The Health Needs of Young Offenders in Southampton

September 2016
Executive Summary

An original report on the health needs of young offenders in Southampton was created in 2013 to assess the level of need within the Youth Offending Service. The report also served as a way to reflect on practice and identify areas in need of improvement. This report acts as a refresh to the 2013 version and includes more information about the context of health needs of young offenders as well as providing more detailed analysis to provide recommendations.

Therefore, the purpose of this report is to identify the level of need of the young people in Southampton Youth Offending Service and whether these needs are being met. Where it is determined that their health needs are not being met, there are recommendations for improvement in order to reduce their likelihood of reoffending.

The intended audience of the report are the Youth Offending Service Management Board as well as youth justice professionals who wish to support good practice by being reflective on the services available/provided. The report will also contribute to the Southampton Joint Strategic Needs Assessment by clearly identifying local needs of young offenders to improve their health and wellbeing.

Southampton Youth Offending Service collaborated with many colleagues during the creation of this report. Some of the professionals consulted were from the departments listed below:

- Southampton Youth Offending Service
- Hampshire Liaison and Diversion Service
- Public Health Strategy Unit
- Child Sexual Exploitation Hub
- Multi-Agency Safeguarding Hub
- Integrated Commissioning Unit
- Hampshire Constabulary

The inclusion of specialist staff from each of these departments has enhanced the quality and integrity of the report and ensures that information has been accurately represented.

Overview

Youth offending

The information provided in the Youth Justice Strategic Report 2016 shows that after a period of reduction in Southampton’s re-offending rate, an increase is evident as the cohort shrinks due to local diversion work. This means that the remaining cohort have a higher level of multiple complex needs which gives a higher re-offending rate. In addition to this, the custody rate and first time entrant rate remain higher than the national and regional averages as well as most comparator cities, despite these rates improving for the city. This is likely to be due to the smaller cohort of young people having a higher level of multiple complex needs.

The report’s strategic context is provided by outlining the Southampton Youth Justice Strategy 2014 – 2017 which sets out the strategic vision for Youth Justice Services in the city. Key priorities for Youth Offending Services are identified as:

- Reduce youth crime
- Reduce first time entrants to the youth justice system
- Reduce custody
- Reduce re-offending

Information from the Southampton Safe City Strategic Assessment is provided and outlines the Youth Offending Service’s responses to the recommendations to improve the management of multiple complex needs.
There is also information on the 2017 Health and Wellbeing Strategy including an explanation of how Southampton Youth Offending Service contributes to efforts of improving the health of the city.

**Health needs**

Discussions with youth practitioners and a review of literature and research shows that there are many factors contributing to the health needs of young offenders. These are broadly covered by four themes; Family Life, Suitable Services, Ability to Engage and Wider Health Needs.

The theme of Family Life covers the importance of early years development, parents and family structure on the health needs of young offenders with an emphasis placed on the acquisition of health needs, behaviours and attitudes.

The theme of Suitable Services covers the importance of access to appropriate health services and the management of transitions as vital to addressing the health needs of young offenders with an emphasis on some of the barriers to meeting their needs.

The theme of Ability to Engage highlights the internal factors motivating young offenders to play an active role in the management of their health needs with an emphasis on clarity and explanation to enable participation.

The final theme of Wider Health Needs identifies broader health needs and their impact on multiple complex needs of young offenders with an emphasis on changes in lifestyles and society needing to be recognised in current practice.

**Who is at risk and why?**

**Health comparisons**

Using data from the *Southampton JSNA Data Compendium* and *National Child and Maternal Health Intelligence Network*, there were health comparisons between Southampton, England and, where possible, statistical neighbours. The comparisons showed that Southampton’s young offenders are a particularly vulnerable group due to the city’s poor health record, particularly in areas which are widely acknowledged as contributing to offending behaviour (alcohol and drug misuse, deprivation and poverty, education and mental health).

**Methodology**

The report analyses the Asset assessments for two cohorts of young offenders; one from the financial year 2012/13 and one from the calendar year 2015. The quantitative information was gathered from scores and responses to questions on the assessments and the qualitative information was gathered from the evidence provided for highest scoring 10% of the 2015 cohort.

**Summary of analysis**

The summary of the analysis shows that the recent cohort of young offenders primarily had higher level of needs than the previous cohort. This is particularly evident in the differences for mental health, substance use and personal relationships.

**Level of population need**

**Overview of analysis**

The overview of the analysis shows that there were a similar number of young people in both cohorts (180 for 12/13 and 183 for 2015) with a similar breakdown of characteristics. Around 80% of both cohorts comprised of males with a higher proportion of females aged under 15 and males aged over
16 for both cohorts. The percentages of Looked After Children were similar (5% for 12/13 and 6% for 2015) however there were no females identified as Looked After Children in the first cohort.

Differences between cohorts
There were five significant differences between cohorts, only one of which reflected a lower level of need for the recent cohort. The percentages of young offenders scoring 2 or more (association with offending) for ‘Lifestyle’ had decreased by 14% from 68% in 12/13 to 54.4% in 2015. However, ‘Education, Training and Employment’ increased by 12% (from 27% to 38.7%), ‘Family and Personal Relationships’ increased by 15% (from 48% to 62.8%) and ‘Perception of Self and Others’ increased by 19% (from 27% to 45.6%). The largest increase in need was the percentage of young offenders scoring 2 or more for ‘Emotional and Mental health’ which had increased by 30% from 23% in 12/13 to 52.9% in 2015.

Gender differences
The most notable gender differences within the current cohort were for ‘Emotional and Mental Health’ with approximately twice as many females reporting concern for the future, having contact/referrals with mental health services and other difficulties. Further to this, there were nearly three times as many females reporting self-harm than males and more than three times as many females who had attempted suicide. The evidence supplied for this need/problem suggests that the biggest influences on current mental health are past behaviours and/or traumatic life experiences.

There were also notable gender differences within the current cohort for ‘Substance Misuse’ with approximately twice as many males reporting that substance use is positive or essential to life and is having a noticeably detrimental effect. In addition to this, there were over five times as many males reporting offending to obtain money for substances as females. However, there were 10% more females reporting other links between substance misuse and offending than males. The evidence supplied for this need/problem suggests that the biggest influences on substance misuse are a history with or reliance on substances as a mood enhancer or coping mechanism.

Although there were other gender differences found within the analysis, these were less significant and less consistent throughout the different needs/problems. However, there was a strong link to past events and underlying issues in the evidence of most needs/problems for both genders which suggests that intervention work should address previous experiences as well as current behaviour.

Current services
The report provides an overview of Southampton Youth Offending Service’s response to the health needs of young offenders is provided, including an outline of the secondment of specialist staff and case overviews for interventions and referrals.

Stakeholder views
Interviews
To gain the views and experiences of young people, 3 interviews were conducted with young people who had been in custody to capture the voices of these young people any differences in healthcare provision and access to information compared to in the wider community.

The feedback reported generally reflected the standards of healthcare expected for young people in secure settings with the young people reporting that it was similar to the healthcare they received in the community.
Questionnaires
To gain the views and experiences of young people, 25 questionnaires were conducted to capture the health behaviours, acquisition of health knowledge and the understanding of health services available.

The findings showed that physical health was not of particular concern and although there were some poor health practices recorded there were also good health practices recorded. In contrast, mental health was more of a concern with high levels of regular problems/symptoms being experienced, although these did not interfere with the daily lives of most of the young people. School was identified as the primary source of information for learning about health, followed by parent(s)/caregiver(s) and health services were identified as the primary source of advice for health issues, followed by parent(s)/caregiver(s).

Evidence of what works
The report reflects on relevant theoretical theories as well as effective practice as evidence of what works in meeting the health needs of young offenders. The values of Desistance Theory and the Good Lives Model underpin the work of the Youth Offending Service while the service is developing its use of an innovative practice called Forensic Case Formulation. The report also looks to the Youth Justice Resource Hub’s Library of Effective Approaches to identify potential improvements to practice.

Recommendations
Youth Justice Partnership
There are recommendations provided throughout the report which require the efforts of the wider network of services. These include the development of interpersonal skills (interaction and communication) and intrapersonal intelligence (self-awareness) from a young age which will ensure that young people are better equipped to communicate and interact with others about their needs which will enable them to access services and address their health needs. There is also a need to promote engagement in the wider health offer across all ages and demographics to improve the health beliefs of parents and other significant adults which are typically internalised by young people and therefore would encourage them to address their needs prior to entering the Youth Offending Service.

Service
There are also recommendations made throughout the report which are specific to the Youth Offending Service, although it may be useful for other services to consider these too. These include adopting an individual holistic approach which encompasses the life stories and experiences of young offenders to identify underlying issues to their offending as well as addressing their current behaviour and needs. An evaluation of engagement tools is recommended to ensure that young people are encouraged to engage and provide information about their needs at the earliest opportunity. Finally, there is a need to ensure that information is captured and recorded correctly as this is vital to guarantee that provision is suitable and appropriate.

Further Data
Although the analysis in this report has provided a valuable insight into the level of the health needs of young offenders in Southampton, the production of further data will advance the position of the service to ensure they provide adequate interventions and support. This includes additional information about more specific areas of the analysis such as absences from school, unsuitable housing conditions and exposure to domestic violence as well as continuing the work on sexually problematic behaviour.
Benchmarking
Further to the previous recommendation, it is vital that steps towards benchmarking be taken in the future in order to enable comparisons across time, between places and between different population groups. This would enable us to learn about patterns in health experience and assess the need for change from the discipline of epidemiology which is key in public health. Therefore, while Southampton Youth offending Service should take measures to ensure that the information is reassessed when more data becomes available, neighbouring Youth Offending Teams should consider collaborative work to expand this area of knowledge and improve the health and wellbeing of their young people.

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OVERVIEW

1. Introduction

1.1 Youth Offending Services are at the forefront of the Government's agenda to reduce crime, particularly youth crime. Set up under the Crime and Disorder Act 1998, each Youth Offending Service must consist of representatives from Probation, Social Care, Health, Education and the Police to deliver co-ordinated youth justice services.

1.2 In Southampton, the key partners are:
   - Southampton City Council e.g. Southampton Children's Services & Learning
   - Hampshire Constabulary
   - National Probation Service
   - Southampton Clinical Commissioning Group

1.3 The principle role of the Youth Offending Service (YOS) is to reduce offending by young people who are involved in the criminal justice system. YOS officers identify the risk factors that place young people at risk of offending and work with them to reduce those factors. This might be addressing their alcohol or drug use, engaging them back into school, or working on their thinking skills.

1.4 Southampton Youth Offending Service provides support and interventions to a range of individuals. Primarily these are young people aged 10 to 17 years of age who have committed criminal offences. However, through the prevention element of the service, its work with parents and carers, and its restorative justice interventions the remit extends to reach a range of people involved in, or affected by, youth crime.

1.5 Overall the youth justice services delivered by the Youth Offending Service include:
   - preventative work, aimed at reducing the numbers of young people who become caught up in the criminal justice system;
   - professional advice and the preparation of reports for court;
   - the assessment and supervision of young offenders;
   - support for the parents of young offenders, and
   - restorative work between offenders and the victims of youth crime.

1.6 The Southampton Youth Justice Strategy 2014-2017 sets out the four key priorities for the city's Youth Justice Service:
   - Reduce youth crime
   - Reduce first time entrants to the youth justice system
   - Reduce custody
   - Reduce re-offending

1.7 There are three key performance indicators for all Youth Offending Teams:

1. Reducing the number of first time entrants into the criminal justice system;
2. Reducing the number of re-offenders and
3. Reducing the number of young people receiving custodial sentences.

Reducing the numbers of first time entrants and re-offending are shared outcomes between Youth Justice Services and NHS England / Health and Wellbeing Boards.
The performance data below is the most recent available, published by the Youth Justice Board and taken from the Youth Justice Strategic Report 2016. Southampton YOS performance is compared against national and regional averages and similar YOTs.

The performance data shows that the Southampton re-offending rate remains below the national average. However, an increase is noted in the most recent cohort. This is because youth re-offending is measured thus: the percentage of young offenders that re-offend in the following 12 months. The main factor contributing to the rise in re-offending is Southampton’s successful efforts to divert young people from crime via Joint Decision Making Panels which ensure that each young person is taken down the most appropriate pathway and receives the right support. This has led to a smaller offending cohort with more complex needs. Therefore, although the number of re-offenders is reducing, this is in a much smaller cohort. This gives a higher re-offending rate.

In Southampton, targeted work is undertaken with the most prolific young offenders or ‘Priority Young People’. Each case has a multi-agency action plan which is reviewed on a monthly basis. The cohort is set each April and tracked for two years. The drop in re-offending from 2011-12 should be attributed to the introduction of the Priority Young People scheme which has seen a consistent reduction in the cohort since its conception.

Southampton Youth Offending Service also analyses offending by its young people in ‘real time’. Live tracker data shows a favourable reduction in re-offending if we compare Southampton data over a two year period.
Although the number of youth custodial sentences has continued to reduce, Southampton’s custody rate remains higher than the national and regional averages and most comparator cities. The YOS has undertaken a review of 18 custodial sentences and identified that one of the principle drivers for custody is lack of compliance by young people with multiple, complex needs.

The first time entrant rate in Southampton has further reduced, although Southampton remains higher than the national average and most comparator cities. The YOS Manager and arbitrating inspector regularly review Joint Decision Making Panel decisions and also track the
number of first youth cautions administered by police. YOS data shows a decrease in first youth cautions from 63 in 2014 / 15 to 38 in 2015 / 16.

First Time Entrants – Southampton and Comparator Youth Offending Teams

Overall, there has been a 4.2% increase in ETE engagement in 2015 / 16, in comparison with the previous year. School age engagement has influenced this improving trend, with above school age engagement showing a decreasing trend in 2015 / 16. Factors influencing this were capacity issues in both the Wheatsheaf programme and City Deal.

Education, Training or Employment (Combined)
2. **Youth Justice Annual Statistics 2014 – 15**


2.2 The following summary is taken from the Hampshire and Isle of Wight Criminal Justice Board’s Youth Crime Strategy:

**Comparisons to the adult system**

2.3 Young people (10-17) accounted for 13% of first time entrants to the criminal justice system in the year ending March 2015. Young adults and adults (18 years and over) accounted for 87%. Young people (10-17) sentenced for indictable offences accounted for 6% of the total people sentenced in the year ending March 2015 with 17,055 court sentences, compared to 9% for young adults (18-20) and 85% for adults (21 and over). Young people (10-17) in custody accounted for 1% of the total prison population in June 2015.

2.4 In the year ending March 2014 the proportion of people who re-offended was highest for young people aged 10-17, with a re-offending rate of 38.0%. Young adults (18-20) had a re-offending rate of 29.9%, while adults (21 and over) had a rate of 24.5% Young people accounted for 19% (2,792 offenders) of the total number of offences involving the possession of a knife or offensive weapon resulting in a caution or sentence in the year ending March 2015. This is 9 percentage points higher than the proportion of young people of offending age.

3. **Broader Context**

There are many factors influencing the health needs of young offenders and several key themes have been identified for the purposes of this report. These are Family Life, Suitable Services, Ability to Engage and Wider Health Needs. A summary of each key theme is outlined below to provide context to the report. It is important to note that the key themes are not distinct and influential factors will be found in more than one theme.

3.1 **Family Life**

This key theme covers the consequences of early years development, the importance of parents and the significance of the family structure. There have been references to the impact of family life on the health needs of young offenders throughout the analysis. Good health and wellbeing is shaped from very early on and determined by many factors (Khan, 2016). There are multiple factors which effect early years development but it is primarily the environment provided by the parents or caregivers which has been identified in the analysis. These observations are supported by Malekpour (2007: 91) who states that ‘[t]he environment provided by the child’s primary caregivers has tremendous impact on all aspects of child’s early development as well as his or her later life’. The analysis shows that family life has the biggest impact on the emotional and mental health of young offenders with a prevalence of attachment disorders due to relationships during early years, however there may also be physical health needs as a result of their early years development (although it should be noted that there is a two-way causal relationship between mental health and physical health). In relation to family life, the observed health needs may be a result of poor general health such as poor diet, lack of exercise, neglect of dental hygiene and exposure to stress and/or fear (where there is domestic abuse or a reliance on young carers). The primary
responsibility of addressing health needs in childhood falls on the parents or caregivers, however there may be barriers to parents providing adequate care due to learnt behaviours and attitudes (Akers, 2007) which regards health as unimportant and young people are also likely to learn attitudes and behaviours from within the family (especially in regards to substance use and educational attainment). In addition to this, there may be a link to deprivation (Alaimo et al., 2001) which affects a parent’s ability to meet their child’s health needs as well as the parents/caregivers possibly possessing a lack of understanding, experience or support. There may also be some who consider their child’s health needs to be the responsibility of the state (assuming that Health Visitors, General Practitioners, and School Nurses etc. are proactive) and although the services do possess a duty of care to children, it is the role of the parent which has the biggest impact on health. ‘Support from parents received during childhood is thought to have significant and lasting health implications because the parent–child relationship serves as the context within which important health-enhancing social and psychological development takes place’ (Shaw, 2004: 4). Therefore, it is important that a systemic approach is adopted during intervention as the family situation affects the needs of the individual (Farrington, 2010). However it should be noted that although there are now several statutory and voluntary parental interventions, these have sometimes been ineffective as punishments and should instead be provided as positive opportunities to parents and families (Goldson, 2002).

3.2 Suitable Services

This key theme covers the importance of access to appropriate services as well as the need to manage transitions between services. There have been references to the impact of the suitability of services on young people throughout the analysis. Although there is a responsibility from parents and caregivers, services are also have a duty to meet the health needs of young people. The World Health Organization (2000: 7) state that in order to flourish ‘[c]hildren and adolescents need clean air, safe housing, nutritious food, clean water and a healthy way of life; they also need friendly services that they can reach and that can reach them’. While the Youth Offending Service is friendly and accessible, there are still concerns surrounding the accessibility and approachability of other services. Although many services possess a variety of assessment tools and proactive staff to ensure that the health needs of young people are being met, barriers to meeting the health needs of young people still exist. A particular concern is the length of time young people are waiting for services to respond, both in terms of referrals and involvement after issues being raised. ‘There is an average 10-year delay between young people displaying first symptoms and getting help’ (Khan, 2016). This concern is more notable for mental health services than other health services and goals to providing better mental health services were outlined by NHS England and Department of Health (2014). They aim to achieve accessible mental health care by 2020 but young people are still vulnerable during this process of improvement which is problematic as a young person’s health needs must be recognised before they can be addressed. There are also concerns around the lack of diagnoses prior to entering the criminal justice system which would have enabled treatment at an earlier stage and may have prevented the offending behaviour. In addition to this, the emotional need for consistency is not always satisfied due to changes within or between services, such as members of staff or being signposted. The observations also show that there may not always be sufficient contact time provided to adequately address the health needs of young people, often due to limited resources. In addition to this, there is a lack of unity between services on the age prescribed to “young people” with variations between the separation of children and adolescents as well as the age capped on some services. This is problematic as some young people may feel too old to be accessing “children’s” services while other young people may not feel ready to access “adult”
services, so it is important that the young person’s maturity and experiences be taken into consideration when determining the suitability of services. Some young people may also experience feelings of loss following the completion or withdrawal of services and the variations in services and treatments means there is a need for tailoring to individual needs. In addition to this, there is occasionally an issue surrounding the integration of services which could present the problem of repetition or missing concerns for the needs of young people. These observations are supported by McGorry et al. (2013) who criticise the appropriateness of adolescent mental health services.

3.3 Ability to Engage

This key theme covers the importance of internal motivation from young people, their understanding of why they are participating and factors preventing engagement. There have been references to the impact of a young person’s ability to engage throughout the analysis. Although services have a duty to meet the health needs of young offenders, there is some concern surrounding the engagement from young people which may hinder the service in addressing their needs, particularly for emotional and mental health needs. ‘Young people perceive a number of barriers to help-seeking for mental health problems. These include stigma and embarrassment, problems recognising symptoms (poor mental health literacy), and a preference for self-reliance’ (Gulliver, 2010: 119). While these barriers do not always affect a young person’s ability to access health services (which may be mandatory or via a referral), they do effect their ability to engage with services. In relation to stigma and embarrassment is the concern surrounding self-image and acquiring a “label” of mental illness or of criminality, which could be considered positive or negative by different young people. For example, some young people may not want to be stigmatised or stereotyped whereas others may relish in having others view them this way (Muncie, 2015). The problems recognising symptoms is likely to affect their willingness to engage as some young people may not recognise their own health needs or they may disagree with services and therefore will be less likely to see the need to engage in certain work. This links into a preference for self-reliance which can be mitigated by making young people aware of the benefits to engaging in certain activities as well as the purposes of undertaking these activities, otherwise they may fail to see the point of participation and believe that they can deal with it by themselves. This is reflected in the Health Belief Model which explains how, among other things, the perceived benefits of an action effects engagement or lack of engagement in health-promoting behaviour (Green and Murphy, 2014). In addition to this, it is suggested that there is a need for young people to recognise their own needs and have some idea of what they want from services in order to be more receptive to work addressing their health needs. There is also the issue of the young people often leading chaotic lives which will interfere with their ability to engage (for example, they fail to attend appointments due to lack of structure/routine or they need to care for family members). Common factors effecting young people’s engagement with services will also affect their attendance at school, this includes poor mental health (low mood/depression, anxiety and behavioural conditions etc.) as well as substance use and, in some cases, bullying interfering with their ability to maintain routine and appointments. This is of particular concern as chaotic lifestyles are likely to contribute to poor health which was supported in the findings related to young carers by Doran et al. (2003).

3.4 Wider Health Needs

This key theme covers young people’s understanding of broader health needs and the rising impact of technology on physical and mental health. There have been references to the awareness of wider health needs throughout the analysis. Although the assessment tools can
provide useful information regarding the health needs of young offenders, there tends to be a lack of broader health needs being addressed within the Youth Offending Service. Things like young people being registered with general health services (such as having a general practitioner or a dentist) are taken for granted and could provide a useful ongoing hub for young people which is separate from YOS involvement. There is also a need to recognise the impact of physical health on mental health and vice versa. ‘Poor physical health can lead to an increased risk of developing mental health problems. Similarly, poor mental health can negatively impact on physical health, leading to an increased risk of some conditions’ (Mental Health foundation, 2016: 1). There also needs to be recognition of changes in physiology which will affect the behaviour of young people and Blakemore et al. (2010) discuss the physical and hormonal changes during puberty which affects many aspects of an adolescent’s life. There is also a need to recognise that some young people and their families may not consider basic health as a priority, especially when the young person or their family are struggling financially. This is where the link to deprivation effects a young person’s access to broader health services which will also affect other aspects of their life. This is supported by Alaimo et al. (2001: 781) who state that ‘poverty adversely affects children’s growth, cognitive development, academic achievement, and physical and emotional health’. This is because families experiencing deprivation are less likely to be able to fund a healthy diet, regular physical activities or over-the-counter medicines/prescriptions (for those over 16 who are NEET). There are also health issues developing which are unique to this generation due to the growing availability of and dependency on technology. There has been an increase in health problems related to the use of technology, such as watching television, gaming, social media and using the internet. These are primarily associated with mental health and a study by Niemz et al. (2005) found that excessive use of the internet caused academic, social and personal problems while Primack et al. (2010) found a link between television exposure and increased odds of depressive symptoms in young people. In addition to this, Cleland Woods and Scott (2016) found young people who were emotionally involved with social media experienced poor sleep, low self-esteem and high levels of anxiety and depression. The analysis found that services often neglected these new health issues in their assessments which means that there is a group of health needs which have not been addressed.

