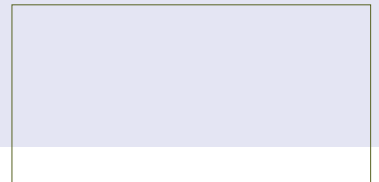
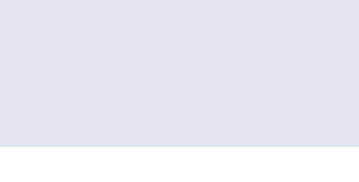
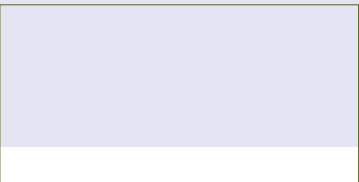


# 'Let's talk about it'



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

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# Contents

<b>Foreword</b>	<b>2</b>
<b>Executive summary</b>	<b>3</b>
<b>Introduction</b>	<b>8</b>
• the role of healthcare organisations	9
• the aim of this review	9
• the way we worked	9
<b>Findings</b>	<b>11</b>
• staffing	11
• access to services	15
• working in partnership	20
• management	23
<b>Conclusions</b>	<b>26</b>
<b>Recommendations</b>	<b>29</b>
<b>Next steps</b>	<b>31</b>
<b>References</b>	<b>32</b>

# Foreword



The particular challenge in working with children and young people who offend is how to ensure that both the child or young person's needs and their propensity to offend are addressed. This joint review by the Healthcare Commission and Her Majesty's Inspectorate of Probation looks at the input made by healthcare organisations in youth offending teams and the extent to which they are able to fulfil this dual role.

We were encouraged by some of our findings, in particular the increase in the availability of healthcare services for children and young people who offend since the inspection programme began in September 2003. In addition, a great deal of effort had been made to recruit substance misuse workers resulting in 90% of youth offending teams having good access to both a worker and further substance misuse services.

However, there were some substantial areas for improvement. Primary care trusts have a statutory duty to provide healthcare workers to youth offending teams. Yet we found that one in six of the youth offending teams we reviewed had no healthcare worker, and a third had no mental health worker. As a result, too many children and young people who offend had insufficient access to appropriate healthcare.

**Anna Walker**  
Chief Executive, Healthcare Commission

It was also disappointing that many youth offending team management boards did not have adequate involvement from a healthcare representative. This undermined attempts by the youth offending team to improve services for the young people or to monitor the health needs of their population. In light of this, the Healthcare Commission will ensure that its annual assessment of NHS trusts in England checks that healthcare organisations comply with their statutory duties.

As this report highlights, reducing offending behaviour is everyone's responsibility and not just the remit of those Government departments, regulators and local agencies to which it is usually allocated. If we take seriously the preventative agenda, then the Departments of Health and the Department for Education and Skills as well as local schools and NHS trusts have a role to play. We hope that this report will continue to stimulate debate on these issues, and more importantly, encourage healthcare organisations to take seriously their responsibilities in these matters to meet the needs of these children, as well as help contribute to a safer society.

**Andrew Bridges**  
Her Majesty's Chief Inspector of Probation

# Executive summary



Children and young people who offend have more health needs than the non-offending population of children. The provision of healthcare for them has improved, but it remains inadequate.

For this reason, healthcare organisations are required to contribute to youth justice services in their area, in an effort to meet these needs and to minimise the extent to which these issues may be contributing to offending behaviour.

This joint review by the Healthcare Commission and Her Majesty's Inspectorate of Probation looks at the role and input made by healthcare organisations in youth offending teams. Youth offending teams, established under the Crime

and Disorder Act 1998, have been created across England and Wales primarily to prevent children and young people, aged between 10 and 17, from participating in offending behaviour. Youth offending teams are made up of local authorities' social services and education departments, the police, probation services and NHS trusts. Their roles include providing reports to courts, supervising young people in the community and addressing the young people's wider developmental issues, such as ensuring they have access to

## Executive summary continued

appropriate healthcare and education to prevent future offending. There are 155 youth offending teams in England and Wales.

This report provides the findings from a review of the inspections of 50 youth offending teams in England and Wales. The inspections were conducted between September 2003 and April 2006. They were led by Her Majesty's Inspectorate of Probation and involved eight other inspectorates, including the Healthcare Commission and Healthcare Inspectorate Wales.

This review was prompted by an analysis of the recommendations from all the reports on the inspections of youth offending teams, which found that, except for the police, healthcare organisations were given more recommendations than any other partner. The review is aimed at helping youth offending teams in supporting children and young people with mental health, physical health or substance misuse needs. It is also aimed at informing the debate on how healthcare and other agencies could best work together to reduce offending by young people, and its subsequent impact on society.

*"I like being able to come in and talk about my problems and my substance misuse worker is good because she helped me to stop smoking drugs."*

## Summary of key findings

Since the inspection programme began in September 2003, there has been an increase in the availability of healthcare services for children and young people who offend. The numbers of healthcare workers placed in youth offending teams has remained fairly constant over this period, but they reported an improvement in the provision of, and support from, mainstream healthcare services to youth offending teams. Despite this, there is a significant amount of work that needs to be done by healthcare organisations to meet all the needs of this group. In particular, services need to be made more accessible for 16 and 17 year olds, as people in this age group are responsible for the majority of crimes committed by young people and they are also responsible for the more serious crimes. We found that in most youth offending teams, much effort had been made to recruit substance misuse workers, resulting in 90% of youth offending teams having good access to both a worker and further substance misuse services. In contrast, English NHS trusts have shown less diligence in fulfilling their statutory duty to provide healthcare workers to youth offending teams. NHS trusts had not increased their provision of healthcare workers to youth offending teams over the last three years. However, among the healthcare staff appointed there had been an increase in the number of healthcare workers who specialise in mental health needs. One in six youth offending teams still had no healthcare worker, and a third of them had no mental health worker.

The Government's intended role for healthcare workers in youth offending teams was that they would ensure that children and young people who offend had access to healthcare services. However, we found that a majority of healthcare workers in youth offending teams spend most of their time providing healthcare services to children and young people themselves. Although we saw this as

a positive and practical response to the difficulties in ensuring that children and young people who offend had access to healthcare services, it has also resulted, at times, in the healthcare worker providing services that reflected their experience and specialities rather than the needs of the young person. It also meant that a young person who offends needed to be involved with the youth offending team on an ongoing basis in order to receive treatment.

We found that youth offending teams' access to and support from their local child and adolescent mental health services had improved over the last three years. However, between one sixth and a quarter of youth offending teams were still experiencing problems in gaining access to these services. A lack of engagement by the healthcare representatives on the management boards of youth offending teams had meant that the youth offending team had no one to ensure that access to these services was provided. In contrast, the support and access offered by substance misuse services had generally been adequate.

For youth offending teams to work effectively, there needs to be effective joint working across specialities. However, in 15% of youth offending teams, significant problems were reported in joint working between specialist health and substance misuse workers and case managers. These problems were exacerbated by the lack of adequate procedures for the sharing of information that affected many youth offending teams.

