Trusts/Young People’s Partnership, Community Safety Partnerships and Cheshire Criminal Justice Board. The YOS Operations Manager is a member of the Multi-Agency Public Protection Arrangements (MAPPA) Strategic Management Board and attends several Safeguarding subgroups in all three local authority areas. The YOS also has an active role and membership in the three domestic abuse multi-agency governance groups in the area.

The Head of Service plays a key role in the Association of YOT Managers. This seeks to improve Youth Justice outcomes nationally by way of influencing strategic direction, as well as sector-led improvement and effective practice dissemination through links to academia and the wider youth justice arena. It is anticipated this role will continue for the duration of the 2014-2017 strategy.

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6 Multi-Agency Public Protection Arrangements (MAPPA) is the name given to arrangements in England and Wales the “responsible authorities” tasked with the management of registered sex offenders, violent and other types of sexual offenders, and offenders who pose a serious risk of harm to the public
YOS Board members have an active role in ensuring that other strategic partners and groups (such as Health and Well Being Boards) are well informed of youth justice issues.

An area for development has been the role of health representation following the extensive redesigning of the health landscape. The YOS Board has recognised the potential for children and young people in the Criminal Justice System to potentially become ‘lost’. Given this a health subgroup has been formed specifically to ensure that complex geographical and responsibility areas are discussed.

The subgroup meets quarterly and is chaired by the Chief Executive of Halton Clinical Commissioning Group who is the health representative on the main Board. The Chair ensures that all relevant health partners are involved in the identification, commissioning and delivery of services, designed to improve health outcomes and thereby reduce offending and reoffending. The group also ensures that local strategic needs assessments include those individuals subject to YOS supervision, both at early and statutory intervention level. The subgroup reports to the YOS Board quarterly.
4. Overview of current provision

4.1 Overview of Service Delivery Model
Current arrangements for dedicated health provision are based upon the previous YOS delivery model and therefore resource availability differs in each geographical area. Table 3 sets out an overview of current provision.

Table 3: Overview of current health provision to young offenders accessing the YOS

<table>
<thead>
<tr>
<th></th>
<th>Cheshire West and Chester</th>
<th>Halton</th>
<th>Warrington</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary health needs</strong></td>
<td>Health assessments are undertaken via 1.5 CAMHS workers employed as Health Workers</td>
<td>No health needs assessment offered - young people are signposted to the relevant services</td>
<td>A health assessment is offered via a new school nurse pilot for both young people on a statutory order as well as those who come via the Divert Team.</td>
</tr>
<tr>
<td><strong>Mental health</strong></td>
<td>Interventions can be provided via the 1.5 CAMHS workers employed as Health Workers to young people on a statutory order. In addition a referral can be made to the local CAMHS service for all young offenders.</td>
<td>Referral pathway is in place for receiving specialist mental health intervention with 5 Boroughs Partnership.</td>
<td>Referral pathway is in place for receiving specialist mental health intervention with 5 Boroughs Partnership.</td>
</tr>
<tr>
<td>Substance misuse</td>
<td>YOS employed Tier 3 worker provides professional consultation to YOS Case Managers in Cheshire West and Chester. In addition, for Cheshire West the YOS have a link to a substance misuse practitioner in the community substance misuse team.</td>
<td>There is one full-time YOS employed Tier 3 substance misuse worker covering Halton and Warrington for young people on a statutory order.</td>
<td>There is one full-time YOS employed Tier 3 substance misuse worker covering Halton and Warrington for young people on a statutory order.</td>
</tr>
</tbody>
</table>

The intention is that CWHYOS works across the whole Cheshire footprint (excluding East Cheshire which comes under the jurisdiction of Safer Cheshire East Partnership). Much work has been undertaken to improve integration which has been initiated through a service redesign and move to one shared database. The expectation is to move to a model where there is greater parity of provision across the footprint thereby addressing inequality in provision and resource with particular reference to health provision.

The re-modelling has resulted in teams split across 3 areas: North, South and Central which are co-terminus with the two local authority boundaries as well as the North and West Division of Cheshire Police. This provides a similar infrastructure of management and support functions.
4.2 Primary Health Needs

Initial Assessment
ASSET\(^7\) or the Divert assessment tools are used to undertake initial assessments. Each asks specific questions on physical, emotional and mental health screening, alongside substance use, speech, language and communication. The assessment also explores the young person’s relationships and support. This is completed by YOS Case Managers (not health practitioners). CWHWYOS work to the principle of screening and identifying the physical and emotional health needs of young people at the earliest point of their contact with the service. This assessment contributes to the support offered at Triage stage and reports written.

Health Action Plans
The health assessment meeting is different to the initial assessment and is undertaken with a health professional. Health needs which are identified by a health professional (i.e. one of the CAMHs workers or school nurse) are addressed via the delivery of an individualised Health Action Plan which is agreed with the young person and delivered flexibly in a range of community and partner settings. Support can be offered via targeted interventions/programmes, brief interventions, health promotion activities, support to access universal or specialist services, building confidence and self-esteem, promoting independence and independent living skills.

Cheshire West and Chester
There are no generic nurses attached to the YOS in respect of physical health. However, all young people in Cheshire West and Chester subject to a court order and supervised by the YOS are offered a health assessment appointment with one of the YOS CAMHS workers (1.5 WTE) who are employed in a

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\(^7\) ASSET is a national assessment tool which the Youth Justice Board expects youth offending teams to use in their work with all young people.
generic health capacity. Any young person with a specific need can be referred by either the case manager or the young person themselves.

**Warrington**

All young people from Warrington receive a health assessment appointment with a school nurse from the area (even if they are not in school) currently operating under a pilot scheme. The YOS officer and school nurse meet together with the young person. This is a statutory appointment however young person can refuse to speak with the nurse as the intervention is provided with informed consent. Figures in regards to uptake are not available as yet. The school nurses provide comprehensive primary health screening and assessment for young people at risk of offending or known offenders and health promotion (family planning, teenage pregnancy, substance misuse guidance).

**Halton**

At present, young people from Halton do not receive a health assessment appointment within the YOS. Young people are signposted and referred where required by the YOS Case Manager. There are no plans at present for a similar pilot with the school nurse service, however results from the Warrington pilot as well as this health needs assessment will inform future plans.
4.3 Young Offenders who are Children in Care

Cheshire West and Chester
In Cheshire West and Chester there is a designated nurse for Safeguarding and Children in Care providing expert advice to all health professionals, the local authority, and the Local Safeguarding Children Board in the area.

Warrington
In Warrington there is a Specialist Children in Care Health Team responsible for ensuring that the health needs of these children are addressed and that statutory requirements are met. The team consists of a paediatrician, a specialist nurse and administrative support. The paediatrician carries out many of the initial health assessments and some of the reviews. The paediatrician also provides advice to other healthcare and social care professionals about the health of children in care. The Specialist Nurse works between health and social care. The role of the nurse is to ensure that all children in care have a health assessment. The nurse carries out the health assessments for children in residential care and young people aged 16 to 18 years and contributes to care planning meetings and children in care reviews.

Halton
In Halton the Looked after Children Health Team (provided by Bridgewater Community Healthcare NHS Foundation Trust) offers a community based team of experienced specialist nurses who provide assessment, care or referral dependent on the child/young people’s needs.

There is liaison between all of the above professionals and the YOS teams to determine who is best placed to undertake any health assessment or specific health need identified when looked after young people are involved with the YOS.
4.4 Emotional and Mental Health
The comprehensive CAMHS agenda has been well documented since the development of Every Child Matters (DFE 2004) and supports the development of a tiered response to levels of need as demonstrated below at Figure 2.

Figure 2: CAMHS provision

**Tier 1: Universal Provision, working with all children.** This involves the adoption of a range of services designed to create the best developmental and emotional start for all children and which are sustained through to adulthood. They include family/infant mental health and emotional wellbeing approaches.

**Tier 2: Early intervention/targeted provision.** This involves early detection and provision of preventative support to children and families in need. At this step structured self-help approaches, behavioural, and/or family support are provided to reduce the impact of mental health and emotional problems and prevent their escalation to greater/more significant difficulties.

**Tier 3: Specialist provision for those with complex needs.** This involves specialist diagnostic assessment and the provision of psychological, systematic and/or pharmacology therapy. Intervention at this step is provided to children and young people who are experiencing moderate mental health and emotional difficulties which are having a significant impact on daily psychological/social/educational functioning. Intervention at this level is normally provided through specialist/specific multi-disciplinary teams.

**Tier 4: Highly specialised provision.** This involves provision of crisis resolution and intensive home/residential/or day care services designed to reduce and/or manage those children and young people who are at immediate risk or who need intensive therapeutic care.
Cheshire West and Chester

There are 1.5 CAMHS workers (seconded from Cheshire and Wirral Partnership NHS Foundation Trust) who provide a health worker role to Cheshire West and Chester young people on YOS orders. This provision is commissioned via West Cheshire CCG and Vale Royal CCG.

The workers provide access to inclusive primary health care services (for example immunisation, fast-tracking access to doctors, dentists, opticians, Family Nurse Partnership and family support) and deliver sexual health interventions, such as access to condoms, Chlamydia screening, advice and information and support to access services such as GUM and community sexual health services.

Both offer consultations to staff and have slots each week in separate geographical areas to enable staff to drop in to discuss any concerns regarding their clients. They CAMHS workers will be offering health screening to all Cheshire West statutory cases which will lead to work with young people with identified needs regarding any health issues including emotional wellbeing, self esteem, low mood and so forth. They also provide health promotion sessions during half term/school holidays such as Mental Health Week which they organise.

Divert cases at present only receive a consultation between YOS case managers and CAMHS Health Worker but this may change as the model starts to work with the new structure.

In summary, the CAMHS Health workers provide a range of support functions and interventions which include:

- Comprehensive primary health needs assessment
- Brokerage role to support access to health care services including both primary and secondary care throughout the young person's involvement with the YOS
- Comprehensive mental health assessment and appropriate therapeutic interventions for children and young people appropriately referred via YOS Case Managers
- Consultation for professionals working with young people under the supervision of Cheshire West, Halton and Warrington Youth Offending Service and to Divert and Court Officers.
- Direct psychotherapy with young people, as well as evaluation of outcomes for children and young people
- Training to YOS staff on the mental health needs of this population.
- Undertaking emergency assessment and management of risk following an urgent referral from within Youth Offending Services.
- Link with tier three/two CAMHS, to undertake appropriate direct intervention in accordance with the Cheshire CAMHS protocol.

**Halton and Warrington**

For young people from Halton and Warrington, the YOS have a referral pathway in place with the Five Boroughs Partnership NHS Trust who provide specialist child and adolescent mental health services. Young people are not fast tracked but subject to the same processes.

The Five Boroughs Partnership CAMHS service deliver specialist services including assessment, triage, consultation, diagnosis, formulation and treatment in a range of settings including community and locality settings. The Tier 3 specialist CAMHS service is provided for the most severe, complex and persistent of child mental health problems/disorders and risk factors which have multi-factorial causation and which require interventions to be delivered on a multi-agency basis. The Five Boroughs Partnership CURT Service is an urgent response team provide urgent assessment and service to young people up to their 18th birthday within 24 hours.
In addition consultation is available to YOS staff by telephone via a named person in the CAMHS team. Where a young person and/or family do not consent to a specialist CAMHS intervention, the YOS Case Manager are able to benefit indirectly through anonymous clinical consultation to seek advice/guidance.

4.5 Substance Misuse
The four-tiered model of drug and alcohol interventions outlined in the *Substance of Young Needs* (HAS, 1996 and 2001) provides a framework to conceptualise the service components of an integrated and comprehensive child-based service. Figure 3 sets out a brief description of the four tiers.

**Figure 3: Substance misuse**

**Tier 1:** The purpose of generic and primary services within this structure is to ensure universal access and continuity of care to all young people. In addition, it aims to identify and screen those with vulnerability to substance misuse and identify those with difficulties in relation to substances. It will be concerned with education improvement, maintenance of health, educational attainment and identification of risks or child protection issues. It will also engage in embedding advice and information concerning substances, within a general health improvement agenda. These should be seen as mainstream services for young people.

**Tier 2:** Youth orientated services, offered by Case Managers with some drug and alcohol experience and youth specialist knowledge, should be working at this level. The aim and purpose of this tier is to be concerned with reduction of risks and vulnerabilities, reintegration and maintenance of young people in mainstream services.
**Tier 3:** Young people’s specialist drug services and other specialised services, which work with complex cases requiring multidisciplinary team-based work, should be working at this level. The aim of Tier 3 services is to deal with complex and often multiple needs of the child or young person and not just with the particular substance problems. Tier 3 services also work towards reintegrating and including the child in their family, community, school or place of work.

**Tier 4:** Tier 4 services provide very specialist forms of intervention for young drug misusers with complex care needs. It is recognised that, for a very small number of people, there is a need for intensive interventions, which could include short-term substitute prescribing, detoxification and places away from home. Such respite care away from home might be offered in a number of different ways, such as residential units, enhanced fostering, and supported hostels.

**Substance Misuse Provision**

There is one full-time Tier 3 substance misuse worker covering Halton and Warrington young people on statutory orders and who also provides professional consultation to the YOS Case Managers in Cheshire West and Chester. Until December 2014 there was also a dedicated Tier 2 Targeted Worker in Cheshire West and Chester, however, following restructure, this post no longer exists. Due to recently identified levels of substance misuse, the Tier 3 Worker has started to offer a session to Divert cases followed by referral to the most appropriate service.

Any Tier 2 level concerns are addressed by YOS officers/Support workers. All Case Managers and support staff have been trained to DANOS\(^8\) standards and the expectation is that they now provide brief and targeted Tier 2 interventions. For Cheshire West and Chester young offenders there is an

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\(^8\) The Drug & Alcohol National Occupational Standards (DANOS) specify the standards of performance that staff in the drug and alcohol field should be working towards. DANOS describe the knowledge and skills workers need in order to perform to the standard required by each unit.
established referral route to the external Tier 3 substance misuse service. Recently the Young People's Substance Misuse Contract for community provision was re-tendered and negotiations are currently underway between the YOS and Turning Point to confirm what the new pathway will be.

**Identification and Screening of Substance Misuse**

The identification of substance misuse is undertaken through a process where, if there is an ASSET score of two or more, this triggers the completion of a substance misuse screening tool (which is a simplified version of DUST). Utilising the screening score, professional judgement and, where needed, consultation with the YOS substance misuse worker, a decision is taken to what interventions the young person requires and whether a referral is needed for Tier 3 intervention.

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Drug Use Screening Tool (DUST) is a screening tool to identify substance misuse risks and other risk factors to assist in a "holistic assessment" of a young person's needs. DUST assists in the professional delivering low level interventions where substance misuse and other risk factors are low.
5. Overview of YOS population

5.1 National characteristics of young offenders

A report from the Ministry of Justice states that in 2012/13, there were 126,809 arrests of young people (aged 10-17) across England and Wales, representing 11.8% of all those arrested. However, young people accounted for only 10.5% of the total population aged 10 and over (i.e. those ‘eligible’ for arrest), suggesting that young people are over-represented in the criminal justice system.\(^{10}\)

The same report states that of the 41,569 young people who received a substantive outcome (a court or out-of-court disposal, which would result in contact with a youth offending service) 81% were male, 78% aged 15 and over, and 75% from a white ethnic background. The number of young people worked with by youth offending teams has declined year-on-year over the past five years, but the number of previous offences per individual has risen over the same time. This implies the youth justice system is working with a smaller number of more prolific, and likely more complex, individuals.

The evidence suggests that young people in contact with the criminal justice system are more likely to experience ill health than others of the same age, particularly in terms of mental health problems, learning difficulties, substance misuse, and speech and language problems. Conversely, it seems involvement in criminal activity can have a deleterious effect on mental health, with young people in prison 18 times more likely to take their own life than their peers in the community.\(^{11}\)

Some social factors are also associated with criminal justice involvement, such as being or having been a looked-after child (LAC) or living in more deprived areas.\(^{12}\)

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5.2 Characteristics of young people and young offenders in Cheshire West and Chester, Halton and Warrington

The age of criminal responsibility in England and Wales is 10. The youth justice system may deal with young people up until turning 18 (18 year-olds will only normally be included if there is only a short period remaining on their order or sentence).

This chapter focuses on the demographic characteristics of young people aged 10-18 in Cheshire West and Chester, Halton and Warrington – where possible comparing young people in the community as a whole with those worked with by the Youth Offending Services.

As noted previously, a randomly selected sample\textsuperscript{13} was taken from the open caseload of Halton, Warrington and Cheshire West and Chester youth offending services as of January 2015. A total of 175 cases were included in the sample. The following data is based on a review of the documentation available on the services’ computer systems for these cases (mainly assessment documents).

For some of the sections below, data from the Office for National Statistics (ONS) has been used; due to the ONS grouping of young people aged 18 into ‘18-19 year olds’, this category has been included in analyses.

5.2.1 Age structure

The population is slightly younger in Halton and Warrington than the North West as a whole, with 11% of the population falling within the remit of youth justice services (being aged 10-17) in both areas. In Cheshire West and Chester, young people aged 10-17 make up 10% of the population, in line with the North West average of 10\%\textsuperscript{14}.