4. Strategic Context

4.1 The Southampton Youth Justice Strategy 2014 – 2017 sets out the strategic vision for Youth Justice Services in the city. The strategy was develop by the Youth Offending Service team alongside key stakeholders and partners including Southampton Voluntary Services (SVS), Hampshire Constabulary, West Hampshire Youth Bench, Solent University and the Southampton Resettlement Forum. The most recent update of the Strategy was adopted by Southampton City Council in March 2016.

The Strategy sets out four key priorities for Youth Offending Services in Southampton:
- Reduce youth crime
- Reduce first time entrants to the youth justice system
- Reduce custody
- Reduce re-offending

4.2 The Youth Justice Strategy supports and aligns with the Southampton Safe City Strategy 2014-2017, which has the following key priorities:
- Reduce crime and anti-social behaviour
- Reduce the harm caused by drugs and alcohol
- Protecting vulnerable people
The Southampton Safe City Strategic Assessment was published in 2015. The full assessment can be found using the following link: https://www.southampton.gov.uk/council-democracy/partnership-working/safe-city.aspx

The following conclusions / recommendations are made:

### YOS responses to Southampton Strategic Assessment recommendations:

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<th>Recommendation</th>
<th>Our response</th>
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<td>Some key outcomes for children and young people in Southampton are poorer than the national average; many of which are risk factors for youth offending. Improving education and economic outcomes for young people who are at risk of offending should be a key priority in order to break the cycle of youth offending in the city.</td>
<td>We are reviewing our Education Pathway which clearly sets out how the YOS will work with partners to improve education, training and employment outcomes for young people. Our restorative practice and early intervention work, alongside our accredited arts programme also supports this priority.</td>
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<td>Outcomes for children in respect of reoffending, first time entrants and custody are improving. However, these areas should continue to be an area of focus for the Partnership in order to drive further performance improvement in line with national and comparator areas.</td>
<td>We have reviewed our Priority Young People and Joint Decision Making Panel processes. We are exploring opportunities to pilot joint decision making for young adults and a problem solving court approach to sentencing in Southampton.</td>
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<td>Partnership working is key to creatively meet the needs of young people involved in the Youth Justice System and to strengthen the early intervention response that is essential for driving forward the best outcomes for the city’s children and young people.</td>
<td>We can evidence creative partnership working across a variety of sectors. We are now using our live tracker information to brief voluntary sector partners on emerging risks or trends. This will support partnership working and help to identify opportunities for future development.</td>
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<td>The Partnership should continue to focus on outcomes for priority groups, such as looked after children. Specifically a process should be developed whereby the YOS is involved at the earliest opportunity in order to effect positive influence for children at risk of contact with the Youth Justice System.</td>
<td>The Southampton Corporate Parenting Board will monitor an improvement plan in respect of youth justice outcomes for looked after children in 2016 / 17. Southampton City Council is a signatory for the Hampshire and Isle of Wight protocol to reduce offending and criminalisation of Looked After Children.</td>
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<td>Restorative justice interventions should continue to be a core component of every young person’s intervention plan; with the wishes and needs of victims being actively considered. Restorative</td>
<td>Restorative justice data is now routinely presented to the YOS Management Board; alongside victim satisfaction feedback.</td>
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justice interventions should be supported by high quality victim impact work.


The Partnership should continue to embrace the whole family approach adopted by the Families Matter Programme and facilitate better outcomes for those most in need by sharing partnership data in support of predictive analytics.

There is a youth justice contribution to the Families Matter Programme at a strategic level, with the YOS Manager attending the local project board.

Operationally, three Families Matter workers are aligned to the YOS team.

The Partnership should seek to have a regular dialogue with the schools forum on improving pupil experience of bullying in the city.

The YOS Restorative Practice in Schools Project continues to develop and is part of the Southampton Headstart, to improve mental health and wellbeing outcomes for young people in the City.

4.3 Southampton Health and Wellbeing Board is currently updating the Health and Wellbeing Strategy. The new Health and Wellbeing Strategy will be published in 2017 and will set the vision for health and wellbeing across the city. Southampton Youth Offending Service contributes to improving the health of the city by:

- Working with health colleagues to inform and update the Joint Strategic Needs Assessment.
- Identifying and raising awareness of health problems/risk behaviours within its service group.
- Promoting positive health choices through its sexual health and relationships, emotional first aid and smoking cessation work.
- Delivering brief interventions for lower level needs and delivering substance and alcohol misuse, intervention at tier two and three level.
- Referring to services where specialist assessment and treatment is required.

WHO IS AT RISK AND WHY?

5. Health Comparisons between Southampton and England

In regards to health needs, young offenders are a particularly vulnerable group due to their often complex circumstances related to a variety of factors such as their environment, family structure and chaotic lifestyles. An examination of health statistics suggests that there is even more concern surrounding young offenders in Southampton due to the city’s primarily poor health record against the national average. This is discussed in more detail below using figures which were collated from various sources and can be found in the Southampton JSNA Data Compendium (Southampton City Council, 2016) and the National Child and Maternal Health Intelligence Network (Public Health England, 2016; National Child and Maternal Health Intelligence Network, 2016) which can be found by following the links below: http://www.publichealth.southampton.gov.uk/healthintelligence/jsna/data.aspx

http://www.chimat.org.uk/ or http://atlas.chimat.org.uk/

Where possible, appropriate geographies (I-Quanta most similar authorities for police and crime data) have been included for comparisons. Southampton’s statistical neighbours* were
identified as Brighton & Hove, Bristol, Derby, Hillingdon, Hounslow, Luton, Portsmouth, Reading, Sheffield, Slough and Southend-on-Sea.

*Cardiff, Eastbourne, Northampton and Watford are also Southampton’s statistical neighbours but there was no sufficient data for comparison.

5.1 Alcohol and Drug Misuse

Although the Data Compendium did not hold specific trends on the use of alcohol and substances by young people, figures by Public Health England Local Alcohol Profiles show that hospital admissions due to alcohol-specific conditions for under 18s were higher in Southampton than in England. This has been a consistent trend from 03/04-05/06 to 10/11-12/13 and is associated with poorer health outcomes which could affect other health needs. Southampton performed worse than our statistical neighbours, suggesting that this is even more of a concern to address in our work with young people. While there is no differentiation between young people who have been in contact with Southampton YOS and those who have not, it is important to recognise that young people in Southampton are more likely to be admitted to hospital for alcohol-specific conditions. This could indicate unhealthy habits around alcohol use in Southampton’s young people and common alcohol related attitudes and habits need to be considered when working with young offenders in Southampton.

5.2 Births and Healthy Start

The Data Compendium provides a lot of information relating to Births and Healthy Starts in Southampton which is useful for understanding the impact of early years development on health needs in later life. Figures by the Children and Young People’s Benchmarking Tool indicate that the under 18 conception rate is higher in Southampton than in England which is a consistent trend from 1998 to 2013. In addition to this, the Vital Statistics Office for National Statistics have figures which show that the number of live births to women aged under 20 is higher in Southampton than in England which is another consistent trend from 2002 to 2013, although the recent difference is less drastic than previous years. These are associated with poorer health outcomes which could also affect other health needs. Southampton performed similarly to our statistical neighbours, suggesting that this is a common concern for geographies with comparable police and crime data. While there is no differentiation between young women who have been in contact with Southampton YOS and those who have not, it is important to recognise that young women in Southampton are more likely to fall pregnant under the age of 18 and give birth under the age of 20. This could indicate a need for better sex and relationship education as well as better access to contraceptives for Southampton’s young people. The culture and attitudes surrounding teenage parenthood also needs to be taken into consideration when working with young offenders in Southampton.

The Children and Young People’s Benchmarking Tool also show that the percentage of mothers (all ages) breastfeeding at initial feed is lower in Southampton than in England and although this is inconsistent with previous trends from 2010/11 to 2014/15, the percentage of mothers breastfeeding at 6 to 8 week check is also lower in Southampton than in England, which has been a consistent trend from 2010/11 to 2013/14. These are associated with poorer health outcomes which could affect other health needs. Southampton performed worse than our statistical neighbours who held data, suggesting that this is even more of a concern in regard to the health of our young people. While there is no differentiation between young people who have been in contact with Southampton YOS and those who have not, it is important to recognise that young people in Southampton are less likely to have been
breastfed at initial feed or breastfed at 6 to 8 week check. This could mean that Southampton’s young people are less likely to have benefitted from the health benefits associated with breastfeeding which could mean a higher prevalence of some health conditions such as type 2 diabetes and obesity. Although there are no direct implications for work with young offenders, this provides a useful background to some origins of health needs. For example, this may contribute to the high rate of childhood obesity in Southampton which will be discussed later.

In addition to this, Health and Social Care Information Centre figures show that the percentage of mothers (all ages) smoking at delivery was higher in Southampton than in England which is a consistent trend from 2010/11 to 2013/14. This is associated with poorer health outcomes which could affect other health needs. There was a mixture of results from our statistical neighbours, suggesting that this is sometimes a concern in regard to the health of young people from statistically similar geographies. While there is no differentiation between young people who have been in contact with Southampton YOS and those who have not, it is important to recognise that young people in Southampton are more likely to be exposed to cigarette chemicals before they were born. This could mean that Southampton’s young people are more likely to suffer from the effects of having a mother who smoked during pregnancy which could mean a higher prevalence of illnesses such as asthma. Although there are no direct implications for work with young offenders, this provides a useful background to some origins of health needs.

Despite Southampton’s poor health record for teenage pregnancy, breastfeeding and smoking during pregnancy, there are some Births and Healthy Start figures where Southampton is currently performing better than England. For example, the Vital Statistics Office for National Statistics reports that low birth weight of term babies is lower in Southampton than in England which is associated with better health outcomes (although there has not been a consistent trend from 2005 to 2014). In addition to this, Public Health Outcomes Framework show that infant mortality rates are lower in Southampton than in England which is associated with better health outcomes and is a consistent trend from 2001-03 to 2011-13 (although there has been some instability). Finally, Primary Care Mortality Database shows that child mortality rates are currently similar for Southampton and England which is inconsistent with the trend from 2007-09 to 2011-13 as Southampton was previously lower. This is also associated with better health outcomes meaning that these are less likely to affect other health needs. Although Southampton performed better for low birth rates, there was a mixture of results from our statistical neighbours for infant mortality rates. This suggests that physical and emotional health related to these factors is less of a concern for young people in Southampton than for the young people of our statistical neighbours. While there is no differentiation between young people who have been in contact with Southampton YOS and those who have not, it is important to recognise that young people in Southampton are less likely to have a low birth weight or lose siblings in infancy or childhood. This could mean that Southampton’s young people are less likely to suffer from health risks associated with low birth weight and are also less likely to experience the emotional impact of the death of their siblings. Although there are no direct implications for work with young offenders, this provides context to the health needs of young people in Southampton.

5.3 Dental Health

Figures from North West Public Health Observatory show that the rate of damaged, missing and filled teeth in children under 5 was higher in Southampton than in England in 2012 (no previous information to determine trends). This is associated with poorer health outcomes.
which could affect other health needs. Southampton performed similarly to our statistical neighbours, suggesting that this is a common concern for geographies with comparable police and crime data. While there is no differentiation between young people who have been in contact with Southampton YOS and those who have not, it is important to recognise that young people in Southampton are more likely to have damaged, missing or filled teeth by the time they are 5. This could mean that Southampton’s young people are more likely to suffer from health risks associated with poor dental health, such as gum disease and diabetes, and this may also indicate other health risks such as high sugar intake which is associated with more health problems such as obesity and heart disease. Although there are no direct implications for work with young offenders, this provides a useful background to some origins of health needs.

5.4 Deprivation and Poverty

The figures on Deprivation and Poverty show that Southampton rates poorly against England in all areas. This is a particular concern as associated health outcomes in all areas have a negative impact which effects the most deprived the most negatively. Figures from HM Revenue and Customs shows that Southampton has a higher percentage of children (under 16) in poverty than England which is a consistent trend from 2006 to 2013. This is associated with poor health outcomes and is likely to affect other health needs. In addition to this, the Department for Education show that Southampton has a higher percentage of pupils in state-funded nursery, primary and secondary schools known to be eligible for and claiming free school meals than England which is a consistent trend from 2011 to 2015. This is also associated with poor health outcomes which is likely to affect other health needs. This was consistent for all statistical neighbours which reinforces the link between deprivation and crime and it also suggests that poverty is an influential factor in police and crime data. While there is no differentiation between young people who have been in contact with Southampton YOS and those who have not, it is important to recognise that young people in Southampton are more likely to live in poverty and be eligible for or claim free school meals. This could mean that Southampton’s young people are more likely to suffer from the effects of deprivation and poverty which is linked to health inequalities such as stress and mental health. In addition to this, there may be bullying at school due to the dependence on free school meals which could lead to further health concerns, particularly concerns around mental health. This needs to be considered when working with young offenders in Southampton, especially as young offenders are more likely to be experiencing deprivation and poverty.

5.5 Economy

Figures from Public Health Outcomes Framework show Southampton having a consistently high percentage of 16-18 year olds not in education, employment or training (NEET) from 2011 to 2014. However, recent information from the Southampton Youth Offending Service Education Pathway 2016 shows that the number is improving: the Southampton NEET percentage in 2010 / 11 was 9.8%; in 2015 / 16 it was 4.7%. This was 0.5% higher than the national average and lower than all core cities. Being NEET can be indicative of failing to engage with wider service offers, including health. This could mean that Southampton’s young people are less likely to benefit from health knowledge and health services gained or accessed via places of education, work or training or wider service access. In addition to this, the NEET category may also be at risk of long term damage to their health. This needs to be considered when working with young offenders in Southampton, especially as young offenders are more likely to be NEET.
5.6 Education

Southampton also has mixed health record in relation to Education. Figures from the Department for Education: LAIT show that permanent exclusions from state-funded schools are higher in Southampton than in England. This is a mostly consistent trend from 2010/11 to 2013/14 and supported by the National Child and Maternal Health Intelligence Network which records the percentage of permanent and fixed exclusions from secondary schools as significantly worse for 2012/13 with no change in trends. The National Child and Maternal Health Intelligence Network also reports Southampton’s fixed period exclusion percentage as the worst in England which is associated with poorer health outcomes. There was a mixture of results from our statistical neighbours, suggesting that this is sometimes a concern to address in the work with young people from statistically similar geographies. In addition to this, Public Health Outcomes Framework figures show that the percentage of half days missed by pupils due to overall absence is higher in Southampton than in England which is a consistent trend from 2010/11 to 2013/14 and is also associated with poorer health outcomes. There was a mixture of results from our statistical neighbours, suggesting that this is sometimes a concern to address in the work with young people from statistically similar geographies. In addition to this, recent information from the Southampton Youth Offending Service Education Pathway 2016 shows that Southampton’s Overall Secondary Absence for the Autumn Term 2015 was 4.8% and ranked 94th out of 152 Local Authorities nationally. The national average for this term was 4.6% which means Southampton’s performance of 4.8% was slightly above the national average. Information from the Education Pathway also shows that Southampton’s Secondary School Persistent Absence for the Autumn Term 2015 was 11.6% and ranked 60th out of 152 Local Authorities nationally. The national average was 12.1% which means Southampton’s performance of 11.6% was slightly below the national average. While there is no differentiation between young people who have been in contact with Southampton YOS and those who have not, it is important to recognise that, while trends are improving, young people in Southampton are still more likely to be permanently excluded or have absences from school. In addition to this, while young people from Southampton are also slightly less likely to be persistently absent from secondary school, Southampton does have higher absences within secondary schools. This could mean that Southampton’s young people are missing out on health education as well as being at risk of negative lifestyles as a result of not attending school. This needs to be taken into consideration when working with young offenders in Southampton, especially as young offenders are more likely to be excluded or miss school for other reasons.

Regarding Special Education Needs (SEN) the percentage of pupils with SEN support is also higher in Southampton than in England, another consistent trend from 2009 to 2015. Therefore, the YOS needs to be considering the educational needs of young people in contact with the service robustly, as part of broader assessments of risk and need.

5.7 Housing

Figures from Public Health Outcomes Framework show that Statutory Homelessness Acceptances are lower in Southampton than in England which was consistent from 2010/11-2011/12. Figures also show that there are less households in temporary accommodation in Southampton than in England which was also consistent from 2010/11-2011/12. These are associated with better health outcomes and while there is no differentiation between young people who have been in contact with Southampton YOS and those who have not, it is important to recognise that young people in Southampton are less likely to experience...
statutory homelessness or temporary accommodation. This could mean that Southampton’s young people are less likely to experience disruption due to homelessness as well as the mental health concerns associated with this. Although there are no direct implications for work with young offenders, this provides context to the health needs of young people in Southampton.

5.8 Mental Health

Although there is no age differentiation for Mental Health figures, young people in Southampton may still be affected by the prevalence of mental health issues, either experiencing it themselves or living with a parent experiencing mental health problems. Figures from Quality and Outcomes Framework show that crude mental illness prevalence is higher in Southampton than in England which has been a consistent trend from 2006/07 to 2012/13. They also show that Southampton has a higher depression prevalence than England, another consistent trend from 2008-09 to 2011-12. While these differences could be the result of better recording in Southampton, these trends are associated with poorer health outcomes which are likely to affect other health needs. In addition to this, NHS IC Indicator Portal shows that mortality from suicide and injuries of undetermined intent is higher in Southampton than in England which is a mostly consistent trend from 2003-05 to 2010-12. This could also be the result of better recording in Southampton, however this is still associated with poorer health outcomes which is likely to affect other health needs. While there is no differentiation between young people who have been in contact with Southampton YOS and those who have not, it is important to recognise that young people in Southampton are more likely to be affected by crude mental illness, depression and mortality from suicide and injuries of undetermined intent. This could mean that Southampton’s young people are more likely to experience mental health problems as well as being more likely to have a significant adult who experiences mental health problems. The wider affects surrounding mental health needs to be taken into consideration when working with young offenders in Southampton.

5.9 Obesity

Earlier sections alluded to Southampton having a poor health record in relation to childhood obesity, this is evident in figures from HSCIC NCMP showing that the prevalence of overweight (including obese) children in Year R is higher in Southampton than in England, although the trends have been inconsistent from 2006/07 to 2014/15. The figures also show that the prevalence of overweight (including obese) children in Year 6 is higher in Southampton than in England which inconsistent with previous trends from 2006/07 to 2014/15. These are associated with poorer health outcomes and could be affecting other health needs. There was a mixture of results from our statistical neighbours, suggesting that this is sometimes a concern in regard to the health of young people from statistically similar geographies. While there is no differentiation between young people who have been in contact with Southampton YOS and those who have not, it is important to recognise that young people in Southampton are more likely to be obese in childhood. This could mean that Southampton’s young people are more likely to be at risk of type 2 diabetes, heart disease and some types of cancer. In addition to this, there have been links to psychological problems such as depression and low self-esteem (this may also be impacted by bullying as a result of obesity). The physical and psychological effects of obesity should be taken into consideration when working with young offenders and planning interventions in Southampton.
In addition to this, the What About YOUth (WAY) survey found that the percentage of 15 year olds who eat 5 portions or more of fruit and veg per day was lower in Southampton than in England in 2014. This is associated with poorer health outcomes and is likely to affect other health needs. The percentage of Southampton’s 15 year olds with a mean daily sedentary time in the last week over 7 hours per day was higher than England in 2014. This is also associated with poorer health outcomes which is likely to affect other health needs. While there is no differentiation between young people who have been in contact with Southampton YOS and those who have not, it is important to recognise that young people in Southampton are less likely to get their recommended amount of fruit and vegetables or their recommended amount of physical activity. This is related to the risk of Southampton’s young people being obese and the health risks associated with obesity. This needs to be taken into consideration when working with young offenders in Southampton.

5.10 Sexual Health

Figures from HPA National Chlamydia Screening Programme show that the uptake of Chlamydia screenings by under 25s was higher in Southampton higher than in England in 2014. Although this is associated with better health outcomes, the sexual health of Southampton’s young people is typically poorer than that of England. For example, the Health Protection Agency found the rate of acute STIs per 100,000 residents (all ages) was higher in Southampton than in England in 2012. This is associated with poorer health outcomes and is likely to affect other health needs. While there is no differentiation between young people who have been in contact with Southampton YOS and those who have not, it is important to recognise that young people in Southampton are more likely to take up Chlamydia screenings but they may also be more likely to have an acute STI. This could indicate a need for better sex and relationship education as well as better access to barrier contraceptives for Southampton’s young people. The culture and attitudes surrounding sex also needs to be taken into consideration when working with young offenders in Southampton.

In addition to this, the Office for National Statistics and Teen Pregnancy Unit also reflect those in Births and Healthy Start, finding that under 18 conception was higher in Southampton than in England which was a consistent trend from 1998-00 to 2010-12. This is associated with poorer health outcomes and is likely to affect other health needs. They also found that under 16 conception was consistently higher in Southampton than in England from 2001-03 to 2010-12 with a lower percentage of Southampton under 16 pregnancies leading to abortion. This is also associated with poorer health outcomes which is likely to affect other health needs. While there is no differentiation between young women who have been in contact with Southampton YOS and those who have not, it is important to recognise that young women in Southampton are more likely to fall pregnant under the age of 18 and less likely to terminate the pregnancy. This could indicate a need for better sex and relationship education as well as better access to contraceptives for Southampton’s young people. The culture and attitudes surrounding teenage parenthood also needs to be taken into consideration when working with young offenders in Southampton.

5.11 Smoking

Southampton also has a poor health record in relation to Smoking, although the figures do not include under 18s, it is important to recognise that young people are likely to be influenced by the attitudes and behaviours of the adults around them. Figures from PHE Local Tobacco Control Profiles show that smoking prevalence was higher in Southampton than in England in 2012 which is associated with poorer health outcomes. In addition to this, Health
and Social Care Information Centre found that the percentage of those setting a quit date that go on to successfully quit in Southampton was slightly lower than in England in 2012 which is inconsistent with the trends from 2006/07 to 2011/12. This is also associated with poorer health outcomes, although previous trends were associated with better health outcomes. Finally, figures from APHO Local Authority Health Profiles show that mortality attributable to smoking (for those over 35) was higher in Southampton than in England which was a consistent trend from 2005-07 to 2009-11. This is associated with poorer health outcomes which could affect other health needs. While there is no differentiation between adults who would have been in contact with Southampton YOS and those who were not, it is important to recognise that adults in Southampton are more likely to smoke and have mortality attributable to smoking while being less likely to successfully quit by a set quit date. This could impact on the health of Southampton’s young people due to being exposed to secondhand smoke, which could lead to problems like bronchitis and cancer, as well as the prevalence of smoking suggesting that it is an acceptable habit. This means that the attitudes and habits surrounding smoking need to be taken into consideration when working with young offenders in Southampton.

