County Durham Youth Justice Service

Health Needs Assessment of Young People who Offend 2023/24

Contents

Executive Summary

Children and young people who are in contact with Youth Justice Services (YJS) are a vulnerable and socially excluded population. They experience multiple and compounding risk factors that contribute to both their risk of offending and re-offending and poorer health and life outcomes than other children and young people. This Health Needs Assessment (HNA) is repeated from a previous assessment in 2017, and comprises a systematic review of literature, collation of relevant data and intelligence, and engagement with young people and YJS workforce.

This HNA concludes that children and young people who offend are less likely than other children and young people to have their health needs recognised and met, from physical health through to mental health. Young people who offend are also less likely to achieve expected level of attainment in education, have lower levels of participation in post-16 learning and lower levels of employment. Without support to address risk factors affecting offending behaviour and poorer health outcomes, young people who offend are at risk of continuing offending behaviour into adulthood and experiencing further adverse outcomes.

County Durham Youth Justice Service (CDYJS) operates a model of support for children and young people that takes a holistic, child-centred approach to addressing risk factors. Since the 2017 HNA, systems and processes have changed significantly, and the service now operates a health team including a range of professionals able to work with young people to deliver specific interventions that meet their needs, including embedded substance misuse workers, a speech and language therapist, public health nurses, and health and wellbeing workers.

Elements of this offer have been highlighted by young people and staff as particularly helpful and effective, including support with substance misuse and communication needs. Areas for further development are indicated to more effectively support young people, both in the YJS, and across the wider health and care system. A series of recommendations have been produced in order to prioritise improvement actions.

CDYJS remains committed to improving the health and wellbeing outcomes of the youth justice cohort. This HNA findings and recommendations will be used to inform service development, improve outcomes, and reduce health inequalities for young people who offend in County Durham.

Term	Meaning
ACE	Adverse Childhood Experience. ACEs are potentially traumatic events that happen in childhood, including experiencing domestic violence, being the victim of neglect and abuse, and growing up in a household with alcohol and drug use problems.
Alcohol-related offences	Alcohol related offences are defined as crimes committed under the influence of alcohol and crimes directly associated with alcohol, for example, being drunk & disorderly and theft of alcohol.
AssetPlus	AssetPlus is the YJB end-to-end assessment and planning framework for young people in custody or known to the YJS in the community. It is used to identify specific risk factors that contribute to offending to plan suitable programmes and interventions.
CAMHS	Children and Adolescent Mental Health Services. CAMHS provide a range of support to children and young people for their mental health in outpatient and inpatient settings.
Care-experienced	A term used to describe children and young people who have lived or who have lived in care at any stage in their life, including residential or foster care or at home with a supervision order.
CDYJS	County Durham Youth Justice Service, responsible for working with young people aged 10-17 years who have offended to support them not to re-offend.
Child in need	A child in need is one who has been assessed by a social worker and found to need help and protection because of risks to their development or health, such as neglect or domestic abuse in the family.
ChildView	The information management system used by CDYJS to monitor young people's information and outcomes.
Conduct disorders	A conduct disorder is defined as persistent behavioural problems across multiple settings that range from defiant, disobedient or violent, to violating the rights of others or societal rules.
CPP	Child Protection Plan. A CPP is made when a child is judged to be at risk of significant harm that affects their health, welfare or development. CPPs are referred to as 'child protection registers' in some nations of the UK.
County Lines	Is a term used to describe drug-dealing networks across police and local authority boundaries by organised criminal groups. Children and young people are often exploited into transporting or dealing drugs as part of these networks.
Criminal exploitation	Is the deliberate manipulation or abuse of power or control over another person for criminal purposes. Some children and young people are vulnerable to exploitation because of their characteristics.
DCC	Durham County Council.
HNA	Health Needs Assessment. In this report, it refers to the systematic assessment of the health needs of a population group, such as this HNA for young people who offend. It also refers to a systematic assessment of a young person's health needs by a PHN within the YJS service.
HWBW	Health and Wellbeing Worker. HWBWs deliver health and wellbeing interventions within the YJS.
Looked after child	A child who has been in the care of their local authority for more than 24 hours, often referred to as children in care. This includes children living in foster care and children's homes.

