Care Quality Commission

HM Inspectorate of Probation
Arolygiaeth Prawf EM

Inspection of Youth Offending
Archwilio Rhaglen Troseddwyr Ifanc

Re:Actions

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

Published July 2011

Acknowledgements

We would like to thank all staff from the youth offending teams inspected (and all those who contributed both to the health questionnaires and the feedback in regional meetings), the members of their Management Boards and the partner health organisations for their assistance and contributions to this review.

CQC Youth Offending Programme Manager	Fergus Currie
CQC Youth Offending Services Inspector	Michelle Fordham
HMI Probation Assistant Chief Inspector	Julie Fox

Contents

Foreword

This report by the Care Quality Commission and Her Majesty's Inspectorate of Probation highlights what has changed to the provision of healthcare services in the community for children and young people who have offended or are likely to offend, since the last review of our inspections, published in *Actions Speak Louder* (2009).

It is becoming increasingly clear that children and young people who have offended, or are likely to offend have a higher percentage of health-related issues than those of the general youth population. Many of these needs, such as those related to substance misuse, may be directly linked to offending behaviour. Others can impact on whether, for example, a young person with speech, language and communication difficulties can experience positive outcomes. Health needs span a range of physical, emotional, mental health and substance misuse problems, which can make young people more likely to offend, but we think they should be tackled at an early stage. This benefits not only the individual, but also the community if this leads to a reduction in offending.

Actions Speak Louder was highly critical of the health services that are expected to contribute to youth offending services and made a significant number of recommendations to promote more effective support. It is certainly pleasing to note that many positive changes have been achieved, but some provision across local authority areas is still not good enough. Nevertheless, health services are now identifying and addressing many more of the health needs of those children and young people who offend or are likely to start offending. We hope that impending changes to the structuring of health services coupled with increasing financial constraints, will not adversely affect these welcome, and necessary, improvements.

Cynthia Bower

Chief Executive
Care Quality Commission

Julie Fox

Assistant Chief Inspector
(for Her Majesty's Chief Inspector of Probation)

Summary

Main findings

Considerable progress has been made since the last review of inspections to effectively identify and address health needs for children and young people who have offended, or are likely to offend, and this deserves recognition.

The management and oversight of health within youth offending teams[1] (YOTs), is considerably better than it was in the last review. All YOT management boards are appropriately represented by health services, and the rate of attendance and involvement with meetings has improved.

The best management boards, who have used health outcome information, have helped drive improvements in the shared service being offered, while ensuring that resources are tailored to meet the right needs. They have also demonstrated value for money from the input of health resources and interventions by using effective evaluation. Unfortunately, health information is often not considered sufficiently frequently or in enough depth at board level.

Virtually all YOTs now have relevant service level agreements which usefully underpin the joint work with health services, and most have been reviewed and updated. The average contribution by health to the YOT budget has increased.

Health needs are now more likely to be assessed using recognised tools, and there is a greater likelihood that the accuracy of these assessments will be checked. There are more effective links with universal health services during the assessment process and better engagement with children and young people. However, links with parents and carers could be improved.

Physical health needs are not sufficiently well assessed, and not enough YOT case managers and health practitioners make joint plans.

YOTs generally make a good range of health materials available, although there is a greater focus on substance misuse and sexual health. The range and variety of interventions being used has improved since the last review, although the skills and expertise of the health practitioners can affect the programme of work that is offered.

Significant efforts have been made to improve the engagement of children and young people in their health interventions through improved flexibility of access to health workers. YOT workers and managers have a better understanding of general health needs, including diet and exercise.

There remain problems with transitions between child and adult services, and community settings and custody, with frequent disruptions to the continuity of service.

The monitoring of health interventions has continued to improve on an individual basis. Aggregated data, with other measures, can assist YOTs to plan their workforce and future provision of health services, but not all of them apply them.

[1] Throughout this report we will use the term 'youth offending team (YOT)' to indicate youth offending teams, youth offending services and youth justice services as set up under the Crime and Disorder Act 1998.

Relationships between health practitioners and courts have improved, which has enabled YOTs to offer appropriate bail programmes with health support.

The supervision and line management of health practitioners within YOTs is now much more consistent, appropriate and supportive. All practitioners have also undertaken at least the basic level of safeguarding training.

Recommendations

In order to enable better health outcomes for young people who offend or who are likely to offend, YOTs, primary care trusts (or their future equivalent) and other relevant agencies or organisations involved with this group of young people should ensure that:

- The resourcing of health provision in YOTs is better planned, targeted and allocated.
- Improvements to health provision in the YOT are based on high-quality health information that is gathered from different sources.
- Each young person has an appropriate assessment of their physical health needs.
- Health and offending behaviour intervention plans are well integrated.
- There is a greater use of family-based work and home visits by health workers.
- Health practitioners and YOT case managers share relevant information in relation to both custody and community settings.
- YOT case managers' and health practitioners' joint outcome measures include the impact of health contributions on offending behaviour.

Introduction

Context

Youth offending teams (YOTs) were established in England and Wales in 1998 under a Crime and Disorder Act which emphasised partnership working in operational and strategic structures in order to reduce and prevent offending behaviour. This legislation had followed the publication of an Audit Commission report (*Misspent Youth*) which had highlighted the extent of offending by young people and had proposed radical changes to the youth justice system. The newly created integrated teams were expected to contain representatives from relevant agencies including social services, the police, education, probation and health. It was anticipated that the multi-agency teams would then be in a good position to meet the variety of needs exhibited by children and young people who offend.