6. Summary of Asset Tool Analysis

Methodology

6.1 The quantitative analysis within this report is based on the comparisons between two cohorts of young offenders which are based on the Southampton Assets at start of Interventions (not including Pre-court Interventions, and the Custodial section of Sentences). The start dates for the first cohort are between 1 April 2012 to 31 March 2013 and the start dates for the second cohort are between 1 January 2015 and 31 December 2015. The first cohort comprises of 180 young people while the second cohort comprises of 183 young people. The first cohort is gathered from a financial year due to the information being captured in the original version of the report. Whereas the second cohort is gathered from the most recent calendar year due to changes in assessments which meant that the most recent financial year’s data was not directly comparable. However, we have deemed that the comparisons between the two available cohorts provides a worthwhile analysis and recommend that future research include cohorts from consecutive years where possible.

It is important to recognise that some Asset scores are based on young people’s self-reports which means that they may not accurately reflect all health needs of young offenders. However, there has been cross-referencing with YOS staff to identify where some needs may be skewed by self-reporting methods and these have been identified within the report.

6.2 The qualitative analysis within this report is based on the highest scoring 10% of the second cohort (Southampton Assets with start dates between 1 January 2015 and 31 December 2015) with the evidence provided by the assessor being reviewed for the highest scoring needs/problems. With the exception of Physical Health and Education, Training and Employment, 4 was the highest assigned score for all needs/problems while the highest score for Physical Health was 2 and the highest score for Education, Training and Employment was 3. The highest 18 total Asset scores ranged from 37 to 27 (out of a maximum of 48) and of these 18, 3 had the highest score for three needs/problems, 7 had the highest score for two needs/problems, 6 had the highest score for one need/problems and 2 had no needs/problems within the highest scores. Thinking and Behaviour was a common high-scoring need/problem with half of the young people in highest scoring 10% scoring a 4 for this factor. This is reflected in the entire cohort as Thinking and Behaviour had the most scores
assigned a 4. Physical Health was the least common high-scoring need/problem which is also reflected in the entire cohort as there were no scores above a 2 and only 4 of the 183 young people in this cohort scored a 2 for Physical Health.

6.3 **Emotional & Mental Health**

Analysis suggests that the new cohort of young people have a higher need to address emotional and mental health issues than the previous cohort. All concerns surrounding emotional and mental health have increased from the previous figures.

- 16.4% of young offenders had a formal diagnosis of mental illness, an increase of 1.4% on the 12/13 figures
- 46.4% have had contact with/been referred to mental health services, an increase of 10.4%.
- Of all young offenders, 76.7% of females and 46.4% of males stated they were coming to terms with significant past event/s, this is up from 61% for females and 37% for males.
- 80.0% of females and 47.1% of males, an increase of 28% and 14.1% respectively, had certain current circumstances (e.g. feelings of frustration, stress, sadness, worry/anxiety)
- 63.3% of females and 18.9% of males stated they had deliberately self-harmed which has almost doubled for females from 33% previously, but only up by 3.9% for males

6.4 **Substance Misuse**

Analysis suggests that while fewer young people have used substances, there are more young people experiencing problematic substance use. Although a lower percentage of young people in this cohort have used alcohol, tobacco or cannabis, there is a significant increase on the percentage of young people who see substance use as positive and/or essential to life as well as a higher percentage who report a noticeable detrimental effect on various aspects of their life.

- 70.5% of young offenders have used alcohol, 77.6% tobacco and 71.6% cannabis and 30.5% of those who have used cannabis have also used another illicit drug. This is a decrease from 87%, 85% and 73% for alcohol, tobacco and cannabis respectively but an increase from 21% for other illicit drugs
- Just over a quarter (25.7%) of all young offenders, 28.1% of males and 13.3% of females see substance use as positive and/or essential to life, this was previously at 24% of males and 0% of females
- 28.8% of males and 16.7% of females reported a noticeably detrimental effect on education, relationships, daily functioning which has increased from 26% for males and 3% for females

6.5 **Family and Personal Relationships**

Analysis suggests that while more young people have significant adults who communicate and/or show interest in them, there are also more young people who have experienced abuse in this cohort. The data shows that a higher percentage of young people have experienced abuse while a lower percentage report that significant adults fail to communicate/show interest in them. This could mean that there is a need to focus more on work surrounding dealing and coping with abuse and less need for work surrounding parental or caregiver involvement.

- 38.3% reported a significant bereavement or loss, which has not significantly increased since 12/13
• 46.4% have experienced abuse, this is an increase of 15.6%, and 29.5% report that significant adults fail to communicate with or show care/interest in them which has decreased from 39%.

6.6 **Lifestyles**

The analysis suggests that this cohort of young people were able to make or have access to more positive lifestyle choices. This means that there would be less work surrounding lifestyle for these young people.
• 62.3% reported they had nothing much to do in spare time, this is a decrease of 5.7% from previous figures
• 55.2% reported participation in reckless activity which has not significantly changed
• 45.9% are associating with predominantly pro-criminal peers which has decreased from 66% since the 12/13 figures

6.7 **Perception of self & others**

Analysis suggests that less young people are perceiving themselves as criminals. This is a positive change from the previous cohort as young people are more likely to desist from crime if they don’t perceive themselves as having a criminal identity.
• 14.4% of males and 6.7% of females perceived themselves as having a criminal identity this is a decrease from 21% for males and 9% for females

6.8 **Thinking and Behaviour**

The analysis suggests that there are no significant differences between this cohort of males and the previous cohort. It also suggests that while females are more likely to struggle controlling their temper, they are less likely to take that aggression out on other people. This could explain the significant rise in female self-harm as they are directing their aggression on themselves instead of other people.
• 68.0% of males and 73.3% of females display aggression towards others which has decreased slightly for males from 69% and more significantly for females from 61%
• 61.4% of males and 80.0% of females have a poor control of temper which has not significantly increased for males but has increase by 24% for females.

6.9 **Education, Training and Employment**

Analysis suggests there are no significant differences but some young people’s educational needs are still not being met. In addition to this, the current cohort has a higher percentage of young people who have Special Education Needs and a higher percentage of these have a statement which is likely to have a positive impact on school life due to the official recognition of their needs which should provoke schools to accommodate this. However, YOS should also consider the content and structure of individual work with young people due to the increase in those who have Special Education Needs. In addition to this, although there is a slight increase in the percentage of young people who report difficulties with literacy, there is a bigger difference in the decrease of those who report difficulties with numeracy.
• 25.1% have a Special Education Needs and of these 69.6% have an Education, Health and Care Plan, this has increased from 14% and 60% respectively
• 17.5% reported difficulties with literacy, which has also increased by 1.5% and 10.4% report difficulties with numeracy, which has decreased since 12/13 by 3.6%
The figures on Special Education Needs and Education, Health and Care Plans are likely to be skewed by self-report methods as they do not correlate with figures from the YOS ETE Advisor. The YOS ETE Advisor confirmed that Education, Health and Care Plans were made for 7 young people in 2015 while the figures above would suggest that this number should be 32 young people. In addition to this, although some young people may have Education, Health and Care Plans through the Local Authority or from previous contact with the Youth Offending Service, there may be some confusion regarding Special Education Needs and attending special units for education. It is also worth noting that Education, Health and Care Plans are often the result of emotional and social behavioural issues rather than Special Education Needs.

6.10 **Vulnerability**

The analysis suggests that this cohort of young people are more vulnerable than the previous cohort and are at more risk from both themselves and others. This is linked to the figures in Emotional & Mental Health which suggest that these young people have more complex emotional and mental health needs than the previous cohort. This also reflects the increase in the percentage of young people who have experienced abuse and could be linked to their offending behaviour.

- 16.4% are assessed as high/very high vulnerability risk and previous figures show that 32% were assessed as medium/high vulnerability risk
- 23.5% had indications of being at risk of self-harm or suicide which is an increase of 9.5% from previous figures
- 61.7% are vulnerable as a result of own behaviour which is a 17.7% increase from previous figures
- 42.6% due to the behaviour of other people which is a 10.6% increase from 12/13 figures

6.11 **Multiple needs/problems**

Analysis suggests that less young people have a two or more needs/problems than the previous cohort but more young people have four or more needs/problems. There are also strong links between the different needs/problems.

- 70.5% of young offenders had an asset score of 2 or more (indicates association with offending) recorded for at least two different needs/problem themes which has decreased from 83%
- 54.1% of young offenders had an asset score of 4 or more which has increased from 42%

**LEVEL OF POPULATION NEED**

7. **Detailed Analysis of Risk Factors**

Asset was a structured assessment tool used by Youth Offending Services (YOS) in England and Wales on all young offenders who come into contact with the criminal justice system. It aimed 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 was used to inform court reports so that appropriate intervention programmes could be drawn up. It highlighted any particular needs or difficulties the young person had, so that these would also be addressed. Asset also helped to measure changes in needs and the risk of re-offending over time.
The asset tool contained a range of questions for several particular needs and problems. The nine key needs/problems identified in this paper are:

1. Emotional and Mental Health
2. Substance Misuse
3. Family and Personal Relationships
4. Lifestyle
5. Physical Health
6. Perception of Self and Others
7. Thinking and Behaviour
8. Education, Training and Employment
9. Vulnerability

An asset score was calculated for each of the need/problem ranging from 0 to 4, the score assesses the likelihood of re-offending. This criteria is important in explaining the number of referrals to specialist workers in comparison to asset scores; as in some cases workers will have referred on the basis of their assessment of wider need rather than the offending risk.

<table>
<thead>
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<tbody>
<tr>
<td>0</td>
<td>Not associated</td>
</tr>
<tr>
<td>1</td>
<td>Some association</td>
</tr>
<tr>
<td>2</td>
<td>Associated</td>
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<tr>
<td>3</td>
<td>Strongly Associated</td>
</tr>
<tr>
<td>4</td>
<td>Very Strongly Associated</td>
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7.1 Gender

A total of 249 assets were completed for 180 young offenders in 2012/13 and of those young offenders, 81% are male and 19% female.

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A total of 478 assets were completed for 183 young offenders in 2015 and of those young offenders, 83.6% are male and 16.4% female.

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<tr>
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<tr>
<td>Total</td>
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<td>100.0%</td>
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</tbody>
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7.2 Age

The number of assets completed by age and gender is highlighted within the table below. There are a higher proportion of female offenders aged 15 and under compared to males for both cohorts. Over half of the females were aged 15 or under whereas over half of males were
aged 16 or over. This corresponds with general knowledge on youth crime, where females are more likely to offend at a younger age compared to males (Muncie, 2015).

<table>
<thead>
<tr>
<th>Young Offenders 2012/13</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Females</td>
<td>Percentage</td>
<td>Cumulative %</td>
<td>Males</td>
<td>Percentage</td>
<td>Cumulative %</td>
</tr>
<tr>
<td>10-13</td>
<td>6</td>
<td>13.0%</td>
<td>13.0%</td>
<td>12</td>
<td>5.9%</td>
<td>5.9%</td>
</tr>
<tr>
<td>14</td>
<td>9</td>
<td>19.6%</td>
<td>32.6%</td>
<td>23</td>
<td>11.3%</td>
<td>17.2%</td>
</tr>
<tr>
<td>15</td>
<td>12</td>
<td>26.1%</td>
<td>58.7%</td>
<td>54</td>
<td>26.6%</td>
<td>43.8%</td>
</tr>
<tr>
<td>16</td>
<td>8</td>
<td>17.4%</td>
<td>76.1%</td>
<td>37</td>
<td>18.2%</td>
<td>62.1%</td>
</tr>
<tr>
<td>17</td>
<td>11</td>
<td>23.9%</td>
<td>100.0%</td>
<td>67</td>
<td>33.0%</td>
<td>95.1%</td>
</tr>
<tr>
<td>18</td>
<td>0</td>
<td>0.0%</td>
<td>100.0%</td>
<td>10</td>
<td>4.9%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Totals</td>
<td>46</td>
<td>100.0%</td>
<td>100.0%</td>
<td>203</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Young Offenders 2015</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Females</td>
<td>Percentage</td>
<td>Cumulative %</td>
<td>Males</td>
<td>Percentage</td>
<td>Cumulative %</td>
</tr>
<tr>
<td>10-13</td>
<td>5</td>
<td>16.7%</td>
<td>16.7%</td>
<td>16</td>
<td>10.5%</td>
<td>10.5%</td>
</tr>
<tr>
<td>14</td>
<td>5</td>
<td>16.7%</td>
<td>33.3%</td>
<td>17</td>
<td>11.1%</td>
<td>21.6%</td>
</tr>
<tr>
<td>15</td>
<td>6</td>
<td>20.0%</td>
<td>53.3%</td>
<td>25</td>
<td>16.3%</td>
<td>37.9%</td>
</tr>
<tr>
<td>16</td>
<td>7</td>
<td>23.3%</td>
<td>76.7%</td>
<td>33</td>
<td>21.6%</td>
<td>59.5%</td>
</tr>
<tr>
<td>17</td>
<td>7</td>
<td>23.3%</td>
<td>100.0%</td>
<td>49</td>
<td>32.0%</td>
<td>91.5%</td>
</tr>
<tr>
<td>18</td>
<td>0</td>
<td>0.0%</td>
<td>100.0%</td>
<td>13</td>
<td>8.5%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Totals</td>
<td>30</td>
<td>100.0%</td>
<td>100.0%</td>
<td>153</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

7.3 Looked After Children

There were 11 young offenders (6.0% of cohort) who completed an Asset and were identified as a current Looked After Child at the time of their Asset. Of these 5.2% were males and 10.0% were females. There were a similar amount of young offenders who were a Looked After Child in the previous cohort (5%) but all of these were male.

It is worth noting that Looked After Children are provided with regular healthcare checks and provisions, however these may not be effective if the young person fails to attend reviews.

7.4 Asset Score by Need/Problem

A summary of the average young offender’s asset score and the proportion that scored over 2 by need/problem is shown in the table below. A score of 2 or more highlights the areas that are associated with the young person offending will need further intervention to address needs.

<table>
<thead>
<tr>
<th>Need/Problem</th>
<th>2012/13</th>
<th>2015</th>
<th>Diff. Av. Score</th>
<th>Diff. %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifestyle</td>
<td>2</td>
<td>1.7</td>
<td>-0.3</td>
<td>-14%</td>
</tr>
<tr>
<td>Thinking and Behaviour</td>
<td>2.3</td>
<td>2.4</td>
<td>0.1</td>
<td>-9%</td>
</tr>
<tr>
<td>Substance Use</td>
<td>1.2</td>
<td>1.2</td>
<td>0</td>
<td>-3%</td>
</tr>
</tbody>
</table>
The figures highlighted are the factors which increased or decreased by 10% or more between cohorts. The table shows that the Lifestyle aspect has decreased by 14% from the 2012/13 cohort to the current cohort of young people while Education, Training and Employment and Family and Personal Relationships have increased by 12% and 19% respectively. Perception of Self and Others has increased by 19% while Emotional and Mental Health has increased by a worrying 30%.

7.5 Emotional & Mental Health

7.5.1 The Asset covers eight questions with regard to the emotional and mental health of the young offender.

- 56.9% coming to terms with significant past event/s (e.g. feelings of anger, sadness, grief, bitterness) which has increased from 42% from 12/13
- 55.9% current circumstances (e.g. feelings of frustration, stress, sadness, worry/anxiety) which has increased from 36% from 12/13
- 34.9% concerns about the future (e.g. feelings of worry/anxiety, fear, uncertainty) which has increased from 24% from 12/13
- 16.1% have had a formal diagnosis of mental illness which has increased from 15% from 12/13
- 49.4% have had contact with, or referrals to, mental health services which has increased from 36% from 12/13
- 15.9% affected by other emotional or psychological difficulties e.g. phobias, eating or sleep disorders, suicidal feelings etc... This has increased from 12% from 12/13
- 25.9% deliberately harmed her/himself and 8.6% previously attempted suicide which has increased from 18% and decreased from 9% from 12/13

7.5.2 The graph below shows the percentage by gender who answered ‘yes’ to the questions above for the 2012/13 and 2015 cohorts. A higher proportion of females have answered ‘yes’ to emotional and mental health questions than males and there is a bigger difference between the cohorts of females than the cohorts of males. The percentages for both males and females was consistently higher for the second cohort than the first cohort.
• There are no gender differences in the increase of young people responding ‘yes’ to coming to terms with significant past events in the second cohort but there were two thirds more females (76.7%) coming to terms with significant past events than males (46.4%) in the second cohort.

• The graph also shows one and a half times as many females responding ‘yes’ to current circumstances in the second cohort (80%) compared to those in the first cohort (52%) whereas the differences between the males of both cohorts was an increase of less than one and a half (33% in 12/13 and 47.1% in 15). There were also 32.9% more females dealing with current circumstances than males (47.1%) in the second cohort.
• There was a similar increase in the percentages of young people responding ‘yes’ to concerns about the future for both males and females but there were almost twice as many females (53.3%) with concerns than males (31.4%) in the second cohort.

• The graph shows that the percentage of females with a formal diagnosis of mental illness had more than tripled from 2012/13 (6%) to 2015 (20%) whereas there was no significant difference for males (17% in 2012/13 and 15.7% in 2015) – although it may be interesting to note that this is the only time that the figures for 2012/13 are higher than the figures for 2015 for this need/problem.

• The graph also shows that nearly twice as many females in the second cohort (73.3%) had contact or referrals with mental health services than females in the first cohort (38%) as well as males of both cohorts of young people (36% in 12/13 and 41.2% in 15).

• The percentage of females affected by other difficulties was nearly three times as high for the second cohort (33.3%) than for the first cohort (12%) which is also more than double the males of the second cohort (15%).

• There was also a significant increase in the percentage of females who had deliberately self-harmed, with nearly twice as many in the second cohort (63.3%) than the first cohort (33%), but more notably, this is more than three times as many females reporting self-harm than males (18.9%) within the second cohort.

• The graph also shows that attempted suicide was reported by more than three times as many females in the second cohort (23.3%) than males in the second cohort (7.2%) which is a similar trend in the previous cohort.

Although these gender differences could be the result of social desirability, with the males giving false reports in order to appear less vulnerable, it is also possible that the current cohort of females have greater emotional and mental health needs than the previous cohort of females and the current cohort of males. This needs to be taken into consideration when planning and delivering activities to address the health needs of young offenders.

When looking at the evidence provided by the highest scoring 10% of the current cohort, it is suggested that concerns surrounding emotional and mental health are linked to past behaviours and/or traumatic life experiences. This could explain the gender differences as females were more likely to experience traumatic life events. **This could mean that there is a need to address previous behaviour and/or life experiences during interventions with young people who score highly for Emotional and Mental Health. There is a need to ensure that a young person’s entire life story is taken into consideration when planning interventions as some young people may not acknowledge certain past events as impacting on their current behaviour.**

The analysis shows a link to all key themes for Emotional and Mental Health. Family Life is reflected in the figures and the evidence, primarily for those coming to terms with past experiences. Suitable Services is reflected in the figures and the evidence, particularly with reference to formal diagnoses of mental illness. Ability to Engage is reflected in the figures and the evidence in relation to other difficulties. Wider Health Needs is reflected in the evidence with concerns surrounding the impact of technology.
7.5.3 There were 52.7% of young offender’s asset scores of 2 or more for Emotional and Mental Health (47.8% of males and 81.4% of females) which is a significant increase from 23% from the previous cohort (22% of males and 29% of females). The pie charts show the asset scores for all young offenders separated by cohort, excluding those left blank.

These pie charts demonstrate the differences in scores between the two cohorts and show that less than one quarter (23%) of the original cohort had asset scores of 2 or more compared to nearly half (45%) of the current cohort of young offenders. This suggests that the emotional and mental health needs of the current cohort are greater than those of the previous cohort.

7.6 Substance Misuse

7.6.1 The Asset covers five questions with regard to the substance misuse of the young offender.
  * 4.6% engage in practices which put him/her at particular risk (e.g. injecting, sharing equipment, poly-drug use). This has not increased significantly (4% in 12/13)
• 29.1% see substance use as positive and/or essential to life which has increased by 10.1% from 19% in 2012/13
• 29.9% noticeably detrimental effect on education, relationships, daily functioning. This has decreased slightly from 22% in 2012/13
• 15.9% offending to obtain money for substances which has not decreased significantly (17% in 12/13)
• 27.6% other links to offending (e.g. offending while under influence, possessing/supplying illegal drugs etc.). This has not decreased significantly (29% in 2012/13)

7.6.2 The graph shows the percentage by gender who answered ‘yes’ to the questions above, separated by cohort. A higher proportion of males reported substance misuse issues compared to females and a significantly higher proportion of males offend to obtain money. Comparisons between cohorts show that a higher percentage of females in the current cohort have reported substance misuse issues for all areas with the exception of offending to obtain money.

Substance Misuse – % of young offenders with a ‘Yes’ response (based on those with response given)

• The graph shows that there are no significant differences between cohorts in relation to practices with particular risk, other than this affecting a small percentage of females in the current cohort while this was not an issue for females of the previous cohort and a slight decrease between the male cohorts.

• The graph also shows that females in the current cohort (13.3%) see substance use as positive and/or essential to life compared to no females in the previous cohort. In addition to this, more than twice as many males (28.1%) see substance use as positive and/or essential to life than females in this cohort – this is also a slight increase on the males of the previous cohort (24%).

• More than five times as many females in the current cohort (16.6%) reported that substance use had a noticeably detrimental effect than the females in the previous cohort (3%). In addition to this, nearly twice as many males (28.8%) had reported that substance use had a noticeably detrimental effect than females in the current cohort.
Although the percentage of young people reporting that they had offended to obtain money for substance use has dropped by about 3% for both genders, there were still over five times as many males (17%) reporting that they had offended to obtain money for substance use compared to females (3.3%) in the current cohort.

The graph shows that twice as many females in the current cohort (33.3%) reported other links to offending compared to the previous cohort (16%) whereas males reporting other links to offending had decreased by nearly 10% from 33% in 12/13 to 23.5% in 15. This is also the only issue for substance misuse where females were significantly higher than males in the current cohort, with a difference of nearly 10%.

Although these gender differences could be the result of social desirability, with the females giving false reports in order to appear less vulnerable, it is also possible that the current cohort of males have greater substance misuse needs than the current cohort of females. This needs to be taken into consideration when planning and delivering activities to address the health needs of young offenders.

When looking at the evidence provided by the highest scoring 10% of the current cohort, it is suggested that concerns surrounding substance misuse are linked to a history with or reliance on substances to enhance mood or cope with circumstances. This might explain the gender differences as males were more likely to have a history of substance use as a mood enhancer. This could mean that there is a need to address the underlying causes of substance use during interventions with young people who score highly for Substance Misuse. Although there is a place for harm reduction and abstinence interventions to address the drug using behaviour, therapeutic services should also be offered as an intervention due to the causes of the behaviour being psychological in nature.