Finally, the NHS in each local authority's area covered by the youth offending team, is required by the Government to provide a representative to the youth offending team's management board. This is to ensure that children and young people who offend have

access to appropriate healthcare services. We found that one in six youth offending teams did not have a healthcare representative on their management board. We were very concerned that, where a representative did exist, too often they were not sufficiently engaged in the work of the youth offending team to make a positive contribution to it and to young people who offend. This resulted in 60% of youth offending teams not having adequate involvement by a healthcare professional at a strategic level. One of the results of this was that in 80% of youth offending teams, there was no overall monitoring of either the health needs of the children and young people or the impact of services on those needs. Due to the lack of healthcare representatives on their management boards, youth offending teams were unable to establish whether the services that the NHS was providing to them were appropriate, whether they were effective in meeting the needs of this population, and whether, consequently, they were helping to contribute to reductions in offending behaviour.

## Recommendations

The Healthcare Commission and Her Majesty's Inspectorate of Probation have made the following recommendations:

PCTs working with youth offending teams should ensure that:

- they fulfil their statutory duty to provide at least one healthcare worker to their local youth offending team
- in light of the Government's planned restructuring of PCTs in England, neither their representation on the management boards of youth offending teams, nor their provision of healthcare workers to and funding of youth offending teams, is compromised

## Executive summary continued

Child and adolescent mental health services should ensure that:

- they implement the Government's guidelines to deliver mental health services to children up to the age of 18

PCTs, local health boards and child and adolescent mental health services should ensure that:

- an appropriate representative from both child and adolescent mental health services and the relevant PCT, PCTs or local health boards attend meetings of the management board on a regular basis and make a positive contribution to the strategic planning of healthcare services for children and young people who offend or are at risk of offending

Healthcare representatives on the management boards of youth offending teams should ensure that:

- they take responsibility for the provision of local healthcare services, which are flexible and which meet the health needs of young people who offend
- they provide appropriately qualified healthcare workers to youth offending teams who have the appropriate specialist skills which meet the needs of children and young people who offend
- protocols and service level agreements between the youth offending team and healthcare organisations are written or updated as appropriate, to cover the specifications of service and roles of healthcare workers, including terms of secondment, arrangements for cover and access to mainstream services

- they take a robust approach to ensuring that healthcare services are available for and accessible to children and young people who offend, especially mental health services for 16-18 year olds
- an agreed, rigorous and workable policy on the sharing of information and keeping records is implemented in their youth offending team
- health needs and the impact of healthcare services on those needs are monitored more robustly and comprehensively

The drug action team and/or local young person's substance misuse service should ensure that:

- they have representation on the management board of the youth offending team
- specific policies on the sharing of information are developed for substance misuse workers in youth offending teams that address the concerns of the young people, the staff in substance misuse services, and the needs of the youth offending team and the public

Managers of youth offending teams, their healthcare workers and their substance misuse workers should ensure that:

- the assessment and referral processes for health and substance misuse issues are sufficiently robust and efficient

The Department of Health and the Youth Justice Board should ensure that:

- following appropriate research, more specific guidance is provided on the role of the healthcare worker in youth offending teams to ensure that the best use of limited resources is made



In England, the Healthcare Commission should ensure that:

- its annual assessment of NHS trusts checks that healthcare organisations comply with their statutory duties in relation to youth offending teams
- findings from the inspections of youth offending teams are fed into their annual assessment of NHS trusts for 2006/2007
- they identify existing measures of health service contributions to youth justice services that can be incorporated into the screening process that accompanies their annual assessment of NHS trusts

In Wales, the Healthcare Inspectorate Wales should undertake similar checks.

# Introduction



Children and young people who offend have a range of characteristics that distinguish them from the non-offending population of children.

They are more likely to have mental health needs, misuse alcohol or drugs, have a learning disability, have spent some of their childhood in care, been subject to poor parenting, witnessed violence in the home, been abused or have been the victim of crime.<sup>1</sup> In response to this, youth offending teams were established in April 2000 under the Crime and Disorder Act 1998. The teams have the dual aim of preventing further offending, while also helping to meet the needs of the children and young people who offend.

The teams are made up of people with expertise in healthcare, education, social care, police and probation services and attempt to address these aspects in a young person's life in a systematic and integrated way. Each youth offending team has a management board, which is usually chaired by the chief executive of the local authority. Members of the board come from the NHS, the local authority, the police and probation services.

## The role of healthcare organisations

Due to the association between mental health disorders and problems relating to the misuse of substances and offending behaviour, the NHS was required to fulfil some specific obligations when youth offending teams were established.<sup>2</sup> In particular, former health authorities, whose responsibilities have now been transferred to PCTs and local health boards, were required to:

- nominate healthcare staff to work with youth offending teams
- make arrangements for the funding of youth offending teams and youth justice services
- discuss the availability of, and access to, health services relevant to preventing young people offending or re-offending
- facilitate arrangements (which include a new statutory power) for the sharing of information among professionals and agencies<sup>3</sup>

These requirements of Government are aimed at improving healthcare services for children and young people with mental health needs who offend and those who misuse substances.

## The aim of this review

This report is a preliminary assessment of the extent to which healthcare organisations have been successful in meeting their responsibilities. At this stage, there is insufficient data available for us to state whether the hoped for impact on offending behaviour is also being realised.

We conducted this review in response to the high number of recommendations made to healthcare organisations following the inspections by Her Majesty's Inspectorate

of Probation of youth offending teams. A formal analysis of these recommendations confirmed that, apart from the police, healthcare agencies were the subject of more recommendations than any other partner. This report is aimed at providing an overview of the contributions that healthcare organisations make to youth offending teams. We also identify good practice and make recommendations as appropriate.

## The way we worked

This review is based on the findings of 50 inspections of youth offending teams – 45 in England and five in Wales. The findings of these inspections were published between September 2003 and March 2006. As part of this review, we asked a number of questions that explored the contributions that healthcare organisations made to youth offending teams at both a strategic and operational level. We analysed the inspection reports and drew on our experiences of inspecting youth offending teams over the past two years. We believe that our findings provide a general indication of the issues affecting all youth offending teams in England and Wales because the 50 reports on inspections we analysed represent almost one third of them. We feel that the recommendations made in this report will be of relevance to youth offending teams throughout England and Wales.

The inspection programme, led by Her Majesty's Inspectorate of Probation with inspectors seconded from the Healthcare Commission and the Healthcare Inspectorate Wales, was split into three distinct phases, each of which had slightly different inspection methodology and criteria. Phase 1 took place from September 2003 to July 2004 and covered 15 youth offending teams, phase 2 took place from September 2004 to July 2005 in 29 youth offending teams and phase 3 started in September 2005 and has covered six youth offending teams until March 2006.

## Introduction continued

In this report we provide information on both significant trends across each of the three phases as well as the findings from the analysis of the reports on all 50 inspections.

There is an increasing recognition by inspectors of youth offending teams of the importance of capturing the views of children and young people who offend on the services that they receive. During the inspections, we obtained the views of this group in one of three ways: face to face interviews with young people, a paper questionnaire sent out to young people known to the youth offending team as well as through an electronic questionnaire. We have included quotes from young people in this report, all of which were in response to the question: What do you like about the youth offending team? We have also included quotes and examples of good practice from the inspection reports that we looked at.