This is the third review of the health contribution to youth offending services in England. The first two (*Let's Talk About It* and *Actions Speak Louder*)[2,3] were carried out by the Healthcare Commission and Her Majesty's Inspectorate of Probation and both were highly critical of the level and quality of support being offered by health services to YOTs. Indeed, in *Actions Speak Louder*, the Chief Executive and the Chief Inspector of the respective organisations stated that "it was very disappointing for us to find that insufficient progress has been made in many key elements over the course of this cycle of inspections".

One of the recommendations from the last report was that the Care Quality Commission (which was taking on responsibility for the inspection of this area of work) "continues the contribution of the Healthcare Commission to inspections of YOTs in order to monitor improvement against the recommendations" which had been made.

The first two health reviews were carried out during a five year cycle of inspections of YOTs led by HMI Probation with health inspectors contributing to every inspection and subsequent report. The first of the reviews included the following recommendations for commissioners and providers of health services to the YOTs:

Recommendations from *Let's Talk About It*

- To ensure that they fulfilled their statutory duty to provide at least one healthcare worker to their local YOT.
- To ensure representation on YOT management boards.
- To develop the use of protocols and service level agreements between YOTs and healthcare services.
- To improve the actual provision of services to YOTs.
- To share information better.

[2] *Let's Talk About It* – A review of healthcare in the community for young people who offend – Justin Thacker, Healthcare Commission and HMI Probation, 2006

[3] *Actions Speak Louder* – A second review of healthcare in the community for young people who offend – Fergus Currie, Healthcare Commission and HMI Probation, 2009

- To assess health needs better.
- To improve the evaluation of services.

The second of the reviews included the following recommendations, some of which indicated that little progress had been made:

Recommendations from *Actions Speak Louder*

- To ensure that health needs are thoroughly and accurately assessed and that appropriate interventions are provided.
- To ensure that initial assessments are carried out using recognised assessment tools and that subsequent referrals to specialist health workers are consistent.
- To encourage court services to consider health needs more consistently by offering training and including health information in bail support packages and pre-sentence reports.
- To ensure appropriate, and sufficiently senior, representatives on youth offending management boards.
- To ensure that YOT health staff and staff in secure establishments communicate with each other effectively to ensure positive health transitions between different environments.
- To ensure that children and young people receive appropriate access and support from child and adolescent mental health services (CAMHS).
- Transitions from child-centred to adult-oriented mental health services take place with care and sensitivity.
- To ensure that service level agreements and relevant protocols, including that relating to sharing information, are in place between health services and YOTs.
- To ensure that the contribution of health services to the aims and objectives of YOTs is consistently monitored and evaluated.

Additional recommendations which related more to government departments and the governance arrangements by strategic health authorities were:

- To ensure a consistent framework and explicit standards for health services to improve health outcomes and contribute effectively to a reduction in youth offending.
- To review assessment tools to ensure they are fit for purpose and can be used consistently.
- To ensure that an analysis of health needs is carried out in each YOT and that there are sufficient resources provided to meet identified needs.
- To ensure there are clearer measures of performance about access to health services and how those services contribute to the work of YOTs.
- To improve oversight and performance management arrangements in relation to health's contribution to the work of YOTs.

The above recommendations are included since progress on these recommendations was to be evaluated in this current review. It also highlights some of the similarities

between the different review recommendations and the lack of progress which had been made with key aspects.

Disseminating and monitoring progress

In order to increase the possibility of more tangible progress, following the second review, specific actions were taken by the Care Quality Commission (CQC) and HMI Probation. Firstly, a series of regional meetings with YOT managers and available health representatives was arranged through the Youth Justice Board (YJB) in order to discuss the findings and recommendations. Some of the messages from the review document were also shared through presentations at national 'health' and 'youth justice' conferences and events. Decisions were then taken about how to ensure that health managers take more responsibility for the outcomes of future inspections and this resulted in administrative processes being reconsidered.

It was agreed that CQC would liaise more explicitly with health services prior to inspections and that the results of those inspections would be communicated directly to the health representative on the YOT management board with a copy being sent to the YOT manager. The health representative would be expected to be responsible for indicating how they would meet any recommendations made.

In addition, it was agreed that recommendations would be shared with the relevant Youth Justice Board and Strategic Health Authority regional representatives as well as forwarding information to the appropriate regional CQC operations manager to enable specific aspects to be followed up where necessary.

HMI Probation decided that the new inspection cycle (beginning in 2009) would be completed in three years, on a region-by-region basis, with a tighter focus on practice and would use fewer resources for each inspection. The Healthcare Commission had ceased to exist by this time and the new contribution by CQC accommodated the HMI Probation alterations while also reflecting their reduced resources now available for this task.

The current inspection cycle has been developed and carried out while significant changes have been introduced within the youth justice system. These included the introduction of the Scaled Approach and the Youth Rehabilitation Order and the withdrawal of the national indicators for health[4].

Current inspection Cycle – April 2009 to date

For the current inspection cycle, therefore, health inspectors have been carrying out a proportionate level of inspections in each region, but have also been operating in a complementary way, rather than being fully integrated with the core inspection by HMI Probation. The initial fieldwork by HMI Probation, consisting of a large number of case assessments (which includes some standard health questions), is completed and the outcome of those assessments is conveyed to the health inspector. This methodology enables the health inspector to carry out shorter inspections, since there is no need to carry out further case assessments. The health visit then takes place and an independent findings letter issued.