The analysis shows a link to all key themes for Substance Misuse. Family Life is reflected in the figures and the evidence, primarily for attitudes towards substance use. Suitable Services is reflected in the evidence, particularly with reference to the suitability of drug services available. Ability to Engage is reflected in the figures and the evidence in relation to detrimental effects. Wider Health Needs is reflected in the evidence with concerns surrounding the physical impact of substance use.

7.6.3 Young offenders are asked whether they are using, have used or never used a range of substances. The type of substance and percentage of young offenders who have/are using are:

- 70.5% of young offenders have used/are using alcohol which has decreased from 87% from 2012/13
- 77.6% tobacco which has decreased from 85% from 2012/13
- 71.6% cannabis which has decreased slightly from 73% in 2012/13. Of those that have used/are using cannabis, 30.5% of these have also used another illicit substance which has increased by nearly 10% from 21% from 2012/13
- 12.6% cocaine which has increased slightly from 11% from 2012/13
- 7.1% amphetamines which has increased slightly from 6% from 2012/13
- Fewer than 20 (<5%) have used any other type of illicit substances which is the same percentage from 2012/13
- 13.1% have never used any substances, which has increased from 5% from 2012/13, and 26.2% are currently not using any substances, which has increased from 21% from 2012/13.
It is important to note that the Assets do not contain specific questions regarding the use of New Psychoactive Substances (also known as “legal highs”) which are considered to be popular amongst young people. This means that there may be missing information on the health needs of young offenders who use New Psychoactive Substances.

7.6.4 The graph shows the percentage by gender who have ‘recently used’ or ‘have ever used’ any of the top 5 substances, separated by cohorts. There are no general trend differences between cohorts but a higher proportion of females in the current cohort are using/have used licit substances (alcohol and tobacco) compared to males of the same cohort who have a higher proportion who are using/have used illicit substances (cannabis, cocaine and amphetamines).

- The graph shows that there is a fifth less use of alcohol in the current cohort of males (68.6%) compared to the previous cohort (85%) and a sixth less alcohol use in the current cohort of females (80%).
- There are no significant differences between cohorts or genders for use of tobacco.
- The graph shows that female use of cannabis has increased by approximately one fifth (56% in 12/13 compared to 66.7% in 15) which removes the gender differences found in the previous cohort (76% for males in 12/13).
- The graph shows that more than three times as many females in the current cohort (10%) reported that they use or have used cocaine compared to the previous cohort (3%) which narrows the gender gap found in the previous cohort (12% for males in 12/13), although
there is still a slightly higher proportion of males in the current cohort (13.1%) who are using or have used cocaine compared to the females in the same cohort.

- There were previously no females who were using or had used amphetamines compared to 6.7% of females from the current cohort. However, there were no significant differences between the two cohorts of males (7% in 12/13 and 7.2% in 15) and no significant gender differences in the current cohort.

This shows that use of the top 5 substances has generally remained the same or decreased from the previous cohort which suggests that this cohort have less substance misuse needs than the previous cohorts. However, it could be the result of young people using different substances than those listed above, especially with the increasing popularity of new psychoactive substances (also known as legal highs). It is interesting that the gender differences are primarily due to the use of licit and illicit substances which may be affected by social desirability if the females of the current cohort gave false reports to avoid disclosure of illegal activity. However, if gender differences are genuine then this needs to be taken into consideration when planning and delivering activities to address the substance misuse of young offenders.

7.6.5 There were 12.3% of young offender’s asset scores of 2 or more for Substance Misuse (13.0% of males and 8.6% of females) which is a significant decrease from 40% from the previous cohort (41% males and 35% females). The pie chart shows the asset scores for all young offenders separated by cohort, excluding those left blank.
These pie charts demonstrate the differences in scores between the two cohorts and show that the proportion of young offenders with an asset score of 2 or more has decreased by nearly one quarter from 40% in 12/13 to 33% in 15. This suggests that the current cohort have less substance misuse needs than the previous cohort.

7.7 Family & Relationships

7.7.1 The Asset covers four questions with regard to the lifestyle of the young offender.
- 11.3% significant adults fail to communicate with or show care/interest in the young person which has decreased from 38% from 2012/13
- 17.8% experience of abuse i.e. physical, sexual, emotional, neglect which has decreased from 31% from 2012/13
- 14.6% significant bereavement or loss which has decreased from 34% from 2012/13
- 21.5% other problems e.g. parent with physical/mental health problem, loss of contact, other stress/tension which has decreased from 48% from 2012/13

7.7.2 The percentage by gender and year who answered ‘yes’ to the questions above can be seen in the graph. The positive responses have generally increased and there are a higher proportion of females at risk for all the indicators in the current cohort.
• The proportion of young people reporting that significant adults fail to communicate with or show care/interest in them has reduced by a third for females (from 45% in 2012/13 to 30% in 15) and a fifth for males (from 36% in 2012/13 to 29.4% in 2015). This change had removed the significant gender differences that were found in the previous cohort.

• The proportion of young people reporting experience of abuse has increased by approximately half for both males (from 30% to 44.4%) and females (from 36% to 56.7%) from 2012/13 to 2015. The gender differences for the current cohort are similar to those of the previous cohort, with slightly more females experiencing abuse than males.

• The graph shows that there has been a slight increase in the proportion of young people reporting significant bereavement or loss with a more significant increase of approximately one fifth for females (33% in 12/13 to 40% in 15) than for males (35% in 12/13 to 37.9% in 15). As with the previous cohort, there are no significant gender differences.

• The proportion of females reporting that there are other problems has increased by approximately one third from 53% in 12/13 to 70% in 15. The proportion of males has also increased but not significantly (47% in 12/13 to 53.6% in 15). This increase for females has created a more substantial gender difference with the proportion of females experiencing other problems being one third higher than the proportion of males.

The only significant gender differences for this need/problem is that more females are experiencing other problems related to family and relationships which means that there is a need to consider this when delivering interventions. Although there has been a decrease in
the proportion of significant adults failing to communicate and show care/interest in the young person, all other indicators have increased which means that there should be less focus on parental/caregiver involvement and more work around dealing with abuse and bereavement.

When looking at the evidence provided by the highest scoring 10% of the current cohort, it is suggested that concerns surrounding family and personal relationships are often linked to witnessing domestic violence or lack of affection/attachment from caregivers as well as the prevalence of pro-criminal attitudes. This could explain gender differences as the females in this cohort were more likely to identify these factors as ‘other problems’. This could mean that there is a need to address poor family dynamics and challenge pro-criminal attitudes during interventions with young people who score highly for Family and Personal Relationships. This could be achieved directly through work with the families or indirectly during conversations with young people. In addition to this, there may also be a place for therapeutic services to deal with previous events for young people who have experienced (either as victims or witnesses) domestic violence or a lack of affection/attachment from caregivers.

The analysis shows a link to some key themes for Family and Personal Relationships. Family Life is reflected in the figures and the evidence for all areas of the need/problem. Suitable Services is not reflected in the figures or the evidence. Ability to Engage is reflected in the evidence in relation to family commitments preventing attendance and engagement. Wider Health Needs is not reflected in the figures or the evidence.

7.7.3 There were 21.7% of young offender’s asset scores of 2 or more for Family and Relationships (20.3% of males and 30.0% of females) which is a significant decrease from 48% from the previous cohort (45% of males and 69% of females). The pie charts shows the asset score for all young offenders separated by cohort, excluding those left blank.
These pie charts demonstrate the differences in scores between the two cohorts and show that the proportion of young offenders with an asset score of 2 or more has increased by approximately one fifth from 49% in 12/13 to 59% in 15. This suggests that the current cohort have greater family and relationships needs than the previous cohort.

### 7.8 Lifestyle

#### 7.8.1 The Asset covers seven questions with regard to the lifestyle of the young offender.

- 7.1% lack age-appropriate relationships which has significantly decreased from 19% from 12/13
- 17.6% associate with predominantly pro-criminal peers which has significantly decreased from 66% in 12/13
- 12.1% lack non-criminal friends which has significantly decreased from 43%
- 23.8% have nothing much to do in spare time which has significantly decreased from 69% in 12/13
- 21.1% participate in reckless activity which has significantly decreased from 55% in 12/13
- 13.4% have inadequate legitimate personal income which has significantly decreased from 52% in 12/13
- 16.1% have other problems (e.g. gambling, staying out late, loneliness etc.) which has significantly decreased from 46% in 12/13

#### 7.8.2 The percentage by gender who answered ‘yes’ to the questions above is shown in the graph below. The proportion of young people reporting Lifestyle indicators has generally decreased or remained the same and the proportion of females is generally higher or similar to the proportion of males.
The graph shows that the proportion of females with a lack of appropriate friendships has increased by more than one half from 15% in 12/13 to 23.3% in 15 whereas the proportion of males has decreased but not significantly (19% in 12/13 to 17.6% in 15). Within the current cohort, the proportion of females is approximately one third higher than the proportion of males who lack age appropriate friendships.

The proportion of young people associating with criminal peers has decreased by approximately one third for both males and females (from 59% in 12/13 to 40% in 15 for females and from 67% in 12/13 to 47.1% in 15 for males). The current proportion of males associating with criminal peers is higher than the proportion of females but this is not a significant difference.

The proportion of young people with a lack of non-criminal friends has decreased by one fifth for females (from 41% in 12/13 to 33.3% in 15) and one quarter for males (from 43% in 12/13 to 31.4% in 15). There are no significant gender differences for the current cohort of young people.
• The proportion of males with nothing to do in their spare time has decreased by approximately one sixth (from 69% in 12/13 to 59.5% in 15) but there is a slight increase in the proportion of females (from 71% in 12/13 to 76.6% in 15) however this is not substantial. In the current cohort, there is a higher proportion (just under one third) of females with nothing to do in their spare time compared to males.

• The proportion of females participating in reckless activity has increased slightly (from 55% in 12/13 to 60% in 15) while the proportion of males has decreased slightly (from 55% in 12/13 to 54.2% in 15) however these are not significant changes. There are also no significant gender differences in the proportion of young people participating in reckless activity.

• The graph shows that the proportion of females with inadequate legitimate personal income has nearly halved (from 58% in 12/13 to 36.7% in 15) while the proportion of males has decreased by approximately one third (from 51% in 12/13 to 34.6% in 15). There are no significant gender differences in the proportions of young people with inadequate legitimate personal income.

• The proportion of young people reporting other lifestyle problems has increased by two fifths for females (from 45% in 12/13 to 63.3% in 15) and decreased by one fifth for males (from 46% in 12/13 to 37.9% in 15). There are more than one and a half times as many females with other lifestyle problems than males in the current cohort.

There are few significant gender differences but these could be the result of response bias, with males wanting to avoid intervention for their lifestyle choices which could explain why all indicators have decreased for males. However it is more likely that the current cohort of females have greater lifestyle needs than the current cohort of males (particularly due to having nothing to do in their spare time and other problems related to lifestyle) and the previous cohort of females (particularly for their lack of appropriate friendships and other problems related to lifestyle). This needs to be taken into consideration when planning and delivering activities to address the health needs of young offenders.

When looking at the evidence provided by the highest scoring 10% of the current cohort, it is suggested that concerns surrounding lifestyle are linked to inappropriate socialisation with pro-criminal peers and adults as well as a lack of productive activities being available which is reflected in the gender differences. This could mean that there is a need to address inappropriate relationships as well as finding productive alternatives use of free time during interventions with young people who score highly for Lifestyle. This could be achieved by identifying specific clubs in the community which would provide young people with productive activities as well as a non-criminal social group. However, these clubs should be accessible so that attendance can be maintained once the young person is closed to YOS. Factors to be considered include participation costs, travel time and costs and age restrictions as well as level of skill required to participate.

It would be useful to further investigate the issue of young people not having anything to do in their spare time with the young people’s perspectives being represented to provide ideas for productive activities they want to engage with.

The analysis shows a link to most key themes for Lifestyle. Family Life is not reflected in the figures or the evidence. Suitable Services is reflected in the evidence, particularly with reference to the availability of services. Ability to Engage is reflected in the figures and the
evidence in relation to all areas of the need/problem. Wider Health Needs is reflected in the figures and the evidence with concerns surrounding the prevalence of technology to use spare time.

7.8.3 There were 19.2% of young offender’s asset scores of 2 or more Lifestyle indicators (18.6% of males and 22.8% of females) which is a significant decrease from 68% from 12/13 (67% of males and 74% of females). The pie charts show the asset score for all young offenders separated by cohort, excluding those left blank.

These pie charts demonstrate the differences in scores between the two cohorts and show that the proportion of young offenders with an asset score of 2 or more has increased slightly from 49% in 12/13 to 51% in 15 which is not a substantial differences. This suggests that the current cohort have similar lifestyle needs to the previous cohort.
7.9  **Physical Health**

7.9.1  The Asset covers six questions with regard to the physical health of the young offender.

- 11.9% health condition which significantly affects everyday life functioning which has not significantly decreased from 12% in 12/13
- 2.3% physical immaturity/delayed development which has decreased from 4% in 12/13
- 0% problems caused by not being registered with GP which has decreased from 1% in 12/13
- 5.2% lack of access to other appropriate health care services (e.g. dentist) which has decreased slightly from 6% in 12/13
- 18.2% health put at risk through his/her own behaviour (e.g. hard drug use, unsafe sex, prostitution) which has increased from 10% in 12/13
- 37.0% other problems (prescribed medication, binge drinking, obesity etc.) which has increased from 21% in 12/13

7.9.2  The graph shows the percentage by gender who answered ‘yes’ to the questions above. There are no general trends in the increase or decrease of the proportion of young people who have physical health indicators but the proportion of females is generally higher or similar to the proportion of males in the current cohort.

- The graph shows the proportion of females with a significant health condition has more than tripled from 6% in 12/13 to 20% in 15 while the proportion of males has reduced by approximately a quarter from 14% in 12/13 to 10.5% in 15. This change has reversed the gender differences and there are now twice as many females than males with a significant health condition.

- The graph shows that there are still no females with delayed physical development and the proportion of males with delayed physical development has nearly halved (from 6% in 12/13 to 3.3% in 15). Therefore there is still a higher proportion of males than females with delayed physical development.
• There are still no females who experience problems due to not having a GP and the proportion of males has reduced from 1% in 12/13 to 0% in 15. There are no longer any gender differences in the proportion of young people who experience problems due to not having a GP.

• The graph shows the proportion of females with a lack of access to other health care has more than tripled from 3% in 12/13 to 10% in 15 while the proportion of males has nearly halved from 6% in 12/13 to 3.3% in 15. This change has reversed the gender differences and there are now more than three times as many females than males who lack access to other health care.

• The proportion of young people with their health at risk through their own behaviour has increased by nearly one quarter for females (from 21% in 12/13 to 26.7% in 15) and by one half for males (from 7% in 12/13 to 10.5% in 15). The differences in the increase has slightly reduced the gender differences from three times as many females with their health at risk through their own behaviour to two and a half times as many females than males.

• The proportion of young people with other health problems has increased by nearly one half for females (from 21% in 12/13 to 30% in 15) and by one quarter for males (from 26% in 12/13 to 32% in 15). The differences in the increase has removed the slight gender difference and although there is still a higher proportion of males with other health problems, this is not a significant difference.

These gender differences are unlikely to be the result of response bias as they are primarily objective measures. This means that the current cohort of females have far greater physical health needs than the previous cohort and the current cohort of males. This needs to be taken into consideration when planning and delivering activities to address the health needs of young offenders.

When looking at the evidence provided by the highest scoring 10% of the current cohort, it is suggested that concerns surrounding physical health are linked to risky behaviour leading to physical harm to self which is reflected in the gender differences. This could mean that there is a need to address personal safety during interventions with young people who score highly for Physical Health. There is also a need to raise awareness around health services available to young people as well as providing general health education.

The analysis shows a link to all key themes for Physical Health. Family Life is reflected in the figures and the evidence, primarily for related to events effecting early physical development. Suitable Services is reflected in the figures and the evidence, particularly with reference to accessing health care. Ability to Engage is reflected in the evidence in relation to physical conditions affecting engagement. Wider Health Needs is reflected in the figures and the evidence with concerns surrounding the understanding of broader health needs.

7.9.3 There were 0.8% of young offender’s asset scores of 2 or more for physical health which is a decrease from 3% from 2012/13. The pie charts show the asset score for all young offenders separated by cohort, excluding those left blank.
These pie charts demonstrate the differences in scores between the two cohorts and show that the proportion of young offenders with an asset score of 2 or more has remained the same at 2% for both the 2012/13 and 2015 cohort. This suggests that the current cohort have similar physical needs to the previous cohort and this is not a priority.

7.10 **Perception of Self & Others**

7.10.1 The Asset covers two questions with regard to the Perception of Self & Others of the young offenders.

- 18.4% display discriminatory attitudes towards others (e.g. race, ethnicity, religion, gender, age, class, disability etc.) which has increased from 9% from 12/13
- 17.4% perceive him/herself as having a criminal identity which has decreased slightly from 18% from 12/13
7.10.2 The graph shows the percentage by gender who answered ‘yes’ to the questions above. A higher proportion of males have perceive themselves as being discriminatory and having a criminal identity than do females.

The graph shows that the proportion of young people displaying discriminatory attitudes has increased by approximately one half for both genders, from 9% in 12/13 to 13.3% in 15 for females and from 9% in 12/13 to 14.4% in 15 for males. The similar increase for both genders means that there is still no significant gender difference, however the proportion of males is slightly higher than the proportion of females displaying discriminatory attitudes.

The proportion of young people who perceive themselves as having a criminal identity has decreased by approximately one quarter for both genders, from 9% in 12/13 to 6.7% in 15 for females and from 21% in 12/13 for males to 15% in 15 for males. The similar increase for both genders means that there are still over twice as many males as females who perceive themselves as having a criminal identity.

The only significant gender difference is for the self-perception as a criminal which could be the result of labelling, particularly if the males have experienced more negative attitudes in response to their behaviour. This means that the current cohort of males might be more vulnerable to the perceptions of others compared to the current cohort of females. This needs to be taken into consideration when planning and delivering activities to address the health needs of young offenders. However, the self-perception as a criminal has reduced for both gender which means they are more likely to desist from offending as criminal behaviour isn’t integral to their identity.

When looking at the evidence provided by the highest scoring 10% of the current cohort, it is suggested that concerns surrounding perception of self and others are linked to criminal identities and mistrust for people in authority. The evidence found that criminal identities were common in the highest scoring males which reflects the gender differences, however the mistrust for people in authority was more common in the highest scoring females. This could mean that there is a need to address personal identity and explore where underlying trust issues stem from during interventions with young people who score highly for...
Perception of Self and Others. It is also important to recognise that mistrust for people in authority is likely to impact engagement as YOS workers will be seen as people in authority which may act as a barrier for some young people.

The analysis shows a link to some key themes for Perception of Self and Others. Family Life is reflected in the figures and the evidence, primarily for attitudes displayed. Suitable Services is not reflected in the figures or the evidence. Ability to Engage is reflected in the figures and the evidence in relation to labelling. Wider Health Needs is not reflected in the figures or the evidence.

7.10.3 There were 10.5% of young offender’s asset scores of 2 or more for Perception of Self & Others (10.0% of males and 12.9% of females) which is a significant decrease from 27% from 2012/13 (29% of males and 21% of females). The pie charts show the asset score for all young offenders separated by cohort, excluding those left blank.

Perception of Self & Others – Asset Score 12/13

Perception of Self & Others – Asset Score 15
These pie charts demonstrate the differences in scores between the two cohorts and show that the proportion of young offenders with an asset score of 2 or more has increased from 27% in 2012/13 to 40% in 2015. This suggests that the current cohort have greater Perception of Self and Others needs to the previous cohort.

7.11 Thinking and Behaviour

7.11.1 The Asset covers ten questions with regard to the Thinking and Behaviour of young offenders.

- 52.7% lack understanding of consequences which has increased from 37% from 12/13
- 78.5% Impulsiveness which has increased slightly from 75% from 12/13
- 46.9% have a need for excitement which has increased slightly from 44% from 12/13
- 45.0% give in easily to pressure from others which has decreased from 53% from 12/13
- 71.5% with a poor control of temper which has increased from 60% from 12/13
- 24.1% with inappropriate social & communication skills which has increased from 14% from 12/13
- 57.3% Destruction of property which has increased from 38% from 12/13
- 75.3% display aggression towards others which has increased from 67% from 12/13
- 13.2% exhibiting sexually inappropriate behaviour which has increased from 7% from 12/13
- 39.1% attempts to manipulate / control others which has significantly increased from 20% from 12/13

7.11.2 The graph shows the percentage by gender who answered ‘yes’ to the questions above. The proportion of young people with Thinking and Behaviour indicators has generally increased or remained the same and there was a higher proportion of females for all areas.
Thinking and Behaviour – % of young offenders with a ‘Yes’ response (based on those with response given)

<table>
<thead>
<tr>
<th>Thinking and Behaviour</th>
<th>Male</th>
<th>2012/13</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of understanding of consequences</td>
<td>Male</td>
<td>39%</td>
<td>50.3%</td>
</tr>
<tr>
<td>Female</td>
<td>30%</td>
<td>73.3%</td>
<td></td>
</tr>
<tr>
<td>Impulsiveness</td>
<td>Male</td>
<td>77%</td>
<td>69.9%</td>
</tr>
<tr>
<td>Female</td>
<td>64%</td>
<td>86.7%</td>
<td></td>
</tr>
<tr>
<td>Need for excitement</td>
<td>Male</td>
<td>46%</td>
<td>42.5%</td>
</tr>
<tr>
<td>Female</td>
<td>33%</td>
<td>50.0%</td>
<td></td>
</tr>
<tr>
<td>Giving in easily to pressure from others</td>
<td>Male</td>
<td>53%</td>
<td>41.8%</td>
</tr>
<tr>
<td>Female</td>
<td>53%</td>
<td>50.0%</td>
<td></td>
</tr>
<tr>
<td>Poor control of temper</td>
<td>Male</td>
<td>61%</td>
<td>61.4%</td>
</tr>
<tr>
<td>Female</td>
<td>56%</td>
<td>80.0%</td>
<td></td>
</tr>
<tr>
<td>Inappropriate social and communication skills</td>
<td>Male</td>
<td>15%</td>
<td>22.2%</td>
</tr>
<tr>
<td>Female</td>
<td>12%</td>
<td>30.0%</td>
<td></td>
</tr>
<tr>
<td>Destruction of property</td>
<td>Male</td>
<td>41%</td>
<td>51.0%</td>
</tr>
<tr>
<td>Female</td>
<td>21%</td>
<td>60.0%</td>
<td></td>
</tr>
<tr>
<td>Aggression towards others</td>
<td>Male</td>
<td>69%</td>
<td>68.0%</td>
</tr>
<tr>
<td>Female</td>
<td>61%</td>
<td>73.3%</td>
<td></td>
</tr>
<tr>
<td>Sexually inappropriate behaviour</td>
<td>Male</td>
<td>8%</td>
<td>12.4%</td>
</tr>
<tr>
<td>Female</td>
<td>3%</td>
<td>23.3%</td>
<td></td>
</tr>
<tr>
<td>Attempts to manipulate others</td>
<td>Male</td>
<td>24%</td>
<td>28.1%</td>
</tr>
<tr>
<td>Female</td>
<td>66%</td>
<td>60.0%</td>
<td></td>
</tr>
</tbody>
</table>
The graph shows that the proportion of young people who lacked understanding of consequences increased by approximately one quarter for males (39% in 12/13 to 50.3% in 15) and more than doubled for females (30% in 12/13 and 73.3% in 15). This reversed the previous gender difference with a higher proportion of females than males lacking understanding of consequences by approximately one half.