\textsuperscript{13} The final sample numbers gave an overall statistical confidence level of 95% with a confidence interval of +/-3.86.

\textsuperscript{14} ONS Data 2013 Mid-Year Estimates
Chart 1: Age distribution of all young people aged 10-18 in Cheshire West and Chester, Halton and Warrington

The age structure of young people in contact with the YOS is older than the whole population of young people in each area, with no YOS clients aged under 12, and most aged 16 to 17. The same pattern is seen nationally, with young people aged 16-17 over-represented among young offenders.

Chart 2: Age distribution of YOS clients, snapshot as at January 2015

O'S Data 2013 Mid-Year Estimates
Warrington has the highest overall proportion of younger clients, with 38% of cases aged 15 and under compared to 29% in Cheshire West and Chester and 22% in Halton. Halton has a high proportion (36%) of young offenders aged 16, and none aged 13 or under.

The age distribution of young offenders receiving Diversion Programme intervention is generally younger than that of those on statutory orders such as Youth Rehabilitation Orders (YRO) or Referral Orders (RO) – with 23% of diversion cases aged under 15 compared with just 7% of statutory cases. This is to be expected since first-time offenders are more likely to receive a diversion intervention.

5.2.2 Gender

ONS data indicates that nationally, 51% of young people aged 10-18 are male. There is very little gender variation between areas.

Table 4: Gender split of young people aged 10-18 in Cheshire West and Chester, Halton and Warrington

<table>
<thead>
<tr>
<th></th>
<th>Males 10-18</th>
<th>Females 10-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cheshire West and Chester</td>
<td>51.6%</td>
<td>48.4%</td>
</tr>
<tr>
<td>Halton</td>
<td>50.8%</td>
<td>49.2%</td>
</tr>
<tr>
<td>Warrington</td>
<td>51.8%</td>
<td>48.2%</td>
</tr>
<tr>
<td>North West</td>
<td>51.2%</td>
<td>48.8%</td>
</tr>
<tr>
<td>England</td>
<td>51.2%</td>
<td>48.8%</td>
</tr>
</tbody>
</table>

Overall, of all cases in the YOS sample, 83% were male and 17% female, indicating that young males are disproportionately represented in the YOS population. This aligns with the national picture of young offenders (81% male). There was some variation between areas – 22% of young offenders in Halton were female, compared to 17% in Warrington and 14% in Cheshire West and Chester.

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16 ONS Data Census 2011
5.2.3 Ethnicity

The general population, including those aged 10-18, in Halton, Warrington and Cheshire West and Chester are less ethnically diverse than the population nationally or in the North West as a whole. The young population in Halton is the least diverse, with 97% of young people aged 10-19 categorised as ‘White British’. In Cheshire West and Chester, 96% are ‘White’ with 95% being ‘White British’, while in Warrington this is 96% and 94% respectively. Each area has 1% listed as ‘White Other’.

Chart 3: Ethnic group of young people aged 10-19 in Cheshire West and Chester, Halton and Warrington

In Cheshire West and Chester and Halton, 2% of young people are listed as ‘Mixed/Multiple Ethnic Group’ and 1% as ‘Asian/Asian British’; in Warrington 2% are classed as ‘Asian/Asian British’ and 2% as ‘Mixed’.

17 ONS Data Census 2011
Of all cases included in the sample, 94% of the young offenders had a white British ethnic background. This is considerably less ethnically diverse than the national average (75% white) and reflects the ethnic makeup of the areas’ population of young people: 97% of young people aged 10-19 categorised as white British in Halton, 95% in Cheshire West and Chester and 94% in Warrington.

Warrington appears to have the most ethnically diverse young offenders in contact with YOS, and Cheshire West and Chester the least. To some extent this is concomitant with the Warrington population as a whole being more diverse, however the difference is quite pronounced (4% of all young people in Warrington belong to ethnic groups other than white British – i.e. are from black and minority ethnic groups – compared to 13% of those in the YOS sample) suggesting that young people from ethnic minorities are over-represented in the youth justice system in Warrington.

Young offenders on a Diversion Programme were generally more likely to have an ethnic background other than white British (9% compared to <5% for YRO and RO cases combined). This is mainly accounted for by Warrington (with 15% of Diversion Programme cases having an ‘other white’ background and 15% ‘unknown’).
5.2.4 Area of Residence

Of the 175 young offenders in the sample, 53% (n=92) were resident in Cheshire West and Chester, 27% (n=47) in Warrington and 21% (n=36) in Halton. This was intentionally reflective of the proportions managed by each area team in the total population of open cases.

Broad area of residence was recorded for each young offender; these are set out in the table below.

Table 5: Area of residence (broad)

<table>
<thead>
<tr>
<th>Area</th>
<th>% of area team</th>
<th>% of total</th>
<th>Number of Young Offenders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cheshire West and Chester</td>
<td>53%</td>
<td>53%</td>
<td>92</td>
</tr>
<tr>
<td>Chester</td>
<td>28%</td>
<td>15%</td>
<td>26</td>
</tr>
<tr>
<td>Ellesmere Port &amp; Neston</td>
<td>36%</td>
<td>19%</td>
<td>33</td>
</tr>
<tr>
<td>Vale Royal</td>
<td>36%</td>
<td>19%</td>
<td>33</td>
</tr>
<tr>
<td>Halton</td>
<td>21%</td>
<td>21%</td>
<td>36</td>
</tr>
<tr>
<td>Runcorn</td>
<td>44%</td>
<td>9%</td>
<td>16</td>
</tr>
<tr>
<td>Widnes</td>
<td>56%</td>
<td>11%</td>
<td>20</td>
</tr>
<tr>
<td>Warrington</td>
<td>27%</td>
<td>27%</td>
<td>47</td>
</tr>
<tr>
<td>Total Sample</td>
<td>27%</td>
<td>27%</td>
<td>175</td>
</tr>
</tbody>
</table>

Postcode data was available for the young people engaged with the YOS. 90% of young offenders had a recorded postcode within the YOS area; the remaining 10% were out of area – these may have moved during the course of their order or intervention due to being accommodated by family or a residential provider (including custodial sentences) in a different area.
The Office for National Statistics (ONS) provides classifications of area type based on the lower super output area. In Halton the majority of young people involved with the YOS were living in areas classified as ‘Disadvantaged Urban Communities’ (61% of young offenders residing in such areas). Warrington and Cheshire West and Chester had a more varied distribution. In Warrington, 34% of young offenders were living in areas classed as ‘Miscellaneous built-up areas’ while 32% were in ‘Disadvantaged Urban Communities’.

The chart below compares the proportion of young offenders in the sample resident in areas classified as ‘Disadvantaged Urban Communities’ with the proportion of lower super output areas (LSOAs) in each local authority classified as such, and gives an indication of the over-representation of young people from such areas. It is evidently not a direct comparison (since population density and number of young people in the population will vary between LSOA classification types and between local authorities) but does indicate the young people from these areas are over-represented. Young people from areas classified as ‘Miscellaneous built-up areas’ were also over-represented in Warrington.
5.2.5 Order

The table below sets out the number and proportion of young offenders in the sample on each type of order. By far the most common were Referral Orders (RO), Youth Rehabilitation Orders (YRO) and Diversion Programme (DP) interventions.

Table 6: Order type

<table>
<thead>
<tr>
<th>Order</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diversion Programme (DP)</td>
<td>90</td>
<td>51%</td>
</tr>
<tr>
<td>DTO Post Custody or Post Sentence</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Referral Order (RO)</td>
<td>52</td>
<td>30%</td>
</tr>
<tr>
<td>Youth Referral Order (YRO)</td>
<td>31</td>
<td>18%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>175</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

*Numbers suppressed (<5)

Young offenders on Detention Training Orders (DTO) were omitted from any analysis by order type due to the extremely small numbers involved.
5.2.6 Offence Type

The most common offence type was assault (28% of offences) followed by theft or burglary (19%) and public order and nuisance offences (11%).

Chart 7: Offence Type
Key Points – Population Overview

- Young people aged 16 to 17 are over-represented in the YOS population compared with the general population of young people in the area. A higher proportion of YOs in Warrington are aged 15 and under than those in the other areas.
- Males are disproportionately over-represented in the YOS population (83% male) compared with all young people aged 10-18 in the area (50-52% male). This is consistent with the national picture of young offenders (83% male) but varies between areas with more female YOs in Halton (22% female, 78% male).
- For the most part the YOS sample is less ethnically diverse than the national YO population (94% white British compared to 75% white) and reflects the ethnic makeup of the areas’ population of young people (94-97% white British). Warrington is unusual with 87% listed as white British compared to 96% of all young people in Warrington, suggesting that young people from ethnic minorities are over-represented in Warrington YOS.
- In almost all cases, the majority of young people involved with youth offending services were living in lower super output areas classified as ‘Disadvantaged Urban Communities’. This was particularly notable in Halton, with 61% of young offenders residing in such areas.
- The most common offence type was assault (28% of offences) followed by theft or burglary (19%) and public order and nuisance offences (11%).
6. Epidemiology

This section sets out the health and wellbeing needs of the young people in contact with Cheshire West and Chester, Halton, and Warrington YOS teams. Where possible, data on the health and wellbeing needs of young people in general (locally or nationally depending on available data) has been included for context and comparison.

6.1 Physical health

6.1.1 Health Conditions

Nationally, asthma is the most common long-term health condition reported among young people, along with epilepsy and diabetes.

The UK has one of the highest prevalence rates of asthma among children and young people worldwide, with one in 11 children (9%) affected\(^\text{18}\). Data from Hospital Episode Statistics for 2012/13\(^\text{19}\) indicates that the North of England has higher rates of emergency admissions for children and young people than the national average (275 per 100,000 age 0-18, compared to 219 per 100,000 nationally), and Halton has a higher rate than either (304 per 100,000). Warrington and Vale Royal have lower admission rates than average, and West Cheshire is similar to the national average (West Cheshire and Vale Royal CCGs together cover the Cheshire West and Chester area).

It is estimated that there are approximately 35,000 children and young people aged 18 or under with diabetes, predominantly (96%) Type 1. The estimated prevalence for Type 1 diabetes in people aged 18 and under is 1 in 430-530, or 189-233 per 100,000 (equivalent to 0.2%)\(^\text{20}\). Boys are slightly more likely to have diabetes than girls, with 52% of those diagnosed being male.

The rates of emergency admissions for children and young people due to diabetes are somewhat higher in the North overall (65 per 100,000 age 0-18, compared to 60 per 100,000 nationally), and considerably

\(^\text{18}\) [http://www.asthma.org.uk/asthma-facts-and-statistics]
\(^\text{19}\) Public Health England: Children and Maternal Health Intelligence Network Disease Management Information Toolkit – Paediatric Asthma, 2012/13 data. Data relate to emergency admissions during 2012/13 for under-19s with a primary diagnosis code of asthma.
higher in Halton (89 per 100,000) than either regional or national averages. However, admissions in Warrington and Vale Royal CCG areas are lower than average.

Epilepsy affects 48,000 children and young people under 18 in England\(^21\). Information from the Joint Epilepsy Council of the UK and Ireland suggests that 1 in 220 children in the UK is affected by epilepsy (equivalent to 0.45\%)\(^22\). Emergency admissions of children and young people aged 18 and under due to epilepsy are generally lower in Halton, Warrington and West Cheshire compared to regional and national average rates. The rate of admissions in Vale Royal, however, is higher (128 per 100,000 compared to 75 per 100,000 nationally).

The health of young offenders is noted to be poorer than that of young people in general\(^23\), although there is a general paucity of research into the physical health of young offenders\(^24\). A review of 15-17 year-olds in custody found 12\% of males of 30\% of females reported a physical health condition\(^25\); other studies have found much higher proportions of imprisoned young offenders with physical health issues, including one reporting 79\% of 17-year-old female YOs with a longstanding condition of disability\(^26\). Research suggests between 11-36\% of young people in contact with Youth Offending Services are identified as having physical health issues; however it also indicates an under-reporting of physical health complaints\(^27\).

The chart below illustrates the proportion of young people in contact with the YOS in Cheshire West and Chester, Halton, and Warrington recorded as having physical health needs.

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\(^21\) Liverpool Public Health Observatory (2013): Health Needs Assessment of Young Offenders in the Youth Justice System on Merseyside.
\(^22\) Joint Epilepsy Council of the UK and Ireland (2011): Epilepsy prevalence, incidence and other statistics. JEC.
\(^23\) Association for Young People’s Health (2014): Adolescent Mental Health. AYPH Research Update No. 16, February 2014; Ryan, M. And Tunnard, J. (2012): Evidence about the health and well-being needs of children and young people in contact with the youth justice system.
\(^24\) Ryan, M. And Tunnard, J. (2012): Evidence about the health and well-being needs of children and young people in contact with the youth justice system.
\(^27\) Ryan, M. And Tunnard, J. (2012): Evidence about the health and well-being needs of children and young people in contact with the youth justice system.
Overall 13% of young offenders in the sample were recorded as having any physical health condition (this was based on whether one was mentioned in assessment, regardless of whether an actual need was identified). Young offenders in Warrington were the most likely to be recorded as having any health condition (17% identified) and young offenders in Halton least likely (6%). This may indicate differences between the population, although the numbers involved are small. It may be more of an indication of variation in recording of health conditions between areas within the YOS.

A small proportion of young people were recorded as having a health condition affecting their daily functioning (determined by the ‘Health condition which significantly affects everyday life functioning’ tick box on ASSET for a statutory assessment, or an impact explicitly mentioned for a diversion case) – 6% overall (n=10).

Minor conditions (not impacting on functioning) included asthma, ‘mild’ cerebral palsy, previous injuries, skin conditions and conditions currently under investigation. Conditions affecting functioning included neurological conditions, digestive disorders, severe asthma, type 1 diabetes, and developmental disorders linked to maternal substance use during pregnancy.

Overall 2% of the sample were recorded as having asthma, 1% as having Type 1 diabetes, and 1% as possibly having epilepsy (one currently under investigation and one not currently taking medication for
the condition). Compared to the national prevalence estimates of 9% with asthma, 0.2% with Type 1 diabetes, and 5.8% with epilepsy, these figures are lower than expected. Possible explanations for this include incomplete identification or recording of health conditions for the young offenders in the sample, as well as the inconsistency of the populations considered – there is a lack of available data on expected prevalence specific to the age group managed by the YOS.

6.1.2 Disability

The 2010 ONS Life Opportunities Survey found that 9% of young people aged 11-15 had a disability as defined by the Disability Discrimination Act (DDA), with 10% identified as having some level of impairment. 8% of 16-19 year olds had a DDA-defined disability and 11% any impairment. The number of cases in the sample of young people in contact with YOS who were reported to have a disability (defined as explicitly stated to be registered disabled or in receipt of Disability Living Allowance) was very small, equating to a considerably smaller proportion than the 9% estimated for the general population of young people nationally.

6.1.3 Risky Health Behaviour and Sexual Health

Sexual health is an important consideration for young people. By the age of 16, around a third of young people (29% of heterosexual females and 31% of heterosexual males) report having had sexual intercourse. A study comprising a representative sample of sexually active individuals in Britain (including England, Scotland and Wales) during 2010-12 investigated the prevalence of sexually transmitted infections, the results of which are set out at Table 7.

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29 Actual number suppressed as <5.
Table 7: Prevalence of sexually transmitted infections among sexually active young people

<table>
<thead>
<tr>
<th></th>
<th>Age Group</th>
<th>16-17 years</th>
<th>18-19 years</th>
<th>All ages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any STI</td>
<td>Women</td>
<td>3.80%</td>
<td>1.50%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Men</td>
<td>0.30%</td>
<td>1.10%</td>
<td></td>
</tr>
<tr>
<td>Chlamydia</td>
<td>Women</td>
<td>2.30%</td>
<td>4.70%</td>
<td>1.50%</td>
</tr>
<tr>
<td></td>
<td>Men</td>
<td>0.00%</td>
<td>0.50%</td>
<td>1.10%</td>
</tr>
<tr>
<td>High-Risk Human Papillomavirus (HPV)</td>
<td>Women</td>
<td>16.30%</td>
<td>29.60%</td>
<td>15.90%</td>
</tr>
<tr>
<td></td>
<td>Men</td>
<td>4.50%</td>
<td>0.90%</td>
<td>8.40%</td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td>Women</td>
<td>0.00%</td>
<td>0.00%</td>
<td>&lt;0.1%</td>
</tr>
<tr>
<td></td>
<td>Men</td>
<td>0.00%</td>
<td>0.00%</td>
<td>&lt;0.1%</td>
</tr>
</tbody>
</table>

Young women were more likely to have any sexually transmitted infection than young men, and were also more likely than women in older age groups to have an infection. The most commonly identified infection was high-risk HPV, identified in nearly 30% of young women aged 18-19, with Chlamydia infection also identified in nearly 5% of young women in this age group.

Risk factors identified for sexually transmitted infections included higher numbers of sexual partners, higher numbers of sexual partners without condom use, first sexual experience under the age of 16, and residing in a more deprived area (IMD quintile 4-5). Area-level deprivation was also associated with reduced likelihood of a young person taking up the HPV vaccination.