Neurodiversity	Is a term often used to describe the diversity of the way people's brains work. Neurodivergent conditions include autism spectrum disorder (ASD) and attention deficit hyperactivity disorder (ADHD).
PHN	Public Health Nurse. PHNs undertake screening, assessment, and interventions for young people in the YJS, as well as liaising with other agencies and making specialist referrals.
Pre-Caution, youth caution and conditional caution	Justice outcomes following investigation of a criminal offence.
SDQ	Strengths and Difficulties Questionnaire. The SDQ is a brief emotional behavioural screening questionnaire for 2–17-year-olds that can be used to target interventions to those in need.
SEMH	Social, Emotional and Mental Health. An umbrella term used to refer to a wide range of difficulties, including behavioural needs.
SEND	Special Educational Needs and Disabilities. An umbrella term used in education to refer to learning difficulties and disabilities that make it harder for children and young people to learn compared to other children of the same age.
SLCN	Speech, language, and communication needs. An umbrella term used to refer to a range of speech and language difficulties or conditions.
SLT	Speech and Language Therapist and Therapy. SLT provision is part of the CDYJS Health Team who provides assessment and intervention for young people who offend.
TBI	Traumatic Brain Injury. When damage is sustained to the brain through a traumatic incident such as a blow to the head or body.
YJB	The Youth Justice Board are responsible for monitoring the YJS and collating and publishing information, as well as commissioning research to support practice development and share evidence-based practice across the sector.
YJS	Youth Justice Services, responsible for working with young people aged 10-17 years who have offended to support them not to re-offend. CDYJS is used to refer to the specific service operating in County Durham.
Young person who offends	A child aged 10-17 who has committed a criminal offence.

Introduction

Purpose

In 2017, a HNA was completed for young people who offend in County Durham. Recommendations identified in the last HNA have been implemented and CDYJS has changed significantly since the last assessment. The policy environment around YJS provision, tackling health inequalities, and the impact of the COVID-19 led to the decision for a new assessment to be undertaken.

The evidence from this updated HNA is essential to ensure continued strategic alignment of service planning and delivery to provide effective and efficient services to young people who offend, supporting them with their health needs and reducing health inequalities. The repeat nature of this HNA also allows progress since 2017 to be monitored.

The CD YJS Management Board and County Durham Public Health team are committed to improving health and wellbeing outcomes for young people who offend across County Durham. This HNA is part of the improvement cycle and is part of a shared ongoing commitment to improving outcomes.

Health Inequalities for Justice-involved Young People

Inequalities in health and wellbeing outcomes for justice-involved young people are well known. The Annual Report of the Chief Medical Officer 2012 highlighted important health needs of young people who offend and the social, environmental, and economic challenges they face in comparison to young people who have not offended[1], and the Equality and Human Rights Commission described young people who offend as a "*critical human rights challenge in England*"[2].

A number of complex and interrelated health needs are identified as risk factors for engaging in offending behaviour in the evidence base. These health needs are often not identified or supported prior to a young person's first offence, and the reasons behind this are complex.

Justice-involved young people also have health needs that continue through contact with YJS and into adulthood. Whilst custodial sentences are a last resort option and detention can provide an opportunity to identify and address previously unmet health needs, the custodial environment can itself be a cause of poor health.

Inequalities have not diminished over time, with the HM Inspectorate of Probation finding in 2020 that justice-involved young people are likely to experience multiple life events or circumstances that impact on their health[3]. Failing to identify and address pre and post offending health needs increases the risk of both re-offending, and poorer health and life outcomes.

Access to mainstream health services remains a key barrier, with many health and care services operating inflexible models that do not meet the needs of justice-involved young people, preventing them from accessing the same standards of healthcare as other population groups, contributing to unfair and avoidable differences in health outcomes.

Core20PLUS5

NHS England categorises people involved in the justice system as an inclusion health group in their Core20PLUS5 model, including young people who offend[4].

The Core20PLUS model aims to provide an evidence-based framework for regional and local health systems to prioritise data and research to reduce inequities, starting with the 20% most deprived population (CORE20) and targeting inclusion health groups (PLUS).

The Core20PLUS5 approach aligns to the NHS Health and Justice Framework for Integration, an ongoing national programme commitment to improving the quality of services for the prison population and people subject to supervision through probationary services, and the Health and Justice Children Programme National Partnership Agreement, 2023-25, which focuses on healthcare delivery in secure settings for children.

The Core20PLUS5 model has also been adapted to justice-involved young people providing the system with specific evidence enabling the system to take a focused approach to reduce health and care inequities for young people who offend.

Figure 1 – Core20PLUS5 Model for Children

Impact of COVID-19

The impact of the COVID-19 pandemic on YJS was unprecedented. Whilst YJS nationally continued to deliver support to young people, many services were paused, including education and rehabilitation services, and others were reduced, such as young people receiving less face-to-face support from YJS and pauses on referrals to external agencies such as CAMHS[5].