When the last inspection has been made in a specific region, HMI Probation lead a regional feedback session for YOT managers and CQC contributes to this, based on an

[4] See Glossary for explanations of the Scaled Approach, the YRO and the national indicators.

analysis of the health inspection findings for that region. Nineteen direct inspections, with fieldwork, have been used to inform this review report, as well as an analysis of the results of responses to the health questions in the case assessments undertaken by HMI Probation.

In addition to the limited number of inspections carried out in each region, CQC also issues a short health questionnaire to each YOT in order to enhance the information being obtained from direct inspections. The information from these questionnaires is also used in this review.

The core case inspections (as the main inspection cycle is known) are also supplemented by additional thematic inspections. These 'thematic' inspections have enabled inspectors to look at specific areas of interest in greater depth, and the subsequent national reports have been well received and are contributing to improvements in practice. CQC have been involved directly with the majority of the thematic inspections and also led one which focused on alcohol misuse and offending behaviour[5].

For this review, information has been drawn from the CQC inspections and questionnaires over five[6] of the nine English regions with an expectation that there will be a further review at the conclusion of this cycle of inspections alongside the analysis from HMI Probation.

Previous findings

A range of factors have affected the development of appropriate health services within youth offending. The first is the lack of a consistent framework to underpin health interventions with this vulnerable group of children and young people. There has been a lack of clarity about mandatory requirements, which includes the choice of health representation on the YOT management board and the nature and level of healthcare resources provided to the YOT. Significant changes to the structure of the NHS, such as the amalgamation of trusts, also affected the degree of commitment shown to this area of work, and the current anxiety for YOTs is that this situation may imminently re-appear.

Even where it was agreed by health services that some YOTs should be provided with the necessary resources, it was often difficult to recruit suitable staff. When individuals were finally in post, a lack of support often resulted in lengthy sickness absences or turnover. A further problem was with the development of vastly differing practices in individual YOTs, which led to a lack of consistency and further inequalities in health provision around the country.

Our reviews highlighted failings in initial health assessments carried out by YOT case managers and a lack of appropriate referrals for specialist health input, where this was available. Links by health practitioners to other settings and agencies, such as court or custody were frequently poor and transitions to adult universal health services were often problematic. Concerns were also raised about the thresholds and referral criteria between the YOT and CAMHS and the impact that this had on progress with health issues.

---

[5] *Message in a Bottle – A Joint Inspection of Youth Alcohol Misuse and Offending* – CQC, HMI Probation, Healthcare Inspectorate Wales and Estyn, 2010

[6] Namely – North East, North West, Yorkshire and Humberside, South West and West Midlands.

Indeed, little had improved between the first and second review in relation to the identification of health needs in the first instance, or the evaluation of any health interventions which had taken place. Lastly, there was a lack of information sharing protocols between health services and YOTs, which had led to varying responses to requests for information on the ground.

All these areas needed attention and the large number of recommendations made reflected our concerns.

Current findings

Governance and resources

Our previous review report made it clear that there were a number of deficiencies in relation to both the management and oversight of health interventions, but also in relation to the resources which were made available to the YOT. The Youth Justice Board had indicated that the average contribution to the overall YOT budget had decreased to 3.4% in 2008, falling from 5.8% which had been considered inadequate in 2004. Indeed, resourcing was considered to be inadequate in nearly half of the YOTs inspected for the last review.

From the inspections undertaken in the current cycle, together with the questionnaire data from 50 YOTs, the current average percentage contribution by health services to overall YOT budgets stands at 5.4%. Although still slightly less than the previously expected contribution, this is a considerable improvement on the figure at the time of the last review. The concern now relates to the existing economic climate and the critical decisions which the health service faces over the coming months. We worry that this may impact on the considerable strides made over the last two years and the need to continue this progress.

Only two YOTs did not have a mental health worker within the YOT to offer specialist assessments and interventions, which contrasts with 10% of YOTs with no mental health worker on-site previously. One had particular difficulties in filling a vacant post. The remaining YOT had a specific interim arrangement with their local CAMHS to provide support for emotional and mental health needs.

The level of resources to meet substance misuse needs has remained in a fairly healthy position, with only two YOTs where there was no worker present within the YOT to identify and meet those needs directly. Even in those cases, however, clear arrangements had been made to ensure a more universal substance misuse service was available to those who needed it within the YOT.

With physical health, the situation has not improved. Previously 30% of YOTs had no direct resource for general health nursing. The figure has improved very slightly (down to 28%), but there remain too few YOTs with that useful resource to ensure that physical health needs are appropriately identified and subsequently met. A few YOTs have been more proactive in this regard and have made concerted efforts to liaise more directly with school nursing services or have tried to ensure that other health workers on-site assess physical health needs in a more holistic way. This is an area which could still benefit from significant improvement.

The level of apathy demonstrated in YOT management boards previously was reinforced by the notable absence of service level agreements and relevant protocols between YOTs and health services. This contributed to a lack of a shared understanding of expectations and roles and responsibilities. All YOTs now have at least one health representative on each of their management boards. The health commissioning side tended to be well represented, although variations remained in terms of effective representation of health providers and substance misuse workers in board meetings. This, nevertheless, is an improvement.

Attendance at board meetings has improved. The average number of board meetings in a year is 4.8, with an average attendance by health representatives of 3.8. Just less than a third attended all the meetings held. There was only one representative who had not attended any of the set meetings in a year – although plans were in place to improve attendance and governance arrangements for health.