Underage conceptions may be associated with other risky health behaviours such as unsafe sex and substance use, as well as mental health problems, social and educational disadvantage and chaotic lifestyles. The chart below illustrates the crude rate of conceptions and maternity (births) per 1,000 under-18s (females aged 15-17). While Warrington and Cheshire West and Chester fall at a similar level or below the regional and national averages for the rate of conceptions in under-18s, Halton has a somewhat higher rate than average.

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9% of the YOS sample were recorded as displaying risky health behaviour (identified using the ‘Health put at risk by his/her own behaviour’ tick box on ASSET or an explicit statement in a Diversion assessment) – this included substance use at a level impacting on health; sexual behaviour deemed ‘risky’ by the assessing practitioner (this applied to 3% of the sample overall) or poor self-care that could impact on health. Young offenders in Warrington were the most likely to display risky health behaviours – 21% were recorded as doing so (compared to just 3% in Halton and 8% in Cheshire West and Chester). 3% of the YOS sample were young parents or currently pregnant; as suggested by the ONS data above this was more prevalent in Halton (8% of the Halton sample).

A small proportion (3%, n=<5) of young offenders in the YOS sample were either young parents or due to become parents. The rate is higher amongst young offenders living in Halton, which reflects the

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33 ONS data [ONS Conception Rates, England and Wales, 2013](#)
The borough's higher overall under-18 conception rate and maternity rate compared to Warrington and Cheshire West and Chester.

Of those who were young parents and were marked as requiring some level of intervention in relation to parenting or their own related health issues, all were receiving interventions from external organisations.

6.1.4 Health Conditions by Order Type

Chart 10: Health conditions by order

Young offenders on YROs or ROs were more likely than those on DP interventions to be identified with any health condition or one affecting functioning; however those on DP interventions were more likely to have a recorded disability.

34‘DTO post sentence/post custody’ cases were omitted due to extremely small numbers (2 young offenders)
It may be that young offenders with a statutory order imposed are more likely to be reported as in poorer health and displaying more risky health behaviour because they are a more complex cohort. However, it may simply be that the assessment (ASSET) carried out by the YOS for these individuals is more thorough and thus more likely to identify these issues.

6.1.5 Physical health interventions

A total of 4% of all cases in the sample were indicated to require some level of intervention in relation to physical health. All of these were recorded as receiving an intervention – either from a YOS worker or a practitioner from an external agency. External interventions for physical health needs included work by Catch-22 regarding child sexual exploitation (CSE) risks, intervention from children's social care (CSC) regarding unsuitable accommodation, investigation of health needs in a young offender's institution, and encouragement by care home staff to see a doctor for a health issue. Interventions provided by YOS staff included work to address substance misuse that was impacting on health, and encouragement to re-register with a GP (resulting in the young person agreeing to attend with a parent).
6.2 Mental Health

6.2.1 Mental Health Disorders

Nationally, 10% of young people aged 5-16 will experience some sort of mental health problem – including emotional, behavioural and hyperactivity disorders. This rises to around 23% by age 18-20. Half of all life-long psychiatric disorders have started by the age of 14, and three-quarters by 24. Other key prevalence data includes:

- 4.4% of all young people (aged 11-16) have an anxiety disorder
- 1.4% are seriously depressed
- 6.6% have a conduct disorder
- 1.4% have severe ADHD, and
- 10-13% of 15-16 year-olds have self-harmed.

Several factors have been found to be associated with poorer mental health among young people, with the prevalence of mental disorders in young higher among those from low-income families, those with both parents unemployed, those living in more deprived areas, those experiencing multiple stressful life events, and those with poorer social networks and social support. Young people with mental health problems were also more likely to have unauthorised absences from school and to have special educational needs. Many such social and educational factors are also associated with offending behaviour.
The presence of mental and emotional disorders in young people has an impact on other health behaviours such as substance use – with smoking, drinking and drug use (particularly cannabis) higher than among those with no disorder\textsuperscript{42}.

The prevalence of mental health disorders among young offenders is recognised to be higher than that in the general population of young people. Research indicates that around 40% of young people in contact with the Youth Justice system\textsuperscript{43} and up to 95% of imprisoned young offenders (aged 16-20) have at least one mental health disorder, and many have more than one disorder\textsuperscript{44}. Almost half (43%) of young offenders in Young Offender Institutions have been found to have ADHD\textsuperscript{45}. 43% of young offenders on community orders have been found to have emotional and mental health needs\textsuperscript{46}.

A considerable number of the 175 young people in the sample were reported to have some level of mental health needs.

Overall, 57% of cases mentioned mental health in some way affecting the young person's functioning – this included anger issues, past trauma, stress, anxiety and so on. For those with an ASSET document this was determined by the 'Is the young person’s daily functioning significantly affected by emotions or thoughts' tick boxes, and for Diversion Programme cases by explicit mention of a mental or emotional health concern. Cases with an ASSET were more likely to have this recorded – again it is unclear whether this is a difference in the needs of young offenders on a YRO or RO, or a difference in assessment.

A lower but not inconsiderable proportion of young offenders had a known mental health diagnosis (17% overall). Of the recorded diagnosed mental health conditions, ADHD was the most common, accounting for 28% of those diagnosed or 5% of the total sample. Also common were developmental problems (17% of those diagnosed) oppositional defiant disorder (ODD, 10%), pathological demand avoidance (PDA, 10%) and autistic spectrum disorders (7%). Other disorders noted included conduct disorder, Tourette’s, attachment disorder and psychosis. Several young offenders had more than one diagnosis recorded.

26% (n=45) were in contact with mental health services at the time of assessment, and 23% had a history of self-harm and/or suicide attempts.
Young people in Halton had the highest levels of recorded mental health needs. They were the most likely to be reported as having their functioning impacted by their mental health, and be in contact with services. They were also more likely to have a history of self-harm or suicide attempts (31%, against an average of 23% across all areas). However young offenders in Cheshire West and Chester were most likely to have a formal diagnosis.
Young offenders on YROs were the most likely to have any type of mental health need, be in contact with services, and have a history of self-harm. Those on DP interventions were generally least likely to have a documented mental health need (though as noted this may be a recording issue as Diversion assessments appear less thorough), but were not significantly less likely to have a formal diagnosis.

The table below shows a broad comparison between estimated national levels of mental health disorder in young people (aged 11-16) and the prevalence found in the sample of young offenders used here. It should be noted that the age groups considered are slightly different so this is not a direct comparison. From this, however, it is possible to see that prevalence of mental health conditions seems higher in the sample cohort.

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47 ‘DTO post sentence/post custody’ cases were omitted due to extremely small numbers (<5 young offenders)
Table 8: National and Local Mental Health Prevalence

<table>
<thead>
<tr>
<th>Health Need</th>
<th>National Estimated Prevalence for Young People (General Population)</th>
<th>National Estimated Prevalence for Young Offenders</th>
<th>Proportion found in YOS Sample</th>
<th>95% Confidence Intervals for YOS Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Identified Mental or Emotional Health Need</td>
<td>10%</td>
<td>43%(^{49})</td>
<td>57.1%</td>
<td>53.3% - 61.0%</td>
</tr>
<tr>
<td>Any Diagnosed/ Diagnosable Mental Health Condition</td>
<td>10%</td>
<td>30-50%(^{60})</td>
<td>16.6%</td>
<td>12.7% - 20.4%</td>
</tr>
<tr>
<td>Conduct Disorder</td>
<td>6.6%</td>
<td>*</td>
<td>*</td>
<td>0.0% - 4.4%</td>
</tr>
<tr>
<td>ADHD</td>
<td>1.4%</td>
<td>43%(^{51})</td>
<td>4.6%</td>
<td>0.7% - 8.4%</td>
</tr>
<tr>
<td>Self-Harm</td>
<td>10-13%</td>
<td>22.9%</td>
<td>19.0% - 26.7%</td>
<td></td>
</tr>
</tbody>
</table>

\(^*\)suppressed due to small numbers (n<5)

6.2.2 ADHD, Learning Difficulties and autistic spectrum disorders.

The key symptoms of Attention Deficit Hyperactivity Disorder (ADHD) are inattention, impulsiveness and hyperactivity. The condition is frequently diagnosed in childhood but approximately half of those affected in childhood will continue to experience symptoms into adolescence. ADHD is estimated to affect around 2-4% of teenagers in the UK\(^{52}\).

The impact of ADHD on school achievement can be severe (due to poor concentration, difficulties focusing and planning) and the condition can also affect relationships with peers and those in authority, self-esteem, and health. Young people with ADHD are disproportionately likely to be involved in the youth justice system\(^{53}\).


\(^{52}\) Young people in prison. Campbell, S. and Abbott, S. (2013): Same Old... the experiences of young offenders with mental health needs. London: Young Minds/The Barrow Cadbury Trust

\(^{53}\) Adolescent ADHD (Attention Deficit Hyperactivity Disorder) AYPH Research Summary No. 12 , December 2012.

\(^{54}\) Harpin V and Young S (2012): The challenge of ADHD and youth offending. Cutting Edge Psychiatry in Practice, 1, 138-143.
Several issues are associated with adolescent ADHD which can put the young person’s physical and mental health at risk. These include increased risky behaviour (such as early substance use and risky sexual behaviour), insomnia and low mood, as well as a range of psychiatric disorders including behaviour disorders, anxiety and depression and eating disorders.

Definitions of learning difficulties and learning disabilities vary. Learning difficulties can be considered as “Any learning or emotional problem that affects, or substantially affects, a person’s ability to learn, get along with others and follow convention”. A learning disability, on the other hand, is “A significant, lifelong condition that starts before adulthood, affects development and leads to help being required to understand information, learn skills, and cope independently”\(^{54}\). The NHS definition of a Learning disability implies an IQ below 70. Learning disabilities are associated with increased prevalence of psychiatric disorders, autistic spectrum disorders, and conduct and emotional disorders\(^{55}\). The terms appear to be frequently used to refer to the same problems in the relevant literature, with learning ‘difficulties’ noted in some reports as equivalent to learning ‘disability’, leading to some confusion with regard to terminology. YOS assessment documentation tended to refer to learning difficulties as ‘difficulties’ rather than ‘disabilities’, reflecting what appears to be the convention in education literature (as opposed to health) so this is the terminology is used here to avoid confusion.

In England in 2010, 2.56% of girls and 4.19% of boys aged 7-15 were identified at School Action Plus or with a Statement of Special Educational Need (SEN) with a primary SEN associated with learning difficulties. 0.38% of girls and 0.60% of boys were identified with a primary SEN of severe or profound multiple learning difficulties (equivalent to severe learning disabilities).

The table below shows area-specific rates of learning difficulties and autistic spectrum disorders for all school age pupils, and how these compare to the England average rate.

\(^{54}\) Mindroom: [http://www.mindroom.org/index.php/learning_difficulties/what_are_learning_difficulties/learning_difficulty_or_learning_disability/](http://www.mindroom.org/index.php/learning_difficulties/what_are_learning_difficulties/learning_difficulty_or_learning_disability/)

Table 9: Rate of learning difficulties (rate per 1,000 school age pupils)\(^{56}\)

<table>
<thead>
<tr>
<th>Children with autistic spectrum known to schools</th>
<th>Cheshire West and Chester</th>
<th>Halton</th>
<th>Warrington</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.18 (Significantly lower)</td>
<td>7.88 (Not Significantly Different)</td>
<td>7.33 (Not Significantly Different)</td>
<td>8.17</td>
<td></td>
</tr>
</tbody>
</table>

| Children with moderate learning difficulties known to schools | 11.18 (Significantly lower) | 15.48 (Significantly lower) | 24.43 (Significantly higher) | 19.65 |

| Children with severe learning difficulties known to schools | 2.84 (Significantly lower) | 3.66 (Not Significantly Different) | 2.2 (Significantly lower) | 3.65 |

| Children with profound and multiple learning difficulties known to schools | 0.86 (Significantly lower) | 1.97 (Significantly higher) | 0.54 (Significantly lower) | 1.23 |

| Children with learning difficulties known to schools | 14.88 (Significantly lower) | 21.11 (Significantly lower) | 27.17 (Significantly higher) | 24.53 |

Rates of all disorders are lower than the England average in Cheshire West and Chester, while rates of moderate learning difficulties are significantly higher in Warrington, and rates of profound and multiple learning difficulties are higher in Halton. Local rates for all known learning difficulties range from 14.88 to 27.17 per 1,000 pupils, equivalent to 2-3% of school-age children and young people. Local rates for known autistic spectrum disorders range from 7.18 to 7.88 per 1,000 pupils, equivalent to up to 1% of school-age children and young people.

No specific prevalence estimates were found for young people in the specific age range worked with by the YOS (11-18).

9% (n=16) of the young offenders in the sample were identified as having learning difficulties (including dyslexia, difficulties with literacy, and unspecified learning difficulties). A further small proportion (n<5) had comments in their assessment that indicated they had suspected learning difficulties or were currently undergoing investigation for learning difficulties. Warrington had the highest proportion of young offenders with learning difficulties at 13%. The identified prevalence of learning difficulties is above the local prevalence indicated by the data above (2-3% of school age pupils).

\(^{56}\) http://www.improvinghealthandlives.org.uk/profiles/
A very small proportion (<5%) of the young offenders in the sample had diagnosed autism or autistic spectrum disorders; this is above the local prevalence indicated by national data concerning all young people (up to 1% of school age pupils). Some (again <5%) were noted as ‘suspected autistic spectrum’ or currently undergoing tests. Cheshire West and Chester had the highest proportions diagnosed or suspected. Halton had no recorded cases of learning difficulties or autism.

7% overall (n=12) were diagnosed with ADHD. No young offenders in Warrington were recorded with ADHD.

Young offenders on Referral Orders were slightly more likely to be recorded as diagnosed with learning difficulties than those on YROs and DP (12% of those on YROs recorded, compared to 10% of those on ROs and 8% on DP). They were also slightly more likely to be recorded as diagnosed with autistic spectrum disorders than those on YROs and DP (however both percentages and numbers were <5 and too small to be considered significant). Young offenders on DP interventions were more likely to be reported as diagnosed with ADHD (11% compared to 6% on YROs and none on ROs). As with other conditions, these variations are as likely to be a result of differences in assessment and recording as differences in need.
Overall 24% (n=42) of the young offenders in the sample were noted as having a statement of special educational needs (SEN).

### 6.2.3 Mental health interventions

40% of the young offenders in the sample (n=70) were assessed as needing some level of intervention for a mental health issue. There was some variation between areas, with Warrington clients being least likely (28%) to be reported as requiring intervention, and Halton (50%) most likely.

**Chart 15: Mental health interventions provided (% of whole sample)**

Of the 70 young offenders assessed as requiring intervention, 31 were receiving intervention from an external provider. 25 were given some level of intervention by the YOS, and 20 were referred by the YOS for intervention elsewhere. Many young offenders received more than one type of intervention (e.g. an intervention from their YOS worker plus onward referral). For a small number (<5) young offenders no intervention was recorded and it was unclear if one had been provided or planned.

External interventions were provided by CAMHS, the NSPCC or Barnardo’s. In addition some young people were working with Quarriers support service, school or college mentors, or being prescribed medication for ADHD. Internal interventions provided by YOS staff included health assessments to identify needs in more detail or discussing anger management, emotional literacy and other mental health issues as part of the young person's order or intervention. Some young people from Cheshire...
West and Chester were referred by the key worker to YOS mental health or substance misuse specialist workers. Referrals were made or planned to a number of agencies in response to mental health need. Mostly these were to CAMHS as well as other mental health services, The Relationship Centre, Barnardo’s and NSPCC for counselling or programmes, and a local youth service for structured and positive activity.

Of the 17 statutory cases marked as intervention required which had progressed to review, less than 20% had an improvement in the situation reported at review. The remainder reported no improvement or it was not specified.

**Chart 16: Interventions Provided for Mental Health by Area (% of those assessed as requiring intervention)**

There did not appear to be a great deal of difference between areas with regard to the type of intervention received (internal, external or referral), despite Cheshire West and Chester having dedicated CAMHS support within the YOS team. Young offenders in Cheshire West and Chester were somewhat less likely to be referred on, and those in Halton were a little less likely to be receiving intervention from an external provider.
6.3 Speech, Language and Communication

National estimates of the prevalence of speech impairment from the Royal College of Speech and Language Therapists include 6.9% of secondary school pupils having speech, language and communication needs\(^{57}\), and a prevalence of speech impairment at 12-14 years of 7.3%\(^{58}\). Rates of communication problems among young offenders are considerably higher. Over half (around 60%) of children and young people in the youth justice system nationally have difficulties with speech, language and communication, with around half of these having very poor communication skills\(^{59}\).

For the purposes of the YOS sample, in cases with an ASSET assessment, the presence of a speech, language or communication problem was defined as an explicit mention of a problem in the assessment notes. For Diversion Programme cases, practitioners should complete a speech and language assessment tool as part of the assessment, resulting in a numerical score which determines the need for an intervention. However, in the electronic assessment files, 30% did not have a speech and language assessment recorded on the system – indicating that either the assessment had not been carried out, or the data had not been inputted (possibly because the score was ‘0’ and no intervention required).