Services had begun to recover to pre-pandemic operating levels in 2022. However, while the number of young people given a caution or sentence fell during the pandemic, the needs of children known to YJS have become more acute because of less support for complex and multiple needs, increased challenges accessing mental health services and reduced education and training provision.

COVID-19 appears to have exacerbated existing challenges such as funding and infrastructure. Coupled with lasting effects of backlogs in the court system and specialist health services, the impact of COVID-19 is still felt across YJS and should be considered when making recommendations for service delivery.

Methods

This assessment was completed utilising data from various sources, including:

1. Literature review consisting of searching research databases and reviewing grey literature including national policy documents and the previous HNA.
2. National and local quantitative data relevant to young people who offend, including data from CDYJS, DCC, health and social care, and other relevant data sources.
3. Qualitative data collected through surveys with young people who offend and professionals working in and with the YJS.

CDYJS Provision

CDYJS works with children and young people aged 10-17 years old who are at risk of becoming involved in offending behaviour and those who have committed a criminal offence in receipt of a Pre-Caution Disposal, Youth Caution or Youth Conditional Caution to prevent re-offending.

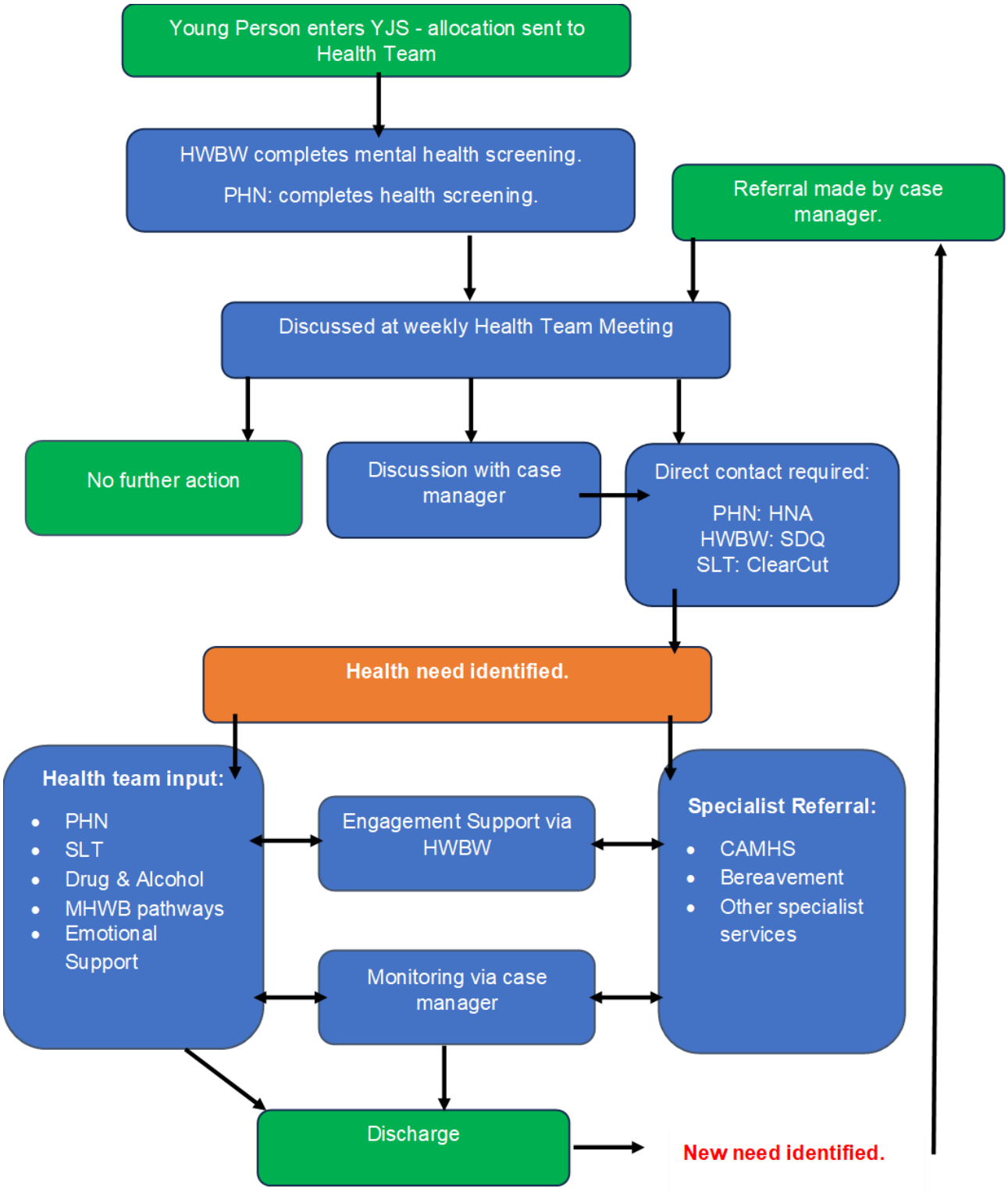
In 2015 the YJB introduced AssetPlus as the tool for statutory Youth Justice cases. The Asset system is designed to provide a holistic end-to-end assessment and intervention plan, allowing one record to follow a child or young person throughout their time in the YJS. The assessment is designed to identify specific risk factors that contribute to young people offending; the risk they pose to others; safeguarding issues; and protective factors which can help to prevent them reoffending.