Virtually all YOTs now have some form of service level agreement (SLA) between health services and the YOT, which compares very favourably with the previous finding that one-third of YOTs had no SLA, an inadequate SLA or just a draft version. Only one YOT was found to have no SLA in place at all, although it was felt by the managers there that wider existing agreements were sufficient and that working relationships were good.

Again, proposed changes to primary care trusts (PCTs) give us concern, since governance arrangements will also have to change. In our experience previous changes to health management have led to a great deal of disruption and have affected attendance and contributions to YOT management boards as well as the basic service delivery elements and health resources for the YOT.

Governance

One care trust conducted extensive analysis to identify the health needs of young people in their area while also focusing on the most effective means of communicating with them. Their analysis of both qualitative and quantitative data identified a number of aspects, including the fact that young people did not find universal health services accessible or appropriate for their needs. The care trust established a new 'brand' with the assistance of young people and used their engagement to effectively market the health services in high street premises. The local services operate from three sites, identified through 'hot spot' analysis, as the areas of greatest need. A range of age-appropriate services are provided which includes sexual health screening, CAMHS and teenage pregnancy advice. The resources are used regularly by YOT clients, other young people, their parents and also health professionals. (Torbay)

Assessment and planning

Initial assessments are still carried out in the vast majority of instances by the YOT case manager, but there are now a number of instances (just over 10%) where health needs are more comprehensively assessed through a triage arrangement, meaning that all children and young people entering these YOTs have a fuller holistic health assessment. In one area, the initial assessment of the service user's risk and protective factors, within ASSET[7], was carried out jointly by the YOT case manager and the health practitioner.

Recognised assessment and referral tools for health needs are now much more likely to be used within the YOT, providing greater consistency – despite residual concerns about the accuracy and usefulness of those tools. Eighty-eight per cent of YOTs

[7] ASSET – assessment tool promoted by the YJB for those children and young people who have offended.

covered by this review were using the SQIFA[8] although only 48% subsequently used the SIFA[9]. The remainder either used other recognised tools (such as HoNOSCA[10] or SDQ[11]), their own versions of assessment tools or simply used more informal methods of accessing specialist health assessments after the ASSET was completed. Substance misuse workers were more likely to use their own assessment tools, such as DUST[12], in order to find out the level and nature of substance misuse, including that relating to alcohol.

The skills and training of YOT case managers in relation to the identification of health needs within ASSET, and with the SQIFA, was seen as more consistent. Their relationship with health workers had improved and was good. Nevertheless, as was pointed out in a recent thematic inspection on interventions, "differing criteria for referral to health practitioners within YOTs were not always understood by case managers". [13]

Inspectors found the initial assessments by health workers were more consistent with better links to universal health services. Cases were seen, for example, where early referrals and support were offered to ensure that young people had appropriate links to GPs and dentists. Further examples were found of health input and subsequent support through CAF meetings.[14] The involvement of children and young people and their parents and carers in the assessment process had also improved and was seen to have positively informed health case planning.

ASSET assessments, including their health components, were more likely to be audited (generally through supervision and case audits) and we found some good examples of 'dip sampling' where random low scoring health assessments were checked for accuracy.

Although physical health assessments had improved, they are still not as robust as the other health areas and we found cases where these health issues have not been assessed appropriately. Examples of this would be where physical health needs existed but were ignored in assessment or where significant physical health needs had been underscored within Asset.

One further area of concern was in relation to integrated case plans between YOT case managers and health practitioners. The main YOT intervention plan is too often developed in isolation from the health practitioner who may be working with a separate intervention plan. Where plans were well integrated, we found a greater likelihood of constructive joint reviews and better sharing of outcomes.

---

[8] SQIFA – screening questionnaire interview for adolescents – generally used, in the first instance, by case workers and may be used following ASSET in order to refer a case to a health specialist.

[9] SIFA – screening interview for adolescents – this is a more involved assessment generally used by a health practitioner within the YOT.

[10] HoNOSCA – The Health of the Nation Outcome Scales for Children and Adolescents – provides a global measure of an individual's current mental health status.

[11] SDQ – strengths and difficulties questionnaire.

[12] DUST – drug use screening tool.

[13] *To get the best results* – A joint inspection of offending behaviour, health and education, training and employment interventions in England and Wales – HMI Probation, CQC, HIW and Estyn, 2011

[14] CAF meetings – multi-agency 'child assessment framework' meetings.

Assessment

The YOT in one area conducted a triage health assessment on a young person who had received a referral order. This assessment identified health concerns which suggested that the young person may have been medically unfit and not in a position to understand, and therefore comply with his order. He was also anxious about attending school and had displayed self-harming behaviour. He had an obsessive interest in football and was excessively analytic in his review of football tables and performance data. Home tutoring was arranged. He was also assessed for Autism with useful health information being gathered for the Pre Sentence Report. The YOT health professional maintained frequent contact with an assessment centre and continued to co-work with the young person, which included home visits and latterly signposting the young person to mainstream health provision in order to support the autistic diagnosis. (Solihull)

Delivery and review of interventions

There is a good range of health materials generally available in YOTs to aid in the understanding of possible interventions. Encouragingly, health workers and YOT case managers are employing a broader interpretation of health needs in young people and are increasingly offering information and support with diet and lifestyle choices. There is a greater concentration on the provision of information relating to substance misuse and sexual health. Information on mental and emotional health is more limited and potentially increases the degree of apprehension and resistance to this area of work by children and young people and their parents and carers.