\(^{57}\) Royal College of Speech and Language Therapists (2009): Resource Manual for Commissioning and Planning Services for SLCN. RCSLT.


A total of 6% of cases (n=10) were identified as having some speech or communication issue. This is lower than would be anticipated based on national data, and may be due to a recording issue (as noted, many (33%) of the electronic Diversion Programme assessment documents did not have the Speech and Language Assessment portion filled in).

Of the 10 cases identified with a problem, eight were recorded as requiring an intervention. The others were recorded as not requiring intervention for their difficulty, had not yet been assessed fully, or this information was not clearly specified in case records. Of those eight requiring intervention, seven were recorded as having one provided – either externally with a speech and language therapist, with whom they were already in contact, through an intervention provided by the YOS, or referral on for an intervention with a speech and language therapist. No information was recorded regarding the outcome for the other case.
6.4 Substance misuse

A 2013 survey found that 3% of secondary school pupils (mostly aged 11-16) reported smoking at least once per week; this increased with age, with just 1% of 11-year olds, but 13% of 15-year olds, smoking regularly. 9% of 11-16 year olds (22% of 15 year-olds) had drunk alcohol in the past week, and 6% of 11-16 year olds had taken any drug (including volatile substances) in the past month.

There is evidence to indicate that substance misuse among young offenders is more common than in the general population of young people. A study on substance misuse among imprisoned young offenders found that prior to custody, 83% were regular smokers, over 60% drank alcohol daily or weekly, and over 80% had used an illegal drug at least once per month.

47% of the young offenders in the sample were recorded as smoking tobacco. This is a much higher proportion than both national (3-13%) and local prevalence data for young people’s smoking, although lower than the 83% of young offenders found nationally (though this was for YOs entering custody, whose needs may differ from those in the community).

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Overall, 40% of the young offenders in the sample were known to currently drink alcohol, and 43% to be using other substances (substances mentioned were cannabis and legal highs) – considerably higher than the national estimates for 11-16 year olds but lower than the 60% and 80% respectively found in YOs entering custody.

There was no consistent recording of the amount of alcohol drunk (only previous or current use) so it was not possible to split the young offender sample by level of consumption.
Those on a YRO were more likely to be reported as engaging in substance use of any kind. Those on DP interventions were the least likely to be recorded as using substances, drinking or smoking. As mentioned above, this may be because those whose offending type and pattern mean they are likely to be given a YRO are a more complex cohort, or because of differences in assessment and recording. Those on statutory orders (RO and YRO) are typically older than those on DP interventions, which may also make them more likely to have begun using substances.

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61 DTO post sentence/post custody’ cases were omitted due to extremely small numbers (2 young offenders)
Young offenders in Warrington were more likely to currently be drinkers, while those in Halton were more likely to be using other substances and to be smokers.

**Table 10: Impact of substance use by area**

<table>
<thead>
<tr>
<th></th>
<th>Cheshire West and Chester</th>
<th>Halton</th>
<th>Warrington</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Use at time of offence</td>
<td>23%</td>
<td>11%</td>
<td>32%</td>
<td>23%</td>
</tr>
<tr>
<td>Risky Drug Taking Behaviour</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>6%</td>
</tr>
<tr>
<td>Substance Use Impacting Functioning</td>
<td>13%</td>
<td>28%</td>
<td>30%</td>
<td>21%</td>
</tr>
</tbody>
</table>

*suppressed due to small numbers (n<5)

23% of young offenders were recorded as being under the influence of substances at the time of their offence, indicating that substance use has a significant impact on offending behaviour. 21% were recorded as having their daily functioning noticeably impacted by their substance use (determined by the ‘Noticeably detrimental effect on education, relationships, daily functioning’ tick box on ASSET for statutory cases, or an explicitly mentioned impact for diversion cases).
Young offenders in Warrington appeared most likely to be experiencing a negative impact due to substance misuse (i.e. substance use reported to be affecting their daily functioning).

**Chart 22: Impact of substance use by order**

![Chart showing impact of substance use by order]

Similarly, those on YROs were more likely to be recorded as requiring an intervention or having their functioning impacted by their substance misuse. However there were no clear differences between those on different orders in terms of being under the influence at the time of their offence.

Interestingly, although those on Diversion Programme interventions were overall less likely to be recorded as using substances at all (36% current drinkers and 29% currently using other substances, compared to 48% and 68% of those on YROs) they were actually the most likely to be under the influence when offending (23% compared to 19% of those on YROs). This implies that intoxication is a common factor in offending for those on DP interventions.

Almost half of the young people in the sample (43%, n=76) were recorded as needing an intervention for their substance misuse. Of those identified as requiring intervention, 85% (n=64) were recorded as having an intervention provided by the YOS – either as part of their statutory order, during their Diversion Programme intervention, or in informal discussion to highlight the issues concerning substance use. 13% of those requiring intervention were already engaging with another service (almost

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61 ‘DTO post sentence/post custody’ cases were omitted due to extremely small numbers (2 young offenders)
all with a young person’s drug and alcohol service, though school and young offenders’ institutions were also noted as providing interventions), and 5% were referred on to external services for substance misuse interventions (some young offenders were referred on in addition to an intervention provided by YOS or another agency).

27 of the young offenders flagged as requiring an intervention had a review assessment completed (their assessment document updated with additional information). 19% of these were recorded as having made an improvement by review. A further 15% (n<5) cases noted the substance misuse intervention was ongoing. The remainder either had not improved or this was not recorded.

6.5 Family and Social Issues
6.5.1 Social Determinants of Health

The Association for Young People’s Health notes the impact of ‘social determinants of health’ on the health and wellbeing of young people\(^\text{63}\). These social determinants include family assets (income and deprivation), housing, social exclusion, adolescent education (or lack of) and unemployment.

22% of young people nationally (aged 11-15) live in families with the lowest levels of income. In Warrington 11% of children live in households where there is no parent in work; in Halton this figure is much higher at 28%, well above regional and national averages (19% and 15% respectively). Figures for Cheshire West and Chester are variable, from 10% in Vale Royal to 12% in Chester and 21% in Ellesmere Port and Neston\(^\text{64}\).

Research indicates that being a looked-after child (also referred to as a child in care or CIC) has a substantial impact on other aspects of a young person’s life, including offending. A third of all young people in contact with the criminal justice system have been CIC (though it should be noted that for many of these their offending behaviour began before becoming a looked after child)\(^\text{65}\).


\(^{64}\) ONS Survey Data (2009) http://www.ons.gov.uk/ons

In Warrington in 2013/14, 41% of children on Child Protection Plans (CPP) were subject to this measure due to neglect; 33% due to physical abuse, 18% due to emotional abuse and 8% due to sexual abuse. 69 children and young people were subject to child protection plans because of neglect and lived in homes with domestic abuse, parental mental ill health and parental substance misuse occurred. In addition, there has been a 42% increase (from 2012/13) in the number of child protection conferences held where Domestic Abuse was a single overriding issue for consideration.

In Cheshire West and Chester in 2013/14, a total of 417 children and young people were subject to Child Protection Plans (CPP), of whom 50% were on CPP due to emotional abuse, 27% due to neglect, 17% due to physical abuse and 6% due to sexual abuse. In addition, 3.7% of reported domestic abuse cases concerned victims aged 16-17 (above the national average of 1.8%).

In Halton in 2013/14, 54% of children and young people subject to Child Protection Plans were on CPP due to neglect, 28% due to emotional abuse, 13% due to sexual abuse and 5% due to physical abuse. 22% of referrals for Children’s Social Care assessments were referred due to domestic abuse.

There is a strong link between living in an area of high social deprivation and multiple health inequalities, including sexually transmitted infections, underage conceptions and obesity. There is also a link with low educational attainment, which is a predictor of poorer health in adulthood.

Nearly 10% of young people aged 16-18 nationally are NEET (not in education, employment or training). Being NEET, and exclusion from secondary school, are recognised as risk factors for offending behaviour. A 2010 report found that young people in contact with a Youth Offending Team...
were five times more likely than their non-offending peers to be NEET, with 50% of the young offenders spending six months (or more) NEET\textsuperscript{72}.

6.5.2 Social Services Involvement and Social Environment

A number of people in the sample were in contact with social services (39%, n=69), and several had had past involvement (a further 29%, n=50). 21% (n=37) were currently accommodated under a care order or were looked after children (this included those permanently accommodated by relatives under care orders) and an additional 8% (n=14%) had been previously. This is concordant with national data suggesting around a third of young people in contact with the Youth Justice System have been looked after (child in care). 2% were currently on the child protection register and 15% had been at some point in the past.

Chart 23: Social services involvement by area\textsuperscript{73}

Young offenders in Halton were more likely to have social services or child protection involvement. They were also more than twice as likely as young offenders in Cheshire West and Chester or


\textsuperscript{73} Past or Current Child Protection Plan figures combined for data protection reasons due to low numbers.
Warrington to be a child in care (CIC) (39% compared to 16% in Cheshire West and Chester and 17% in Warrington).

### Table 11: Social Services Involvement by order

<table>
<thead>
<tr>
<th>Social Needs</th>
<th>Diversion Programme</th>
<th>Referral Order</th>
<th>YRO</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>CIC/Care Order-Past</td>
<td>*</td>
<td>*</td>
<td>23%</td>
<td>8%</td>
</tr>
<tr>
<td>CIC/Care Order-Current</td>
<td>17%</td>
<td>23%</td>
<td>32%</td>
<td>21%</td>
</tr>
<tr>
<td>On Child Protection Plan-Past or Current</td>
<td>6%</td>
<td>25%</td>
<td>39%</td>
<td>17%</td>
</tr>
<tr>
<td>Social Services Involved-Past</td>
<td>12%</td>
<td>38%</td>
<td>58%</td>
<td>29%</td>
</tr>
<tr>
<td>Social Services Involved-Current</td>
<td>46%</td>
<td>29%</td>
<td>42%</td>
<td>39%</td>
</tr>
</tbody>
</table>

*suppressed due to small numbers (n<5)

Those on Youth Rehabilitation Orders were overall more likely to be or have been CIC, be or have been on Child Protection, or have past involvement from social services. However those on a Diversion Programme were more likely to have current social services involvement.

29% (n=50) of the young offenders in the sample overall were living away from their parents, either being looked after/officially accommodated elsewhere under a care order or living with relatives on a voluntary basis. 29% (n=51) had a known offender in their immediate family or living with them; 25% (n=43) had a record of parental substance misuse.

Close to half of the YOS sample had experienced abuse or neglect from parents or carers, including domestic violence (40%, n=70) or a major bereavement or trauma (27%, n=47). Young offenders from Halton were more likely to have been recorded as experiencing abuse or neglect (50%) or bereavement and other trauma (47%) than those from other areas. Young offenders in Cheshire West and Chester were the most likely to have a known offender in their family or household (34%).

Nationally, a survey of offenders (all ages) found that 41% reported witnessing domestic abuse as a child and 29% experienced physical, sexual or emotional abuse as a child. Other research with young

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74 ‘DTO post sentence/post custody’ cases were omitted due to extremely small numbers (2 young offenders)
75 Past and current figures have been combined for data protection reasons due to small numbers involved.
offenders indicates that around 42% of young offenders on custodial sentences have been in care, and around 17% were on the child protection register\textsuperscript{77}.

**Chart 24: Social Environment by order\textsuperscript{78}**

A clear pattern is evident from the chart above – young offenders on a YRO were more likely than those on other orders to experience negative factors in their social and family environment; those on DP interventions were least likely. As mentioned previously this may be partly due to differences in assessment and recording between ASSET and Diversion Order assessments, however the differences between those on YRO and RO interventions could not be accounted for by this (since both are assessed using ASSET).

\textsuperscript{78} ‘DTO post sentence/post custody’ cases were omitted due to extremely small numbers (2 young offenders)
A total of 48 young offenders in the sample (27%) were recorded as needing an intervention of some kind in relation to a family or social issue. Of these the majority (85% of those requiring intervention, n=41) were receiving an intervention from an external organisation (mainly social services/children’s social care). A small number (n<5) had a family intervention provided by the YOS as part of their order and four were referred to relevant organisations for further intervention (for some young people more than one of these applied).

6.5.3 Child sexual exploitation

A total of 7% (n=13) of those in the sample were flagged as currently being at risk of child sexual exploitation (CSE). Of these, 11 were marked as requiring an intervention – most were receiving interventions from other organisations (including Children’s Social Care and Catch-2279); some (n<5) also received interventions from the YOS, or were referred on for intervention.

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6.5.4 Housing

A number of the young offenders had a housing issue recorded at assessment – a total of 13% of the sample (n=22). Very few (<5%) had an accommodation problem so severe that their housing was under immediate threat or were NFA (no fixed abode). Housing problems were more common for those in Halton, with 25% having any issue.

Those on YROs were more likely to have a housing problem – 26% compared to 21% on an RO and 6% on DP.

Nine young offenders were recorded as needing a housing intervention – 5% of the sample. All were having their needs met either by other organisations and/or from the YOS.

6.5.5 Education and educational needs

Over half (51%, n=89) of the young offenders had information in their assessment indicating they had issues with absence from school. This was defined by either the ‘Is there evidence of non-attendance’ tick box in an ASSET assessment, or an explicit mention of school absence in a DP assessment, and could relate to unauthorised absence and/or school exclusion. It did not include those who had a history of school or college absence but were no longer of school age.

Chart 26: Educational issues and needs
24% of all the sample cases mentioned the young person having a statement of special educational needs (SEN). This could be due to learning difficulties or, more commonly, for behavioural problems. 22% were recorded as having some level of literacy or numeracy problems. 27% of the young offenders had problems with peer relationship or bullying – either being bullied or bullying others.

School absence varied by area, with 69% of those in Halton, 57% of those in Warrington, and 40% of those in Cheshire West and Chester having a record of school absence. Young people in Warrington were slightly more likely than the sample as a whole to have a SEN statement (28%) and to have literacy or numeracy problems (26%). Problems with bullying and peer relationships were more common in Chester and Cheshire West and Chester (35%).

**Chart 27: Education issues by order**

Those on YROs were more likely to have a record of school absence than DP cases and slightly more likely than RO cases. Young people on Referral Orders were the most likely to have a SEN statement and also more likely to have literacy or numeracy problems reported, while those on YROs were most likely to have issues with relationships.

40% of the sample (n=70) were recorded as needing an intervention relating to their education, training or employment. Of these 70, 44 (63% of those requiring intervention) had their needs met by external organisations including schools, special educational establishments, educational psychologists,
education access team, education welfare officer, and Warrington careers service was also mentioned. Three (4%) were referred on, and 36 (51% of those requiring an intervention) had an intervention provided by the YOS (work with YOS Education, Training and Employment specialist officers, and YOS workers liaising with schools or colleges to ensure support, were commonly cited).

6.6 Vulnerability
Both ASSET and the Diversion Programme assessment allow a practitioner to record a vulnerability score of high, medium or low based on all the factors involved in a young offender’s case. The majority (51%, n=90) of cases were marked as ‘Low’ risk or vulnerability, 30% (n=53) as ‘Medium’, and just 14% (n=25) overall were marked as ‘High’ vulnerability.

Chart 28: Vulnerability Score

Those on YROs were more likely to be marked as ‘High’ vulnerability or risk (19%) compared with those on ROs and DP interventions (each 13%). 28% of young offenders in Halton were marked as ‘High’ vulnerability, compared to 13% in Cheshire West and Chester and a smaller proportion (n<5) in Warrington.
Key Points – Mental Health

- 57% of young offenders in the sample were recorded as having some level of mental health need affecting their daily functioning; 17% had a formal diagnosis recorded.
- Compared to national prevalence estimates for young people (where available), young offenders in Cheshire West, Halton and Warrington appear to have lower rates of asthma and epilepsy, and lower rates of disability. However, differences in methodology, comparisons of different age groups (due to variation in available data) and possible recording issues make direct comparisons – and therefore conclusions – difficult.
- Young offenders on YROs or Referral Orders were more likely than those on Diversion Programme interventions to be identified with any health condition or one affecting functioning; however those on Diversion Programme interventions were more likely to have a recorded disability. Young offenders with a statutory order imposed may be a more complex cohort, with correspondingly higher levels of need, or it may simply be that the assessment (Asset) carried out by the YOS for these individuals is more likely to identify these issues.
- A total of 4% of all cases in the sample (n=7) were indicated to require some level of intervention in relation to physical health. All of these were recorded as receiving an intervention.