CDYJS assesses the health of young people entering the service through health screening and health needs assessments, including their speech, language, and communication needs. Support is offered through a dedicated Health Team commissioned through the County Durham 0-25 Family Health Service and provided by Harrogate and District NHS Foundation Trust and Tees, Esk and Wear Valley NHS Foundation Trust, and the service works closely with other health services. This process is outlined in **Figure 2**.

Through the AssetPlus assessment process, case management, and Health Team input, CDYJS support young people with:

- Education, training, and employment
- Offending behaviour work
- Suitable accommodation on release
- Health and mental health provision
- Provision of support for dealing with finances, debts, and benefits
- Engaging with parents and carers
- Managing risk issues in relation to victims
- Managing any risk of serious harm to others

Figure 2: CDYJS - Health Assessment Process



Chapter 1: Literature Review

Aim

The previous HNA compiled extensive evidence in 2016/17 on health needs and health inequalities of young people who offend. The purpose of this literature review is to review previous evidence for relevance and combine with a new literature search to compile an update evidence base to inform the HNA.

Methodology

The literature review consisted of three parts:

1. A grey literature search for relevant policy documents and/or reports that may contain reference lists containing relevant articles, including relevant websites such as the Prison Reform Trust

2. A full literature search using the MEDLINE database for available evidence on health and wellbeing needs of young people who offend.

3. Reviewing evidence previously highlighted in the 2017 CD YJS HNA for continued relevance.

The database search strategy was based on key terms of relevance. Key terms were selected informed by the 2017 HNA, the grey search for relevant documents, and through conversations with the CDYJS for evidence that may be new, emerging, or of particular importance.

208 documents were retrieved and reviewed through the search after discounting duplicates. A number of these documents were policy papers related to delivery of YJS and cited a small number of core references. Approximately 120 items were peer-reviewed journal articles, of which many were discarded as not relevant to the UK population or of poor methodological quality (see 'quality of evidence').

Discussion

General overview

There is a growing body of evidence on the health needs of young people who offend and increased evidence available since the 2017 HNA. However, the focus continues to be on young people in custody rather than those managed by services in the community. As before, literature primarily focuses on health-related risk factors *for offending and re-offending* rather than health outcomes for the individual.

The research literature on health and wellbeing needs of young people who offend can be broadly split into three categories:

1. **Health and wellbeing inequalities and risk factors that increase or decrease risk of offending in childhood and adolescence.**

Most of the literature found covered a range of health-related risk factors for youth offending, from individual risk factors such as learning disabilities through to community risk factors, such as poverty and deprivation.

Some literature focused on protective factors, conditions that mitigate the risk of a young person offending and having contact with YJS and poorer health outcomes.

2. **Ongoing health and wellbeing inequalities observed in the young people who offend population.**

Limited literature details health and wellbeing challenges because of a young person committing an offence. For example, being isolated away from family and friends due to detention can contribute to deteriorating mental health.

3. **Interventions to support improved health and wellbeing and reduce inequalities for young people who offend.**

Some literature explored interventions to tackle or improve health outcomes for young people in contact with the justice system. These studies generally focused on a specific sub-group of young offenders; for example, those with a diagnosed specific mental health condition.

Quality of the evidence

As in the 2017 HNA, most research literature focuses on evidence gathered in the USA and other countries with significantly different YJS and population health needs than in the UK. Some literature has therefore been discarded on the basis that it is not relevant or not generalisable to the UK setting, and those included should be interpreted with caution. Some evidence was discarded based on methodological quality.

Depth of evidence varies by health need, with more evidence on mental health needs than physical health needs, and some studies reported on combined needs; for example, substance misuse and learning disability both categorised as mental health needs. This can make it difficult to isolate specific needs of young people who offend, acknowledging that generally, needs are inter-related, and it is not possible to isolate them from one another.