# Findings



Too many primary care trusts are failing in their statutory duty to provide healthcare workers to youth offending teams.

## Staffing

Since 2003, there has been little change in the number of healthcare workers appointed to youth offending teams, other than a small move towards appointing healthcare workers who specialise in mental health. There is a shortage of healthcare workers and mental health workers in youth offending teams. We found that the role of healthcare workers in youth offending teams varies significantly across England and Wales and these roles are not in keeping with what was originally envisaged by the Government. On the other hand, we found that most youth offending teams had a substance misuse worker. Substance misuse workers were also clearer about their roles, which were more consistent throughout England and Wales.

We found that one in six youth offending teams did not have a healthcare worker. We also found that a third of youth offending teams did not have a mental health worker. The Crime and Disorder Act 1998 requires primary care trusts to provide a healthcare worker to all youth offending teams. The equivalent function in Wales is carried out by local health boards. In addition, since 2002 the Government has designated specific funding for the provision of substance misuse workers to all youth offending teams in recognition of the close association between offending behaviour and the misuse of substances. This means that every youth offending team should have at least one healthcare worker and one substance misuse worker. We found that there are more substance misuse workers on youth offending teams than healthcare workers. Eighty three

## Findings continued

per cent of youth offending teams had a healthcare worker and 89% of youth offending teams had a substance misuse worker. These figures have not changed significantly since September 2003, when the programme of inspection began. We found that youth offending teams had made great efforts to appoint substance misuse workers and the 11% vacancy rate was largely a reflection of the national shortage of specialised workers in this field. The situation for healthcare workers was, however, very different. The funding for these posts is insecure and subject to the changing priorities of PCT and the local health board concerned. In addition, we often found that the healthcare representatives on the management board were not sufficiently engaged in the work of the youth offending team to ensure that active steps were taken to recruit healthcare workers or find alternative healthcare services. For example, one youth offending team inspection report stated:

“Little progress had been made with regards to the position funded by the health service. We were concerned that not enough effort had been put into recruiting for the health posts or providing an alternative service, and felt that the management board should have taken a more active approach in holding the PCT accountable.”

We found that PCTs and local health boards are appointing healthcare workers with more relevant skills such as having mental health backgrounds, to youth offending teams. The proportion of healthcare workers with mental health background has increased from just under 60% in 2003 to just over 80% in 2006. This is supported by an increase in funding for child and adolescent mental health services over the last few years. However, when we combined these figures with the number of healthcare workers appointed to youth offending teams, we found that a third of youth offending teams did not have any

mental health workers (excluding those youth offending teams where we have no information). Our own inspection program found that during 2004/2005, 18% of children and young people had physical health needs, 42% had substance misuse issues and 44% had emotional or mental health needs. When we asked the young people themselves what the youth offending team had helped them with, twice as many referred to emotional and/or psychological issues as physical health issues.

“We talk about ways I can control my emotions, for example, how to control my temper a lot better and how to look at life from a different perspective.”

In recognition of the dual aim of preventing further offending, and meeting the health needs of children and young people who offend, the original guidance to NHS trusts on the role of the healthcare worker was left deliberately broad. The guidance stated that the role of this healthcare worker would be to:

- help ensure that both the physical and mental health needs of young offenders which may be relevant to preventing further offending are identified and are addressed through appropriate services
- liaise with any health professionals who are currently providing healthcare services to the young offender, such as those in primary care settings, including concerning the provision of information for court reports

- provide advice on healthy lifestyles, sexual health or drug and alcohol issues as part of work under offending behaviour programmes<sup>4</sup>

In addition, because children and young people who offend have difficulties in gaining access to mainstream services, for example due to a lack of parental support, the Government issued further guidance which emphasised that the primary role of healthcare workers would be to help increase such access to young people, rather than to provide healthcare services themselves.

“The role of health staff seconded or otherwise made available to youth offending teams is expected to focus on facilitating access to a broad range of health services, reflecting both the physical and mental health needs of young offenders, rather than on the provision of specific specialist services by the nominees themselves.”<sup>5</sup>

It was clear, however, that this aim had not been realised. Our review of the inspections has shown that, since the establishment of youth offending teams, more than 90% of healthcare workers had been delivering healthcare services themselves, and for most of these workers this has been their main function. The following series of quotes from inspection reports illustrate the kind of work that most healthcare workers in youth offending teams were undertaking:

“Health staff were involved in the delivery of D.Fuse, an anger management group that focused on a range of issues, including literacy skills and sexual health.”

“(The health worker) ran immunisation sessions, some minor injury work and provided a significant amount of sexual health advice.”

“The child and adolescent mental health service specialist ran an anger management group and, at the time of the inspection, was setting up a sexual health awareness group for boys.”

“The health worker was delivering tier 1-3 services and onward referral for tier 3-4 was facilitated by close contacts with child and adolescent mental health services and the adult mental health service.”

“The health worker had negotiated a trial project with a local supplier to provide fresh fruit on a weekly basis to distribute to children and young people.”

These quotes demonstrate the wide range of direct interventions that were being provided by healthcare workers. We found that those with physical health backgrounds focused on physical health issues, such as immunisations, minor injuries work, healthy eating and drinking and sexual health, while those with backgrounds in mental health services focused on psychological, psychotherapeutic or counselling approaches for young people, either delivered as a specific anger management course, or more general one to one work. This has led to a number of consequences. The first is the wide variation in provision of services. In some youth offending teams, physical health services predominate, in others the focus is on emotional and/or mental health services. We found that the work done by healthcare specialists in different youth offending teams was rarely consistent. This pattern would be understandable if it was based on the health needs of the population. However, we found that the provision of a healthcare worker was based on a formal analysis of needs in only one youth offending team. The types of intervention available in any youth offending team appeared to depend mostly on the background and training of the health specialist, rather than on a careful analysis of the needs of the children and young people.



## Findings continued

This variation in the provision of services was also evident in the use of the Youth Justice Board's mental health screening tool. This tool has been provided to youth offending teams to assist in the screening and early assessment of the emotional and mental health needs of this population. Our findings indicated that between one fifth and one third of youth offending teams were not using this tool, and that in some localities, an area wide decision had been made to not use the tool. This was acceptable where another validated tool was being used instead, but this was not always the case and in some youth offending teams, young people were assessed and referred on the basis of a process that was not sufficiently robust. One inspection report read:

"The referral process to the health worker was unclear and many referrals appeared to be based on intuition rather than effective screening. There was no systematic monitoring of cases to identify children and young people in need and the sample showed that, where there was evidence of healthcare issues, only two out of four cases were referred."

We found a lack of consistency in the approach taken by healthcare workers in youth offending teams. Their approach was not always based on the needs of children and young people who offend and was also not in line with the Government's guidance on their roles. Rather than facilitating access to mainstream services, the youth offending team's healthcare worker was more often engaged in delivering an outreach service to the youth offending team. Most healthcare workers were doing some work to facilitate access to mainstream healthcare services and liaising with these services but this was not treated as a priority.

We are not criticising the choice by healthcare workers to provide treatment directly to children and young people rather than facilitate access to mainstream healthcare services, as it may be the only option for a healthcare worker who is finding it difficult to engage with mainstream NHS services. In other words, the healthcare worker might have realised that they may be providing the only form of healthcare that this young person will ever get.