The range and variety of interventions being offered and used has increased since the last review, although these can be affected by the skills and inherent experience of the individual health practitioners. A planned intervention can also be affected by the need to manage any immediate crisis which arises. There are many good examples of effective partnership-working arrangements designed to offer a greater number of options, which can be accessed through voluntary organisations and services available to all.

Considerable efforts have been made to improve the engagement of children and young people in health interventions through improved flexibility in meeting times (including evening and weekend appointment times) and venues (including accessible or neutral locations). A variety of appointment reminders including texting and assisting with transport issues have improved the likelihood of young people attending, particularly in rural locations. Two areas which could be improved are the degree of relevant family work undertaken, which is very often minimal, and the level of home visits by health practitioners. Where there have been good examples of home visits and strong links between child-centred work and family-based interventions, the level of understanding of family dynamics and their influence on possible progress has been much clearer.

We have seen many more good examples of relevant information being shared between the different disciplines and a growing number of cases where health practitioners are accessing and contributing to YOT case recording and management systems. While this is an improvement on previous inspections, there are still occasions where information is duplicated between health and YOT files, or is still kept in entirely separate electronic or paper files containing records of health attendance and limited snippets

of health intervention information. Insufficient details of health information led to a lack of impact on case reviews but equally resulted in the health intervention being ignored in outcome analysis and affecting the nature of future planning.

Transitions

When considering transitions for this review, we are looking at both transitions between community and secure settings and also the transitions between child and adult services.

Transition arrangements, in general, remain problematic, particularly those between the YOT in the community and the secure estate where the nature and level of support for health issues can vary considerably. Although communication issues between YOT health practitioners and those in the secure estate are being actively addressed in a number of YOT areas, we still come across too many instances in case files and interviews where relevant information has either not been exchanged or is not used appropriately in intervention plans.

In many YOTs, good individual links had been made with secure settings with for example, a couple of YOTs who had bi-monthly liaison meetings with their local young offender institutions (YOI) as well as ensuring that a health representative attended reviews and pre-release meetings. Over half of the YOTs had made similar positive efforts to ensure the attendance of health workers at planning and review meetings prior to release. Where this took place, future constructive engagement with the young person was much more likely.

Overall, however, we found that arrangements for release from custody were not operating as smoothly as required to ensure continuity of health interventions. Resource difficulties sometimes meant that there was no health presence at important pre-release meetings and there were occasions where mainstream health appointments were sought but not specifically arranged prior to release. The effect of these two issues alone created real problems in ensuring engagement with community-based health practitioners.

Good communication and information exchange is more often seen where specific and direct links have been established between the YOT and individual secure settings and where health practitioners regularly attend initial, review and pre-release meetings. This is obviously more difficult to accomplish where resources are tight or where secure settings are too far away although, with current technology, more arrangements could be made to use video or telephone conferencing.

The transition from child-centred services within the YOT to adult services can be difficult for children and young people to achieve smoothly and effectively. The nature of adult substance misuse and mental health services, for example, can be substantially different for a service user and will often be more difficult to access independently. A few YOTs, or local authorities, have appointed transition workers in an attempt to deal with this crucial time. Health practitioners in other YOTs have maintained their involvement with young people in the absence of realistic exit strategies involving adult services.

Delivery

A young Ethiopian woman was experiencing difficulty in engaging with the YOT and was regularly breaching her curfew order. She was referred for a speech, language and communication assessment as part of the YOT research programme. The assessment identified that the young woman had difficulty understanding verbal instructions. It was recommended that the case manager supplement verbal communication with visual aids. A weekly timetable of the young person's commitments was prepared and printed in colour for her to follow. The timetable separated the days of the week into morning, afternoon and evening with pictures used to identify the different commitments – i.e. education, YOT appointments, gym and curfew. By simplifying the presentation of the information, the young person was able to understand and comply with her court order. The YOT has now installed 'communicate in print' software on five computers to enable staff to access and use the resources more widely with YOT clients. (Sheffield)

Monitoring and outcomes

Given that there remains a problem in ensuring that initial intervention plans by health practitioners and YOT case managers are integrated, it is hardly surprising that both reviews and outcomes of the separate plans are often independently considered.

While the monitoring of health interventions has continued to improve, particularly on an individual basis, it still remains less likely that this information will be aggregated or integrated with other measures within a YOT. This leads to a lack of a consistent overview – e.g. themes across a case load, and a lack of understanding about the effectiveness of interventions.

A wide range of methods are described by YOTs as being used to monitor the impact of health contributions to offending behaviour. Foremost among those are the ASSET review (undertaken three monthly or when a change of situation occurs), case meetings between practitioners and clinical supervision. Inspections found that ASSET reviews often don't effectively include health changes, and case meetings are sometimes not well recorded or used to inform future practice. Clinical supervision is usually undertaken in isolation from the rest of the work within a YOT.

Many YOTs indicated that health impact monitoring was simply incorporated into existing arrangements for sharing information between health practitioners and YOT case managers and these would include planning meetings, risk management meetings and informal discussions. Inspections, however, indicated that this was not always the case. Direct feedback, though, from children and young people, including re-visited *What do you think?* self-assessments, was seen on inspections to be well used and effectively shared within some YOTs.