The literature did not provide evidence of a causal relationship between health needs and offending, though it is an accepted academic view that multiple factors interact and increase the risk of offending behaviour rather than individual causal relationships.

Some literature did not make it clear when the health need was observed, and therefore whether it occurred before offending, or a consequence of offending; or both. We have therefore treated this literature as a combination of both, recognising the complexity of young people's lives and the multiple factors that may influence their behaviour at any time.

1. **Health and wellbeing inequalities in childhood and adolescence that increase risk of offending.**

Risk and Protective Factors

Risk and protective factors are complex and many of the factors explored in this literature review are both directly and indirectly associated with other health and wellbeing outcomes and inequalities for justice-involved young people; for example, Adverse Childhood Experiences (ACEs) are a risk factor for substance misuse, which in turn is a risk factor for offending; and deprivation is a risk factor for ACEs, and also for offending directly.

The consensus across the literature is that risk factors are cumulative and interact with each other, and this clustering effect across multiple areas increases risk of offending[6, 7]. Changes in risk factors over time, and how serious they are, also have an impact[8].

No single protective factor can reduce the risk of a young person offending or improve their health outcomes. However, addressing a range of risk factors through interventions could reduce risk.

Adverse Childhood Experiences (ACE)

ACEs are a risk factor for offending in childhood and adolescence across a range of events, including experiencing abuse, domestic violence, traumatic events, and substance abuse. Findings include:

Children living in deprived areas are more likely to experience ACEs and, independently of deprivation score, ACEs correlate with worse health, criminal justice, employment, and education outcomes across the life course[9]

In 2012, 39% of children in contact with YJS in England and Wales had experienced childhood neglect, abuse, or been on a CPP[1].

Children with incarcerated parents are commonly exposed to other ACEs and are particularly vulnerable to these experiences compared to children with parents who are not in prison[10].

Sexual assault and exploitation in childhood is a risk factor for substance misuse and other high-risk behaviours in adolescence, including risk of offending[11,12] and higher risk of very serious criminal offending[13].

A high proportion of young women in contact with YJS report having experienced sexual abuse or violence[14] in childhood, and in 2012, one in 10 girls in contact with the YJS in England experienced sexual exploitation in childhood[1].

Protective factors include family harmony and positive, supportive family relationships[1].

Looked-After and Care-Experienced Children

Experiencing care, either temporarily or permanently, is a risk factor for criminal offending in adolescence. Findings include:

Care-experienced young people continue to be disproportionately represented in the Criminal Justice System despite falling numbers of children in the YJS[15]

General risk factors for becoming a looked-after child are similar to risk factors for youth offending and approximately 27-50% of children in custody have experienced care[16,17]

Care-experienced children are more likely to have misused substances and missed education, which are both linked to higher offending rates than non-care experienced children, and in 2018 this was recognised by the Department of Education who launched a protocol to reduce offending in children who had experienced care[15].

Protective factors include competent, stable care with healthy attachment and clear boundaries[1].

Poverty and Socio-Economic Status

Poverty can be directly and indirectly linked with offending behaviours and is a key risk factor. Findings include:

Global research has shown a link between economically-disadvantaged communities and higher youth offending rates[18].

Children who live in poverty experience other risk factors such as higher levels of stress, ACEs and more limited educational opportunities affecting social, cognitive, and neurological development[19]

The longer a young person lives in poverty the more likely they are to engage in high risk or criminal behaviour[20]

Poverty reduces resources available to young people, causing general disadvantage compared to young people in higher socioeconomic groups; for example, reduced educational achievement, which can be indirectly linked to offending behaviours[21]

Challenges resulting from poverty can lead to children being exposed to stress, pressure, conflict, and violence, increasing the risk of offending behaviour [22,23]

Areas of deprivation have lower levels of supervision of children and young people[24] and areas with high levels of youth offending report lower social cohesion and high social disadvantage[25]

40% of children in England and Wales known to Youth Justice Services in 2012 had experienced homelessness[1].

Engaging in criminal behaviour acts as a barrier to a young person's ability to improve their socio-economic position after an offence has occurred[26]

Protective factors include positive bonds across the community, participation in community activities including school, supervision, and safe neighbourhoods[1].

Social, Emotional, and Mental Health (SEMH)

SEMH needs, considered here as a broad spectrum can be a risk factor for youth offending. Key findings include:

Persistent mental ill-health (diagnosed or undiagnosed) and behaviours associated with conduct disorders are risk factors to offending[27]

Conduct disorders are highly prevalent across the youth offending population[28]

Diagnosed mental health conditions and mental health concerns are highly prevalent across the youth offending population, with 72% of AssetPlus assessments in 2020 raising concerns in relation to a child's mental health[29].