Given the wide variation in the provision of services and the fact that the role undertaken by most healthcare workers is not as originally intended, it is incumbent upon the Departments of Health and the Youth Justice Board to both examine what the most effective provision might be, and subsequently provide more specific guidance on the role and function of the youth offending team healthcare workers in light of their findings.

In contrast to healthcare workers in youth offending teams, we found that substance misuse workers were clear about their roles and were providing fairly consistent services across England and Wales. The role of the substance misuse worker had always been more clearly defined from the outset as assisting in the screening and identification of young people with substance misuse issues, and then providing direct interventions as appropriate. We found that in 100% of cases where a youth offending team had a substance misuse worker, that worker was delivering direct interventions to the young person. Their role has always been deliberately concerned less with facilitating access to other services and more about the provision of services themselves, and this is what we have found. Such consistency is in part due to the more secure funding for substance misuse workers, firstly from the Youth Justice Board, and now through the Young People Substance Misuse Partnership Grant.



The guidance accompanying that grant states:

“Youth offending teams must have access to a named substance misuse worker to provide specialist support to young people supervised by youth offending teams, pre-sentence, on community sentences and being resettled from custody (and that) youth offending teams receive at least the same level of funding from the Young People Substance Misuse Partnership Grant as from the Named Drug Worker Fund.”

“I get to talk to someone if I have something that is troubling me or on my mind and I like the practical work I do over here, for example talking to the nurse about anything.”

### Access to services

Over the last three years, the provision of child and adolescent mental health services for youth offending teams has improved. However, between one sixth and a quarter of youth offending teams are still experiencing poor access to and support from child and adolescent mental health services. In particular, services for 16 and 17 year olds are inadequate in many areas. In contrast, the support and access offered by substance misuse services was generally satisfactory.

Child and adolescent mental health services are provided in a four tiered framework of care.<sup>6</sup> Tier 1 comprises a primary level of care delivered by non-mental health specialists such as GPs, school nurses, social workers or workers in youth offending teams. Tiers 2 to 4

are delivered by specialist mental health practitioners such as child psychologists or psychiatrists, psychotherapists, family therapists, specialist nurses or primary mental health workers. When working at tier 2, these practitioners see young people by themselves, but receive referrals from the rest of the youth offending team workers. Tiers 3 and 4 comprise the same workers but deal with more severe and complex cases usually as part of a multidisciplinary team. Tier 4 often consists of providing inpatient care.

Healthcare workers in youth offending teams either work at tier 1 or tiers 2 and 3 depending on their own clinical background. Despite this, they need good access to services at tier 3 and 4 for their more complex and difficult cases. As part of our review, we examined whether:

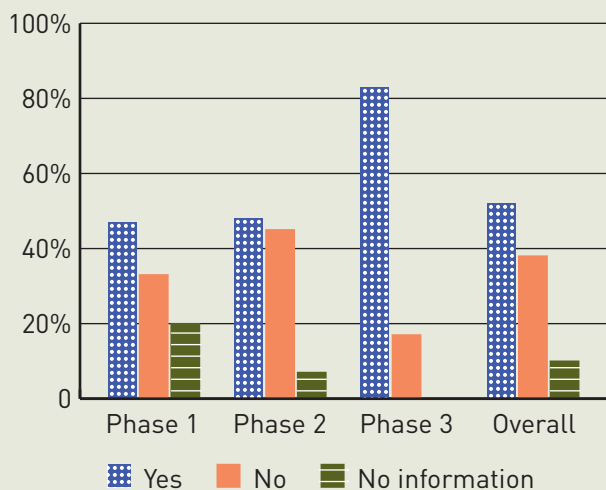
- the youth offending team’s healthcare workers had good access to tier 3 and 4 child and adolescent mental health services for advice, support and referral as necessary
- tier 3 and 4 services were adequately provided in the locality

The figure below shows the proportion of youth offending teams where the healthcare worker has good access to advice and support from, and opportunities to refer patients to, child and adolescent mental health services.

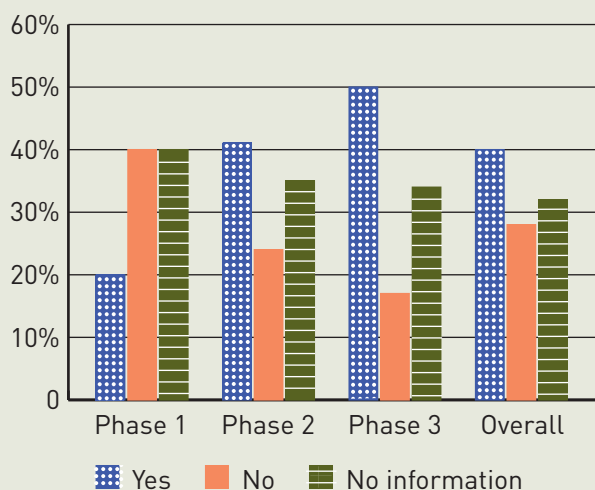
These graphs show an improving pattern of services provided to youth offending teams. We saw an improvement from just under half of workers having good access to specialist child and adolescent mental health services for advice, support and referral to just over 80% of workers having good access. Similarly, in relation to the provision of adequate tier 3 and 4 services, there was an improvement in the proportion of inspection reports indicating good provision from 20% to 50%. At the same time, the proportions indicating problems in provision had decreased from 40% to fewer than 20%.

## Findings continued

**Figure 1:** Proportion of youth offending teams where the healthcare worker has good access to advice and support from, and opportunities to refer patients to, child and adolescent mental health services



**Figure 2:** Proportion of youth offending teams with adequate provision of tier 3 and 4 services



However, although there was improvement in access to services from one phase to the next, the numbers of youth offending teams with poor access to tier 3 and 4 services remains somewhere between one sixth and a quarter (excluding those for whom we had insufficient information and those we have not yet visited). The following quotes from the reports that we analysed illustrate the kind of problems that were encountered:

“The inspection highlighted a number of difficulties relating to the provision of health services to the (youth offending team), and we were particularly concerned that the healthcare representatives on the management board did not appear to be aware of these issues. Both healthcare workers provided a range of appropriate interventions but there were no formal protocols covering referral to tier 3 or 4 services: those successful referrals which did take place were due more to the personal contacts of the worker than formal process. As a result, both workers had been forced at times to manage cases beyond their expertise.”

“The problems caused by multiple PCTs serving a single youth offending team area were keenly felt in accessing child and adolescent mental health service provision, where variance across the area seemed to contribute to a ‘post-code lottery’ type differentiation in services (whereby the quality of service provided depended upon the part of the area the child or young person lived in).”

“CAMHS (child and adolescent mental health services) access was variable, in part because six PCTs served the county. Although the general perception was that, by dint of the work done by the health representatives on the management board and task group, matters were improving, it was clear that this area of work was not able to meet the (youth offending team’s) needs.”