Key performance indicators as a measure for health performance, although abandoned by the YJB, continue to be used by many YOTs even though they are limited to a process measure of the speed of assessment and subsequent intervention. Some

additional measures (such as TOPs[15], SDQ[16] and CGAS[17]), however, have been introduced by some YOTs to provide more helpful feedback to YOT management boards on the progress made in relation to health.

A fifth of YOT management boards in this review had no formal arrangement for considering health aspects, with the remainder ranging from a position of discussing issues as required to an acknowledgement that health would be included in general quarterly or annual updates. Even where health aspects are tabled and discussed in board meetings, the information shared is often of limited value and frequently unchallenged. In the best examples where health outcome information is requested, shared reasonably regularly, and augmented by case examples and analysis, management boards have helped drive forward improvements in the shared service being offered while ensuring that resources are tailored to meet the right needs. The good use of appropriate evaluation can also help to demonstrate value for money from the input of health resources and interventions. Unfortunately this activity is restricted to a minority of YOT boards.

Monitoring

A 14-year old YOT client agreed to engage with the Integrated Resettlement Service. He had poor educational attainment and had received little to no parenting in relation to setting boundaries. This young person had poor personal hygiene, a bad diet, erratic eating habits and was smoking cannabis. While he enjoyed practical work, he experienced difficulties engaging in a formal, structured learning environment. He enrolled on the cooking/lifestyles programme and to achieve the necessary accreditation, he had to complete all three modules: healthy lifestyles, preparing a healthy lunch and food hygiene awareness. Each session had aims and objectives explained to him and the worker concentrated on reinforcing his knowledge of foods and healthy lifestyles principally through discussion. The programme was designed to equip the young person with the necessary knowledge to make informed choices of what, when and where to eat. He learnt how to plan 'five food groups' meals, make and differentiate between healthy and nutritious 'Smoothies', and how to have the odd 'treat'. He completed over 52 hours of the programme, remained fully engaged throughout and had the skills to establish a sustainable eating routine which helped to successfully ease his transition into independent living. (Barnsley)

[15] Treatment Outcomes Profile – an assessment method used to measure progress in substance misuse but limited to the older age group. TOP information is submitted to the National Drug Treatment Monitoring System (NDTMS) where quality assurance and analysis are undertaken.

[16] Strengths and Difficulties Questionnaires – is a brief behavioural screening questionnaire for up to 16 year olds which is recommended as an outcome measure by CAMHS.

[17] Children's Global Assessment Scale – this is a numeric scale (1 through 100) used by mental health clinicians and doctors to rate the general functioning of children under the age of 18.

Additional aspects

Work with courts

In the previous review, a small number of additional areas were highlighted which were felt to need attention. The first of these related to court work and the limited involvement of health services even where this was seen as appropriate, and indeed, necessary.

The relationship between health practitioners and courts has improved, with many YOTs able to offer bail programmes with health support where this is required. This is often not, however, as proactive as it might be in ensuring that these options are both established and well understood by YOT court staff and sentencers.

A greater number of opportunities have been made available for YOT court workers and other court staff to learn more generally about available health interventions within the YOT. This now occurs in well over half the YOTs considered in this review and this doesn't include a number of settings where this training was scheduled to take place.

Information sharing

Information-sharing remains a residual issue for health services and YOTs, despite a large increase in the number of information-sharing protocols which now exist and are periodically updated. Eighty per cent of YOTs now have an up-to-date information-sharing protocol with health, with additional protocols being developed. A few (8%) YOTs have an over-arching protocol as part of, for example, Children's Trust arrangements or subsumed in their service level agreement. Although the increase in protocols is encouraging and many are closely linked to advice from the Department of Health[18], problems are still evident in inspections with, for example, important and relevant health information not being disclosed to a YOT case manager. Individual examples of this have included additional information about self-harming or the extent of a substance misuse issue. Where information has been passed from a health worker to a YOT case manager, this has sometimes made little impact on case planning.

The expectations within a protocol are not therefore necessarily being met. There is not enough understanding about the nature of specific confidential aspects and the need to share information in a multi-disciplinary team. The default position has to be that information is normally shared within the YOT, with the young person's agreement, unless there are clear reasons for this not to be done. Young people are invariably comfortable with information being shared between all involved professionals and the only issue that has been highlighted in inspections is the occasional anxiety about specific information (principally concerning levels of substance misuse or aspects relating to sexual health) being shared with parents.

Case recording systems within the YOT and with health indeed often remain separate and require the health practitioner to duplicate or summarise relevant information. The two systems need to facilitate an effective level of sharing rather than creating artificial and unnecessary barriers. There are certainly YOTs where the health workers have simply contributed to the existing YOT recording system and have then provided

[18] *When to share information – best practice guidance for everyone working in the youth justice system*, Department of Health, 2008

summaries of interventions to other universal health services to provide continuity of treatment, and this has worked well.

Line management of health practitioners

A further area of concern raised in previous reviews related to the confused and often insufficient arrangements for the supervision and line management of health practitioners in YOTs. This is an area which has improved considerably since, with the overwhelming majority of health workers now receiving an appropriate frequency of clinical supervision sessions and good line management. For the emotional and mental health side, clinical supervision is invariably provided by CAMHS, while with substance misuse this is generally undertaken by senior personnel in their own organisation. For those health practitioners specialising in physical health, the arrangements are more variable but remain sound.

Line management, in the majority of cases, is appropriately exercised by an operational manager within the YOT, although sometimes arrangements are carefully organised between the YOT and health services to ensure a more joint approach. Health practitioners are, by and large, satisfied and happy with the arrangements for both supervision and line management.