A high proportion of children who display offending behaviour have experienced ACEs affecting their mental health. In 2012, 62% of justice involved children self-reported difficulty coming to terms with past events or trauma[29].

Substance misuse is a common challenge affecting mental health. In 2012, 95% of justice-involved children reported substance misuse issues and in 2020, 76% of completed AssetPlus assessments raised concerns around substance misuse[29]. Cannabis was the most commonly reported substance misused by young people who offend followed by alcohol, with smaller numbers reporting misuse of ecstasy and powder cocaine. Substances follow trends seen in other young people but are used at a significant higher rate by young people who offend.

In 20/21, 25% of referrals to substance misuse services came from Youth Justice Services[29].

Justice-involved children report being confused trying to navigate services for help with substance use and abrupt ends to service at the end of their sentence[29].

Mental health difficulties in young people may manifest as behavioural problems, self-destructive and high-risk behaviour, and social withdrawal. These behaviours can be misinterpreted and dismissed[29].

Neurological Conditions, Neurodiversity, and Learning Disabilities

Diagnosed and undiagnosed neurodevelopmental conditions are disproportionately prevalent in the justice-involved youth population. Findings include:

Children with the neurodevelopmental conditions ADHD or diagnosed as autistic are more likely to have experienced ACEs, have poorer health outcomes across the life course and are at higher risk of offending[30].

Neurodiversity is disproportionately present in justice-involved young people, with around one third with a diagnosis and more waiting for diagnosis compared to around one sixth of the general population[31].

Up to 47% of autistic adults did not have an autism diagnosis to disclose when they first entered the justice system[32].

Young people entering YJS may not have accessed a diagnosis because of factors such as being in care and moving around the system or exclusion from school[33]; or because of limited parental engagement with health and education services[34]

Justice-involved young people diagnosed as autistic report a lack of understanding about their needs and in meeting them, with negative consequences on future life chances[35].

The need for neurodiversity to be explored and considered in the Justice system more broadly has been recognised with evidence briefings and recommendations but they are not specific to young people[31].

Comorbidity of ADHD and conduct disorders is linked to repeat offending in adolescence[36]

Impulsivity and lack understanding and or considering the consequences of decisions as a result of some mental health and neurological conditions may increase the risk of offending behaviours[37]

Children with symptomatic ADHD are more likely to enter YJS earlier than others and are more likely to engage in other behaviours linked to increased risk of offending, including drugs and alcohol[38]

The prevalence of self-reported and known TBI is around 65-76% for the population of young people in custody settings, compared to between 5-24% in the general population[39]

Diagnosed learning disability is significantly higher amongst young people in custody with an estimated prevalence of 23-32% compared to 2-4% general population[1] with studies suggesting that this may be an underestimation.

Education, Training and Employment (ETE)

Poor educational achievement and lack of progression into training and employment compared to the rest of the population is a common factor for children who offend. Findings include:

Low school attainment is an important risk factor for offending with young people who offend citing lack of training and qualifications as the most important factor that contributed to their behaviour. Low attainment typically begins in primary school along with low literacy and numeracy, truancy, poor relationships with teachers, exclusion, low engagement with education, and young people being unable to access the curriculum due to additional needs[40].

60% of detained young people have speech, language, and communication needs[1] with some studies estimating as high as 90%[41]

Many young people entering secure settings aged 15-17 have literacy levels below where they should be with approximately half of with the expected literacy levels of a 7–11-year-old[42]

In 2011-12, 18% of sentenced children in custody had a Statement of Special Educational Needs to 3% of other population[43].

9/10 boys aged 15-17 in custody have been previously excluded from school[42.]

Just 1% of children who committed an offence with a less than 12-month sentence post leaving KS4 achieved 5 or more GCSEs graded A*-C including English and maths [42].

81% of justice-involved children surveyed in 2012 did not have any qualifications[42].

Education and training acts as a protective factor for offending and re-offending through the learning process of providing young people with skills and qualifications and in setting behavioural norms[40].

Children as Victims of Crime

Many young people who commit crimes are also victims of crime and are often identified as criminals rather than victims. Findings include:

Over half of young people involved with YJS in England and Wales had also been a victim of crime[1].

Children involved in county lines operations have significant vulnerabilities and needs that contribute to their exploitation and criminal behaviour, and their needs as victims are not always met, with adverse outcomes as a result[7].

Children known to the YJS who have been victims of criminal exploitation are more likely to re-offend[44].

Children who are encountered as offenders should receive the same safeguards as other children, including investigating exploitation and crimes committed against the child[2].