The proportion of females who reported impulsiveness had increased by approximately a third (from 64% in 12/13 to 86.7% in 15) while the proportion of males who reported impulsiveness decreased by about one tenth (from 77% in 12/13 to 69.9% in 15). This reverses the gender differences with a quarter more females than males reporting impulsiveness.

The graph shows that the proportion of females with a need for excitement has increased by approximately one half from 33% in 12/13 to 50% in 15 while the proportion of males has remained similar (46% in 12/13 and 42.5% in 15). This has reversed the gender differences with a higher proportion of females than males now reporting a need for excitement.

The graph shows that the proportion of males who give in easily to pressures from others has decreased by approximately one fifth from 53% in 12/13 to 41.8% in 15 while the proportion of females has remained similar (53% in 12/13 and 50% in 15). This has created a gender differences with a higher proportion of females than males now reporting that they give in easily to pressures from others.

The proportion of females with poor control of temper has increased by approximately one half (from 56% in 12/13 to 80% in 15) while the proportion of males with poor control of temper has remained similar (61% in 12/13 to 61.4% in 15). This reverses the gender differences with about a third more females than males reporting poor control of temper.

The graph shows that the proportion of young people who had inappropriate social and communication skills increased by approximately one quarter for males (15% in 12/13 to 22.2% in 15) and more than doubled for females (12% in 12/13 and 30% in 15). This has created a gender difference with about a third more females having inappropriate social and communication skills compared to males.

There has been an increase in the proportion of young people who reported destruction of property by approximately one quarter for males (41% in 12/13 to 51% in 15) and by almost triple for females (21% in 12/13 and 60% in 15). This has reversed the gender difference with approximately one sixth more females reporting destruction of property compared to males.

The graph shows that the proportion of females who display aggression towards others has increased by approximately one fifth from 61% in 12/13 to 73.3% in 15 while the proportion of males has remained similar (68% in 12/13 and 69% in 15). Although there is a higher proportion of females than males who display aggression towards others, there are no significant gender differences.

The graph shows that the proportion of females with sexually inappropriate behaviour has increased by nearly eight times from 3% in 12/13 to 23.3% in 15 while the proportion
of males has increased by over one half (8% in 12/13 and 12.4% in 15). This has reversed the gender differences with nearly twice as many females reporting sexually inappropriate behaviour compared to males.

- The proportion of females reporting attempts to manipulate others has decreased slightly from 66% in 12/13 to 60% in 15 while the proportion of males has increased slightly from 24% in 12/13 to 28.1% in 15. The gender difference has remained similar with over twice the amount of females reporting attempts to manipulate behaviour than males.

The gender differences could be the result of social desirability with males wanting to appear to have more control over their thinking and behaviour. However, if the results are genuine, this means that the current cohort of females have greater thinking and behaviour needs than to the current cohort of males and the previous cohort of young people. This needs to be taken into consideration when planning and delivering activities to address the health needs of young offenders.

When looking at the evidence provided by the highest scoring 10% of the current cohort, it is suggested that concerns surrounding thinking and behaviour are linked to traumatic life experiences, poor family structure/parental control, negative peer relationships and behavioural and mental health problems. This validates the gender differences as females have been observed as having more experience of each of these factors. This could mean that there is a need to address multiple areas of influence during interventions with young people who score highly for Thinking and Behaviour. Once again, therapeutic services may be an effective intervention for addressing this need/problem, especially Cognitive Behavioural Therapy which could help young people to change how they think and what they do.

The analysis shows a link to all key themes for Thinking and Behaviour. Family Life is reflected in the figures and the evidence, primarily for past experiences effecting current thinking and behaviour. Suitable Services is reflected in the figures and the evidence, particularly with reference to finding services which suit their needs. Ability to Engage is reflected in the figures and the evidence in relation to all areas of the need/problem. Wider Health Needs is reflected in the evidence with concerns surrounding understanding of broader health needs.

7.11.3 There were 29.1% of young offender’s asset scores of 2 or more for Thinking and Behaviour (27.9% of males and 35.7% of females) which is a significant decrease from 86% from 12/13 (88% of males and 79% of females). The pie charts show the asset score for all young offenders separated by cohort, excluding those left blank.
These pie charts demonstrate the differences in scores between the two cohorts and show that the proportion of young offenders with an asset score of 2 or more has decreased slightly from 86% in 12/13 to 77% in 15 which is not a substantial difference. This suggests that the current cohort have similar thinking and behaviour needs to the previous cohort.

7.12 **Education, Training & Employment**

#### 7.12.1 The Asset covers three questions with regard to Education, Training and Employment.

- 27.8% of young offenders had an SEN (an increase from 14% in 12/13)
- 19.2% have difficulties with literacy (an increase from 16% in 12/13)
- 10.7% have difficulties with numeracy (a decrease from 14% in 12/13)

#### 7.12.2 The graph shows the percentage by gender who answered ‘yes’ to the questions above. There was no general trend in differences between cohorts but there was a higher proportion of males for each indicator.
The graph shows that the proportion of young people identified as having SEN has increased slightly for females (from 12% in 12/13 to 16.7% in 15) and almost doubled for males (from 14% in 12/13 to 26.8% in 15). This increased the gender difference with over a half more males identified as SEN than females.

The proportion of females with difficulties with literacy has decreased by approximately one half from 6.7% in 12/13 to 14% in 15 while the proportion of males has increased slightly from 17% in 12/13 to 19.6% in 15. This change has created a gender differences with nearly three times as many males identified as having difficulties with literacy compared to females.

The proportion of females with difficulties with numeracy has decreased by approximately one half from 6.7% in 12/13 to 14% in 15 while the proportion of males has decreased by approximately one fifth from 14% in 12/13 to 11.1% in 15. This change has created a gender differences with nearly twice times as many males identified as having difficulties with numeracy compared to females.

It is possible that the current cohort of males have greater educational needs than to the current cohort of females and the previous cohort of young people. This needs to be taken into consideration when planning and delivering activities to address the health needs of young offenders. Although it should be noted that these figures are vulnerable to self-report, enquiries with the YOS ETE Advisor suggests that just over 20% of the current cohort have an Education Health and Care Plan and a further 47% have some form of special educational needs. Therefore, it would be useful to identify what SEN the young offenders have and whether there are other learning difficulties to accommodate.

When looking at the evidence provided by the highest scoring 10% of the current cohort, it is suggested that concerns surrounding education, training and employment are linked to poor relationships with school staff and peers, lack of attendance and/or restricted options. This was not captured by the quantitative analysis and therefore cannot validate the gender differences. This could mean that there is a need to address social skills and underlying issues affecting attendance as well as explore opportunities to enhance employability during
interventions with young people who score highly for Education, Training and Employment. Some underlying issues, such as mental health problems and substance misuse, may be improved with therapeutic interventions, however there may be other causes of non-attendance, such as bullying or caring for family members, which would benefit from alternative approaches.

The analysis shows a link to all key themes for Education, Training and Employment. Family Life is reflected in the evidence, primarily for attitudes towards education. Suitable Services is reflected in the figures and the evidence, particularly with reference to meeting Special Education Needs. Ability to Engage is reflected in the figures and the evidence in relation to SEN effecting the ability to engage with education. Wider Health Needs is reflected in the evidence with concerns surrounding the impact of technology on school attendance.

7.12.3 There were 13.4% of young offender’s asset scores of 2 or more for Education, Training and Employment (14.0% of males and 10.0% of females) which is a decrease from 27% in 12/13 (27% males and 26% females). The pie charts show the asset score for all young offenders separated by cohort, excluding those left blank.
These pie charts demonstrate the differences in scores between the two cohorts and show that the proportion of young offenders with an asset score of 2 or more has increased by a third from 27% in 12/13 to 36% in 15. This suggests that the current cohort have slightly greater education, training and employment needs than the previous cohort.

7.13 **Vulnerability**

7.13.1 The Asset covers four questions with regard to whether there is evidence that s/he is likely to be vulnerable as a result of the following:

- 51.7% the behaviour of other people (e.g. bullying, abuse, neglect, intimidation, exploitation) which has increased from 32% in 12/13
- 47.7% other events or circumstances (e.g. separation, anniversary of loss, change of care arrangements) which has increased from 23% in 12/13
- 70.7% own behaviour (e.g. risk taking, ignorance, drugs, acting out, inappropriate response to stress) which has increased from 44% in 12/13
- 23.2% have indications that s/he is at risk of self-harm or suicide which has increased from 16% in 12/13

7.13.2 The graph shows the percentage by gender who answered ‘yes’ to the questions above. The trend shows an increase for both genders for all indicators and there was a higher proportion of females for all indicators.

- The graph shows that the proportion of young people who are vulnerable due to the behaviour of others has increased slightly for males (from 32% in 12/13 to 39.2% in 15) and by over one half for females (from 35% in 12/13 to 60% in 15). This has increased the slight gender difference from the previous cohort to a more significant one with one and a half times the amount of females than males who are vulnerable due to the behaviour of others.

- The graph shows that the proportion of young people who are vulnerable due to other circumstances or events has nearly doubled for males (from 22% in 12/13 to 40.5% in 15)
and by approximately one half for females (from 27% in 12/13 to 40% in 15). This has removed the slight gender difference from the previous cohort.

- The proportion of young people who are vulnerable due to their own behaviour has increased by nearly a third for males (from 44% in 12/13 to 59.5% in 15) and by over three quarters for females (from 45% in 12/13 to 80% in 15). This has created a significant gender difference with a third more females who are vulnerable due to their own behaviour compared to males.

- The proportion of young people who show indications of self-harm or suicide has increased slightly for males (from 14% in 12/13 to 16.3% in 15) and more than doubled for females (from 24% in 12/13 to 60% in 15). This has created a more significant gender difference with nearly four times as many females showing indications of self-harm or suicide.

These gender differences could be the result of social desirability, with males wanting to appear less vulnerable, however females are generally more vulnerable than males throughout society. This means that the current cohort of young people are more vulnerable than the previous cohort, with the 15 females being a particularly vulnerable group. This needs to be taken into consideration when planning and delivering activities to address the health needs of young offenders.

When looking at the evidence provided by the highest scoring 10% of the current cohort, it is suggested that concerns surrounding vulnerability are linked to a wide range of issues. This includes concerns around exploitation, experience of abuse (physical, sexual and financial), substance misuse, foster placements, self-harm/suicide and other risks of vulnerability. The gender differences are not validated in the evidence as the highest scoring males having as many areas of concerns as the highest scoring females. This could mean that there is a need to address multiple areas during interventions with young people who score highly for Vulnerability. Previous intervention suggestions would be sufficient with even more emphasis on therapeutic services to address the diverse range of experiences and needs of vulnerable young people.

7.13.3 There were 21.1% of young offenders are rated as having a high or very high vulnerability risk which has significantly increased from 6% in 12/13. The pie charts show the breakdown between very high, high, medium and low risk separated by cohorts.
These pie charts demonstrate the differences in scores between the two cohorts and show that the proportion of young offenders rated as having high or very high vulnerability has more than tripled from 6% in 12/13 to 21% in 15. This suggests that the current cohort are much more vulnerable than the previous cohort.

7.14 Multiple Need/Problems

7.14.1 12.8% of Assets that did not have a score above 2 for any need/problem in 2015. The number of different needs/problems with a score of 2 or more is shown in the table below. 82.6% of Assets had scored 2 or more on two or more different needs/problems in 2015.

7.14.2 There were 58.8% of Assets with 5 or more scores of 2 or more in 2015. There were also 27.6% with 8 or more scores of 2 compared to 2012/13 which had a maximum of 7 scores of 2 or more. This highlights that young offenders generally have a wide range of needs or difficulties to be addressed to reduce the risk of re-offending over time and the most recent cohort have a higher level of multiple complex needs than the previous cohort.
7.14.3 The tables below show the percentage of clients who score 2 or more for a primary and secondary needs/difficulties.

<table>
<thead>
<tr>
<th>Primary and Secondary Needs with a score of 2 or more – 12/13</th>
<th>Secondary Need: Asset Score 2 or more</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Need:</strong> Asset Score 2 or more</td>
<td><strong>Family and Personal Relationships</strong></td>
</tr>
<tr>
<td>Family and Personal Relationships</td>
<td>37%</td>
</tr>
<tr>
<td>Education, Training and Employment</td>
<td>94%</td>
</tr>
<tr>
<td>Lifestyle</td>
<td>50%</td>
</tr>
<tr>
<td>Substance Misuse</td>
<td>3%</td>
</tr>
<tr>
<td>Physical Health</td>
<td>50%</td>
</tr>
<tr>
<td>Emotional and Mental Health</td>
<td>33%</td>
</tr>
<tr>
<td>Perception of Self and Others</td>
<td>50%</td>
</tr>
<tr>
<td>Thinking and Behaviour</td>
<td>50%</td>
</tr>
</tbody>
</table>

| **Primary Need:** Asset Score 2 or more                       | **Family and Personal Relationships**|
| Family and Personal Relationships                            | 49%                                  |
| Education, Training and Employment                           | 70%                                  |
| Lifestyle                                                    | 47%                                  |
| Substance Misuse                                             | 1%                                   |
| Physical Health                                              | 68%                                  |
| Emotional and Mental Health                                  | 61%                                  |
| Perception of Self and Others                                | 94%                                  |
| Thinking and Behaviour                                       | 94%                                  |

<table>
<thead>
<tr>
<th>Primary and Secondary Needs with a score of 2 or more – 15</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Need:</strong> Asset Score 2 or more</td>
</tr>
<tr>
<td>Family and Personal Relationships</td>
</tr>
<tr>
<td>Education, Training and Employment</td>
</tr>
<tr>
<td>Lifestyle</td>
</tr>
<tr>
<td>Substance Misuse</td>
</tr>
<tr>
<td>Physical Health</td>
</tr>
<tr>
<td>Emotional and Mental Health</td>
</tr>
<tr>
<td>Perception of Self and Others</td>
</tr>
<tr>
<td>Thinking and Behaviour</td>
</tr>
</tbody>
</table>
In 2015, clients who score 2 or more for Substance Misuse also scored 2 or more for:

- 100% for Family and Personal Relationships
- 100% for Lifestyle
- 70% for Education, Training and Employment
- 66% for Thinking and Behaviour
- 54% for Emotional and Mental Health
- 47% for Perception of Self and Others

In 2015, clients who score 2 or more for Emotional and Mental Health also scored 2 or more for:

- 96% for Thinking and Behaviour
- 81% for Family and Personal Relationships
- 64% for Lifestyle
- 63% for Perception of Self and Others
- 44% for Education, Training and Employment
- 31% for Substance Misuse

**CURRENT SERVICES**

8. **Responding to the health needs of young offenders**

8.1 Due to the multitude of problems to be addressed, interventions plans with young offenders need to be holistic and family centred. This will ensure needs are addressed appropriately, improve outcomes for youth offenders and reduce the likelihood of re-offending.

8.2 A number of specialist staff are seconded into the Youth Offending Service in order to meet the needs of young people. These include a full time substance misuse worker, a part time mental health worker, a full time YOS ETE Advisor, three full time Families Matter (Troubled Families) lead practitioners and a City Deal worker (across 2 posts). There will also be a part time YOS Health Navigator joining the team soon which will be a flexible role and attuned to the individual needs of the young people in the service.

8.3 All specialist workers undertake 1:1 work with young people as part of their individual supervision plans, after referral by Youth Offending Service Officers. The YOS has also developed an offending behaviour programme which includes components that contribute to addressing young people’s risks and needs. Sessions cover safe relationships, promote healthier life style choices and address the consequences of risk taking behaviour. The programme is assessed by the Youth Justice Board as an ‘area of emerging practice’.

8.4 Work with young people in custody falls within the remit of the service and the YOS mental health and substance misuse workers have to ensure strong links with health care colleagues in the secure estate. These links are more important than ever following the impact of section 104 of the Legal Aid, Sentencing and Punishment of Offenders Act which gave all remanded children looked after status.
8.5 In the community, YOS specialist workers undertake expedite referrals to ensure wider service access. For example, into Community Adolescent Mental Health Services (CAMHS), Forensic CAMHS and the Behavioural Resource Service. ‘Step down’ exit planning also requires YOS involvement in local Targeted Assessment Panel arrangements.

8.6 A specific area of work for YOS involves interventions with young people who have received either a caution or court order after committing sexual offences. YOS officers undertaking this work are trained in the AIM (Assessment, Intervention, Moving On) model. The Criminal Justice Joint CJJ Inspection (2013) Report: Examining Multi-Agency Responses to Children and Young People who sexually offend identifies the need for robust partnership frameworks in this area.

8.6.1 Work has also begun investigating sexually problematic behaviour utilising police data to identify young people who had been brought to the attention of the police for matters relating to sexual offences. YOS is working with the Child Sexual Exploitation Hub to access the records of the young people and analyse their history of service contacts and interventions to see if there were missed opportunities in preventing the sexually harmful behaviour from occurring. Although only a small percentage of cases have been analysed so far, this is a detailed piece of work which will have implications for education and social care sectors as well as the criminal justice sector. The preliminary findings suggest that there have been cases with multiple contacts with multiple services which resulted in no further action (NFA) and ‘advice’ sometimes accompanying the NFA. As these cases escalated to sexually harmful behaviour occurring, some of which were sentenced for serious sexual offences, completing the work will establish whether this is a common occurrence.

8.7 In 2012/13 a total of 52 children accessed advice and guidance sessions as part of the Southampton Offending Behaviour Programme. Although there is no comparable date for 2015, the analysis provided identifies the level of need for this cohort of young people and will be reassessed when health staffing cohort is complete. The table below details how many children attended each health-related session. The programme components are varied: the Barnardo’s, Headway and Take a Risk sessions address risk taking behaviour; Substance Misuse, Smoking, Midwifery and Sexual Health and Relationships promote positive lifestyle choices and relationships; Basic Life Support provides young people with practical lifesaving skills.

<table>
<thead>
<tr>
<th>Name of Session</th>
<th>Overall Number of attendees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnardo’s</td>
<td>14</td>
</tr>
<tr>
<td>Substance Misuse</td>
<td>16</td>
</tr>
<tr>
<td>Smoking</td>
<td>6</td>
</tr>
<tr>
<td>Basic Life Support</td>
<td>10</td>
</tr>
<tr>
<td>Take a Risk</td>
<td>15</td>
</tr>
<tr>
<td>Midwife</td>
<td>8</td>
</tr>
<tr>
<td>Headway</td>
<td>15</td>
</tr>
<tr>
<td>Sexual Health and Relationships (SRE)</td>
<td>9</td>
</tr>
</tbody>
</table>

8.8 The development of the Southampton Offending Programme has provided the opportunity to work with partner agencies to provide general advice and guidance to young people. Work is being undertaken with the Youth Justice Board to evaluate this piece of work; within the YJB’s developing effective practice remit.
8.9 Information regarding the work of the YOS Health Worker is restricted to the financial year 2012/13 due to the role being replaced by a Community Mental Health Nurse. However, the YOS Health Navigator role will incorporate and enhance the work carried out by the YOS Health Worker. In 2012 / 13, 56 referrals were made to the YOS Health Worker; 21 females and 35 males. Young people kept 138 appointments with the worker and five young people refused to engage.

8.10 The table below shows the reasons for referral to the health worker. Some young people were referred for multiple reasons:

<table>
<thead>
<tr>
<th>Reason for Referral</th>
<th>Number of Young People</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual Health and Relationships</td>
<td>39</td>
<td>70%</td>
</tr>
<tr>
<td>Smoking</td>
<td>19</td>
<td>34%</td>
</tr>
<tr>
<td>Nutrition and Weight</td>
<td>&gt;5</td>
<td>&gt;10%</td>
</tr>
<tr>
<td>Dentist</td>
<td>&gt;5</td>
<td>&gt;10%</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>&gt;5</td>
<td>&gt;10%</td>
</tr>
<tr>
<td>Deliberate Self Harm</td>
<td>&gt;5</td>
<td>&gt;10%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>&gt;5</td>
<td>&gt;10%</td>
</tr>
<tr>
<td>Sleeping Problems</td>
<td>&gt;5</td>
<td>&gt;10%</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>&gt;5</td>
<td>&gt;10%</td>
</tr>
<tr>
<td>Blood Disorder</td>
<td>&gt;5</td>
<td>&gt;10%</td>
</tr>
<tr>
<td>Register with GP</td>
<td>&gt;5</td>
<td>&gt;10%</td>
</tr>
</tbody>
</table>

8.11 Of the number of young people referred, 26 were then referred onto other agencies. The table below shows the referral routes. Again, young people may have been referred to more than one agency.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Number of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quitters</td>
<td>6</td>
</tr>
<tr>
<td>Specialist Sexual Health Outreach Nurse</td>
<td>5</td>
</tr>
<tr>
<td>GUM</td>
<td>5</td>
</tr>
<tr>
<td>Barnardo’s</td>
<td>&gt;5</td>
</tr>
<tr>
<td>Midwife</td>
<td>&gt;5</td>
</tr>
<tr>
<td>Practice Nurse</td>
<td>&gt;5</td>
</tr>
<tr>
<td>Asthma Nurse</td>
<td>&gt;5</td>
</tr>
<tr>
<td>HIV nurse</td>
<td>&gt;5</td>
</tr>
<tr>
<td>Haematology Nurse</td>
<td>&gt;5</td>
</tr>
<tr>
<td>Hampshire Constabulary (Vice)</td>
<td>&gt;5</td>
</tr>
</tbody>
</table>

8.12 Due to periods without a substance misuse worker, data across the years is not directly comparable. However, in 2012 / 13, the YOS substance misuse worker intervened with 56 young people at a Tier Three (specialist) level. The vast majority of specialist work was completed within the remit of statutory YOS intervention. Although ongoing support is offered to all young people exhibiting substance misuse issues; only three agreed to a referral into wider substance misuse services for ongoing support that year.

8.13 In 2012 / 13 the Youth Offending Service Parenting Officer supervised 19 Parenting Orders and 51 voluntary parenting disposals. Revised Court arrangements were piloted, placing the Parenting Officer in Court at key times. Forty group work sessions were delivered over the year using ‘How to Understand Your Child’s Behaviour’ and ‘Emotional First Aid for Parents’ courses. Although YOS no longer has a Parenting Officer, the level of family support provision
was strengthened through the placement of three Families Matter workers in the team (although recent data is not directly comparable). In addition to this, the Health Navigator role will provide this support in the near future.