Safeguarding

During this inspection cycle, checks were made to provide re-assurance about the extent and level of safeguarding training which health practitioners had carried out. All health practitioners in YOTs had undertaken at least the basic level of safeguarding training with the majority achieving level 3 and others working towards this position with only a handful remaining at the basic level 1.

Information sharing

A 16-year-old male received a six-month detention and training order (DTO). He had a varied offending history which included criminal damage, public order offences, cannabis use and possession of an offensive weapon. Historically, he had found it difficult to engage with substance misuse services. On being released from custody, he was placed into local authority care as a looked-after child (LAC). The young person was assessed by the YOT and referred to the substance misuse worker. Both then worked well together and agreed a care plan to address cannabis, alcohol and other illicit substance misuse. What helped to support the achievements in this case, however, was the close liaison which had taken place with Wetherby YOI substance misuse workers and the subsequent dialogue and liaison with LAC staff. This all assisted the young person to comply with the requirements of his DTO licence, to re-engage with education and to rebuild family relationships. (East Riding)

The impact of *Actions Speak Louder* – feedback from YOTs

The CQC YOT Programme Manager and the Assistant Chief Inspector of Probation undertook a series of regional meetings with the YJB and YOT Heads of Service during 2010. Feedback was invited about what had changed for YOT Heads of Service since the publication of *Actions Speak Louder*.

Most YOTs reported that they tabled the review report at a management board meeting and that this had subsequently resulted in working groups and/or the development of an action plan to meet the recommendations made. Where YOTs felt that the report validated the services they already offered, discussions still took place at board level.

With strategic involvement and contribution from health services, 15 of the YOTs canvassed throughout the country stated that there had been no noticeable change since the publication of the report. Responses, however, varied from a positive example – "report had no impact due to the fact that we have had no significant problems" to the more concerning – "unsuccessful bids for additional funding so minimal impact" and "if anything, the links with health have deteriorated and they are difficult to engage with…the health representative has not attended the YOT management board for a year".

Positive changes cited by specific YOTs, however, included:

- the undertaking of a comprehensive health needs audit
- the significant development of a physical and emotional health pathway
- more regular attendance and engagement of health at YOT management boards
- a greater awareness of the need to consider the physical health needs of children and young people who offend
- improved PCT involvement together with more funding and staff
- a revised agreement with CAMHS regarding pathways
- amended health roles within the YOT
- greater clarity on protocols
- more comprehensive health screening
- some improvements in recording and information-sharing.

Where interventions were concerned, feedback from YOT Heads of Service was a little more limited but did include:

- positive comments about the development of health screening
- initiatives relating to obesity
- improvements in links to LAC health services
- some developments in CAMHS provision
- increased prevention work
- more training around alcohol misuse
- a greater level of work generally on healthy lifestyles.

On the less positive side, YOTs confirmed continuing difficulties in terms of CAMHS involvement as well as highlighting issues with health screening where young people were reluctant to consent and that health practitioners in some areas focused almost exclusively on assessments with a consequent lack of delivery of interventions.

Although some YOT Heads of Service indicated that little had changed in relation to outcomes for children and young people since the publication of the last review, others did state that there was a greater level of evidence of specific health issues being improved, such as sexual health and contraception, minor ailments, healthy living, smoking and diet. Individual YOTs suggested that mental health monitoring was better and that more information about health interventions was being shared.

YOT managers alluded to budget constraints beginning to have an impact on the health contribution to their service, both in relation to substance misuse and emotional and mental health. Even where appropriate support had been provided, there were concerns about the resilience of these arrangements and their sustainability.

Improved links

A female YOT client aged 16 years received an 18 month Referral Order. She was alcohol-dependent and had a history of violence and theft. Her heavy alcohol use would lead to highly-charged arguments and she was referred to CAMHS where she was assessed and latterly received an intervention to specifically address her self-harming behaviour. She was also referred to Tier 3 substance misuse services and workers were able to secure a Tier 4, nine-month residential alcohol rehabilitation placement which was out of area. During this period, she completed a life history and identified the catalysts for her behaviour. The placement helped her to develop management techniques. On completion, she was accommodated in a half-way residential housing facility to help her to safely adjust back into the community. She stopped abusing alcohol and maintains occasional social contact with the YOT, keeping them updated with her positive progress. (Stoke)

Conclusion

This is a positive review which highlights improvements in the health contribution to youth offending services since the previous inspection cycle. This is certainly not, however, a time for complacency since there is still more that can, and should, be done to improve health outcomes for those children and young people who are, or may become, involved with offending behaviour.

There is a growing anxiety, and initial evidence from more recent inspections[19], that the current level and quality of health resources and interventions may be difficult to sustain in both this economic climate and the planned changes to funding arrangements. Disinvestment in this group of children and young people at this time, given recent advances, would be short-sighted, both for them and for local communities.

It is even more important now for YOTs to demonstrate the positive outcomes they are able to achieve and to ensure that sound data about this includes the results of health interventions. Health representatives on YOT management boards need to ensure that their commissioned services are providing good value for money and that the right interventions are being delivered to the appropriate young people.