Key Points – Physical Health

- 6% of young offenders in the sample have a health condition that impacts on their daily functioning.
- Compared to national prevalence estimates for young people (where available), young offenders in Cheshire West, Halton and Warrington appear to have lower rates of asthma and epilepsy, and lower rates of disability. However, differences in methodology, comparisons of different age groups (due to variation in available data) and possible recording issues make direct comparisons – and therefore conclusions – difficult.
- Young offenders on YROs or Referral Orders were more likely than those on Diversion Programme interventions to be identified with any health condition or one affecting functioning; however those on Diversion Programme interventions were more likely to have a recorded disability. Young offenders with a statutory order imposed may be a more complex cohort, with correspondingly higher levels of need, or it may simply be that the assessment (Asset) carried out by the YOS for these individuals is more likely to identify these issues.
- A total of 4% of all cases in the sample (n=7) were indicated to require some level of intervention in relation to physical health. All of these were recorded as receiving an intervention.
Key Points – Substance Misuse

- 47% of the young offenders in the sample were recorded as smoking tobacco. Nationally at least 3% of young people are estimated to be smokers – the proportion found here is much higher and is in fact higher than the local prevalence of adult smoking.
- Overall, 40% of the young offenders in the sample were known to currently drink alcohol, and 43% to be using other substances (substances mentioned were cannabis and legal highs) – considerably higher than the national estimates of 9% of 11-16 year olds drinking and 9% having tried drugs (although the age groupings are not entirely coterminous).
- Young offenders in Warrington were more likely to currently be drinkers, while those in Halton were more likely to be using other substances and to be smokers.
- Those on a YRO were the most likely to be reported as engaging in substance use of any kind; those on the Diversion Programme were the least likely.
- 23% of young offenders were recorded as being under the influence of substances at the time of their offence. Interestingly, although those on Diversion Programme interventions were less likely to be recorded as using substances at all, they were relatively more likely to be under the influence when offending, suggesting that intoxication is an important factor in offending for those on DP interventions.
- Almost half (43%) of the young people in the sample were recorded as needing an intervention for their substance misuse; 85% of these had one recorded.

Key Points – Speech, Language and Communication

- Nationally it is estimated that 6.9% of secondary school pupils have speech, language and communication needs; for those involved with the youth justice system, however, this rises to more than half. A total of 6% of cases in the sample (n=10) were identified as having some speech or communication issue. This is lower than would be anticipated based on national data, and may be due to a recording issue (30% of the electronic Diversion Programme assessment documents did not have the Speech and Language Assessment portion filled in, indicating that either the assessment had not been carried out, or the data had not been input.
- Of 8 cases recorded as needing an intervention, all but one had an intervention or onward referral recorded.
Key Points – Family and Social Issues

- 21% of the sample (n=37) were currently accommodated under a care order or were looked after children (LAC).
- Young offenders in Halton were more likely to have social services or child protection involvement. They were also more than twice as likely as young offenders in Cheshire West or Warrington to be LAC.
- Close to half of the sample had experienced abuse or neglect from parents or carers, including domestic violence (40%, n=70) or a major bereavement or trauma (27%, n=47). Young offenders from Halton were more likely to have been recorded as experiencing abuse or neglect (50%) or bereavement and other trauma (47%) than those from other areas.
- Young offenders on a YRO were more likely than those on other orders to experience negative factors in the social and family environment; those on DP interventions least likely.
- 3% of the sample were young parents or currently pregnant. This varied by area: 8% of those in Halton were young parents.
- 13% of the sample had a housing issue recorded (1% severe or NFA). This was more common for those in Halton, with 25% having any issue and 3% a severe issue.
- Over half (51%, n=89) of the young offenders had information in their assessment indicating they had issues with absence from school. 22% were recorded as having some level of literacy or numeracy problems, and 27% had problems with peer relationship or bullying. Problems with peer relationships were more common in Chester and Cheshire West (35%).
- Those on YROs were more likely to have a record of school absence, and issues with relationships, than those on other orders.
- All those who were recorded as needing an intervention relating to family, education, or housing were recorded as receiving intervention or onward referral.
7. Stakeholder consultation

7.1 Stakeholder Survey
An online survey was used to gather input from various stakeholders regarding the health needs of young offenders in Halton, Warrington and Cheshire West and Chester. A total of 14 respondents from eight different organisations completed the survey. A list of the questions asked in the survey can be found in Appendix 2.

7.1.1 Survey Respondents
Respondents from eight organisations answered the survey. Further detail of the organisations and respondents can be found in Appendix 1.

Table 12: Organisations responding to the survey

<table>
<thead>
<tr>
<th>Organisation Name (as given by respondent)</th>
<th>No. Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beacon Counselling Trust</td>
<td>1</td>
</tr>
<tr>
<td>Bridgewater Community NHS Trust</td>
<td>4</td>
</tr>
<tr>
<td>Forum Housing Association</td>
<td>2</td>
</tr>
<tr>
<td>Halton Council</td>
<td>1</td>
</tr>
<tr>
<td>NHS Vale Royal and NHS West Cheshire Clinical Commissioning Groups</td>
<td>2</td>
</tr>
<tr>
<td>Public Health</td>
<td>1</td>
</tr>
<tr>
<td>St Werburghs Medical Practice for the Homeless</td>
<td>1</td>
</tr>
<tr>
<td>Warrington Borough Council</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>14</td>
</tr>
</tbody>
</table>
7.1.2 Common health and wellbeing needs of young offenders
Respondents were asked what they considered to be the most commonly occurring health and wellbeing needs of young offenders in the area. The most commonly identified needs were in relation to mental health, identified by 83% of the participants, with substance misuse also felt to be a common issue (drugs were identified as an issue by 64% of participants and alcohol by 57%). Physical health needs were thought to be a common issue by 43% of the 14 respondents.

A range of health and other issues were identified, including:

- Dental/oral health
- Incomplete immunisation status
- Sexual health/contraception
- Neglected long-term physical conditions (e.g. asthma)
- speech, language and communication problems
- poor numeracy and literacy
- gambling

It was also noted that many young offenders may have multiple needs affecting their wellbeing.

“It is difficult to isolate specific health areas ... as often young offenders will present with multiple issues which interdepend on one another. The key is being able to address the interdependence in a co-ordinated way to improve things for them.”

Respondents were also asked to identify any complex and intersecting needs potentially contributing to health inequalities for young offenders; similar factors to those mentioned above were identified, with mental health, substance misuse and home environment identified by the highest proportions of respondents.

“All of the above can be both a cause and result of offending and associated behaviours and as such cause health inequalities.”

“Many come from homes and communities where anti-social behaviour is part of surviving in the community.”
7.1.3 Current Healthcare Provision

Respondents were asked how well they felt current healthcare provision addressed the needs of young offenders, and to identify any services they thought worked particularly well. They were also asked to identify any gaps or challenges relating to current healthcare provision for young offenders, and any barriers to access. The responses have been grouped thematically into successes and challenges below.

Current Provision – Successes and Achievements

Respondents noted several intervention types they felt worked well, such as low-level CBT, motivational interviewing, life skills interventions, group projects (for some young people), and certain criminal justice interventions (which were felt to have value in increasing the support available to young offenders).

“Bail and Remand Support Schemes with opportunities to provide a supervised community placement prevent admission to custody … Restorative Approaches within housing settings are equipped with the potential to carry out reparation and [have] educational value”

Respondents also noted certain services which specifically worked well with young offenders and/or provided high quality interventions. These included:

- Mental health services, mainly CAMHS, including specific speech and language and learning disability provision (once young people were able to access the service).
- Young people’s substance misuse services

“There has been a very good interface between YOS and Warrington’s Youth Service (which manages the young people’s substance misuse offer in the community). If a YOS young person requires a specialist service, then they have been referred to the YP service. YOS staff are invited to any training that Warrington Drug and Alcohol Action team offer around substance misuse”

- Speech and Language Therapy services (although some respondents did note that access to this provision was perceived to be limited)
- Several other services addressing social and wider needs were also mentioned as providing high quality, effective interventions and having good links with the YOS – these included The
Relationship Centre, Cornerstones, Power in Partnership, the YMCA and Careers Service (both specifically mentioned in relation to Warrington), and some supported housing and homelessness services.

"Assertive Outreach and Floating Support provide a range of intensities across delivery hours and value the role of trusted relationships that mentor/provide guidance”

Current Healthcare Provision – Gaps, Challenges and Barriers
Access to and engagement with health and wellbeing services – ability to access health and wellbeing services in a timely fashion was seen as a problem particularly in relation to mental health interventions for young offenders.

"Long waiting lists for mental health services in particular are not addressing the needs of young people at an early enough stage”

Several respondents noted that young offenders can find engagement with mainstream services particularly difficult, and while good quality services are often available they are not always engaged with. A number of systemic factors were identified as barriers to engagement for young people, including inconvenient location of services and the lack or cost of transport, inflexibility of provision locations and times, and appointment times unsuited to young people’s lifestyles.

Attitudes of professionals to young people, and lack of trust in professionals by young people, were also cited as prohibitive factors to engagement. Services could do more to appreciate the impact on engagement of conditions such as ADHD and mental health issues, and adjust provision to maximise engagement, as well as ensuring terminology and language are at an appropriate level for young people.

“Services not always understanding of the issues and not equipped to manage behaviour that can be challenging”

“Often young adults do not understand the complex vocabulary and language used in interventions with them. As a result they ‘act out’, behave inappropriately to hide the problem. Many young people with ADHD are more prone to poor decision making and poor choices”
"[Health and wellbeing services/professionals] are not welcoming and many will be judgemental when dealing with young people. Venues are too clinical and often very formal. Health provision needs to be provided in YP [young person] friendly buildings”

Joint working and communication between services – it was suggested that improved liaison and communication between criminal justice organisations and healthcare provision could be beneficial – for example, GP practices being informed about YOs returning from an institution to the community and offering a comprehensive health check on release.

“The key is to ensure that the service follows the individual to ensure they receive the support that they need. It would be helpful for health workers to work more closely with the YOS to ensure that the health needs of individuals are supported as a priority”

Some comments were made regarding provision for wider needs of young offenders, which could impact on their health and wellbeing. Provision in areas such as appropriate housing and training courses were cited as being inadequate to address the needs of young offenders.

“Shortage of supported housing… Supply chain for the most vulnerable/complex/chaotic is reducing and recent report (Young and Homeless 2014), cited the (increasing) reluctance from providers to work with the most at risk”

“Gaps in training provision - need more hands-on landscape/gardening, maintenance, garage, low level provision, music/DJ-ing, workshops to engage”

Other concerns mentioned included:

- Speech, language and communication difficulties – it was suggested that these, coupled with other issues such as ADHD, poor social skills, literacy/numeracy problems and learning difficulties, could have an impact on young offenders’ health and wellbeing as well as their ability to benefit from interventions. Support for those with speech and communication difficulties was perceived to be limited.
- Continuity of care for young offenders once an order/disposal was completed – with the high levels of support offered by the YOS declining to lower levels once the order had finished.
• Geographical inequalities in provision. For example, the lack of embedded mental health personnel in the YOS provision in Warrington was seen as problematic. School nurses were noted as an important resource, although their involvement varied between areas.

7.1.4 Developments in Health and Wellbeing Provision
Respondents were asked if they had been involved in any developments aiming to improve the offer of and engagement with health and wellbeing services for young offenders.

Several current/recent developments were mentioned with regard to Warrington in particular, including a pilot to improve communication between YOS and school nurses and to utilise school health services to assess young offenders’ health needs, and making services such as careers advice more accessible by bringing provision into the YOS.

"We have been doing a small scale pilot with YOT (for Warrington residents) working with school health to conduct health screens for new young offenders...."

"Employed YOT Careers Adviser to work specifically with YOT"

Partnership working enabling agencies to support each other and share information and expertise was mentioned in regard to Youth Contract provision, and also to support YOS staff working with young people engaged in substance misuse (Warrington-specific).

The Healthy Conversations Programme pilot delivered by Forum Housing was noted as having been delivered in an accessible setting and aimed to improve young people’s understanding and motivation regarding health issues.

7.1.5 Supporting Parents and Carers
Respondents were asked about support available for parents and carers of young offenders. The consensus was that improving support for parents and carers would have a positive impact on the young people’s health and wellbeing.

"Workers need to support not just the young person but whole family - the cycle of behaviours/low aspirations/low engagement with services is often entrenched in family/social group values so working with the young person alone will not achieve a change."
“Not currently much focus on this – needs involvement of parents to support young offenders so they engage positively in society and do not re-offend”

The need to inform and educate parents and carers about signs and symptoms of mental health problems, substance misuse and other issues, and how to handle them, was highlighted, as was the important role of the parent/carer in supporting the young person to prevent reoffending.

“We need to ensure they are informed about mental illness and how to avoid it. They also need to understand how to deal with substance misuse and keep young people engaged in communication”

7.1.6 Support for Young Parents
Respondents were also asked about support available for young offenders who are also young parents. Although many stated they were not aware of how young parents would be supported, the Family Nurse Partnership to support new and soon-to-be young parents (under 19) was noted, plus some other initiatives (via youth services and the ‘Pathfinder Project’) depending on area of residence.

7.1.7 Potential Improvements
Respondents were asked to identify any suggested improvements in their final comments.

Making services more young person-friendly was suggested as a way to improve accessibility and engagement of this hard-to-reach population, as well as early identification (at referral/assessment) of young offenders’ health and wellbeing needs.

Co-located and/or integrated services, flexible appointment times (e.g. drop-in clinics), and services located in the community or operated on a satellite basis – such as making a variety of services available to young offender via their school – were suggested as means to maximise engagement.

“I have found that any intervention that includes visiting them where they live (where appropriate) seems to be more effective than offering appointments at health centres.”

“YOS need to integrate more with universal and other targeted services”

The role of specialist practitioners, or training, to respond appropriately to the needs of young offenders was felt to be important, as was education of young people themselves and early identification/intervention.
“Young people need support to understand their own health and how to manage their health independently”

“It would be really positive to promote preventative / services interventions to encourage young people to adopt healthy lifestyle behaviours from an early age. ”

7.2 Stakeholder interviews

7.2 Key themes from discussions with professionals

Interviews were conducted between February and March 2015 with members of the Youth Offending Service including both practitioners and managers as well as external stakeholders holding either strategic responsibility or providing wider support services to young offenders. A total of 42 professionals were interviewed.

Two key issues in particular were highlighted:

- the variation of in-house YOS health provision according to the residence of young people due to existing structure of health provision being based upon previous YOS structures
- the challenge in ensuring that young people engage with support services whilst part of a statutory order or as a preventative measure under the YOS Diversion Scheme.

7.2.1 Early Identification of physical and mental health needs

The Diversion Scheme

Halton and Warrington were one of six pilot sites selected to develop a Youth Justice Liaison and Diversion (YJLD) scheme to enhance health provision. The YJLD pilot scheme was developed in 2008 to facilitate help for children and young people with mental health and developmental problems, speech and communication difficulties, learning disabilities and other similar vulnerabilities at the earliest opportunity after entering the youth justice system. The pilots were initially funded until March 2012 by the Department of Health. The scheme now operates across the YOS as a pathfinder site. The liaison
and diversion pathfinders are part of a National Diversion Programme to establish liaison and diversion services in all police and court services by the end of 2014.

The key aim of the project is to divert children and young people with specific health needs or learning difficulties away from the Youth Justice System, by providing appropriate and professional support at the earliest stage. The referrals for this scheme come directly from Cheshire Police and the scheme is currently available to all young people who are first time entrants (with a possible future scope looking at providing referrals for children and young people who are already involved in the YJS).

As part of the process, on receiving a referral, one of the Divert workers will undertake an assessment with the young person identifying any concerns and then further refer to the appropriate services and/or provide a package of support. Contact will also be made with any services including Children's Social Care. A full comprehensive feedback form is then provided to Cheshire Police ahead of the child or young person answering bail with a view that any identified concerns or difficulties will be taken into consideration by the Police with the matter potentially having no further action taken (NFA) and the young person diverted away from the YJS.

In line with the YJLD model, Divert Officers screen for a wide range of needs and undertake further in-depth assessments for young people who consent to be part of the scheme and who present with mental health, learning, communication difficulties or other vulnerabilities. A variety of short screening tools that cover a range of needs are used such as:

- the Common Assessment Framework (CAF),
- Screening Questionnaire Interview for Adolescents (SQifA),
- Screening Interview for Adolescents (SIFA),
• tools for the assessment of speech and communication needs, learning disabilities (Learning Disability Screening Questionnaire), autism (e.g. Autism Spectrum Quotient (AQ)—adolescent version), and
• substance misuse (e.g. the AUDIT C short screening tool for hazardous alcohol use).

Currently no specific tool is available for Acquired Brain Injury but recommended screening questions are asked\(^8^0\) as traumatic brain injury has been associated with offending higher and particularly violent offences.\(^8^1\)

Once the assessment is complete a recommendation is sent to the OIC (Officer in Charge) who will decide the outcome of the offence based on the information received and liaise with the family and the Diversion Team.

If required the Divert Officer will make referrals to other agencies to address any additional needs identified – for instance CAMHS, speech and language therapy, education provision and others. They may also undertake a specific intervention with the young person to address their behaviour such as consequences, victim empathy, Tier 2 substance misuse.

Within the Diversion Team the intervention is over a shorter period and is non statutory. The first priority is to ensure the young person is registered with a GP and to support with access. The main goals are identification and initiation, and if the young person scores high on a vulnerability risk register this will trigger a risk management process and vulnerability plan.

\(^8^0\) Acquired brain injury. Recommended screening questions are:

a. Have you ever lost consciousness for more than 10 minutes after a blow to the head?

b. Has this happened on more than one occasion?