2. Ongoing health and wellbeing inequalities observed in the young people who offend population

Health needs outlined in section 1 generally persist through a young person's contact with the Youth Justice Service unless specifically identified and addressed. In addition, there are some needs that arise as a result of a young person's offending behaviour.

SEMH

Findings include:

Mental health needs can develop as a result of detainment[45] including depression as a result of involvement in criminal behaviour[31] and in 2012, 43% of young people on community orders had identified ongoing SEMH needs[1].

Young people who offend who transition to adult custodial settings are at increased risk of suicide and self-harm[46]

Contact with YJS can lead to stigmatisation, discrimination, and differences in treatment within communities, affecting mental health, image of self-worth, and increasing the likelihood of future offending[47]

Poverty and Deprivation

Poverty is both a cause and consequence of poor health and wellbeing and offending. Findings include:

Offending and the consequences can negatively impact young people's ability to achieve their hopes and aspirations such as achieving job roles[48] and improving their socio-economic position[26].

Young people who experience other risk factors for offending can be affected by a 'spiral of adversity' where life factors such as employment and income have their outcomes affected[49]

Homelessness

Involvement with the YJS can make it more difficult to find suitable accommodation for young people and the lack of suitable accommodation on leaving custody increases the risk of re-offending[6].

Education

Recent research by the YJB indicates that education access at most secure estates for young people is not good enough, with a deterioration in amount and quality of education compared to before the COVID-19 pandemic[50], further disadvantaging young people.

3. Interventions to Support Health

Most literature on specific interventions to support justice-involved young people are around mental health. It should be noted that research literature for mainstream health services, for example, interventions offered by CAMHS, and drug and alcohol services still apply to young people who offend, though adaptations may be required as outlined below.

Mental Health

Justice-involved children face challenges gaining access to services including long waiting lists and high thresholds and may face additional barriers from being seen as 'offenders' before children with mental health needs[29].

Early intervention is essential. Identifying mental health needs at the point of arrest and providing early support through liaison and diversion services can improve outcomes for depression and self-harm[51]. The more support a child is provided with through these services, the greater the improvement.

There is some evidence for psychological interventions such as Cognitive Behavioural Therapy (CBT) improving depression, anxiety, and self-harm for children in custody[52] but more research is required on children supervised in the community.

Some evidence exists for group-based CBT in reducing depressive symptoms compared to usual care or no treatment, but more research is needed in relation to group vs individual CBT for young people who offend[52].

Engaging children through 'factual', positively framed questions about 'tangible' things rather than their emotions is more effective to elicit conversation than more abstract questions about their emotions or mental health[53].

Justice-involved young people report that mental health support is inadequate, and five issues have been identified as requiring improvement. These are: developing consistent relationships with young people; greater staff skills, knowledge, and competence; better coordination between services; assertive pathway management for children with more complex needs; and easy to access information for children and their families[54]. These recommendations apply to mainstream health services as well as those specific to young people who offend.

Guidance identifies key areas for successful delivery of early interventions, including mental health screening at every stage of YJS undertaken by skilled staff, local services available for complex needs, needs assessment information shared with appropriate agencies, and mental health needs being made known to police and courts.

Education, Training and Employment (ETE)

Interventions to support 16–18-year-olds in mainstream colleges under YJS supervision can be effective in improving educational attainment and supporting desistance[55]

After school programmes have been found to reduce general crime by 8% with academic and vocational programmes more effective than recreational programmes and targeting children 11-14 also found to be more effective than older groups[56]

Mentoring programmes can reduce crime by, on average, 26% and reduce behavioural difficulties, substance misuse and improve self-regulation, reducing risk of violence. Programmes with male mentors and self-chosen mentors are more effective[56].

Interventions aimed at preventing school exclusions have a moderate impact on violent crime and programmes that include training on self-regulation and mentoring appear more effective[57].

Supporting entry to employment through vocational skills training and placements have shown popularity amongst justice-involved young people and improved educational attainment[57].

Reading interventions focused on improving literacy can be effective, showing on average six months progress in reading for each month of the course, but can suffer from high drop-out rates[57].

Engagement and Co-production

Services that embed a 'child first' approach to engaging and collaborating with children and young people to make decisions in service delivery have been found to improve positive relationships with staff and ensure children and young people feel important and valued[58].

YJB guidance provides a framework in which to place children at the heart of service provision for services to better identify and tackle influences on offending behaviour[58].

Policy Landscape

In 2021 the YJB published their strategic plan, 2021-2024[59].