This variance or lack of provision of mental health services outside the youth offending team meant that a number of children and young people with considerable mental/emotional health problems were not having these needs met, or at least, were experiencing long delays in getting access to mental health services or support. In spite of the best efforts made by healthcare staff to support children and young people and make appropriate referrals, some could wait up to 18 months, making the successful referral of a child or young person aged 15 years unlikely. Reasons for such severe delays ranged from the consequence of 'ad hoc' links between the youth offending team and child and adolescent mental health services, to child and adolescent mental health services themselves being too stretched.

On a number of occasions we found a highly motivated, hard working healthcare worker in a youth offending team struggling to get young people seen by the mainstream services. The following quotations are illustrative of this:

“Difficulties in the partnership arrangements between child and adolescent mental health services and the youth offending team, manifested by the lack of effective referral protocols and agreement on information sharing, hampered positive health outcomes for children and young people. Despite her best endeavours, the youth offending team health worker had great difficulty accessing appropriate tier 3 and 4 services for the youth offending team client population, and full assessments and subsequent referrals were subsequently often delayed.”

“Another area of concern was the ability to access child and adolescent mental health services for children and young people, particularly for 16 and 17 year olds. The NHS trusts did not prioritise these referrals and, as a result, the youth offending team had to deal unaided with a difficult group in the most positive manner.”

Mainstream services provided a range of reasons to justify their lack of engagement with youth offending teams. We found that some of these reasons were entirely understandable, but on many occasions they merely indicated an unwillingness to be flexible in the face of the needs of young people whose lifestyles are characteristically chaotic. Reasons given for not accepting a referral from the youth offending team healthcare worker were:

- the young person has an accompanying substance misuse problem, and the psychiatrist would be unable to conduct a thorough mental health assessment until someone else sorted out the substance misuse problem
- given that the young person was known to the youth offending team, they must have a conduct disorder (disordered anti social behaviour), and as there was little evidence of effective interventions for conduct disorders, the local child and adolescent mental health services would not see the person
- the young person has been excluded from school and is not in full time education, and therefore does not meet the criteria for referral for the child and adolescent mental health services
- the young person is not registered with any GP in the catchment area (this was a young person who was living in three different locations, and had not registered with a GP in any of those locations)
- the young person is 16 or 17 years old

## Findings continued

“I can communicate better because we get 1- 2- 1 discussions about what I want to do, how I feel etc.”

The solution to these problems lies outside the remit of the youth offending team’s healthcare worker who, although often very experienced, is usually at a too junior level to influence the healthcare organisations to provide these services and change their criteria for referral in order to accept more young people. It is for this reason that the engagement of suitably senior health personnel in the work of the youth offending team’s management board is of paramount importance. The health service circular that accompanied the establishment of youth offending teams specifically indicated that:

“Health authorities, and, where appropriate, primary care groups, will be expected to engage in local discussions about the availability of health services which may be relevant to preventing youth offending, for example in relation to mental health problems and drug abuse<sup>7</sup>.”

We found that these discussions were not taking place as the health service’s representative on the management board of the youth offending team was simply unaware of the gaps in service that existed.

There were, however, many examples of effective partnerships between the youth offending team and child and adolescent mental health services, as the following three examples demonstrate.

### Example of good practice

The health worker was an experienced mental health nurse, who undertook tier 1 and 2 interventions herself and referred tier 3 and 4 to child and adolescent mental health services. There was no problem about getting children and young people seen urgently. Referral protocols were in place, supported by effective informal links.

The youth offending team was well served by a regular assessment service offered by child and adolescent mental health services. Joint assessment with child and adolescent mental health service workers and youth offending team staff took place on a weekly basis in the One Stop Shop centre. The child and adolescent mental health service worker had access to a psychiatrist for advice on cases and working relationships between staff were positive.

The clinical psychologist was initially based full time in the youth offending team providing Tier 3 level services but, subsequently, divided her time between child and adolescent mental health services and the youth offending team. This change had resulted in more effective working across the two organisations and better exchange of information, with the youth offending team becoming aware of children and young people already known and working with child and adolescent mental health services.

The common thread running through these examples is the value of effective partnerships, the main determinants of which are the attendance and participation of the healthcare representative on the management board. In this sense, there is huge scope to improve links between youth offending teams, their management boards and healthcare organisations.

One particular group that has historically been disadvantaged by the provision of child and adolescent mental health services are 16 or 17 years old, particularly if they have left full time education. Traditionally, child and adolescent mental health services were a service that stopped at the end of the statutory school age. Often, adult mental health services did not commence until 18 years of age therefore 16 and 17 year olds fell through this gap in provision. For young people who offend, this is particularly problematic, as it is this age group that commit the majority of crimes by young people. It is also this age group that commit the more serious crimes. Approximately 40% of children and young people who offend have mental health needs, and therefore a lack of mental health services for this particular age group could have significant consequences for both the young person and the wider community. The English and Welsh National Service Frameworks for Children, Young People and Maternity Services identified a service from birth to 18 years of age as one of their markers of good practice. Given this, we examined the youth offending team reports for their comments on the adequacy of provision of services for this age group. Of the 16 reports in which mental health services for 16-18 year olds were mentioned, in 13 (80%) the comments were negative, indicating a lack of suitable services for this group. Even if we assume that services were adequate in all the areas that did not specifically mention them in their reports, it still leaves a quarter of youth offending teams indicating inadequate mental health services for this age group.

One quote illustrates the problem and the challenge inherent in solving it:

“The local children’s, families and adolescents consultation services, who provided the main tier 3 gateway to mental health services, only provided a service to under 16s who were attending school. If the child or young person was not attending school, or was post statutory school age,

the youth offending team experienced difficulty in accessing treatment on their behalf. There was thus no effective service for post 16 year olds or those not attending school. Following a best value review, the PCT had recognised the gap in mental health services for 16-18 year olds, which would now form part of a wider integrated children’s strategy. However, there did not appear to be any interim strategy other than a continued ad hoc approach.”

In some areas, services have been specifically targeted at this age group precisely because of the difficulties in gaining access to mainstream services for them.

#### Example of good practice

**The youth offending team had set up a team of health and drugs workers called Project MAX who provided specialist assessment and, where appropriate, would refer cases on for further intervention. It was an example of the way the partners had identified resources to meet the assessed needs. The team included a clinical psychologist and psychiatrist from the forensic services, as well as child and adolescent mental health services, healthcare, and drug and alcohol services for children and young people. Priority was given to those aged 16-18 years because of the lack of any other appropriate services for adolescents and the need to manage their transition into adult services.**

Compared to the provision of specialist child and adolescent mental health services, substance misuse workers in youth offending teams generally had good access to their parent organisations for support and advice. One of the reasons for this is that, in contrast to youth offending team’s healthcare workers, substance misuse workers are generally well connected to their parent organisations, and usually receive both effective support from



## Findings continued

those organisations, and also have good links into those organisations for onward referral and support of the more difficult cases.

Two inspection reports express this point:

“Substance misuse workers provided a range of interventions including group work. More complex cases were referred straightforwardly to local substance misuse specialist services.”

“Following referral, the substance misuse workers adopted a variety of approaches to work including information sessions, family/parental work, group sessions, solution focused therapy and motivational interviewing. They also made use of diversionary schemes, when appropriate. There was good access to tier 3/4 substance misuse provision when required”.<sup>1</sup>

Despite these positive comments about tier 4 services, we found that the general pattern across the country was that there was insufficient provision of residential substance misuse units for young people. The overall pattern, though, was that provision of tier 3 substance misuse services was more easily accessible than tier 3 child and adolescent mental health services.