The YOS are currently facing high numbers of young people referred to the Divert scheme. Some Divert Officers reported constraints on capacity restricting the opportunity to provide an effective intervention other than screen and signpost. In addition the recommendations they provide are voluntary and practitioners identified that more time is needed to establish a relationship with the young person to encourage take-up of services. Divert staff also noted that they felt that more could be achieved if there was additional capacity to support brief interventions over at least three months.

Research backed by examples from the YOS practitioners indicates that the impact is greater for vulnerable clients whose offending behaviour is not ‘ingrained’ and hence who are still open to change. Effectively intervening with first time offenders appears to be more effective in preventing the development of attitudes and behaviour that cause offending in comparison to intervening in clients with previous offences in whom offending behaviour is likely to be more established. However longer-term re-offending data would be required to compare the comparative effectiveness of the Diversion scheme versus standard/YOT practice in preventing re-offending in first time offenders.

A significant number of young people screened were reported to have multiple complex issues requiring additional support which the Divert Officers felt could be met through direct access to the Tier 3 substance misuse worker and the CAMHS Health Workers. It is expected that individuals on the scheme require more resources from the health sector as previously unidentified vulnerabilities are identified and then managed.

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

This is backed by a national evaluation of the scheme carried out in 2011 by the Centre for Mental Health which used data from all six YJLD pilot sites (including Halton and Warrington) and found that the young people referred to the scheme had multiple interrelated complex needs, including social, psychological and mental health issues. Behavioural issues (69%), social problems (51.6%) and safeguarding concerns (36.8%) were the three most frequently identified problems. The average number of vulnerabilities was 3.6 (with a range of between 1 and 16), with the highest proportion of young people (80%) being identified as having between one and five vulnerabilities.

A service such as the Diversion Scheme could offer long term potential cost savings that are likely to far outweigh the cost of providing services across a lifetime of crime. Research evidence suggests that non-criminalising responses to low-level youth behaviour are preferable to escalating formal justice system involvement. However, evaluation of the long-term costs and benefits of the scheme is essential before any judgements can be made on its cost-effectiveness.

All of the professional staff interviewed recognised the importance and value of diversion and reported an increase in local police cooperation at an operational level. Practitioners were able to give examples of where the triage operated particularly well with effective referral mechanisms and relationship with wider health and social care partners, for example with Children's Contact and Referral Team (CART) and Troubled Families.

Due to the nature of how the scheme is funded, the YOS senior management recognise that the scheme needs to make a financial case for continued investment. The New Economics Foundation (NEF) have developed a pilot cost-avoidance model for schemes to help them estimate costs avoided (through avoided formal justice system processing - either cautions or (more rarely) court) to
themselves and their partners. This draws on national unit costs data, and a small number of assumptions. CWHWYOS has piloted the tool and NEF are looking to potentially look beyond ‘immediate’ cost avoidance to some of the medium- or longer-term outcomes (and associated value) generated by schemes like Divert.

**Recommendations:**

1. Use findings from current health needs assessment to inform the development of wider health inequality proxy measures to help develop the cost-avoidance measures as this will then provide an informed view of how the scheme has impacted upon health and access to provision. In addition it would be useful to measure changes in any identified mental health needs and other vulnerabilities (over a three month contact period).

2. Use findings of presenting and emerging need to inform whether this warrants investment into health provision which would support specialist intervention at point of entry to the system within the Diversion Team.

**Young people managed through statutory orders**

Practitioners and managers echoed research findings which point to higher rates of neglect among young people regarding their person health and hygiene and the impact of neglect from their parents or carers.

Participating in a health assessment is dependent upon informed consent and three different models currently operate. In Cheshire West and Chester young people subject to a court order are offered a health assessment appointment with one of the YOS CAMHS workers employed in a generic health capacity. In Warrington a new pilot has recently begun where all young people receive an appointment with a school nurse. This is facilitated by the YOS Case Manager who is present at the first meeting. If successful this scheme has the potential to be rolled out in Halton where young people are signposted.
externally for a health assessment appointment. There was, previously a full-time health worker in Halton who undertook health assessments but this post has not been replaced. It is not known what the take up of health assessment is for the Warrington pilot and it will take some months before a comparison can be made between the three different models. There is however less consistency reported with young people referred in Halton, where specialist services did not always respond and provide the requested assessments.

The Actions Speak Louder (2009) report highlights how, if young offenders physical health needs are poorly assessed, then interventions will be limited in their impact. The report also suggested that if a dedicated health worker is not available to a YOT then a satisfactory alternative arrangement may be that well trained YOT staff would carry out the initial assessments of health need, using an agreed holistic health assessment tool. This will then be followed by referrals to specialist health workers and universal services need to be carried out consistently when required.

ASSET is the main means of screening for problems/disorders that might trigger the need for consultation or a referral to a health specialist, particularly when there is a score of two or more. The Case Managers use the initial assessment ASSET to ask specific questions on physical, emotional and mental health screening, alongside substance use and speech, language and communication. The assessment also explores the young person’s relationships and support. A study found that while ASSET had good ability to identify the factors likely to increase a young person’s risk of reoffending it has been shown to under-identify health inequalities or conditions if these are not considered to be directly linked to any risk of further offending. In Cheshire West the CAMHS Health workers review

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82 Actions Speak Louder: A second review of healthcare in the community for young people who offend (2009)
83 ASSET is a national assessment tool which the youth justice board expects youth offending teams to use in their work with all young people.
ASSET scores and determine whether they reflect the problems that are evident and adjust them accordingly if they do not but this is not available across all sites.

The multiplicity of challenges experienced by children and families engaged with the YJS frequently makes contact with these children unreliable, and the potential for every contact with the young person to be an opportunity to assess and address their physical health needs should be maximised.85

**Recommendations**

3. If provision cannot be met by a dedicated health worker then appropriately trained and supported YOT staff could carry out the assessment function and refer appropriately to universal and/or specialist services. Using an agreed holistic health assessment tool.

**7.2.2 Emotional and mental health needs**

The number of 16 to 17 year olds unable to access either children’s or adult services was a concern to a number of stakeholders as is the high threshold for acceptance of CAMHS referrals, which is reported to exclude young children with lower level, multiple and often complex mental health needs and learning disabilities.

Stakeholders were unanimous in their view of the benefits of having a specialist who is physically present in the team with an understanding of mental health problems and disorders, and who is available for consultation and advice to practitioners as well as young people. The benefits of this form of provision that were reported included timely and accurate assessments being undertaken, appropriate referrals or interventions made and better access to treatment and specialist CAMHS. In addition, the importance of raising awareness within the team of mental health problems and disorders, of providing training and advice and increasing caseworkers’ confidence to appropriately

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identify problems or to seek advice was cited. They also were reported to play a vital role in raising awareness in other professions who work with the YOT, such as police and court staff. This, in turn, was felt to increase the capability of youth justice services to work more effectively with children with such impairments including ensuring timely referrals for more specialist assessments and better data collection to inform future service planning and delivery. Stakeholders also noted that young people do not have to be referred and passed on to specialists and engage with new workers and professionals, particularly in circumstances where they are nervous or reluctant about accessing mental health services.

YOS staff consistently asked for the same CAMHS provision to be made available across the YOS sites as well as to the Diversion scheme. Given this, it must be noted that that the YOS CAMHS workers are employed in a wider health capacity and recognise the interlink between physical, emotional and wider need, recognising that there cannot always be strict demarcation between the problems that are impacting on emotional health and wellbeing. Young people frequently have problematic behaviour that may not be symptomatic of a disorder, but of other deep-seated problems. Responding to non-acute needs presents difficulties as they may fall below the threshold for CAMHS intervention (that is diagnosable disorders).

YOS staff view the presence of a mental health specialist in the team as having a significant impact in enabling access to services for young people, as they know the procedures to navigate and there is less likelihood that referrals to CAMHS will be challenged or considered inappropriate (in Cheshire West and Chester).
**Recommendations:**

4. Review pathway in place with Five Borough Partnership to ensure it serves the level of need and throughput and is consistent in providing consultation to YOS officers. Community CAMH services in Halton and Warrington should also adopt an assertive outreach approach to maximise engagement and reduce delay.

5. Explore whether resources are available to support a generic health role which combines both physical and mental health needs to serve Halton and Warrington. In determining the best model, commissioners and YOTs should be aware of the range of different YOT health commissioning models available and make decisions taking into account a needs assessment of all vulnerable young people in the area, an audit of what other services (voluntary and statutory) are available in the locality, the extent of difficulties faced in accessing local specialist services and the evidence base.

**7.2.3 Therapeutic support**

Managers and YOS officers identified that young people do not presently always receive a sufficiently intensive period of evidence-based therapeutic support that is required to reduce their reoffending risks and improve their life chances. There were suggestions around the greater use at the point of release of evidence based approaches such as multi-systemic therapy (which is no longer available in the borough).

**7.2.4 Challenges working with wider services**

YOS staff reported young people often face persistent problems accessing support from mainstream specialist health and social care services. This appears due in large part to inflexible exclusion criteria, failure to recognise multiple and Safeguarding needs, and the poor design of services that are not experienced by young people as accessible or engaging. It was felt that service design issues require urgent attention by commissioners.
7.2.5 Restorative justice
Stakeholders cited the promising evidence supporting the use of restorative justice as an alternative to prosecution using various options which include face to face contact. Restorative justice can reduce reoffending and promote accountability for offending. It also offers an opportunity to motivate young people to engage or reengage with treatment but support needs to be accessible and available. A number of stakeholders were eager that this option be pursued.

7.2.6 Substance misuse
There was consistent feedback from YOS case managers who felt the professional consultation from the Tier 3 substance misuse officer was invaluable and that young people engaged well with the worker once a young person agreed to access the support. However there was also an acknowledgement by both the substance misuse worker and wider YOS staff regarding the challenges of influencing any changes in attitude – particular emphasis was placed on the fact that young people no longer viewed using drugs as an anti-social activity but is readily accepted by many as a tool to heighten enjoyment and is an ingrained part of their lifestyle.

Parker et al. (1998) developed the idea that drug use has become ‘normalised’ amongst young people, which involves the incorporation of drugs, drug use and drug users into their everyday lives. Thus, drug use may be ‘normalised’ amongst young offenders as much as amongst young people in general and therefore decoupled to some extent from recognised risk factors. Even if young offenders continue to take drugs at a higher rate than the general population, this ‘normalisation’ might alter the relationship between drugs and offending. As evidence of this, YOS practitioners reported young offenders not perceiving their drug or alcohol use to be problematic. Those who did see a problem had no desire to stop, as they perceived their use to be in some way beneficial to them.

Workers also reported some young people to be naive and ill-informed about drugs, their potency and addictiveness, and with little interest or insight in where a long term problematic drugs career might take them. It was observed that young people typically delayed accessing services until their social dislocation and the severity of their reliance were problematic and they were facing a consequence such as exclusion from school or loss of a job.

Multiple life experiences and problems were common amongst young offenders who also were in receipt of support for substance misuse. Inter-related issues included:

- school exclusion
- parental divorce or separation
- a family member with a criminal record, and
- a family bereavement.

Most did not like school or get on well there and used drugs or alcohol in order not to think about their problems. Low self-esteem, boredom and feeling low in mood was also common.

High numbers of young offenders were reported to be in possession of cannabis. This included those who brokered access (helping others access cannabis but not for profit), sold on a few occasions to those who were involved more regularly in cannabis transactions, although did not perceive themselves to be 'dealers'.
7.2.7 Autism

There were key areas of concern that were consistently highlighted with regards to autism. These included:

- a strong sense of a lack of understanding of autism, particularly regarding those at the higher-functioning end of the spectrum (including Asperger’s syndrome)
- lack of support around key difficulties such as sleep
- sensory differences
- non compliance with medication and behaviour, and
- the difficulties in accessing an assessment.

Where a communication screening flags up a concern, the YOT officer has to go back to the young person's GP who makes the referral as a direct referral cannot be made from the YOS.

In addition there are occasions where the young person and/or their family do not wish for the assessment to be undertaken and will not engage in the referral process. This can create significant delay and hamper the engagement required to assess and effectively develop a plan with the young person.

Due to the hidden nature of the conditions, YOS workers may not understand the underlying causes of an individual's behaviour. People with autistic disorders are vulnerable in any situation where their condition is not recognised which can result in inappropriate treatment of individuals with autistic spectrum disorders.
**Recommendation:**

6. There is a need for more dedicated specialists for young offenders with learning disabilities and other developmental needs to be aligned with the YOS including the Diversion Scheme to assist in identifying young people with learning disabilities and other developmental disabilities.

7. Clarity and awareness is needed of the local ASD Pathways and what is available to the YOS staff, young people and their carers. This would help to co-ordinate involvement between the YOS and appropriate agencies and promote partnership with parents and young people.

7.2.8 Looked After Children

An internal audit carried out within the YOS in 2013 found a significant proportion of young offenders were subject to care orders under Section 31 and in receipt of Section 20 voluntary accommodation. Although there is a lack of precise data on the number of children and young people in the youth justice system who have also been in contact with children's social care services as a child, in need or looked after child, the evidence indicates considerable overlap.

Young offenders who are also a child in care have tended to have led chaotic lives, and were described as difficult to engage by YOT staff and subject to numerous breakdowns in placements which create highly unstable environments.

Some interviewees noted that the risk factors associated with looked after children can be mitigated by the presence of protective factors which are recognised as helping to build a young person's resilience. Building resilience is a key objective in the care of looked after children. Along with the appropriate

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87 Note that the term 'looked after child' includes children subject to a care order (section 31 of the Children Act 1989) and children who have been accommodated by agreement between their parents and the local authority or, if the young person is 16 or over, with their agreement (section 20 of the Children Act 1989
support, resilience can help young people to overcome adversity and resist the negative effects created by risk factors.

For diverting children who show anti-social behaviour and preventing reoffending and escalation of offending, a multi-dimensional approach is needed that combines relationship building, education / activities and boundary setting and requires a multi-agency approach.

**Recommendations:**

8. The YOS, in partnership with children’s services departments should provide preventive services for pre-teenage children that address common risk factors for care and crime and promote resilience.

9. Youth offending teams should work in close collaboration with looked after children teams to offer advice and preventive services / appropriate interventions for looked after children at risk of offending / re-offending.

10. The YOS should ensure training for its staff regarding the impact of abuse and neglect on looked after children in relation to offending, care placements and pathways.

**7.2.9 Education**

YOS staff gave anecdotal accounts of the educational background of young people supervised by the youth justice system with the general population which on average show that young offenders have had difficult and often poor previous experiences of education. Low attainment, persistent truancy, exclusion and Special Educational Needs are some of the most prevalent risk factors associated with offending behaviour. The correlations between education, offending and re-offending are well documented.
The YOS Educational workers has useful protocols in place with local education partners, including schools, colleges and careers companies. These give clear guidance on the additional support needs of young offenders, and in the best cases they describe how the education requirement of the new Youth Rehabilitation Orders will work.

The YOS Education, Training and Employment (ETE) workers are reported to have good relationships with local authority education services. They are established members of education placement panels and are effective champions for the needs of the children and young people in the YOS. They raise the profile of children who otherwise could be lost to the system.

Local authorities however need to do more work with head teachers in primary and secondary schools to make schools more inclusive. Local authorities do not always challenge schools enough to improve outcomes for YOS children and young people. More vocational courses are needed to be made available via school, as many of the young people at the YOS prefer to undertake courses which have practical skills with less teaching using traditional academic methods. Many of the young people are reported to have a very poor relationship with school which subsequently impacts upon their overall attitude to learning, their self esteem and motivation levels.

**7.2.10 Housing**

Establishing the number of young offenders that are in housing need is difficult, as this information is not specifically asked for within the youth justice context; nor is it collected nationally in any clear or specific way for the general population. The issue is further complicated as young offenders are not necessarily street homeless but may experience other forms of homelessness. These may include those who are thrown out of the family home, ‘sofa surfing’, living in a temporary hostels and homeless accommodation. The reasons tend to include: the behaviour of others and the young person’s victimisation, their own behaviour, or other family circumstances such as the loss of the family home, family breakdown or bereavement.
YOS workers had found that finding suitable alternative accommodation was more difficult for those aged 16 and 17 years. Further, there was a shortage of suitable hostel provision or supported lodgings, and many young people were not considered sufficiently mature to live totally independently. A number of stakeholders indicated that the type of accommodation they required most was emergency accommodation for those in crisis, for those likely to be denied bail and for those to be released from custody. In addition, remand fostering and supported lodgings were also identified. The YOS commented that what they needed was a range of “flexible provision to be able to meet the varying range of needs of young people”.

Given the complexity of housing legislation and the different responses according to age and locality practitioners were often unsure about what can be expected and how to go about accessing help; practical advice and support.

**Recommendations:**

11. Housing policy does not appear at present to reflect the needs of young people which often require an immediate response to acute need on a short-term basis. Additionally, the YOS lack access to short term emergency accommodation that could, in the first instance, act as a stop gap. The housing needs of young people with whom the YOS comes into contact need to be fed into housing/homeless forums in order to determine how these needs can best be met.