8.14 Differences in the number of referrals will be affected by the absence of the Community Mental Health Nurse for a period in 2015. However, the table below shows the diagnoses, numbers of young people exhibiting the symptoms and referral routes for the 2012/13 and 2015 cohorts. Again, some young people experienced more than one set of symptoms.

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Referred to</th>
<th>Number of Young People (12/13)</th>
<th>Number of Young People (15)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depressive type symptoms or emotional difficulties</td>
<td>Brookvale Child and Adolescent Mental Health Services* or Orchard Centre*</td>
<td>26</td>
<td>11</td>
</tr>
<tr>
<td>Self-Harm</td>
<td>Brookvale Child and Adolescent Mental Health Services* or Orchard Centre* or General Practitioner</td>
<td>21</td>
<td>&gt;5</td>
</tr>
<tr>
<td>No Mental Health Illness / Behavioural problems</td>
<td>Family Engagement Worker Early Help Teams or TAF or No further action</td>
<td>21</td>
<td>10</td>
</tr>
<tr>
<td>Clinical Depression confirmed Diagnosis</td>
<td>Brookvale Child and Adolescent Mental Health Service* or Orchard Centre* or College Keep Adult Mental Health Services or No Limits</td>
<td>18</td>
<td>6</td>
</tr>
<tr>
<td>ADHD / Autism</td>
<td>Brookvale Child and Adolescent Mental Health Services* or Orchard Centre* or College Keep Adult Mental Health Services</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Schizophrenia / Schizoaffective type symptoms or firm diagnosis</td>
<td>Brookvale Child and Adolescent Mental Health Services* or College Keep Adult Mental Health Services</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Conductive Disorder (Oppositional Defiant Disorder or other behavioural problems)</td>
<td>Forensic Child and Adolescent Mental Health Services</td>
<td>5</td>
<td>&gt;5</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Brookvale Child and Adolescent Mental Health Services* or Orchard Centre*</td>
<td>10</td>
<td>&gt;5</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>------------------------------------------------------------------------</td>
<td>----</td>
<td>----</td>
</tr>
<tr>
<td>Drug induced psychotic symptoms</td>
<td>No Limits / or relevant mental health service if required with SYOS Substance Misuse input</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>Bipolar type symptoms</td>
<td>Brookvale Child and Adolescent Mental Health Services*</td>
<td>&gt;5</td>
<td>&gt;5</td>
</tr>
<tr>
<td>Post Trauma Stress Symptoms</td>
<td>Brookvale Child and Adolescent Mental Health Services* or Orchard Centre*</td>
<td>15</td>
<td>&gt;5</td>
</tr>
<tr>
<td>Attachment problems and substance misuse</td>
<td>Brookvale Child and Adolescent Mental Health Services* or Behaviour Resource Service</td>
<td>14</td>
<td>10</td>
</tr>
</tbody>
</table>

*These services are now called Better Care Centre (CAMHS WEST)*

8.15 There are other notable services currently open to young offenders in Southampton and they could provide additional support in meeting some of their health needs. Some of these services are utilised by YOS, such as having Families Matter (Troubled Families) lead practitioners based with YOS to provide personalised and practical support to families experiencing worklessness or school absence in addition to youth offending. Southampton YOS is part of Southampton’s Children and Families Service who provide a range of early intervention and prevention work to address the health needs of children and young people, some of which acts as a preventative measure of offending behaviour. These links are often employed for joint decision making panels to ensure that young people are given the most appropriate support. There are other noteworthy services in Southampton offering information, advice and support for young people which could provide a useful link for the Youth Offending Service, especially as YOS provides some internal services which are available externally. Although the internally delivered services are likely to be of higher quality, utilising more services provided by external organisations would alleviate some of the YOS workload as well as provide non-criminal socialisation for young offenders during group sessions. The higher age limit for some other services would also provide a longer period for young offenders to work on meeting their health needs in comparison with the Youth Offending Service. Therefore, it may be beneficial for Southampton YOS to widen their referrals to other services.

8.16 Throughout the analysis it is evident that females are typically more vulnerable than males, yet there are few services aimed specifically at young women who offend. This may be due to the male-dominated nature of crime which means that services have been unintentionally tailored to address the needs of young men. However as a consequence, this makes the services less approachable for females, especially if their offending is linked to sensitive subjects such as previous experience of abuse which will need to be addressed in a different way. A report by the National Offender Management Service (2015) outlines the need to target intervention for female offenders separately from intervention for male offenders due to different factors affecting desistance between genders. Therefore, there is a need to
develop services for young women in order to target factors affecting their offending and promote desistance from crime.

STAKEHOLDER VIEWS

9. Snapshot Studies

9.1 Interviews

To gain the views and experiences of young people, interviews were conducted with young people who were in or had been in custody. It was important to capture the voices of these young people and see if there was any difference in healthcare provision and access to information compared to the young people in the wider community. Chitsabesan et al. (2006) and Harrington et al. (2005) found that the health needs of young offenders were greater for those in the community than those in custody, however the needs for both groups were high and often unmet. These differences may be because ‘[t]here are usually multiple providers of health and social care in secure settings covering a wide range of services. This includes general practice and personal care, through to acute and end of life care.’ (Care Quality Commission, 2015: 4). The interview questions were based on themes from the report *Healthcare Standards for Children and Young People in Secure Settings* by the Royal College of Paediatrics and Child Health et al. (2013). These themes include Information, Assessments, Care/Treatments and Staff/Environment. The results are summarised below and the interview schedule can be found in the Appendix.

9.1.1 Overview

The aim of the interviews were to capture the experiences of young people who were in or had been in custody (Young Offender Institutions and Secure Training Centres - excludes those being held on remand) and were currently still open to YOS. 3 young people who had been in custody were interviewed which typically represents around one quarter of all young people who were in or had been in custody and were still open to YOS during the data capturing timeframe. Although this is a very small sample, it is a good proportion of the target population for the purposes of the study. However, it should be acknowledged that these results will not be generalisable due to the small size of the sample but they will still provide a useful insight into the healthcare for young people in custody.

None of the young people had any issues surrounding health that they wanted to discuss first.

<table>
<thead>
<tr>
<th>Responses – Opening Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are there any issues surrounding health that you want to discuss first?</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>No</td>
</tr>
</tbody>
</table>

9.1.2 Information

All of the young people interviewed referred to posters as the main source of information for health issues. All posters were reported as being placed on the walls of the wings and each young person recalled different information from the posters. There was a mixed review about the success of these posters with one young person referring to the poster about the negative effects of drugs as not colourful and not useful. Another young person recalled a
A poster about the effects of alcohol and drugs on the body as something that caught their attention but wasn’t particularly useful. The other young person recalled a poster about sexually transmitted infections as being bright and useful.

Responses – Information

<table>
<thead>
<tr>
<th>Tell me about the information you get about health issues (drug use, diet, exercise etc. – people/posters/leaflets etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Posters on wall about drugs</td>
</tr>
<tr>
<td>Not colourful</td>
</tr>
<tr>
<td>All the bad things about drugs</td>
</tr>
<tr>
<td>Not useful</td>
</tr>
<tr>
<td>Posters on alcohol and drugs</td>
</tr>
<tr>
<td>Person/skeleton with effects shown</td>
</tr>
<tr>
<td>Caught attention but not useful</td>
</tr>
<tr>
<td>Posters on the wings about HIV/STIs</td>
</tr>
<tr>
<td>Bright and useful</td>
</tr>
</tbody>
</table>

When asked about accessing health advice, all of the young people identified the healthcare team as their main point of contact. All of the young people were also satisfied with their knowledge on accessing health advice but they generally didn’t need health advice.

Responses – Accessing Advice

<table>
<thead>
<tr>
<th>Tell me about accessing health advice</th>
</tr>
</thead>
<tbody>
<tr>
<td>There’s a healthcare team</td>
</tr>
<tr>
<td>All right</td>
</tr>
<tr>
<td>Nurse but didn’t really need it</td>
</tr>
<tr>
<td>Healthcare staff</td>
</tr>
<tr>
<td>Clear access</td>
</tr>
</tbody>
</table>

There was generally low awareness of the health programmes available at the institution, however this is likely to be due to the young people not being eligible/invited to participate.

Responses – Health Programmes

<table>
<thead>
<tr>
<th>Tell me about the kinds of health programmes you are aware of</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loads of programmes on drugs and alcohol</td>
</tr>
<tr>
<td>Not useful personally</td>
</tr>
<tr>
<td>Not aware of any</td>
</tr>
<tr>
<td>Never did a health programme</td>
</tr>
</tbody>
</table>

All young people believed they received enough information about health while in the institutions and, for those who commented, they believed the level of information was similar to that available outside of custody.

Responses – Adequate Information

<table>
<thead>
<tr>
<th>Do you feel like you get enough information about health?</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Yeah, it’s jail”</td>
</tr>
<tr>
<td>Enough info</td>
</tr>
<tr>
<td>About the same as outside</td>
</tr>
<tr>
<td>“I already knew a lot of the stuff”</td>
</tr>
<tr>
<td>Enough</td>
</tr>
<tr>
<td>About the same as outside</td>
</tr>
</tbody>
</table>
9.1.3 Assessments

The information provided about healthcare assessments are mostly limited to those conducted during the induction which happens on their first night in custody, however one young person’s assessment did not happen until “hallway” into their sentence. All young people had their height and weight measured, one young person thought they may have had blood tests and another young person had vaccinations. Assessment of mental health varied with one young person only being asked if they took medication for mental health and another having their mental health assessed via questionnaire. Only one young person mentioned being assessed for substance use during their induction which was conducted via questionnaire and accompanied by a “boring” DVD. The only additional health assessment to the one upon induction was an eye test for one young person which happened two months into their sentence following some speculation about the quality of their eyesight. All young people understood and agreed to the health assessments but didn’t know if they would have had the option to postpone the assessment.

Responses – Assessments

<table>
<thead>
<tr>
<th>Tell me about any times you have had your health needs assessed</th>
</tr>
</thead>
<tbody>
<tr>
<td>First night</td>
</tr>
<tr>
<td>It was all right</td>
</tr>
<tr>
<td>Nothing about mental health - only asked about medication for mental health</td>
</tr>
<tr>
<td>Understood and agreed</td>
</tr>
<tr>
<td>No other time</td>
</tr>
<tr>
<td>Halfway into sentence</td>
</tr>
<tr>
<td>They said they were late in doing it (should’ve been first two weeks)</td>
</tr>
<tr>
<td>Height, weight, blood tests (I think)</td>
</tr>
<tr>
<td>Questionnaires on mental health and substance use</td>
</tr>
<tr>
<td>DVD on substance use (found it boring)</td>
</tr>
<tr>
<td>They explained everything</td>
</tr>
<tr>
<td>Felt like I had a choice/agreed but I just did it when they came</td>
</tr>
<tr>
<td>About the same as treatment outside</td>
</tr>
<tr>
<td>Check up during induction - height, weight, shots (first night)</td>
</tr>
<tr>
<td>Eyes checked at 2 months</td>
</tr>
<tr>
<td>Understood – they explained as they were doing it</td>
</tr>
<tr>
<td>Felt like I had a choice</td>
</tr>
</tbody>
</table>

9.1.4 Care/Treatments

All young people knew they had access to general health services (including mental health services and substance use support) while in custody but didn’t typically know about the emergency health services available to them which is the main difference between being in custody and being in the wider community. The young people reported being given this information on induction which may affect their recollection of information due to the induction typically taking place on the first night. The young people generally didn’t receive many healthcare plans or treatments due to not having many health issues but one young person voluntarily attended a group addressing drug use, one young person took threadworm tablets due to an outbreak in the prison and another young person took a chlamydia test they were offered on their first night. All young people reported that these treatments were provided in a timely manner and offered at the earliest opportunity as well as having the
care/treatments explained to them. They also reported being treated fairly and, where applicable, seeing the same person throughout their treatment. For the one young person who had received similar care outside of custody, they reported that the process was similar within the wider community. The involvement of parents in treatment was not relevant for the young people interviewed.

Responses – Services

<table>
<thead>
<tr>
<th>Tell me about the services you have access to</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare</td>
</tr>
<tr>
<td>Mental health</td>
</tr>
<tr>
<td>Drugs</td>
</tr>
<tr>
<td>Had access but didn’t use</td>
</tr>
<tr>
<td>They tried to give me vaccinations but I refused</td>
</tr>
<tr>
<td>Did a group for drugs</td>
</tr>
<tr>
<td>If you need anything you ask Gov. to call healthcare</td>
</tr>
<tr>
<td>They tell you about all of this on induction</td>
</tr>
<tr>
<td>I went to a drugs group</td>
</tr>
<tr>
<td>I agreed to it</td>
</tr>
<tr>
<td>Only took a couple of weeks (to get on)</td>
</tr>
<tr>
<td>Same leader every time</td>
</tr>
<tr>
<td>We had regular conversations</td>
</tr>
<tr>
<td>Treated fine</td>
</tr>
<tr>
<td>No parents involved (wouldn’t want them) – don’t really get on with my family</td>
</tr>
</tbody>
</table>

| Dentist, opticians, mental health, substance use |
| Don’t know about emergency services – just ring buzzer (999 outside) |
| Told about it during induction                  |
| Had threadworm tablets (outbreak)              |
| Agreed to this and it was explained            |
| Same person both times (nurse)                 |
| Treated fairly                                 |

| All general health services                   |
| Had a chlamydia test on the first night – similar to when it happened at No Limits |
| No healthcare plans/interventions/treatments  |

9.1.5 Staff/Environment

Two of the young people did not know who was in charge of their healthcare and one young person believed it was the nurse. The Healthcare Standards for Children and Young People in Secure Settings report suggests there should have been a named lead healthcare professional for each young person.

Responses – Healthcare Lead

<table>
<thead>
<tr>
<th>Tell me about the person who is in charge of your healthcare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Don’t know them</td>
</tr>
<tr>
<td>Nurse is in charge</td>
</tr>
<tr>
<td>Not aware</td>
</tr>
</tbody>
</table>

All young people reported being treated fairly by staff with confidentiality and they all had their treatments explained. The young person who received threadworm tablets due to the outbreak received information on the tablets via a PowerPoint presentation. One young person also reported that the healthcare staff encouraged them to be responsible. The young
people reported being treated in a similar manner as when they have accessed healthcare outside of custody.

Responses – Treated by Staff

<table>
<thead>
<tr>
<th>Tell me about the way you are treated by healthcare staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fine</td>
</tr>
<tr>
<td>Confidentiality explained – “nothing can’t be said outside of the room”</td>
</tr>
<tr>
<td>Encouraged responsibility – “I think at the end of the day it’s up to me what I do anyway”</td>
</tr>
<tr>
<td>Drugs group was explained the first time (he joined)</td>
</tr>
<tr>
<td>Yes confidentiality was explained</td>
</tr>
<tr>
<td>Everything was explained</td>
</tr>
<tr>
<td>PowerPoint on the tablets</td>
</tr>
<tr>
<td>Fine/fair</td>
</tr>
<tr>
<td>Same as outside</td>
</tr>
</tbody>
</table>

The young people didn’t have much experience with the health facilities, however they all described the rooms as “normal”, neither inviting not uninviting. The young people described the room as being private although one young person did indicate that other people knew what the group room was used for.

Responses – Facilities

<table>
<thead>
<tr>
<th>Tell me about the rooms where healthcare takes place</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Just like this but bigger” – standard kind of office room</td>
</tr>
<tr>
<td>Used for “all group stuff”</td>
</tr>
<tr>
<td>“People know what it’s for”</td>
</tr>
<tr>
<td>Nurses room was just a white room with a desk (not scary)</td>
</tr>
<tr>
<td>In the education corridor</td>
</tr>
<tr>
<td>“Just ask staff to take you on your own” (private)</td>
</tr>
<tr>
<td>“Normal room”</td>
</tr>
<tr>
<td>Private</td>
</tr>
</tbody>
</table>

Feedback on healthcare was sought from two out of the three young people who chose not to provide feedback. The other young person did not recall being asked for feedback.

Responses – Feedback

<table>
<thead>
<tr>
<th>Have your thoughts/views taken into consideration in relation to healthcare?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leaflets were given but didn’t fill them out</td>
</tr>
<tr>
<td>Don’t think so</td>
</tr>
<tr>
<td>They asked for feedback but didn’t do it</td>
</tr>
</tbody>
</table>

All young people were told about the complaints procedure upon induction but no one needed to make a complaint.

Responses – Complaints

<table>
<thead>
<tr>
<th>Tell me about the complaints procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Told on induction</td>
</tr>
<tr>
<td>Didn’t need to</td>
</tr>
<tr>
<td>Told on induction</td>
</tr>
<tr>
<td>During induction</td>
</tr>
<tr>
<td>Didn’t complain</td>
</tr>
</tbody>
</table>
9.1.6 Conclusion

Only one young person had a final comment about their healthcare in custody which was that it was similar to the healthcare outside of custody.

Responses – Final Words

<table>
<thead>
<tr>
<th>Is there anything else you would like to add?</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
</tr>
<tr>
<td>“About the same” as the outside</td>
</tr>
<tr>
<td>Nope</td>
</tr>
</tbody>
</table>

The information provided typically aligns with the standards outlined by the *Healthcare Standards for Children and Young People in Secure Settings* report with only a couple of issues arising under the Assessments theme. The main findings of the interviews are:

- **Information**: The young people in this study were satisfied with the information they received about health issues within custody and they typically believed this was at a similar level to the information they received outside of custody.

- **Assessments**: The young people in this study did not report having many health assessments outside of their initial assessment performed during their induction. All of the young people understood and agreed to their health assessments being conducted. However, the areas covered in the initial assessments seemed to vary for each young person with some young people reporting a more thorough assessment than others. In addition to this, one young person reported that they did not receive their initial assessment within the two week window which is cause for concern as the healthcare team may have missed health needs that needed to be addressed. **Both of these issues would have risked missing certain health needs of the young people which may have been detrimental to their health and wellbeing.**

- **Care/Treatment**: While all of the young people reported knowing that they had access to general health services within custody, they were less certain of the emergency health services available to them. The young people in this study did not generally report having many healthcare plans or treatments and the healthcare they did receive was provided in a timely manner. They were also treated fairly throughout the process and likened the healthcare to that available within the wider community.

- **Staff/Environment**: The young people in this study did not know their named lead healthcare professional but were satisfied with the way they were treated by staff and the rooms in which they received healthcare which was reported as being similar to their experiences in the wider community. The institutions were mostly reported as asking for feedback on the healthcare provided and the complaints procedure was recalled as being explained upon induction but not required by any of the young people in the study.

Although transitions were not explored within this study, it would be useful for any future studies to investigate the presence of YOS health workers within custody as this would provide ongoing support and a link to healthcare in the wider community during the transition from custody to community. YOS currently introduce the substance misuse worker to any young people in custody who are identified as needing this support, however the introduction of the
Health Navigator role offers potential for providing additional support for a wider range of health needs during transition periods.

9.2 Questionnaires

In addition to the interviews, a questionnaire was also conducted. The questionnaires were a snapshot sample of 25 young people who came in contact with a YOS case holder within a three week period. This represents approximately one third of the young people open to YOS during the distribution timeframe and, although this is a good sample size, it should be acknowledged that two thirds of the young people open to YOS remain unrepresented in the results. The questions were closed questions with the option to provide a comment on each question and focused on health behaviours, the acquisition of health knowledge and the understanding of health services available. The results are summarised below and the form used to gather data can be found in the Appendix.

9.2.1 Overview

Demographics of Sample

The demographics of the sample were generally representative of the young people within the service.

<table>
<thead>
<tr>
<th>Responses – Gender - %</th>
<th>Responses – Age - %</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Are you male or female?</strong></td>
<td><strong>How old are you?</strong></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>0%</td>
</tr>
<tr>
<td>Female</td>
<td>45%</td>
</tr>
<tr>
<td>I'd rather not say</td>
<td>36%</td>
</tr>
<tr>
<td></td>
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</tbody>
</table>

Responses – Ethnicity - % | Responses – English as First Language - %
- 83% of the young people identified themselves as male while 13% of the young people identified themselves as female and 4% chose not to answer this question.
- There were no participants who identified themselves as being under the age of 14. Half (50%) of the participants were aged between 14 and 16 and 45% were aged 17 or older (5% chose not to answer this question).
- 88% of young people identified themselves as being ‘White’ with 4% identifying as ‘Mixed Race’ or being from another ethnic background. 4% of young people chose not to answer this question.
- With the exception of the 8% of young people who chose not to answer, all young people identified English as their first or preferred language.

The proportions are generally representative of the young people in Southampton Youth Offending Service for all areas except age. Although there are a higher number of young people aged over 14 within the service, those aged 13 and under remain unrepresented in the sample. It should also be noted that there are also young people from other ethnic groups who are unrepresented in the sample, although the proportions are unlikely to be significant in a sample of this size.

9.2.2 Physical Health

Physical Health Responses

As with the Asset analysis, physical health was not reported as a major concern for the young people in this study.
79% of young people reported their physical health to be ‘Very Good’ (42%) or ‘Good’ (37%) with the remaining 21% reporting that their physical health was ‘Okay’. No one reported their physical health as being ‘Bad’ or ‘Very Bad’.

Out of the 25 young people in the sample, 16 of them (64%) did not report regularly experiencing any of the listed physical problems/symptoms. However, the most common physical problem/symptom was painful joints (experienced by 24%), followed by skin problems (experienced by 16%). Less than 10% of the sample regularly had difficulty breathing and less than 5% of the sample regularly experienced constant thirst/hunger or dizziness/headaches/confusion.

**Accessing Services**

The majority of young people had reported accessing general health services at some point in their lives.
83% of young people reported ever seeing a doctor compared to 13% who hadn’t seen a doctor. Of those who had seen a doctor, half opted to report that it was “not often”.

63% of young people reported ever having an eye test compared to 29% who haven’t had an eye test. Of those who have had an eye test, a third opted to report that it was “a long time ago” while just a fifth opted to report this as a regular occurrence (approximately once a year).

96% of young people reported seeing a dentist compared to 4% who hadn’t seen a dentist. Of those who had seen a dentist, only one quarter opted to report this as a regular occurrence (approximately every six months).

Dental Health

The majority of young people reported having good dental health habits which were primarily learned from parents who they would also go to for advice, alongside health services.

Responses – Brushing Teeth - %

How often do you usually brush your teeth?

- More than twice a day: 17%
- Twice a day: 54%
- Once a day: 0%
- Less than once a day: 4%
- I don't know: 25%
71% of young people reported usually brushing their teeth the recommended number of twice or more a day. A quarter (25%) reported usually brushing their teeth once a day while only 4% reported usually brushing their teeth less than once a day. Three young people opted to comment that they thought they were supposed to brush their teeth twice a day and one young person opted to report that they thought they were supposed to brush their teeth three times a day.