### Working in partnership

**Fifteen per cent of inspection reports quoted problems in joint working between specialist health and substance misuse workers and case managers on youth offending teams. Three times as many reports told of inadequacies in the sharing of information and keeping of records.**

Youth offending teams were deliberately designed to function as multi-agency teams in which the expertise of a range of professionals could come together to deliver an integrated

package of interventions for the young person that would address all of their needs and safeguard the public in the most effective fashion. For such an approach to work in practice, it is essential for youth offending teams to have good teamwork across all the disciplines. In particular, it is necessary for there to be good working relationships between the youth offending team’s specialist staff (health and substance misuse) and the youth offending team’s case managers – those staff who take the lead on arranging the package of interventions designed for the young person. As part of our survey of youth offending teams’ inspection reports, we explicitly examined whether good links do exist between these groups of staff. In 15% of the youth offending teams’ inspection reports that we looked at, the team reported problems with joint working.

A particularly striking finding in a number of youth offending teams was that, despite the presence of an available health or substance misuse specialist, the youth offending teams’ case managers did not always refer their young people to the specialist workers. The following quotations from youth offending team reports illustrate the kind of problems that we encountered:

“The assessment of mental, emotional and physical health needs by case managers, and the process of referral into the health team, required attention. Despite reports of a greater understanding of the role of health workers amongst wider youth offending team colleagues, only two-thirds of the 60% of cases with emotional and mental health needs were referred to the health team”.

“There was an acceptable level of service provided in relation to substance misuse, with an appropriate partnership agreement. However, the youth offending team staff did

<sup>1</sup> The four tiered approach to substance misuse services is broadly similar to that for mental health services, moving from primary prevention to residential, highly specialised, multi-disciplinary provision.

not avail themselves of this service. Of the 17 newly assessed children and young people who reached the threshold of referral, none were referred. This was despite two reminder emails about how to contact the worker and make referrals”.

It was not always clear to the inspection teams why there was this breakdown in team-working. However, one of the factors that was mentioned often was the lack of adequate exchange of information.

When youth offending teams were first established, guidance was issued by both the Department of Health and the Youth Justice Board concerning agreements on sharing information between healthcare staff and other youth offending team workers. In particular, the guidance drew attention to section 115 of the Crime and Disorder Act which provided power where none previously existed “for the disclosure by any person of information to relevant authorities or persons acting on their behalf which is necessary or expedient for the purposes of any provision of the Act”. The practical implication of this was that health professionals could disclose health information in the absence of consent if such information was “necessary or expedient” to prevent further offending. Furthermore, the guidance made it clear that local areas were expected to develop protocols on how this would work in practice in their specific setting. We found that 12% of the youth offending teams that we looked at said that they share information within the team well and keep good records while almost three times as many teams (34%) said the opposite.

The following quotations from youth offending team reports gives a flavour of the kind of problems that were encountered:

“There were no clear arrangements made for the health worker’s confidential practice, particularly relating to the taking and keeping

of notes. This meant either no record was made at all on some occasions or records were being kept separate from the care works file and held outside of the normal arrangements for the management and destruction of files.”

“There was a lack of clarity about the confidentiality of health information within the staff group. No formal data sharing agreement existed and, as a result, we found that there was still confusion amongst staff in relation to access to health information.”

In some youth offending teams almost all of the information gathered was shared with other staff, while in others it was minimal. In both cases, in many youth offending teams we found practitioners unhappy with the arrangements and this led to poor joint working between staff.

This problem was worse in relation to substance misuse workers than in relation to healthcare workers. Because substance misuse workers were more involved in their parent organisations, they had policies on the sharing of information, which were adhered to rigidly. The problem was that many of these policies were drawn up by the substance misuse agencies independently of the youth offending team. Therefore, other workers in youth offending teams did not know the full extent to which the misuse of substances related to the young person’s offending behaviour.

The absence of a protocol also led to a range of unacceptable practices by staff, including notes kept on scraps of paper, notes that had no formal status, and information kept nowhere but in the practitioner’s ‘head’.

“There was also no information sharing protocol between the drugs worker and the youth offending team and, as a result, there was a lack of clarity around what information could or should be passed between these agencies.”

## Findings continued

“We were concerned however, that the agreement with [the drug agency] did not allow the substance misuse worker to share information with youth offending team staff with regard to the assessment and treatment of the children and young people referred. This had severely affected the case supervisor’s ability to make an overall assessment of the child’s or young person’s needs and their progress.”

“In general, case managers worked well with their colleagues across the youth offending team. However, certain aspects of the work of the drugs and alcohol service providers were felt to be less satisfactory by several practitioners in the youth offending team. [The substance misuse] workers were part funded by the youth offending team, but employed by [a charitable trust] who operated a strict confidentiality agreement in relation to work with children and young people. Whilst the manager regarded the information sharing protocol as adequate, many practitioners felt that, in practice, its use limited the information flow between the agencies. The case managers interviewed found this approach problematic in their assessment and work with children and young people and pointed to the possible compromise of safeguarding arrangements”.

“The thing I like about my youth offending team is that I can go to a calm group meeting.”

It is, perhaps, the case that part of the reason for this situation was the fact that usually there was no representation from the drug action team on the youth offending team’s management board or representation from the agencies providing the substance misuse services. This meant that protocols on sharing information were being developed in isolation rather than in consultation with the youth offending team.

Despite some of the problems mentioned above, it is also the case that in many youth offending teams there were no problems at all in relation to sharing information and good working relationships between different parts of the youth offending teams. The following example of good practice highlights the innovative and commendable practice employed in one youth offending team that was making a real difference to the lives of the young people.

### Example of good practice

**Every case, including final warnings, was subject to review at a resources meeting, which was held when the initial asset and sentence plan had been completed. Its purpose was to quality assure the sequencing and range of interventions proposed. It would also commission any specialist intervention required. Any specialist intervention (for example drugs work within a bail support package) required urgently could be fast-tracked and brought to the next meeting for review.**

**The meeting was chaired by a middle manager and was minuted. The case manager attended and described the case. Where specialist interventions had been proposed, the case manager invited the relevant workers, who were expected to attend wherever possible, to advise on readiness and suitability for interventions. The electronic asset was projected onto a screen for review. Asset scores would be challenged. Links were made with other youth offending team cases to ensure a consistent approach to family circumstances. Guidance was then provided to the case manager on any changes proposed on how to proceed with a case. A typical review would take between 20 and 30 minutes. A copy of the minutes and actions was sent to all relevant staff and was placed on the electronic case record.**



## Management

**One in six youth offending teams had no NHS representation on their management board. Sixty per cent of youth offending teams had no adequate engagement of healthcare at a strategic level. A third of youth offending teams had no protocols or service level agreements underpinning their work with the NHS.**

Throughout this report, we have drawn attention to the way in which a lack of adequate engagement of healthcare organisations in the management board of youth offending teams has contributed to the problems that have been highlighted. The inter departmental guidance on the establishment of youth offending teams expressed a clear expectation that healthcare organisations would contribute to the provision of youth justice services in their area by nominating a healthcare representative to the management board of the youth offending team. We explored this issue by looking at whether PCTs and local health boards had identified an appropriate representative of sufficient seniority to sit on the board and secondly, whether this person engaged satisfactorily in the work of the youth offending team. We found that 16%, or approximately one in six youth offending teams, had no NHS representation on their management board. The impact of this was described by one youth offending team as a matter of “considerable concern”, as, without it, the youth offending team manager lacked the appropriate support at board level in pursuing health matters for children and young people supported by the youth offending team.