12. The availability of dedicated and specialist assistance to help young people to cope on a day to day basis with their living arrangements and to advocate for them if they get into difficulties is an area of support that some local authorities are already investing in, for example through floating support, but which needs further consideration with regard to young people and should be specifically available for all 16 and 17 year olds living independently. Those who have had fractured family relationships and move in and out of home are in effect trying to make the transition to independent living.
7.3 Young people's findings
A small number of young people managed through a statutory order gave their consent to be interviewed. All were White, male and between the ages of 15-17 years.

7.3.1 Overall health
All the young people interviewed said they gave very little thought to their general health and tended to ignore symptoms if feeling unwell. In general, the young people had not thought to seek help or speak to someone if they struggled with their eating (often low appetite), erratic sleeping, irritability, mood swings, sadness and at times headaches.

"I can't remember the last time I saw my doctor...I can't sleep at night I am wide awake, I tend to sneak out back and go out without my mam knowing and go and sit at my mates"

"My eating is not good. I'm just not hungry I don't know why. I just ignore stuff and get on with it"

7.3.2 Mental health
Some of the young people had experience of being referred to CAMHS.

"I got referred to CAMHS when I was diagnosed with ADHD, it was ages ago. I've been on medication for 10 years now, I see CAMHS every 6 months for my review".

All spoke negatively of their experiences, main reasons included the waiting time either in between appointments or from referral to assessment as well as not finding sessions helpful and the expectation of having to speak about their problems.

"In 1 year I received 2 appointments, how's that supposed to help me?"
"I had to wait 5-6 months before I got my appointment with CAMHS and then I couldn't be arsed going. If they saw me when I felt s**t then I can say they helped"

"They [CAMHS] kept on asking me how I felt. I just stayed quiet. I would rather speak to my friend"

"I don't want to talk about my problems, why do they have to ask so many questions, I don't know what the answer is"

Many were dismissive of talking therapies and didn't understand how the sessions could help them. The implication for services is that greater emphasis should be placed on explaining to young people the methods and reasoning behind treatments. If a young person thinks he or she is being fobbed off with a lesser form of therapy, he or she is not likely to engage in or complete the treatment.

Some of the young people appeared to have been strongly influenced by rumours of the effectiveness of certain treatment methods; others were determined to try only those services that their friends had used.

Some were also unwilling to speak to any professional about their mental health and were angry at the suggestion of a referral. The stigma of mental illness was evident highlighting the importance of how suggestion of a referral should be broached bearing in mind the preconceived perceptions young people held.

"I'm not mad, I'm not seeing some mental health worker"

"Why does everyone think I'm crazy and always trying to get me to see someone"
Three of the young people had worked with the in-house YOS CAMHS Health workers, but described them as YOS workers and not separate to the YOS team.

"Yeh I've seen *****, we went through stuff. I got an appointment with the doctors cause I needed to get my asthma checked".

"We've gone over stuff to help me when I get angry, they [YOS CAMHS Health workers] gave me tips, it was hard at first but I've tried a few. They also check my medication regularly".

However one of the young men felt the assessment process was too long and he couldn't see the purpose of the session.

"I get asked so many questions and we do these anger scales, I don't see the point"

7.3.3 Substance misuse

Young people who had seen the YOS substance misuse worker spoke positively of the input received and valued their experience and knowledge:

" ***** is ace, really sound guy, he knows his stuff and he's been helping me to look at consequences and stuff"

"He's really helped me with lots of stuff, he understands why I smoke weed but I do wanna cut down now I wanna get a job and it don't look right if I can't get up cause I've been smoking all night"

"I used party drugs, cocaine, ketamine, I have to grow up now. I feel better without the drugs I want to work now".
"Got into a lot of debt with my weed habit"

### 7.3.4 Anger Management

All the young people spoke of not feeling they were able to control their anger and, that they had 'always been angry' from a young age and found themselves in trouble at school, at home and now with the police.

"Look at my door I completely smashed it last night I can't believe it I went mad, mum called the police"

"I have done work on my anger...that was hard...I walk away now when someone in the street says something to me. Usually I would want to smash his face but I just look and walk away"

"I've had problems with behaviour since I were 3, years 7-11 I was in a BSD school, been on medication for ADHD for 10 years, I want to go to college. My ex-girlfriend had an abortion I didn't know, I feel so angry"

### 7.3.5 Education

The support received from the Education workers was well thought of and was felt to be more tailored to their individual needs and likes.

"I can do hands on construction Mondays and Fridays. I enjoy the practical stuff much more. I go college Tuesday - Thursdays"

"I don't want to go to school I want to work. They're [Education Workers] helping me"

All of the young people spoke of the poor relationship they had or have with school and how much they disliked the environment.
"You can't learn at a PRU none of the kids let you, the naughty kids take all the focus from the teachers"

"I always struggled with maths, I got frustrated and mad but the teachers always sent me out cause I was disruptive. It's given me really low self esteem".

7.3.6 Relationships
Relationships came up in most discussions, young people were clearly upset at the relationship they had with family members and struggled to talk about them.

"I hate it when my mum drinks she gets really angry and starts to go mad at me. I don't get on with my step dad and can't stand my half sister. They have got each other, who have I got...no-one"
"I live with Nan and granddad, my mum didn't want me around said I caused trouble. I don't ever see her".

"My relationship with my girlfriend is really important to me, it's keeping me going."

"I do get pressure from some friends it's difficult when they don't understand, some respect I am tagged though so go in when I do."

7.3.7 Leisure
Some of the young men spoke how sports helped them to keep focused.

"I enjoy football and want to get back into it"

"Training 3 times a week never got into trouble but I got angry and the coach banned me, I think I will be different now"
They were working with the YOS Case Manager to access local leisure facilities and establish a routine with different activities which they welcomes as 'kept them busy' and 'stopped them getting bored'.

7.2.8 Relationship with YOS Case Manager/ YOS Support Worker

All of the young people understood the role of their YOS Worker and respected what they had to do. "Yeh they're alright, they are then when I need them"

"They are sound, she gets me"

Although some said they would prefer to solve their problems by themselves and displayed a defiant self-sufficient attitude, in the main because they had always had to since young.

"I know how to sort myself out, I've always had to do it...just me"
8. Conclusions and recommendations

8.1 Conclusions

8 The young offenders in the sample population had higher levels of health need compared to their peers who are not engaged with offending services in relation to several areas – mental health, learning difficulties, substance misuse and social issues.

9 Young offenders have high levels of co-morbidity – that is, the young people supported by the YOS have multiple health conditions (for instance simultaneous mental health and substance misuse needs) that need to be addressed. The population being served is therefore a particularly complex one to support as they may require interventions across multiple disciplines.

10 The health needs of young offenders interplay with a range of social factors – including family environment and housing – that further complicate and can exacerbate their physical and mental health needs.

11 Young offenders exhibit high levels of risk taking across a range of domains – risky health behaviours, risky sexual behaviours, high levels of alcohol consumption, substance misuse and so forth. It is likely that some of their health needs are partially accounted for by this underlying attitude to risk and poor decision-making. Helping young offenders make better and more informed choices will in turn impact on their wider health.

12 There was pronounced variation in the prevalence of physical and mental health conditions across the three YOS areas (Halton, Warrington, Cheshire West and Chester). It is likely that this is more a function of the different ways in which health services are delivered (and therefore the extent to which health conditions are picked up) across the three areas than a measure of actual prevalence and need. That is, some health systems seem to be better placed to detect and respond to the health needs of young offenders than others.

13 Following on from Conclusion 5, it follows that there is not equitable access to healthcare across the three areas and that a young person’s experience of health provision is likely to vary in relation to where they live. Access to mental health services would appear to have the greatest levels of variation.

14 Young offenders on Youth Rehabilitation Orders (YROs) tended to be more likely overall to have identified needs in relation to substance misuse, mental health, and some social issues than those on Referral Orders and on the Diversion Programme. This may be due to this being a more complex cohort of young offenders, or it may be attributable to differences in assessment and recording.
8.2 Recommendations

13. Use findings from current health needs assessment to inform the development of wider health inequality proxy measures to help develop the cost-avoidance measures as this will then provide an informed view of how the scheme has impacted upon health and access to provision. In addition it would be useful to measure changes in any identified mental health needs and other vulnerabilities (over a three month contact period).

14. Use findings of presenting and emerging need to inform whether this warrants investment into health provision which would support specialist intervention at point of entry to the system within the Diversion Team.

15. In Halton where provision cannot be met by a dedicated health worker then appropriately trained and supported YOT staff could carry out the assessment function and refer appropriately to universal and/or specialist services. Using an agreed holistic health assessment tool.

16. Review pathway in place with Five Borough Partnership to ensure it serves the level of need and throughput and is consistent in providing consultation to YOS officers. Community CAMHS services in Halton and Warrington should also adopt an assertive outreach approach to maximise engagement and reduce delay.

17. Explore whether resources are available to support a generic health role which combines both physical and mental health needs to serve Halton and Warrington. In determining the best model, commissioners and YOTs should be aware of the range of different YOT health commissioning models available and make decisions taking into account a needs assessment of all vulnerable young people in the area, an audit of what other services (voluntary and statutory) are available in the locality, the extent of difficulties faced in accessing local specialist services and the evidence base.

18. There is a need for more dedicated specialists for young offenders with learning disabilities and other developmental needs to be aligned with the YOS including the Diversion Scheme to assist in identifying young people with learning disabilities and other developmental disabilities.
19. Clarity and awareness is needed of the local ASD Pathways and what is available to the YOS staff, young people and their carers. This would help to co-ordinate involvement between the YOS and appropriate agencies and promote partnership with parents and young people.

20. The YOS, in partnership with children’s services departments should provide preventive services for pre-teenage children that address common risk factors for care and crime and promote resilience.

21. Youth offending teams should work in close collaboration with looked after children teams to offer advice and preventive services / appropriate interventions for looked after children at risk of offending / re-offending.

22. The YOS should ensure training for its staff regarding the impact of abuse and neglect on looked after children in relation to offending, care placements and pathways.

23. Housing policy does not appear at present to reflect the needs of young people which often require an immediate response to acute need on a short-term basis. Additionally, the YOS lack access to short term emergency accommodation that could, in the first instance, act as a stop gap. The housing needs of young people with whom the YOS comes into contact need to be fed into housing/homeless forums in order to determine how these needs can best be met.

24. The availability of dedicated and specialist assistance to help young people to cope on a day to day basis with their living arrangements and to advocate for them if they get into difficulties is an area of support that some local authorities are already investing in, for example through floating support, but which needs further consideration with regard to young people and should be specifically available for all 16 and 17 year olds living independently. Those who have had fractured family relationships and move in and out of home are in effect trying to make the transition to independent living.
9. Appendices

Appendix 1: Individuals and organisations responding to online survey

<table>
<thead>
<tr>
<th>Name of organisation/team</th>
<th>Job title</th>
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</thead>
<tbody>
<tr>
<td>Beacon Counselling Trust</td>
<td>Clinical Director</td>
</tr>
<tr>
<td>Bridgewater Community Healthcare NHS Foundation Trust</td>
<td>Specialist Nurse for Children &amp; Young People in Care</td>
</tr>
<tr>
<td>Bridgewater Community NHS Trust</td>
<td>Manager</td>
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<tr>
<td>Bridgewater Community NHS Trust</td>
<td>Team Leader School Nursing</td>
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<tr>
<td>Bridgewater Community NHS Trust</td>
<td>Children’s Services Manager</td>
</tr>
<tr>
<td>Forum Housing Association</td>
<td>Head of Service</td>
</tr>
<tr>
<td>Forum Housing Association</td>
<td>Operational Safeguarding and Health Need</td>
</tr>
<tr>
<td>Halton Council</td>
<td>Commissioning Manager</td>
</tr>
<tr>
<td>NHS Vale Royal and NHS West Cheshire Clinical Commissioning Groups</td>
<td>Designated Nurse safeguarding Children</td>
</tr>
<tr>
<td>NHS West Cheshire CCG</td>
<td>Starting Well Commissioning Lead</td>
</tr>
<tr>
<td>Public Health</td>
<td>Health Improvement Specialist</td>
</tr>
<tr>
<td>St Werburghs Medical Practice for the Homeless</td>
<td>Specialist Nurse Practitioner for the Homeless</td>
</tr>
<tr>
<td>Warrington Borough Council</td>
<td>Head of Service - Drug and Alcohol Action Team</td>
</tr>
<tr>
<td>Warrington Borough Council</td>
<td>Interim 11-19 Education, Training &amp; Skills Manager</td>
</tr>
</tbody>
</table>
Appendix 2: List of survey questions for Stakeholder Survey

1. Your details:
   - Name
   - Job title
   - Name of organisation/team
   - Contact details
2. What are the most common health and well being needs for young offenders?
   - Drugs
   - Alcohol
   - Mental health
   - Learning disabilities
   - Homelessness
   - Physical health (please specify below)
   - Other
   - Comments
3. Are you aware of any additional complex and intersecting needs which impact young offenders and may cause health inequalities?
   - Poor physical health
   - Mental health issues
   - Substance misuse
   - Learning difficulties
   - Homelessness
   - Offending pattern
   - Home environment
   - Comments
4. To what extent does current provision address the health and well being needs of the young offender population?
5. Can you identify interventions/ services which work particularly well?
6. Do you see any gaps or systemic challenges in current service provision?
7. Can you identify any areas which may present as a barrier to a young person accessing health provision? It could be specific to a health condition or lifestyle of the young offender. In your answer consider how well the young person on average engages with health care and which services may have lower take up.
8. Have you been involved in any policy/practice developments to help minimise the challenges in providing your service to young offenders? If so, what has been the impact of those developments?
9. What are your feelings about the quality of health services used by offenders outside of the Youth Offending Service? How could these be improved? Are there any specific issues for young people moving in and out of the YOS system with continued health needs?

10. How could the support that parents/other relatives/carers of young offenders be improved? How are young offenders who are also parents supported?

11. Please provide any additional comments which may relate to service delivery, strategy, commissioning or young people themselves
## Appendix 3: Consultation Themes

### Professional Stakeholder Consultation

For staff working directly with young offenders

- How are physical and mental health needs of young offenders identified? (differentiate different pathways, identify screening/assessment processes and IT arrangements for data storing)

- What are the levels of threshold used which trigger referral for intervention from a health professional?

- How confident/equipped do generic YOS staff feel able to identify health problems?

- What healthcare provision is available across the young offender pathway in custodial and community settings?

- Which services do you tend to refer to? Internal and externally. Describe quality of relationships and information sharing with both internal and external providers/practitioners.

- What are the mechanisms to support integrated working? E.g. multi-agency meetings/forums/joint home visits/assessments etc.

- What is in place to encourage and widen access e.g. home visits, evenings, weekends, peer/buddy system, delivery incorporated into other settings e.g. education, social care, coincide with other appointments, use of social technology etc.

- What is quality of provision like for 16-18 year olds? Any other gaps?
- Do any young people referred to the YOS already have prior identified diagnosis/ medical condition/ disability etc? If yes, how much information is received and describe level of joint working/ discussion with the YP's health worker?

- Describe level of need against these areas:

  **Physical health conditions** - e.g. (self-neglect, poor hygiene, nutrition, weight, dental, sexual health, medical condition, drugs, alcohol, teenage pregnancy)

  **Mental health** - e.g. (self harm, depression, stress, sleep difficulties, psychosis etc.)

  **Behavioural** - e.g. (challenging behaviour)

  **Disability** - (e.g. learning difficulties/ disability, speech and language, physical disability, autism, aspergers)

  **Finance** - (e.g. impact upon employment/ education/ aspirations and engagement/ stress etc.)

**Relationships**

- Have you seen a change in presenting issues?

- What about wider health related needs such as accommodation and education, training and employment needs?

- Feedback regarding any correlation with - age, gender, ethnicity, lifestyle choices, geography, social aspect, looked after status, home situation

- Feedback regarding any correlation with category of offence, repeat/first offence, type of community order etc.

- Impact of provision upon positive outcomes for YP entering and leaving youth offending services
YOS management

- Describe the arrangements for health provision (mental health, disability, speech and language, drugs/ alcohol, other etc.)? Who is directly employed by the YOS and who is contracted?

- How confident are generic YOS staff to identify health problems?

- Describe provision and allocation of resources/ emphasis across prevention/ early intervention, general health care, specialist intervention

- Describe quality of provision available and take up, significant challenges/ gaps in provision?

- What is in place to encourage and widen access e.g. home visits, evenings, weekends, peer/ buddy system, delivery incorporated into other settings e.g. education, social care, coincide with other appointments, use of social technology etc.

- Have you seen a change in presenting issues? What about wider health related needs such as accommodation and education, training and employment needs?

- What is the relationship with primary care and acute settings like?

- Describe impact of provision upon positive outcomes for YP entering and leaving youth offending services
### Commissioners

- How is health provision commissioned for young offenders? In particular understanding delivery against mainstream provision for example CAMHs, speech and language, generic health, sexual health, drugs/ alcohol, provision for wider health needs, such as accommodation and education, training and employment needs.

- Describe provision and allocation of resources/ emphasis across prevention/ early intervention, general health care, specialist intervention

- Describe quality of provision available and take up, significant challenges/ gaps in provision?