Out of the 25 young people in the sample, 16 (64%) reported learning about dental health from their parent(s)/caregiver(s), 8 (32%) reported learning about dental health from school and 5 (20%) also reported learning about dental health from the media with one young person specifically identifying adverts as a source of learning. Less than 10% of the sample learnt about dental health from friends and less than 5% of the sample learnt about dental health from other family. No one reported learning about dental health from their religion/other beliefs or the internet.

When asked where they would go for advice on dental health, 17 young people (68%) identified health services (including dentist) and 11 (44%) identified parent(s)/caregiver(s). 6 young people (24%) would seek advice from the internet, with one young person reporting there was “lots of information on the internet”, and only 4 young people (16%) would go to a school nurse for advice on dental health.

**Food and Nutrition**

The majority of young people reported having poor food and nutrition habits which were primarily learned from school and parents. They also identified health services and parents as the main places they would go for advice.
Only 29% of young people reported usually having 2 or more servings of fruit a day and only 24% reported having 2 or more servings of vegetables a day. This suggests that less than one third of the young people in the study get their recommended 5 or more servings of fruit and vegetables per day. Half (50%) reported usually one serving
of fruit or less a day and 59% reported usually having one serving of vegetables or less a day.

- For the young people who opted to report the types of fruit and vegetables they ate, they identified a variety of fruit as well as smoothies as part of their fruit intake but there was less variety identified for their vegetable intake with references to only having salad or vegetables with their dinner but not particularly liking it.

- Out of the 25 young people in the sample, 17 (68%) reported learning about food and nutrition from school, 14 (56%) reported learning about food and nutrition from parent(s)/caregiver(s) and 4 (16%) also reported learning about food and nutrition from the internet. 12% of the sample learnt about food and nutrition from friends, less than 10% learnt about food and nutrition from the media and less than 5% of the sample learnt about food and nutrition from their religion/beliefs or other family. 1 young person also identified “football” as a source of learning about food and nutrition.

- When asked where they would go for advice on food and nutrition, 14 young people (56%) identified health services (including dietician) and 10 (40%) identified parent(s)/caregiver(s). 6 young people (24%) would seek advice from the internet and less than 10% would go to friends or seek advice somewhere else. Less than 5% would go to a school nurse, other family or a teacher for advice on food and nutrition. 1 young person also identified a “shop” as a source of advice about food and nutrition.

Fitness and Exercise

The majority of young people reported having levels of physical activity which were primarily learned from school and parents. They also identified health services and parents as the main places they would go for advice.

Responses – Physical Activity - %

![Chart showing frequency of physical activity](chart.png)

- More than 2 hours a day: 26%
- 1-2 hours a day: 30%
- 30 minutes a day: 7%
- 3 hours a week: 4%
- 2-3 hours a week: 4%
- 1-2 hours a week: 11%
- Less than 1 hour a week: 0%
- I am rarely physically active: 0%
- I don't know: 4%
56% of young people reported being physically active for more than the recommended one hour a day. Only 15% reported not being physically active everyday with just a quarter of those being “rarely physically active”. It is worth noting that nearly a fifth (18%) did not know how often they were physically active. For the young people who opted to report the types of physical activity they do, they identified a range of sports including running, cycling and playing football.

Out of the 25 young people in the sample, 18 (72%) reported learning about fitness and exercise from school, 12 (48%) reported learning about fitness and exercise from parent(s)/caregiver(s) and 8 (32%) also reported learning from media. 6 (24%) of young people learnt about fitness and exercise from the internet and less than 10% learnt about fitness and exercise from friends. No one reported learning about fitness and exercise from other family or their religion/other beliefs. 1 young person also identified “jail” (young offender institution) as a source of learning about fitness and exercise.

When asked where they would go for advice on fitness and exercise, 13 young people (52%) identified health services (including fitness centres) and 11 (44%) identified parent(s)/caregiver(s). 6 young people (24%) would seek advice from the internet, 4 (16%) would seek advice from a teacher and 3 (12%) would seek advice from friends. Less than 10% would go to a school nurse or other family or for advice on fitness and exercise.
**Technology Use**

Nearly all young people reported spending more than 3 hours a day on some form of technology/device and identified school and parents as primary sources of learning about screen habits. They also identified their parents as where they would go to for advice, alongside health services.

**Responses – Technology Use**

Which of the following do you use for more than 3 hours a day? (Please tick all that apply)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Games console</td>
<td>8</td>
</tr>
<tr>
<td>Gaming</td>
<td>4</td>
</tr>
<tr>
<td>Television</td>
<td>11</td>
</tr>
<tr>
<td>Social media (Facebook, Twitter, Snapchat etc.)</td>
<td>15</td>
</tr>
<tr>
<td>Surfing the internet (excluding homework)</td>
<td>5</td>
</tr>
<tr>
<td>Other technology (please explain)</td>
<td>0</td>
</tr>
<tr>
<td>None</td>
<td>1</td>
</tr>
</tbody>
</table>
The most common screen-time was spent on social media with 60% of the young people reporting that they spent more than 3 hours a day on it. Facebook and Twitter were commonly used and one young person opted to report that they spent 10 hours a day on social media and had 2314 friends and 152 followers.

44% of young people also spent more than 3 hours a day watching television and 32% spent more than 3 hours a day playing on games consoles. One fifth (20%) reported spending more than 3 hours a day surfing the internet (excluding homework) and 16% reported spending more than 3 hours a day gaming on a mobile device or computer. Only 1 young person (less than 5%) did not spend more than 3 hours a day using technology/devices.

Out of the 25 young people in the sample, 12 (48%) reported learning about screen habits from school, 9 (36%) reported learning from parent(s)/caregiver(s) and 6 (24%) also reported learning from their friends. 5 (20%) of young people learnt about screen habits from the internet and less than 5% learnt about screen habits from other family. No one reported learning about screen habits from their religion/other beliefs. 3 young people also reported that they only learnt about screen habits from their own use.

When asked where they would go for advice on screen habits, 10 young people (40%) identified parent(s)/caregiver(s), 9 (36%) identified health services and 5 young people (20%) would seek advice from the internet. Less than 10% would seek advice from other family and less than 5% would go to friends, a school nurse or teachers for advice on screen habits. 3 young people reported that they would not seek advice for use of technology/devices.
Smoking

The majority of young people reported smoking or previously smoking and identified school and parents as primary sources of learning about smoking. They also identified health services as their primary source of advice on smoking, followed by their parents.

Responses – Smoking - %

Do you smoke?

- Yes, everyday: 63%
- Yes, sometimes: 17%
- No but I used to: 8%
- No but I've tried it: 8%
- No and I never have: 4%

Responses – Learning about Smoking

Where have you learnt about smoking? (Please tick all that apply)

- Parents/Caregiver(s): 10
- Other family: 1
- Friends: 13
- School: 7
- Religion/other beliefs: 5
- Internet: 3
- Other: 3

Responses – Advice about Smoking

Where would you go for advice on smoking? (Please tick all that apply)

- Parents/Caregiver(s): 10
- Other family: 0
- Friends: 0
- School Nurse: 3
- Health services: 15
- Teachers: 2
- Internet: 2
- Other: 1
• 71% of young people reported that they smoke with 63% of the participants reporting that they smoked everyday. 8% of young people reported that they used to smoke and 4% reported trying it with 17% of young people reporting that they have never tried smoking.

• Out of the 25 young people in the sample, 13 (52%) reported learning about smoking from school, 10 (40%) reported learning about smoking from parent(s)/caregiver(s) and 7 (28%) also reported learning from their friends. 5 (20%) of young people learnt about smoking from media and 3 (12%) identified the internet as a source of learning about smoking. Less than 5% learnt about smoking from other family and no one reported learning about smoking based on their religion/other beliefs. 1 young person also reported learning about smoking through YOS.

• When asked where they would go for advice on smoking, 15 young people (60%) identified health services (including Smokefree services) and 10 (40%) identified parent(s)/caregiver(s). 3 young people (12%) would seek advice from the school nurse and less than 10% would seek advice from teachers or the internet. No one reported that they would seek advice on smoking from friends or other family.

Alcohol

The majority of young people did not report regularly drink alcohol and identified school and parents as primary sources of learning about alcohol. They also identified health services as their primary source of advice on alcohol, followed by their parents.

Responses – Alcohol - %

Do you drink alcohol?

- Yes, everyday
- Yes, sometimes
- No but I used to
- No but I've tried it
- No and I never have
• 59% of young people reported that they drink alcohol with just 13% of the participants reporting that they drink everyday. 4% of young people reported that they used to drink and 37% reported trying it with 13% of young people reporting that they have never tried drinking alcohol.

• Out of the 25 young people in the sample, 14 (56%) reported learning about alcohol from school, 10 (40%) reported learning from parent(s)/caregiver(s) and 8 (32%) also reported learning about alcohol from media with 1 young person referencing a documentary. 6 (24%) of young people learnt about alcohol from their friends and 5 (20%) identified the internet as a source of learning about alcohol. No one reported learning about alcohol from other family or based on their religion/other beliefs. 1 young person also reported learning about alcohol through YOS.

• When asked where they would go for advice on alcohol, 18 young people (72%) identified health services (including alcohol support services) and 12 (48%) identified parent(s)/caregiver(s). 5 young people (20%) would seek advice from the internet, 4 young people (16%) would seek advice from their friends and less than 10% would seek advice from a school nurse. Less than 5% would seek advice from other family and no one reported that they would seek advice on alcohol from teachers.

Illegal Drugs

The majority of young people did not report regularly use illegal drugs and identified school as the primary source of learning about illegal drugs. They also identified health services as their primary source of advice on illegal drugs, followed by their parents.
29% of young people reported that they use illegal drugs with just 12% of the participants reporting that they do it everyday. 17% of young people reported that they used to use illegal drugs and 17% reported trying it with 37% of young people reporting that they have never tried illegal drugs. 3 young people identified cannabis as the illegal drug they use.
- Out of the 25 young people in the sample, 15 (60%) reported learning about illegal drugs from school, 8 (32%) reported learning from parent(s)/caregiver(s) and 8 (32%) also reported learning about illegal drugs from friends. 7 (28%) of young people learnt about illegal drugs from media and 5 (20%) identified the internet as a source of learning. Less than 10% identified other family as a source of learning about illegal drugs and no one reported learning about illegal drugs based on their religion/other beliefs. 1 young person also reported learning about illegal drugs through the police and 2 young people identified YOS as a source of learning.

- When asked where they would go for advice on illegal drugs, 14 young people (56%) identified health services (including drug support services) and 12 (48%) identified parent(s)/caregiver(s). 6 young people (24%) would seek advice from the internet, 5 young people (20%) would seek advice from their friends and less than 10% would seek advice from a school nurse. Less than 5% would seek advice from other family and no one reported that they would seek advice on illegal drugs from teachers. 1 young person also identified YOS as a source of advice.

**Sex, Sexual Health and Relationships**

Most young people who answered this question reported being sexually active and school was identified as the primary source of learning about sex, sexual health and relationships. The young people also identified health services as their primary source of advice on sex, sexual health and relationships.

**Responses – Sexually Active - %**

<table>
<thead>
<tr>
<th>Are you sexually active (including oral sex)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>I'd rather not say</td>
</tr>
</tbody>
</table>

42% 33% 25%
Only 58% of the young people chose to answer this question. 33% of the sample reported being sexually active while 25% reported not being sexually active.

Out of the 25 young people in the sample, 17 (68%) reported learning about sex, sexual health and relationships from school, 8 (32%) reported learning from parent(s)/caregiver(s) and 6 (24%) also reported learning about sex, sexual health and relationships from media. 5 (20%) of young people learnt about sex, sexual health and relationships from the internet and 3 (12%) identified their friends as a source of learning. Less than 5% identified other family or religion/other beliefs as a source of learning about sex, sexual health and relationships.

When asked where they would go for advice on sex, sexual health and relationships, 17 young people (68%) identified health services (including GUM clinic) and 9 (36%) identified parent(s)/caregiver(s). 6 young people (24%) would seek advice from the internet, 5 young people (20%) would seek advice from their friends and less than 5% would seek advice from a school nurse, other family or teachers.

Satisfaction with Physical Health

The young people in this study were generally satisfied with their physical health and/or access to services to physical health.
92% of young people were happy with their general physical health and/or access to services to physical health. Only 8% of the sample were not happy with their general physical health and/or access to services to physical health.

9.2.3 Mental Health

Mental Health Responses

As with the Asset analysis, mental health was reported as more of a concern than physical health for young people in this study.
Unlike with physical health, only 67% of young people believed that their mental health was ‘Good’ or ‘Very Good’. 21% described their mental health as ‘Okay’ while 8% described it as ‘Bad’ and 4% described it as ‘Very Bad’.

Only one fifth of the sample did not have any mental health problems/symptoms. The most common problem/symptom linked to mental health was moodiness or angry outbursts (44%) followed by trouble concentrating or remembering things (40%) and problems with sleep (36%). A significant number (32%) also identified themselves as having trouble understanding other people while 16% identified regular sadness/hopelessness or lack of confidence/belief in themselves. Less than 10% had regular feelings of panic, fear or unease and less than 5% regularly saw or heard things which weren’t real.

Despite the high prevalence of mental health problems/symptoms, 64% of young people reported no interference with their daily life. However, 20% reported that this interfered with their school work while 16% reported interference with relationships with parents or friends. 12% also reported interference with relationships with other family and less than 5% reported interference with general maintenance (including eating, showering, dressing etc.). 1 young person reported that their mental health interferes with attending “other services”.

Only half of the young people thought their mental health needs were being met and school was cited as the primary source of learning about mental health. Health services were identified as the primary source for advice on mental health, followed by parents.
- 50% of young people thought that their mental health needs were being met and 29% were not sure if their mental health needs were being met. Over one fifth (21%) of young people did not think their mental health needs were being met with one young person reporting that they had asked for therapy nine months ago and still hadn’t received it due to funding.
• Of the 25 young people in the sample, 13 (52%) reported school as a source of learning about emotional and mental health. 8 (32%) reported media as a source of learning about emotional and mental health and 7 (28%) reported parent(s)/caregiver(s) as a source. Only 3 (12%) identified the internet as a source of learning and no one identified other family, friends or religion/other beliefs as a source of learning about emotional and mental health. YOS and “jail” were each cited as a source of learning by 1 young person.

• In relation to seeking advice, 15 (60%) said they would go to health services (including counselling) while 11 (44%) said they would go to parent(s)/caregiver(s). 6 (24%) would also seek advice from the internet while 3 (12%) would seek advice from friends. Less than 10% would seek advice from other family or a school nurse while less than 5% would seek advice from teachers about emotional and mental health.

Despite the higher level of need around mental health, the majority of young people in this study reported being satisfied with their mental health and/or access to services to mental health.

Responses – Satisfaction with Mental Health and Services - %

Are you happy with your general mental health and/or access to services for mental health?

- 78% of young people were happy with their general mental health and/or access to services to mental health. Only 9% of the sample were not happy with their general mental health and/or access to services to mental health while 13% were unsure.

9.2.4 Conclusions

Learning about Health

Across all areas of health covered in the questionnaire, school was the most influential source of learning followed by parent(s)/caregiver(s). Media also played a substantial part in the learning about health with peers and the internet also being notable. Other family was less influential and religion/other beliefs were the least influential.
School gained recognition 127 times as a source of learning about health.

Parent(s)/caregiver(s) gained recognition 94 times as a source of learning about health.

Media gained recognition 53 times as a source of learning about health.

Friends gained recognition 37 times as a source of learning about health while the internet was credited 36 times.

Other family were credited 7 times and religion/other beliefs were credited only 2 times.

The ‘Other’ option was credited 17 times and most examples given were linked to criminal justice agencies (YOS, the police and young offender institutions) with some other examples such as football and developed learning through own interest.

**Seeking Advice**

Across all areas of health covered in the questionnaire, health services were the most influential source of advice followed by parent(s)/caregiver(s). The internet also played a substantial role in providing advice about health with peers and the school nurse also being notable. Other family and teachers were the least likely to be identified as sources of advice on health.
Health services (including GPs, health centres, young person’s clinics and more specialised services) were cited as a source of advice 132 times.

Parent(s)/caregiver(s) were cited as a source of advice for health issues 96 times.

The internet was reported as a method for advice 48 times.

Friends were identified as sources for advice 23 times with the school nurse being identified 18 times.

Other family and teachers were each credited as sources for advice 10 times.

The ‘Other’ option was only credited 8 times and examples included YOS and shops.

Main Findings

The main findings of this questionnaire are:

- **Physical health**: The young people in the study generally reported not having physical health problems and although some areas show that the majority as having poor health practices (specifically fruit and vegetable intake, time spent on devices and smoking), there are also areas where the majority have good health practices (such as dental health, physical activity and absence of drug use). The majority (92%) of young people happy with their general physical health and/or access to services to physical health. However, due to the complexity of the needs of the most prolific young offenders in the service, it is important that YOS provide health support and the introduction Health Navigator will ensure that all young offenders are happy with their access to health services.
• **Mental Health:** There is more concern around mental health for the young people in this study with the majority reporting regularly experiencing mental health problems/symptoms. However, the occurrence of this does not usually interfere with their daily lives. Although only half of the young people in this study believed that their emotional and mental health needs were being met, 78% of young people were happy with their general mental health and/or access to services to mental health.

• **Learning about health:** School was the most reported source of information for learning about health (127 times in total) and parent(s)/caregiver(s) also featured heavily in the acquisition of health knowledge (94 times in total). Media, friends and the internet were moderately featured (53 times, 37 times and 36 times respectively) while religion/other beliefs was the least influential in the young people’s learning about health (just 2 times in total). YOS and other criminal justice agencies (the police and young offender institutions) were given as examples of ‘Other’ sources of information alongside “football” and developing own learning (‘Other’ appeared 17 times in total).

• **Seeking advice for health:** Health services were most commonly identified as places the young people would go for advice (appearing 132 times in total) and parent(s)/caregiver(s) also featured heavily as a source of advice (96 times in total). The internet was the third most popular place to seek advice on health but didn’t feature as heavily as the first two (48 times in total). Friends and school nurses were sometimes identified as sources of advice (appearing 23 times and 18 times respectively) and ‘Other family’ and teachers were the least likely to be identified as sources of advice on health (both appearing 10 times in total). The ‘Other’ option was only credited 8 times and examples included YOS and shops as places young people would go for advice on health issues.

**EVIDENCE OF WHAT WORKS**

10. **Desistance Theory**

The following summary is taken from the Southampton Youth Offending Service’s Risk Assessment & Risk Management Policy:

Desistance from offending is a dynamic rather than a static process. It requires both individual factors (subjective internal change) and social context (social external change). Change may be gradual or rapid.

There are two types of desistance:

**Primary:** ‘refraining’ or ‘period of absence of’ (e.g. widening the gap between offending episodes’).

**Secondary:** ‘ceasing’ as a result of deep-seated change (e.g. developing an identity and perceiving self as a non-offender’).

Southampton Youth Offending Service recognises that a strengths-based focus on behavioural change should contribute strongly to risk management and risk minimisation. Such an approach:
• Supports approach engagement strategies with young people and their families
• Provides holistic service provision routed in ‘genuine’ partnership working
• Provides transparent, family-focused support
• Supports long-term solutions

11. **The Good Lives Model**

The following summary is taken from the Southampton Youth Offending Service’s Risk Assessment & Risk Management Policy:

Research has indicated a wide range particular factors that might contribute to the likelihood of risk. These are summarised as:

- Previous offending – violent, sexual, persistent etc.
- Evidence of harm being caused previously
- Sophisticated planning
- Pattern of offending
- Remorse (lack of)
- Victim empathy (lack of)
- Responsibility for actions (lack of)
- Age
- Accommodation
- Lifestyle
- Relationships – family / peer
- Level of supervision
- Education
- Motivation
- Stability
- Substance Misuse
- Mental Health issues
- Self-Harm

The Good Lives Model is a strengths-based approach which supports professional understanding of the complex interaction between an individual and his or her environment; and the resultant impact upon managing risk.

GLM recognises the need to build capabilities / strengths in people to reduce their risk of re-offending. The model focuses on the idea that people offend to secure a valued outcome in their life – offending is the product of a desire / goal for something that is inherently human / normal.

The desire / goal manifests itself in harmful behaviours, due to weaknesses / deficits within the individual and their environment. Deficits prevent the securing of the desire / goal in prosocial ways, therefore leading to inappropriate / damaging means (i.e. offending).

**Primary needs** are defined as aspects of life sort by an individual.

**Secondary goods** are the means by which those needs are secured (i.e. through employment, friendship, sport)
Primary Needs:

- **Achieving** *(status, knowledge, competence)*
- **Being my own person** *(independence, autonomy, self-management, control of others / situations)*
- **Having a purpose and making a difference** *(spirituality, fulfilment, hope, generosity)*
- **Having people in my life** *(attachment, intimacy, romance, family, social / community relationships)*
- **Emotional health** *(self-esteem, emotional safety, managing feelings)*
- **Physical health** *(sleep, diet, hygiene, physical safety)*
- **Sexual health** *(sexual knowledge, sexuality, sexual development)*
- **Having fun** *(thrill, excitement play)*

12. **Forensic Case Formulation**

Southampton YOS are developing their use of Forensic Case Formulation which is a psychologically informed approach based on many psychological theories which account for dynamic interactions between biological, psychological and social factors. The main theory underpinning Forensic Case Formulation is the Bio-Psycho-Social Model of Health which recognises that there are multiple domains of human experience which influence health and illness (physical, mental and emotional health/illness).

**Bio (Biological):** The biological aspect of the model recognises that children are born with a temperament which acts as a survival instinct.

**Psycho (Psychological):** The psychological aspect of the model recognises that children learn ways of surviving in unpleasant environments (such as dissociation or withdrawal). These strategies are functional in unpleasant environments in early life but they can become very dysfunctional when utilised in other environments.

**Social:** The social aspect of the model recognises that children are dependent and require their emotional and physical needs to be met and developed by external sources. Therefore, a parent or caregiver’s response to a child is critical to their social and emotional development because the child will internalise these behaviours.

Forensic Case Formulation allows practitioners to develop hypotheses regarding the connections between biological, psychological and social factors which can be used to develop interventions and facilitate communication between key agencies.

The use of case formulation has significantly impacted upon HMIP inspection findings for Buckinghamshire Youth Offending Service and a quote referencing the quality of this practice can be found below.

‘An innovative practice called ‘case formulation’ had been introduced recently. This involved a range of staff from other agencies, including a forensic psychologist, meeting to discuss all the factors that might be influencing a child or young person’s offending. Staff told us that it helped them form a clearer analysis of the case, and to identify the most effective way of intervening.’ (HM Inspectorate of Probation, 2015: 2)
In addition to this, Flintshire, Carmarthenshire and Blaenau Gwent & Caerphilly YOTs are being used as case studies for the effectiveness of Case Formulation as a response to the complex needs of a shrinking cohort in Wales (YJB Cymru, 2015). Although the current evaluation of the project is ongoing, the implementation of case formulation looks promising.