Even where youth offending teams had a healthcare representative on their management board, we often found that this person had not sufficiently engaged in the work of the youth offending team. In particular, they had not engaged in the

five responsibilities for the management boards of youth offending teams that were set out in the inter departmental circular that accompanied the establishment of youth offending teams.

These were to:

- determine how the youth offending team should be composed and funded, how it will operate and what functions it should have
- determine how the appropriate youth justice services will be provided and funded
- oversee the formulation, each year, of a draft youth justice plan
- oversee the appointment or designation of a youth offending team manager
- agree measurable objectives linked to key performance indicators as part of the youth justice plan<sup>8</sup>

*“I get to speak freely and discuss private matters”*

Youth offending teams are primarily the responsibility of the local authorities and the local authority’s chief executive usually chairs the board. However, as a member of that board, the healthcare representative has some responsibility for the youth offending team and its work. He or she is responsible for making sure that healthcare, that is relevant to the prevention of offending, is being provided to the youth offending team. We therefore examined the youth offending teams’ reports for evidence that the healthcare representative on the board had engaged in the work of the youth offending team in the way indicated by the guidance. Excluding those youth offending teams’ reports that made no comment, we found that half of the youth offending teams’ reports provided evidence of good engagement

## Findings continued

by the healthcare representative, and half reported inadequate engagement.

If we combine these figures with the 16% of youth offending teams where there is no NHS representative, then overall, in approximately 60% of youth offending teams there is no adequate healthcare engagement at a strategic level. This is one of the most significant findings in this report, as we believe that it is this lack of strategic involvement that underpins many of the problems that have already been mentioned. The following three quotations from youth offending teams' reports illustrate this:

"The inspection highlighted a number of difficulties relating to the provision of health services to the youth offending team, and we were particularly concerned that the health representatives on the management board did not appear to be aware of these issues."

"Neither the PCT nor the management board health representative... had any direct knowledge of, or contact with, the youth offending team health worker."

"Engagement with the management board by the three PCTs was insufficient to ensure that they were able to contribute sufficiently to the strategic planning of services to children and young people with mental and physical health needs. Long term recruitment problems had meant that there were no clear routes into Tier 3 or 4 mental health services for children and young people known to the youth offending team."

One report went so far as to make a recommendation that the healthcare representatives on the management board should meet the healthcare staff seconded to the youth offending team to familiarise themselves with their work and the difficulties they encounter. We would argue that this be considered good practice relevant to all

management boards and youth offending teams, as without an understanding of the context of the work, the healthcare representative's capacity to advise the board on matters of health is undermined.

One of the key actions set out by the Government for health organisations in their contribution to youth justice services was the requirement to discuss the availability of, and access to, health services relevant to preventing young people from offending or re-offending.<sup>9</sup>

A failure adequately to fulfil this task was evident in the lack of any jointly agreed protocols or service level agreements between the youth offending team and the relevant NHS trusts. These agreements, which may cover issues such as the exchange of information, routes of referral and the provision of healthcare workers, are an essential means by which the youth offending team can hold the local NHS accountable for the services that it is providing. In the absence of such agreements, the youth offending team is left in a precarious position unable to be confident of the provision of healthcare that is being made available to it. Our survey of youth offending teams' reports found that in a third of youth offending teams either no such agreements existed or they were inadequate in some respect. The following quotations from reports illustrate the problem:

"The agreed health protocols had neither been signed nor dated by the parties involved. This may have contributed to the confusion regarding the service available for Tier three referrals."

"The service level agreement between the youth offending team and child and adolescent mental health services was out of date and did not adequately address consultations, referrals and joint working at an operational level."

We found that in the one occasion where the provision of healthcare services to the youth

offending team was based on a comprehensive analysis of health needs, the healthcare representative on the management board of the youth offending team was extensively involved.

Example of good practice

**The management board is appropriately represented by health. In particular, the inspection team was impressed by the extent to which the PCT representative was engaged with the youth offending team. For instance, at the inception of the youth offending team, an analysis of needs was conducted by the PCT to ensure that the youth offending team was provided with the most appropriate staff given the diverse health requirements of the youth offending team population.**

It is important to stress that, in 40% of youth offending teams not only was there a healthcare representative on the management board, but this person was also adequately engaged in the work of the youth offending teams. Until recently, healthcare organisations did not contribute significantly to youth justice services and we therefore acknowledge and commend the degree of engagement that is now visible in many youth offending teams.

In a period of continual change, and with a huge range of competing agendas, it is very difficult for PCTs' and local health boards' senior managers to consider youth offending teams as a priority in the way that we would like. Nevertheless, we found excellent practice in many parts of England and Wales and it is therefore possible that the good work that is done in some parts can be extended to all. This will be even more important given the imminent restructuring of PCTs, and we can only hope that the funding and support that is provided to many youth offending teams will not be lost during this time of change.

# Conclusions



The responsibility for reducing offending behaviour must not just lie with the Home Office or Youth Justice Board, but also with the Departments of Health. It is not just the responsibility of the youth offending team, but also the local NHS.

Children and young people who offend present a dual challenge to society. On the one hand, they are clearly a group of people who are in need. We have already mentioned the fact that, compared to the non-offending population of children, they are significantly more likely to have mental and physical health

needs, have problems related to the misuse of substances, have a learning disability, have spent some of their childhood in care, have been subject to poor parenting, witnessed violence in their home, and have been abused or been the victim of crime.<sup>10</sup>

At the same time, we cannot ignore the fact that they are responsible for approximately 25% of all crimes in the UK.<sup>11</sup> The cost of youth crime is at least £1bn per year, and probably much higher, and this does not even take into account the social costs such as fear, isolation and the breakdown in their community caused by their behaviour.<sup>12</sup>

The issue that remains is how to balance our responsibilities to meet their needs and the needs of the wider community. We are not remotely suggesting that there is a simple answer to this question, but with respect to healthcare, we need not always view these responsibilities in opposition. As the recent report from the Royal College of Psychiatrists has indicated, it is possible to use psychological and psychiatric treatments in an 'even-handed manner' where both the young person's therapeutic needs and the propensity to offend are addressed.<sup>13</sup>

Unfortunately, our survey of the inspection reports of youth offending teams has demonstrated that this type of provision of services does not always exist. While it is true that support and services for young people who offend has improved significantly over the last three years, current levels of provision of healthcare for children and young people who offend, especially mental health services, are unsatisfactory.

Many of the main building blocks for an improved service exist but there is a lack of a will to move this forward. This is most evident in the reluctance of healthcare representatives on the management boards of youth offending teams to become more involved in the strategic oversight and planning of healthcare services for children and young people who offend. There are many reasons for this including the extremely wide brief that many of these individuals hold and the consequent demands placed on them to respond to a range of competing agendas.