- Funding arrangements for tier 4 placements, availability of adequate provision e.g. for co-morbidity

- What are the local commissioning arrangements for YP and health including young offenders?

- How will this needs assessment data be used to commission services? Examples of where the needs assessment has triggered new developments.

### Strategic Representatives

- What is the local strategic position in regards to health and YP

- Outline key priorities and delivery plan for young offenders
- How is integration supported for YP moving in and out of the YOS system with continued health needs?

- What are the local challenges and are there any pilots/ projects/ opportunities for funding/ collaboration

- Future aspirations for local strategy and provision

- What is your involvement as a strategic representative in the commissioning arrangements?

### Sample YP health providers

- Outline how provision is delivered to young offenders include; resource (staff), mechanisms for integration with YOS provision, referral pathway details, sharing of information and joint working

  Appraisal of current arrangements, demand and capacity

- Levels of need, gaps in provision, challenges to support YP/ family, transition for 16-18 year olds

- Availability of provision for wider health needs, such as finance, accommodation and education, training and employment needs, relationships.

- How is integration supported for YP moving in and out of the YOS system with continued health needs?
### Young People Consultation Themes

#### Access & Support

What health services have you used/ been aware of before attending the YOS (explore understanding of health services and health needs)?

- Describe level of need against these areas:

Physical health conditions - e.g. (self-neglect, poor hygiene, nutrition, weight, dental, sexual health, medical condition, drugs, alcohol, teenage pregnancy)

Mental health - e.g. (self harm, depression, stress, sleep difficulties, psychosis etc.)

Behavioural - e.g. (challenging behaviour)

Disability - (e.g. learning difficulties/ disability, speech and language, physical disability, autism, aspergers)

Finance - (e.g. impact upon employment/ education/ aspirations and engagement/ stress etc.)

Relationships

Since you have been attending the YOS which type of services/ support have you received? (Broaden out)

Did you agree with the areas which were identified for you to receive support? Any areas which you found difficult to accept/ prioritise at first?

Were there any areas which you asked for help with?

What has been your experience of receiving services (go into detail depending upon area) (e.g. what kind of support have you received 1-2-1/ group/ peer/ buddy)
<table>
<thead>
<tr>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>What has been the most positive aspects for you in receiving this support? (ask for some detail to how they know this, how do they feel different physically and emotionally).</td>
</tr>
<tr>
<td>How flexible did you find the support, where do you tend to have your appointments?</td>
</tr>
<tr>
<td>Has receiving this support helped you with other aspects of your life?</td>
</tr>
<tr>
<td>Were there any challenges at the initial stages or as the appointments progressed? Was there any aspects which you found difficult to engage with or found of less relevance?</td>
</tr>
</tbody>
</table>
Appendix 4: 95% Confidence Intervals

Low numbers suppressed for data protection reasons (n<5) are marked with **; categories with no young offenders identified in the sample are marked with '-'.

<table>
<thead>
<tr>
<th>Physical Health</th>
<th>Cheshire West</th>
<th>Halton</th>
<th>Warrington</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Point Estimate</td>
<td>CI (low)</td>
<td>CI (high)</td>
<td>CI (low)</td>
</tr>
<tr>
<td>Health Condition (Any recorded)</td>
<td>13.04%</td>
<td>9.18%</td>
<td>16.90%</td>
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</tr>
<tr>
<td>Health Condition Affecting Functioning</td>
<td>7.61%</td>
<td>3.75%</td>
<td>11.47%</td>
<td>**</td>
</tr>
<tr>
<td>Disability (registered disabled/receiving DLA)</td>
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<td>**</td>
<td>**</td>
<td>**</td>
</tr>
<tr>
<td>Risky Health Behaviour</td>
<td>**</td>
<td>**</td>
<td>**</td>
<td>**</td>
</tr>
<tr>
<td>Risky Sexual Behaviour</td>
<td>2.17%</td>
<td>0.00%</td>
<td>6.03%</td>
<td>5.56%</td>
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<th>Youth Rehabilitation Order (YRO)</th>
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<td>CI (high)</td>
<td>CI (low)</td>
</tr>
<tr>
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<td>5.03%</td>
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<td>17.31%</td>
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<tr>
<td>Health Condition Affecting Functioning</td>
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<td>**</td>
<td>**</td>
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<tr>
<td>Disability</td>
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<td>**</td>
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<tr>
<td>Risky Health Behaviour</td>
<td>**</td>
<td>**</td>
<td>**</td>
<td>9.62%</td>
</tr>
<tr>
<td>Risky Sexual Behaviour</td>
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### Vulnerability Score/Risk Level

<table>
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<th>Halton</th>
<th>Warrington</th>
<th>Overall</th>
</tr>
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<td>CI (high)</td>
<td>Point Estimate</td>
</tr>
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<td>13.04%</td>
<td>9.18%</td>
<td>16.90%</td>
<td>27.78%</td>
</tr>
<tr>
<td>Medium</td>
<td>25.00%</td>
<td>21.14%</td>
<td>28.86%</td>
<td>33.33%</td>
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<tr>
<td>Low</td>
<td>55.43%</td>
<td>51.57%</td>
<td>59.29%</td>
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<tr>
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### Vulnerability Score/Risk Level

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<th>Overall</th>
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<td>Medium</td>
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<td>13.92%</td>
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<td>40.38%</td>
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<tr>
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<td>59.47%</td>
<td>67.19%</td>
<td>42.31%</td>
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<tr>
<td>Not Specified</td>
<td>5.56%</td>
<td>1.70%</td>
<td>9.42%</td>
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### Halton, Warrington, Cheshire West and Chester

#### Young Offenders Health Needs Assessment

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<tr>
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<th>Warrington</th>
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<tr>
<td>Formal Mental Health Diagnosis</td>
<td>21.74%</td>
<td>20.05%</td>
<td>25.60%</td>
<td>13.89%</td>
</tr>
<tr>
<td>In contact with Mental Health services</td>
<td>23.93%</td>
<td>20.05%</td>
<td>27.77%</td>
<td>38.89%</td>
</tr>
<tr>
<td>Self Harm/ suicide attempts (past or current)</td>
<td>21.74%</td>
<td>17.88%</td>
<td>25.60%</td>
<td>30.56%</td>
</tr>
<tr>
<td>Autism/Autistic Spectrum</td>
<td>**</td>
<td>**</td>
<td>**</td>
<td>**</td>
</tr>
<tr>
<td>ADHD</td>
<td>8.70%</td>
<td>4.84%</td>
<td>12.56%</td>
<td>**</td>
</tr>
<tr>
<td>Learning Difficulty</td>
<td>10.87%</td>
<td>7.01%</td>
<td>14.73%</td>
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<tr>
<td>SEN Statement</td>
<td>26.09%</td>
<td>22.23%</td>
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<td>13.89%</td>
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<tr>
<td>Speech/Communication problem</td>
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<tr>
<td>Mental Health Affecting Functioning</td>
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<tr>
<td>Formal Mental Health Diagnosis</td>
<td>18.89%</td>
<td>15.03%</td>
<td>22.75%</td>
<td>9.62%</td>
</tr>
<tr>
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<td>13.92%</td>
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<td>21.15%</td>
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<td>**</td>
<td>**</td>
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</tr>
<tr>
<td>ADHD</td>
<td>11.11%</td>
<td>7.25%</td>
<td>14.97%</td>
<td>-</td>
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<tr>
<td>Learning Difficulty</td>
<td>7.78%</td>
<td>3.92%</td>
<td>11.64%</td>
<td>11.54%</td>
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<tr>
<td>Speech/Communication problem</td>
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### Substance Misuse

<table>
<thead>
<tr>
<th>Substances</th>
<th>Cheshire West</th>
<th></th>
<th>Halton</th>
<th></th>
<th>Warrington</th>
<th></th>
<th>Overall</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Point Estimate</td>
<td>CI (low)</td>
<td>CI (high)</td>
<td>Point Estimate</td>
<td>CI (low)</td>
<td>CI (high)</td>
<td>Point Estimate</td>
<td>CI (low)</td>
</tr>
<tr>
<td>Current Alcohol Use</td>
<td>36.96%</td>
<td>33.10%</td>
<td>40.83%</td>
<td>36.11%</td>
<td>32.25%</td>
<td>39.97%</td>
<td>48.94%</td>
<td>45.08%</td>
</tr>
<tr>
<td>Previous Alcohol Use</td>
<td>38.04%</td>
<td>34.18%</td>
<td>42.90%</td>
<td>58.33%</td>
<td>54.47%</td>
<td>62.19%</td>
<td>61.70%</td>
<td>57.84%</td>
</tr>
<tr>
<td>Current Drug Use</td>
<td>40.22%</td>
<td>36.36%</td>
<td>44.08%</td>
<td>52.78%</td>
<td>48.92%</td>
<td>56.64%</td>
<td>42.55%</td>
<td>38.69%</td>
</tr>
<tr>
<td>Previous Drug Use</td>
<td>54.35%</td>
<td>50.49%</td>
<td>58.21%</td>
<td>52.78%</td>
<td>48.92%</td>
<td>56.64%</td>
<td>46.83%</td>
<td>42.95%</td>
</tr>
<tr>
<td>Smoker</td>
<td>39.13%</td>
<td>35.27%</td>
<td>42.99%</td>
<td>63.89%</td>
<td>60.03%</td>
<td>67.75%</td>
<td>51.06%</td>
<td>47.20%</td>
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<tr>
<td>Substance Use at time of offence</td>
<td>22.83%</td>
<td>18.97%</td>
<td>26.69%</td>
<td>**</td>
<td>**</td>
<td>**</td>
<td>31.91%</td>
<td>28.05%</td>
</tr>
<tr>
<td>Risky Drug Taking Behaviour</td>
<td>**</td>
<td>**</td>
<td>**</td>
<td>**</td>
<td>**</td>
<td>**</td>
<td>**</td>
<td>**</td>
</tr>
<tr>
<td>Intervention Required</td>
<td>38.04%</td>
<td>34.18%</td>
<td>42.90%</td>
<td>38.89%</td>
<td>35.03%</td>
<td>42.75%</td>
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### Substance Misuse by Diversion Programme

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<th>Point Estimate</th>
<th>CI (low)</th>
<th>CI (high)</th>
<th>Referral Order (RO)</th>
<th>Point Estimate</th>
<th>CI (low)</th>
<th>CI (high)</th>
<th>Youth Rehabilitation Order (YRO)</th>
<th>Point Estimate</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Current Alcohol Use</td>
<td>35.56%</td>
<td>31.70%</td>
<td>39.42%</td>
<td></td>
<td>42.31%</td>
<td>38.45%</td>
<td>46.17%</td>
<td></td>
<td>48.39%</td>
<td>44.53%</td>
<td>52.25%</td>
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<tr>
<td>Previous Alcohol Use</td>
<td>26.67%</td>
<td>22.81%</td>
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<td>59.62%</td>
<td>55.76%</td>
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<td>86.46%</td>
<td>94.18%</td>
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<tr>
<td>Current Drug Use</td>
<td>28.89%</td>
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<td>32.75%</td>
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<td>49.99%</td>
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<td>63.88%</td>
<td>71.60%</td>
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<tr>
<td>Previous Drug Use</td>
<td>44.44%</td>
<td>40.58%</td>
<td>48.30%</td>
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<td>71.15%</td>
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<td>75.01%</td>
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<td>73.56%</td>
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<td>Substance Use at time of offence</td>
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<td>19.47%</td>
<td>27.19%</td>
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<td>23.08%</td>
<td>19.22%</td>
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<td>19.35%</td>
<td>15.49%</td>
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<tr>
<td>Risky Drug Taking Behaviour</td>
<td>5.56%</td>
<td>1.70%</td>
<td>9.42%</td>
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<tr>
<td>Intervention Required</td>
<td>13.33%</td>
<td>9.47%</td>
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### Substance Misuse Impacting Functioning and Intervention Required

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<th>Referral Order (RO)</th>
<th>Point Estimate</th>
<th>CI (low)</th>
<th>CI (high)</th>
<th>Youth Rehabilitation Order (YRO)</th>
<th>Point Estimate</th>
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<td>30.58%</td>
<td>38.30%</td>
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<td>50.00%</td>
<td>46.14%</td>
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<tr>
<td>Previous Alcohol Use</td>
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<tr>
<td>Intervention Required</td>
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125
## Social, Family and Education

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<th>Warrington</th>
<th>Overall</th>
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<tbody>
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<td>Point Estimate</td>
<td>CI (low)</td>
<td>CI (high)</td>
<td>CI (low)</td>
</tr>
<tr>
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<td>9.78%</td>
<td>5.92%</td>
<td>13.64%</td>
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</tr>
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<td>CIC/Care Order-Current</td>
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<td>12.44%</td>
<td>20.16%</td>
<td>38.89%</td>
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<tr>
<td>On Child Protection Plan-Past/Current</td>
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<td>24.86%</td>
<td>19.00%</td>
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<tr>
<td>Social Services Involved-Past</td>
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<td>17.88%</td>
<td>25.60%</td>
<td>44.44%</td>
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<tr>
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<td>Diversion Programme</td>
<td>Referral Order (RO)</td>
<td>Youth Rehabilitation Order</td>
<td>Overall</td>
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<td>CI (low)</td>
<td>CI (high)</td>
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<td>Parent/ Carer Substance Misuse</td>
<td>15.56%</td>
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<tr>
<td>Past / Current Abuse / Neglect</td>
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<tr>
<td>Bereavement / Loss / Trauma</td>
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</table>
## Glossary

<table>
<thead>
<tr>
<th>Term/Abbreviation</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASSET Assessment</td>
<td>ASSET is: ‘a common, structured, assessment tool used across the youth justice system in England and Wales. The purpose of an ASSET Assessment for making a comprehensive and holistic assessment; identifying the needs of a young person; identifying factors contributing to offending behaviour; identifying risk and vulnerability and identifying positive factors as well as problems.’ ASSET includes detailed sections covering assessment of mental health, substance misuse and social variables. Physical health is also assessed although in less detail.</td>
</tr>
<tr>
<td>Confidence Interval (Ci)</td>
<td>A measure of how representative the selected sample is: The range of values either side of the point estimate within which the true value probably lies.</td>
</tr>
<tr>
<td>Confidence Level (Cl)</td>
<td>A measure of how representative the selected sample is: The likelihood that the true value falls within the confidence intervals. E.g. with a Cl of 95% and a Ci of +/- 3.86, we can be 95% sure that the true value lies within 3.86 units either side of the point estimate.</td>
</tr>
<tr>
<td>DANOS</td>
<td>Drugs and Alcohol National Occupational Standards</td>
</tr>
<tr>
<td>DP</td>
<td>Diversion Programme. The Diversion Programme is a scheme aimed at first-time entrants into the criminal justice system, and includes assessment, referral/s to appropriate interventions, and support. ‘The key aim of the project is to divert children and young people with specific health needs or learning difficulties away from the Youth Justice System, by providing appropriate and professional support at the earliest stage’.</td>
</tr>
<tr>
<td>DTO</td>
<td>Detention Training Order</td>
</tr>
<tr>
<td>LAC</td>
<td>Looked-After Child (in the care of a Local Authority)</td>
</tr>
<tr>
<td>LSOA</td>
<td>Lower Super Output Area (Geographical boundary area)</td>
</tr>
<tr>
<td>ONS</td>
<td>Office for National Statistics</td>
</tr>
<tr>
<td>Random sample</td>
<td>A sample in which every item in the population (all items) has the same probability of being chosen</td>
</tr>
<tr>
<td>RO</td>
<td>Referral Order. A Referral Order ‘refers the young offender to a Youth Offending Team and places the young person under their supervision for a period of 3-12 months’ and will include a Referral Order Contract agreed with the young person and their parent/carer to prevent further offending, which may include a letter of apology to the victims, community service, sessional training programs, or advice and support.</td>
</tr>
<tr>
<td>SEN</td>
<td>Special Educational Needs</td>
</tr>
<tr>
<td>SLT</td>
<td>Speech and Language Therapy</td>
</tr>
<tr>
<td>Statutory Order</td>
<td>An order imposed by the courts with a requirement to attend/participate (including YRO, RO and DTO)</td>
</tr>
<tr>
<td>Term/Abbreviation</td>
<td>Meaning</td>
</tr>
<tr>
<td>------------------</td>
<td>---------</td>
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<tr>
<td>Stratified sample</td>
<td>A sampling technique wherein the researcher divides the entire population into different subgroups or strata, then randomly selects the final subjects proportionally from the different strata (so that each stratum is represented in the sample in the same proportion as it is present in the entire population).</td>
</tr>
<tr>
<td>YOS</td>
<td>Youth Offending Service</td>
</tr>
<tr>
<td>YOT</td>
<td>Youth Offending Team</td>
</tr>
<tr>
<td>YRO</td>
<td>Youth Rehabilitation Order. A Youth Rehabilitation Order is 'a generic community order', often with requirements imposed by the court, such as a curfew (with electronic tag), activity or exclusion requirements, supervision by the YOS, or drug treatment attendance.</td>
</tr>
</tbody>
</table>