13. **Evidence of Good Practice**

There are multiple examples of good practice as evidence of what works and the *Library of Effective Approaches* by the Youth Justice Resource Hub (2016) is a helpful reference tool and a comprehensive collection of well-evidenced approaches and interventions. The library can be found at the link below:

https://yjresourcehub.uk/effective-practice/library-of-effective-approaches.html

The Effective Approaches Library contains developing and innovative approaches to working with young people targeting many areas of work. Some of the areas relevant to this report are health and wellbeing, mental health, early intervention, family, education, training and employment, substance misuse and social media.

In addition to some of the effective practice found in the library is the HM Government (2011) *Ending Gang and Youth Violence* report has identified the following areas to improve practice:

- **Focusing resources on the right people and right places** – there is an emphasis on the need for local autonomy to improve the freedom and flexibility to prioritise local resources on local priorities

- **Foundation years** – there is an emphasis on early interventions to promote warm, loving, supportive parenting which could prevent problematic behaviour in later life

- **Primary years** – there is a need for close co-ordination and communication between schools, parents and other local services to lead successful interventions

- **Teenage years** – there is a need for effective systems for the identification of high risk individuals as well as information sharing and agreement on joint plans for support and interventions

- **Girls and young women** – there is a need to improve services to support children and young women under the age of 18 suffering rape and sexual as current provision is not sufficient

- **Improving the Criminal Justice Response** – YOTs were identified as being well placed to gather and share intelligence while YOIs have gang identification and behaviour management strategies in place

- **Early adulthood** – prison leavers claiming Jobseekers Allowance are now referred immediately on release into the Work Programme. There is also a continued exploration of ways to improve the health and education provision for young people in the secure estate and for those released from custody which includes addressing any underlying special educational needs, disability or mental health issues
• **Sharing information to save lives** – there is an emphasis on the need for local agencies to share all the information and intelligence they hold as police intelligence may not be enough to identify and implement interventions for high risk individuals.

**RECOMMENDATIONS**

14. **Conclusion**

14.1 Analysis of the Asset Tool indicates that young offenders have a multitude of needs/problems. Most offending is associated with the following needs/problems themes, Thinking & Behaviour (77%), Family & Personal Relationships (62.8%), Lifestyle (54.4%) and Emotional and Mental Health (52.9%). A high proportion of young offenders also have problems with self-perception problems, education/training/employment and substance use.

14.2 82.6% of young offenders had an asset score of 2 or more on at least two different need/problem themes and 67.1% had four or more problems/needs identified. This highlights multiple need/problems are association with offending.

14.3 There are shared health and youth justice outcomes around reducing first time entrants into the criminal justice system and re-offending. Further, although the principle remit of the Youth Offending Service is to reduce offending and re-offending; the contribution to wider public health priorities is evident through the delivery of services that meet local need around teenage pregnancy, sexual health and substance misuse and, ‘on the ground’, through referrals by YOS officers who recognise the wider health needs of the offending cohort.

14.4 Local priorities arising from this report are:

• Developing the understanding that better access to continuity of care through the offender journey, and integrated delivery of services, can help reduce offending and re-offending, benefiting the health and wellbeing of the wider local community. This should include when a young person is discharged from young offender services.

• Building on relationships that already exist at a local level between health and youth justice services.

• Capitalising on the detailed insight that YOS and health professionals often have into the individual health and social care needs of people in contact with the YJS.

• Developing evidence-based interventions that produce the most effective and cost-effective health and wellbeing outcomes for offenders and those at risk of offending or re-offending at the local population level.

• Considering that the YOS has highly trained and experienced staff actively involved in a wide range of physical and mental health, substance misuse and social care work.

15. **Limitations**

Although every effort has been made to incorporate as much relevant information as possible, there are some limitations to the scope of this report. These are listed and summarised below:

• **Cohorts from non-consecutive years.** The explanation for the gap between the cohorts has been outlined in the methodology of the report as being due to changes...
in assessments and data systems. The missing information may have provided valuable comparison and trends for the increase of decrease of certain needs and is therefore a limitation to this report.

- **Self-report methods.** Some of the Asset scores are based on self-reports from the young people which may skew the data. This is evident in the reported level of Special Education Needs and Education, Health and Care Plans which appeared far higher in the data compared to the information held by the YOS ETE Advisor. Therefore, the information should be used as an indicator of need rather than an objective measure.

- **Lack of comparative dimension.** Unfortunately, it was not possible to directly compare Asset scores in Southampton with those of our statistical neighbours. This has been mitigated by including statistical neighbours in the broad health data comparisons but the direct comparison would place the report in a better position to inform health strategies.

Some of these limitations have been incorporated in the recommendations below.

16. **Recommendations**

There have been specific recommendations throughout the report but some broader recommendations to meet the health needs of young offenders include:

- **Replicate the study with further comparative dimensions and additional information to inform health strategies.** As epidemiology is a key discipline in public health, it would be useful to repeat this study with comparisons across time, between places and between different population groups to learn about patterns in health experience and to assess the need for change. Unfortunately it was only possible to use the two cohorts and to compare differences between genders but future studies should aim to include comparisons across consecutive years and between ages, ethnicities and statistical neighbours. It would also be useful to include additional information about more specific areas of the analysis to help inform health strategies. For example, information on how indicators were dealt with prior to offending, such as absences from school, unsuitable housing conditions and exposure to domestic violence, to highlight if needs could have been met at an earlier stage to prevent offending. Accompanying this is a recommendation for a similar analysis of young people at risk of coming into contact with the Youth Offending Service to identify the level of need prior to entering the criminal justice system.

- **Develop interpersonal skills and intrapersonal intelligence from a young age.** It is clear from the analysis that young offenders lack interpersonal skills and intrapersonal intelligence which are typically developed in the family and wider community. This is because young offenders are less likely to develop these qualities due to poor family life and disengagement from school and the wider community, therefore demonstrating a need to develop these qualities as early as possible. By developing interpersonal skills at primary schools, young people will be better equipped to communicate and interact with others about their needs and feelings which could enable them to seek help at an earlier stage and/or prevent their offending behaviour. In addition to this, encouraging introspection and self-awareness at primary schools will enable young people to acknowledge their feelings, motivations and goals which could prevent some of the negativity they inflict on themselves and others. This would also act as some of the basic building blocks for introducing restorative practice approaches in schools.
• **Adopt an individual holistic approach to interventions with young offenders.** It is evident from the analysis that males and females have different health needs and this needs to be taken into consideration when planning and delivering interventions. This is especially true for the gender differences in response to mental health with a need to address the prevalence of self-harm for females. In addition to this, there needs to be a holistic approach with life stories and experiences accounted for as they can influence current behaviour. Therefore, there is a need to tailor work with young offenders based on individual current needs and individual past experiences. We should also promote use of therapeutic services for young people who are exhibiting problematic behaviour as this could be the result of negative life experiences which need to be addressed.

• **Introduce more effective engagement tools and robust assessments to ensure all concerns are recognised.** Along with the need to adopt an individual holistic approach is the need to introduce more effective engagement tools to ensure that information about the level and nature of health needs of young offenders is accurately captured and detailed. As suggested by the Broader Context section, changes in modern life are presenting new health issues which may not be captured by current assessments and non-engagement from young people remains a barrier. The analysis showed a relatively high number ‘other’ problems which may be at risk of not being thoroughly captured in the assessment should the young people not engage. These issues include, but are not limited to, the increasing use of technology, the use of new psychoactive substances and indirect experience of abuse, specifically domestic violence. Therefore, there is a need to reconsider the tools used to capture the health needs of young offenders which should equip staff with the ability to encourage as much engagement as possible. In addition to this, the Youth Justice Partnership should consider resourcing the Case Formulation model to improve assessments.

• **Ensure the correct recording of information.** In addition to the previous recommendation is the need to ensure the correct recording of information. Although this was a problem found in systems outside of the Youth Offending Service, this is an incredibly important aspect of assessments as the incorrect information could prevent adequate intervention and may lead to further offending. In addition to this, some health needs may be exacerbated if they are left unmet and this is particularly true for emotional and mental health needs of young offenders. Information sharing has also become an important part of multi-agency work so incorrect information presents challenges in assuring effective partnership working. Therefore, it is vital that any information recorded is checked for accuracy by everyone, regardless of the service they work in, to ensure that the health needs of young offenders can be met in the most suitable way.

• **Promote engagement in the wider health offer outside of the Youth Offending Service.** We should aim to promote the use of health services across the city to improve the chances of young offenders having their health needs met. This should be encouraged across all ages as the knowledge and habits of parents and other significant adults have a great impact on young people (outlined in the Broader Context section). By encouraging involvement in the wider health offer, some young people may be enabled to seek help for their health needs at an earlier stage which prevent them from committing offences. Even for those who have already become involved in the youth justice system, the promotion of the wider offer, such as using
services external to YOS, will provide them with non-offending peers which may act as a protective factor from re-offending. Therefore, it is important to promote engagement in the wider health offer for everyone living in the city as this could address some health needs of young people and prevent offending or re-offending.
RESOURCES

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Appendix: Tools from Snapshot Studies

Interview Schedule

Probes: Can you elaborate on that? Why is that? Can you give an example? Would you say that’s good or bad? Do you have any suggestions? **Was this different when you weren’t in custody?**

<table>
<thead>
<tr>
<th>Introduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are there any issues surrounding health that you want to discuss first?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Theme</th>
<th>Questions</th>
</tr>
</thead>
</table>
| **Information** | • Tell me about the information you get about health issues (drug use, diet, exercise etc. – people/posters/leaflets etc.)  
  o What do these look like?  
  o Are they useful?  
  • Tell me about accessing health advice  
  • Tell me about the kinds of health programmes you are aware of?  
  o Drug use  
  o Mental health  
  o Sexual behaviour  
  • Do you feel like you get enough information about health? |
| **Assessments** | • Tell me about any times you have had your health needs assessed  
  o When did this happen?  
  o What was the assessment for?  
    ▪ General (including weight/height/BMI)  
    ▪ Mental health  
    ▪ Substances  
    ▪ Other  
  o Did you understand the assessment?  
    ▪ How/why they were doing it  
  o Did you feel fully involved in the assessment?  
    ▪ Did you have a choice?  
    ▪ Was it explained to you?  
    ▪ Did you get a chance to try doing it another way/time? |
| **Care/Treatments** | • Tell me about the services you have access to  
  o General – medical (vaccinations)/dental/optical  
  o Specialist - sexual health (contraceptives/screenings) / mental health/substance misuse  
  o Emergency – if something goes wrong (all above)  
    ▪ Do you know how to access health services?  
    • How do you know? |
<table>
<thead>
<tr>
<th><strong>Staff/Environment</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Tell me about the person who is in charge of your healthcare</td>
</tr>
<tr>
<td>- Do you know there name?</td>
</tr>
<tr>
<td>- Do you know how to find/contact them?</td>
</tr>
<tr>
<td>• Tell me about the way you are treated by healthcare staff</td>
</tr>
<tr>
<td>- Are you encouraged to take responsibility for your actions?</td>
</tr>
<tr>
<td>- Do they encourage you to be independent?</td>
</tr>
<tr>
<td>- Do they explain things to you?</td>
</tr>
<tr>
<td>• Tell me about the rooms where healthcare takes place</td>
</tr>
<tr>
<td>- What is it for? (Consultation/screening/assessment)</td>
</tr>
<tr>
<td>- What does it look like?</td>
</tr>
<tr>
<td>- Is it private and confidential?</td>
</tr>
<tr>
<td>- Is it accessible?</td>
</tr>
<tr>
<td>• Have your thoughts/views taken into consideration in relation to healthcare?</td>
</tr>
<tr>
<td>- Asked about ways to improve healthcare</td>
</tr>
<tr>
<td>• Tell me about the complaints procedure</td>
</tr>
<tr>
<td>- How would you make a complaint?</td>
</tr>
<tr>
<td>- Have you made a complaint?</td>
</tr>
<tr>
<td>- Were you told about the outcome?</td>
</tr>
</tbody>
</table>

**Is there anything else you would like to add?**

**Thank you for your participation**
Young Person’s Health Questionnaire

Please complete the questionnaire by ticking the relevant boxes and providing information in the box next to the question. There are boxes next to all questions should you wish to add any comments. **Your answers are anonymous and will only be used to improve services.**

**YOU DO NOT HAVE TO ANSWER ALL QUESTIONS IF YOU DO NOT WANT TO.**

<table>
<thead>
<tr>
<th>a. Are you male or female?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td>I’d rather not say</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>b. How old are you?</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-11</td>
</tr>
<tr>
<td>12-13</td>
</tr>
<tr>
<td>14-15</td>
</tr>
<tr>
<td>16</td>
</tr>
<tr>
<td>17 or older</td>
</tr>
<tr>
<td>I’d rather not say</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>c. My ethnicity is most closely described as...</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am White</td>
</tr>
<tr>
<td>I am Black</td>
</tr>
<tr>
<td>I am Mixed Race</td>
</tr>
<tr>
<td>I am Asian</td>
</tr>
<tr>
<td>I am from another ethnic background</td>
</tr>
<tr>
<td>I’d rather not say</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>d. Is English your first/preferred language?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>I’d rather not say</td>
</tr>
</tbody>
</table>
1. How would you describe your overall physical health?
- Very Good
- Good
- Okay
- Bad
- Very Bad

2. Do you regularly experience any of the following? (Please tick all that apply)
- Difficulty breathing
- Painful joints
- Constant thirst or hunger
- Limited physical movement or ability
- Skin problems
- Dizziness, headaches or confusion
- Other pain or physical problems (please explain)

3. Have you ever seen a doctor (for any reason)? How often do you visit a doctor?
- Yes
- No
- I don’t know

4. Have you ever had an eye test? How often do you have eye tests?
- Yes
- No
- I don’t know

5. Have you ever seen a dentist? How often do you visit a dentist?
- Yes
- No
- I don’t know

6. How often do you usually brush your teeth? (If you know the recommended amount please write it in the box)
- More than twice a day
- Twice a day
- Once a day
- Less than once a day
- I don’t know

7. Where have you learnt about dental health? (Please tick all that apply)
- Parent(s)/Caregiver(s)
- Other family (please explain)
- Friends
- School
- Media (books, magazines, newspapers, TV, films, video games etc. – please explain)
- Religion/other beliefs
- Internet (please explain)
- Other (please explain)
8. **Where would you go for advice on dental health? (Please tick all that apply)**

- Parent(s)/Caregiver(s)
- Other family (please explain)
- Friends
- School Nurse
- Health services (dentist, health centres, GP, young person’s clinic etc.)
- Teachers
- Internet (please explain)
- Other (please explain)

9. **How many servings of fruit* do you usually eat?** (If you know the recommended amount please write it in the box)

<table>
<thead>
<tr>
<th>What kinds of fruit do you eat?</th>
</tr>
</thead>
<tbody>
<tr>
<td>More than 6 servings a day</td>
</tr>
<tr>
<td>4-5 servings a day</td>
</tr>
<tr>
<td>2-3 servings a day</td>
</tr>
<tr>
<td>1 serving a day</td>
</tr>
<tr>
<td>Less than 5 servings a week</td>
</tr>
<tr>
<td>I rarely eat fruit</td>
</tr>
<tr>
<td>I don’t know</td>
</tr>
</tbody>
</table>

*One serving might be 1 banana or 1 handful of grapes or 1 large slice of pineapple

10. **How many servings of vegetables* do you usually eat?** (If you know the recommended amount please write it in the box)

<table>
<thead>
<tr>
<th>What kinds of vegetables do you eat?</th>
</tr>
</thead>
<tbody>
<tr>
<td>More than 6 servings a day</td>
</tr>
<tr>
<td>4-5 servings a day</td>
</tr>
<tr>
<td>2-3 servings a day</td>
</tr>
<tr>
<td>1 serving a day</td>
</tr>
<tr>
<td>Less than 5 servings a week</td>
</tr>
<tr>
<td>I rarely eat vegetables</td>
</tr>
<tr>
<td>I don’t know</td>
</tr>
</tbody>
</table>

*One serving might be 1 tomato or a 5cm piece of cucumber or 3 heaped tablespoons of peas

11. **Where have you learnt about food and nutrition? (Please tick all that apply)**

- Parent(s)/Caregiver(s)
- Other family (please explain)
- Friends
- School
- Media (books, magazines, newspapers, TV, films, video games etc. – please explain)
- Religion/other beliefs
- Internet (please explain)
- Other (please explain)

12. **Where would you go for advice on food and nutrition? (Please tick all that apply)**

- Parent(s)/Caregiver(s)
- Other family (please explain)
- Friends
- School Nurse
- Health services (dietician, health centres, GP, young person’s clinic etc.)
- Teachers
- Internet (please explain)
- Other (please explain)
13. **How often are you physically active***? (If you know the recommended amount please write it in the box) **What kinds of activities do you do?**

- More than 2 hours a day
- 1-2 hours a day
- 30 minutes a day
- 3 hours a week
- 2-3 hours a week
- 1-2 hours a week
- Less than 1 hour a week
- I am rarely physically active
- I don’t know

*This might include doing sports, freerunning, cycling, skateboarding, dancing and anything that raises your heart rate and makes you sweat*

14. **Where have you learnt about fitness and exercise? (Please tick all that apply)**

- Parent(s)/Caregiver(s)
- Other family (please explain)
- Friends
- School
- Media (books, magazines, newspapers, TV, films, video games etc. – please explain)
- Internet (please explain)
- Other (please explain)

15. **Where would you go for advice on fitness and exercise? (Please tick all that apply)**

- Parent(s)/Caregiver(s)
- Teachers
- Other family (please explain)
- Internet (please explain)
- Other (please explain)
- School Nurse
- Health services (fitness centres, health centres, GP, young person’s clinic etc.)

16. **Which of the following do you use for more than 3 hours a day? (Please tick all that apply)**

- Games console
- Surfing the internet* (excluding homework)
- Gaming*
- Other technology (please explain)
- Television
- Other (please explain)
- Social media* (Facebook, Twitter, Snapchat etc.)
- *Using a mobile/computer/laptop/tablet

17. **Where have you learnt about screen habits (use of technology)? (Please tick all that apply)**

- Parent(s)/Caregiver(s)
- Religion/other beliefs
- Other family (please explain)
- Internet (please explain)
- Friends
- Other (please explain)
- School
- Media (books, magazines, newspapers, TV, films, video games etc. – please explain)
18. **Where would you go for advice on screen habits? (Please tick all that apply)**

- Parent(s)/Caregiver(s)
- Other family (please explain)
- Friends
- School Nurse
- Health services (health centres, GP, young person’s clinic etc.)

19. **Do you smoke?** (If you have any comments please write them in the box)

- Yes, everyday
- Yes, sometimes
- No but I used to
- No but I’ve tried it before
- No and I never have

20. **Where have you learnt about smoking? (Please tick all that apply)**

- Parent(s)/Caregiver(s)
- Other family (please explain)
- Friends
- School
- Media (books, magazines, newspapers, TV, films, video games etc. – please explain)

21. **Where would you go for advice on smoking? (Please tick all that apply)**

- Parent(s)/Caregiver(s)
- Teachers
- Internet (please explain)
- Other (please explain)

22. **Do you drink alcohol?** (If you have any comments please write them in the box)

- Yes, everyday
- Yes, sometimes
- No but I used to
- No but I’ve tried it before
- No and I never have

23. **Where have you learnt about alcohol? (Please tick all that apply)**

- Parent(s)/Caregiver(s)
- Religion/other beliefs
- Internet (please explain)
- Other (please explain)

- Friends
- School
- Media (books, magazines, newspapers, TV, films, video games etc. – please explain)
24. Where would you go for advice on alcohol? (Please tick all that apply)
- Parent(s)/Caregiver(s)
- Other family (please explain)
- Friends
- School Nurse
- Health services (alcohol support services, health centres, GP, young person’s clinic etc.)
- Teachers
- Internet (please explain)
- Other (please explain)

25. Do you use illegal drugs (including “legal highs” or solvents)? (If you have any comments please write them in the box)
- Yes, everyday
- Yes, sometimes
- No but I used to
- No but I’ve tried it before
- No and I never have

26. Where have you learnt about illegal drugs? (Please tick all that apply)
- Parent(s)/Caregiver(s)
- Religion/other beliefs
- Other family (please explain)
- Internet (please explain)
- Other (please explain)
- Friends
- School
- Media (books, magazines, newspapers, TV, films, video games etc. – please explain)

27. Where would you go for advice on using illegal drugs? (Please tick all that apply)
- Parent(s)/Caregiver(s)
- Teachers
- Other family (please explain)
- Internet (please explain)
- Other (please explain)
- Friends
- School Nurse
- Health services (drug support services, health centres, GP, young person’s clinic etc.)

28. Are you sexually active (including oral sex)? (If you have any comments please write them in the box)
- Yes
- No
- I’d rather not say

29. Where have you learnt about sex, sexual health and relationships? (Please tick all that apply)
- Parent(s)/Caregiver(s)
- Religion/other beliefs
- Other family (please explain)
- Internet (please explain)
- Other (please explain)
- Friends
- School
- Media (books, magazines, newspapers, TV, films, video games etc. – please explain)
30. Where would you go for advice on sexual health or relationships? (Please tick all that apply)

- Parent(s)/Caregiver(s)
- Teachers
- Other family (please explain)
- Internet (please explain)
- Friends
- Other (please explain)
- School Nurse
- Health services (GUM clinic, health centres, GP, young person’s clinic etc.)

31. Are you happy with your general physical health and/or access to services for physical health? (Please give details)

- Yes
- No
- I don’t know

32. How would you describe your overall mental health?

- Very Good
- Good
- Okay
- Bad
- Very Bad

33. Do you regularly experience any of the following? (Please tick all that apply)

- Sadness or Hopelessness
- Feelings of panic, fear or unease
- Moodiness or angry outbursts
- Trouble understanding other people
- No confidence/belief in yourself
- Other mental health concerns (please explain)
- Problems with sleep
- You see/hear things that aren’t real
- Trouble concentrating or remembering things

34. Does this stop you from doing any of the following? (Please tick all that apply)

- Spending time with parents
- Going to school or doing schoolwork
- Spending time with other family
- Other activities (please explain)
- Spending time with friends
- General maintenance (eating, sleeping, showering, brushing teeth, dressing yourself etc.)

35. Do you think your emotional and mental health needs are being met? (Please explain)

- Yes
- No
- I don’t know
36. Where have you learnt about emotional and mental health? (Please tick all that apply)

- Parent(s)/Caregiver(s)
- Other family (please explain)
- Friends
- School
- Media (books, magazines, newspapers, TV, films, video games etc. – please explain)
- Religion/other beliefs
- Internet (please explain)
- Other (please explain)

37. Where would you go for advice on emotional and mental health? (Please tick all that apply)

- Parent(s)/Caregiver(s)
- Other family (please explain)
- Teachers
- Friends
- Internet (please explain)
- Other (please explain)
- School Nurse
- Health services (counselling, health centres, GP, young person’s clinic etc.)

38. Are you happy with your general mental health and/or access to services for mental health? (Please give details)

- Yes
- No
- I don’t know

39. Do you have any other comments regarding your health or about health services available to you?

Thank you for completing the questionnaire.