Inspections of YOTs by HMI Probation, complemented by contributions from CQC, continue to find examples of all aspects of healthcare needs in children and young people with key links to their involvement in offending behaviour. These needs include learning difficulties and communication problems as well as dentistry, hearing or vision needs, in addition to the more usual substance misuse and emotional and mental health aspects. Case managers and health workers are also more likely to consider health and well-being in a broader context, looking, for example, at how fitness and healthy eating can be equally important in a young person's life. It is therefore vital that all these elements are well assessed and the relevant needs met in order to maximise the potential for positive and sustainable change.

While improvements are rightly credited to individual YOTs, feedback from them indicates that youth justice inspections have provided a catalyst for change. It is therefore important that joint inspections continue in order to help maximise the likelihood of sustaining improvements and providing consistently high quality inputs on health issues for these children and young people.

[19] These are inspections which have been undertaken over a three-month period following the span of inspections used to inform this report.

Appendix A – Additional reading

1. Core Case Inspections of Youth Offending work: Aggregate findings across four English regions and Wales, HMI Probation, 2011
2. *Let's Talk About It* – A review of healthcare in the community for young people who offend, Justin Thacker, Healthcare Commission and HMI Probation, 2006
3. *Actions Speak Louder* – A second review of healthcare in the community for young people who offend, Fergus Currie, Healthcare Commission and HMI Probation, 2009
4. *Message in a Bottle* – A Joint Inspection of Youth Alcohol Misuse and Offending – Fergus Currie and Les Smith, CQC, HMI Probation, Healthcare Inspectorate Wales and Estyn, 2010
5. *Healthy Children, Safer Communities* – Department of Health, 2009
6. National Standards for Youth Justice Services – YJB and Home Office, 2004
7. *Key Elements of Effective Practice* – Youth Justice Board (YJB), 2008
8. *Risk and Protective Factors* – YJB, 2005
9. *When to share information – best practice guidance for everyone working in the youth justice system*, Department of Health, 2008
10. *Standards for Better Health* – Department of Health, 2004 (updated 2007-2008)
11. *Sustaining the Success – extending the guidance*, Youth Justice Board, 2004
12. *To get the best results: A joint inspection of Offending Behaviour, Health and Education, Training and Employment Interventions in Youth Offending work in England and Wales* – HMI Probation, Care Quality Commission, Ofsted, Estyn and Healthcare Inspectorate Wales

Appendix B – Glossary

ASSET	Asset is a structured assessment tool to be used by YOTs in England and Wales on all young offenders who come into contact with the criminal justice system. It aims to look at the young person's offence or offences and identify a multitude of factors or circumstances – ranging from lack of educational attainment to mental health problems – which may have contributed to such behaviour. The information gathered from Asset can be used to inform court reports so that appropriate intervention programmes can be drawn up. It will also highlight any particular needs or difficulties the young person has, so that these may also be addressed. Asset will also help to measure changes in needs and risk of re-offending over time.
CAMHS	Child and adolescent mental health services: part of the National Health Service, providing specialist mental health and behavioural services to children and young people up to at least 16 years of age.
CCI	Core Case Inspection. HM Inspectorate of Probation's inspection programme for Youth Offending Teams in England and Wales.
CQC	Care Quality Commission. The independent regulator of health and adult social care in England.
National indicators	National indicators have been derived from Public Service Agreements and agreed across Government through the 2007 Comprehensive Spending Review. The outcomes they measure and the indicators themselves provide a statement of Government's priorities for delivery by local government and its partners. They are the only indicators on which central government will set targets for local government.
Safeguarding	Overseen by the Local Safeguarding Children Board: set up in each local authority (as a result of the Children Act 2004) to coordinate and ensure the effectiveness of the multi-agency work to safeguard and promote the welfare of children in that locality.
Scaled Approach	Evidence suggests that interventions are more effective when their level and intensity is matched to an assessed likelihood of re-offending, and when they are focused on the risk factors most closely associated with a young person's offending. The focus of the Scaled Approach is to tailor interventions to the individual, based on their assessed likelihood of re-offending and risk of serious harm. The Scaled Approach was devised to enable YOTs to use assessments of risk as a basis for their work. It will be used when a young person is on a Referral Order, a YRO or during the community element of a custodial sentence. Under the Scaled Approach practitioners determine the likelihood of re-offending and risk of serious harm to others. This, alongside professional judgement, helps to establish which intervention level a

	young person needs: standard, enhanced, or intensive. The intervention level determines the minimum statutory contact a young person will have with the YOT or other assigned professionals.
Universal services	These are health services provided for the general population rather than those provided for specific groups of children and young people or adults.
YJB	Youth Justice Board for England and Wales oversees the work being done by all 157 YOTs across England and Wales. It will cease to function as a non-departmental public body during 2011/12, and its functions will be transferred into the Ministry of Justice.
YRO	The Youth Rehabilitation Order (YRO) is a generic community sentence for young offenders and combines a number of sentences into one generic sentence. It is the standard community sentence used for the majority of children and young people who offend. It simplifies sentencing for young people, while improving the flexibility of interventions.

How to contact us

Care Quality Commission

Phone: 03000 616161
Email: enquiries@cqc.org.uk
Website: www.cqc.org.uk

Registered office:
Care Quality Commission
Finsbury Tower
103–105 Bunhill Row
London EC1Y 8TG

Her Majesty's Inspectorate of Probation

Phone: 0161 869 1300
Email: hmip.enquiries@hmiprobation.gsi.gov.uk
Website: www.justice.gov.uk/inspectorates/hmi-probation

Registered office:
HM Chief Inspector of Probation
2nd Floor, Ashley House
2 Monck Street
London SW1P 2BQ