Nevertheless, we found that one of the factors behind this reluctance is an unwillingness to take into account both the wider networks in which children and young people who offend live, and the impact of their behaviour on society. Many healthcare representatives understand their responsibilities as nothing but the 'healthcare' needs of the populations they serve. We agree that this must remain their primary responsibility but we would advocate a broader approach that ensures greater attention is paid to the individual circumstances of young people as well as the consequences of not fully addressing their healthcare needs. A young person who offends and has an attention deficit disorder, for example, is not exactly the same as any other young person with a similar disorder and services must be provided to this young person in a way that takes account of this. This is not to argue for preferential treatment for children and young people who offend, but to argue for equal treatment, which means giving due consideration to their often complex individual needs.

*"The youth offending team gives me the chance to talk about how I feel."*

The result of targeting services more effectively will benefit both communities and improve outcomes for the young person. Too often, when distributing scarce resources, the impact on the wider community is ignored. However, targeting resources in this way will ensure that money is spent more wisely.

A recent view among some healthcare professionals was that, apart from its strictly medical consequences, child abuse was not their responsibility but the responsibility of social services departments or someone else. We have seen the consequences of that kind of thinking in a series of high profile cases and

## Conclusions continued

quite rightly, such a view is no longer tenable. The agenda of *Every Child Matters* represents part of the Government's response and is appropriately encouraging the further integration of children's services precisely to avoid similar cases. Child protection is now considered to be the responsibility of everyone who works with children.

We would advocate a parallel approach for children and young people who offend. In 2004, the Audit Commission, in its review of youth justice services, indicated that what was required was to convince "health and mental health services of the crucial role that they have to play" in contributing to youth justice services.<sup>14</sup> We echo that finding. The responsibility for reducing offending behaviour must not just lie with the Home Office or Youth Justice Board, but also with the Departments of Health. It is not just the responsibility of the youth offending team, but also the local NHS. Only when this change of mindset is achieved, will we see improved outcomes for these children and the wider community.

# Recommendations



In line with their statutory duties, many PCTs provide excellent funding and support to youth offending teams. However, we have found that too many PCTs have failed in this regard by providing insufficient funds and/or staff to youth offending teams. We, therefore, recommend that every PCT ensures that it fulfils its statutory duty to provide at least one healthcare worker to the local youth offending team. In addition, in light of the Government's restructuring of English PCTs, we recommend that PCTs ensure that neither their representation on the management boards of youth offending teams, nor their provision of healthcare workers to and funding of youth offending teams, is compromised.

The National Service Framework for Children, Young People and Maternity Services sets a standard that all children up to 18 years should have access to good quality mental health services and we recommend that child and adolescent mental health services implement these guidelines.

In over half of youth offending teams, there is no adequate engagement of healthcare professionals at a strategic level. While children and young people who offend have a range of unidentified physical and mental health needs, it is mental health needs that are more prevalent, and that are more closely associated with offending. For this reason, we recommend that PCTs, local health boards and child and adolescent mental health services ensure that

they identify an appropriate representative to attend and participate in the management board of the local youth offending team in order to facilitate the strategic planning of services for this group of children.

This report has identified a number of weaknesses in the provision of healthcare services to youth offending teams. In order to address these weaknesses, we recommend that the healthcare representatives on the management boards of youth offending teams take the following action:

- take responsibility for the provision of local healthcare services which are flexible and which meet the healthcare needs of young people who offend
- provide appropriately qualified healthcare workers to youth offending teams who have the appropriate specialist skills to meet the needs of children and young people who offend
- ensure that protocols and service level agreements between the youth offending team and healthcare organisations are written or updated as appropriate to cover the specifications of service and roles of healthcare workers, including terms of secondment, arrangements for cover and access to mainstream services



## Recommendations continued

- take a rigorous approach to ensuring that health services are available for and accessible to children and young people who offend, especially mental health services for 16-18 year olds
- develop an agreed, rigorous and workable policy on the sharing of information and keeping records, and ensure that it is implemented in their youth offending team
- monitor the health needs of the youth offending team's population more effectively and the impact of healthcare services on those needs

We found good provision of substance misuse services to youth offending teams. However, this provision could be improved by ensuring that adequate policies on sharing information are developed that address the concerns of the young people, the staff in substance misuse services, the needs of the youth offending teams and the public. In order to facilitate such effective joint working, we recommend that the local drug action teams and/or substance misuse services are represented on the management boards of the youth offending teams.

In many youth offending teams, staff from different agencies and public bodies work seamlessly together. However, we were surprised at the number of youth offending teams where there are problems related to joint working. In particular, significant opportunities to help young people in relation to health and/or substance misuse were often missed due to inadequate referral and assessment. Therefore, we recommend that managers of youth offending teams, healthcare workers and substance misuse workers ensure that effective and robust processes for assessment and referral are put into operation, to ensure that every child and young person with needs has those needs

identified, adequately assessed and is referred for specialist intervention as necessary.

From the outset, healthcare workers in youth offending teams have adopted a wide range of working practices. Due to an increasing familiarity with the health needs of children and young people who offend, there is some evidence of a convergence in working patterns. However, we recommend that the Departments of Health and Youth Justice Board look carefully at this issue in order to ensure that the most effective use is made of limited resources. We recommend that they examine the most effective ways of providing healthcare to youth offending teams and develop guidelines on best practice. This would also assist local commissioners in identifying best practice for youth offending teams.

In England, the Healthcare Commission provides an annual assessment of the performance of all NHS trusts. In 2006/2007, the Commission will ensure that its annual assessment of NHS trusts checks that health organisations comply with their statutory duties in relation to youth offending teams. It is also incumbent upon the Commission to use all of the information it gathers to contribute to that assessment. Therefore, the Commission will ensure that for 2006/2007, it will incorporate the findings of the inspections of youth offending teams in its annual health check. In addition, the Commission will identify already available measures of health service contributions to youth justice services that can be incorporated into the screening process that accompanies the annual health check of NHS trusts. The Healthcare Inspectorate Wales will also undertake similar checks.



# Next steps



The Healthcare Commission, Healthcare Inspectorate Wales and Her Majesty's Inspectorate of Probation will continue to inspect and report on their healthcare arrangements for youth offending teams. We will continue to develop our methodology for this inspection, taking into consideration the need to ensure that inspection of local public services is both efficient and effective. We aim to produce reports that are informative to the public, useful to professionals, and which serve the needs of children and young people.

The Healthcare Commission and Her Majesty's Inspectorate of Probation will also continue to liaise with the Department of Health and Youth Justice Board regarding developments in policy in this area.

Finally, we will continue to seek ways to listen to the views of children and young people themselves, and the wider public, on the services that they receive, in order to identify the most effective means to improve public services that both meet the needs of the children and safeguard the public.

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આ માહિતી વિનંતી કરવાથી અન્ય રૂપે અને ભાષાઓમાં મળી શકે છે.  
મહેરબાની કરી ટેલિફોન નંબર 0845 601 3012 પર ફોન કરો.

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**341**