The plan recommend that robust health screening and assessment takes place for young people on entry to YJS as part of a holistic approach that includes exploring a range of risk factors, including those explored in this literature review. However, information on these factors is primarily used to understand why the offending behaviour took place to implement interventions to support the child and reduce the risk of reoffending, rather than improving health.

Conclusion

Young people at risk of offending and who have offended have complex lives with several health and wellbeing risk factors that contribute to poor outcomes across a range of areas.

The evidence base is relatively like that found in the 2017 HNA. There are few new references of significant importance, and instead research tends to have focused on in-depth exploration of known issues.

Research is still focused on identifying and addressing health-related risk factors for offending behaviour rather than specific interventions to address these risks before or after offending. However, any intervention to reduce risk factors, particularly those that address multiple, interacting risk factors linked to offending behaviour are likely to be of net positive benefit to young people who offend and the communities they live in; for example, through improved educational attainment and gainful employment.

Evidence on specific interventions around mental health is emerging and it should be noted that evidence on adapting interventions to meet the needs of young people who offend applies to mainstream health services, as well as those specific to young people who offend.

National policy has changed, with a new strategic plan for YJS published in 2021. However, this plan does not hold any requirements or recommendations related to health that differ significantly from previous iterations.

Chapter 2: County Durham Population

Age Profile

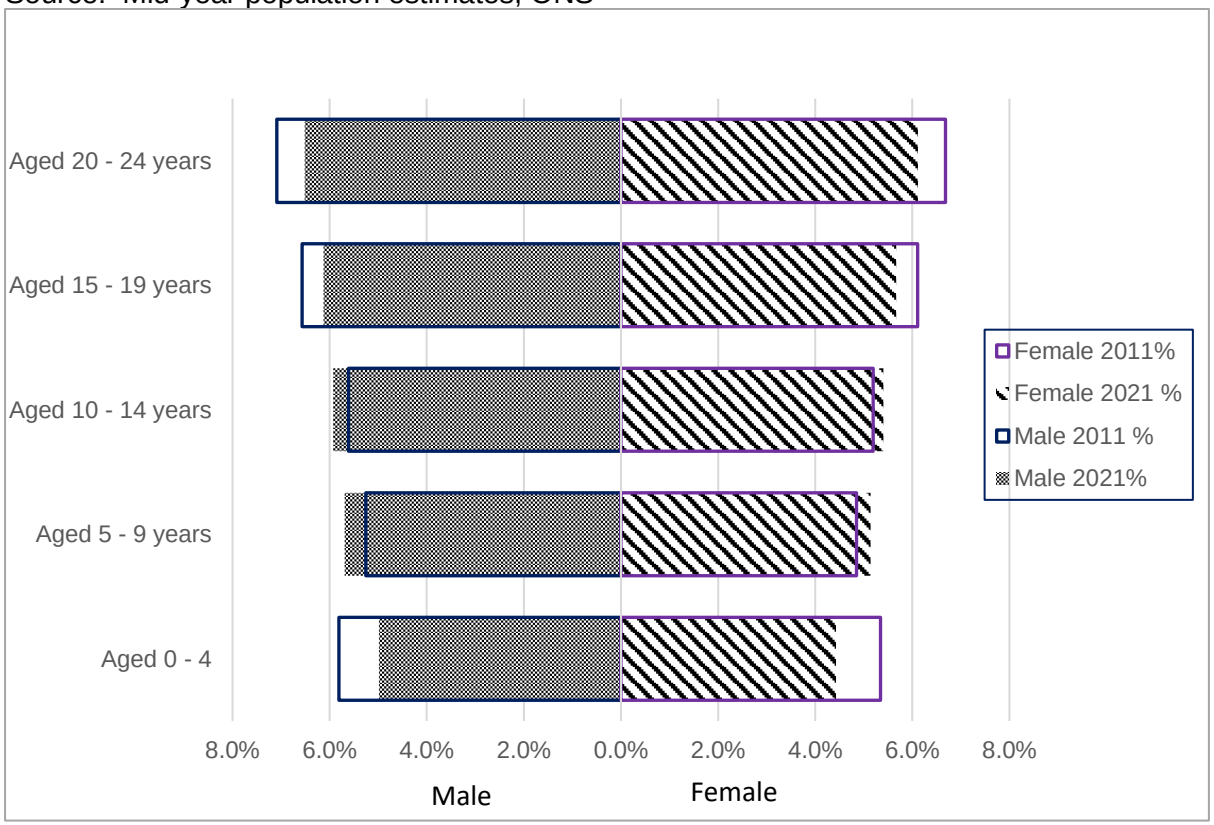
County Durham has an estimated population of 521,346[60]. Since 2011, the population has increased by 8,500 people (1.6%).

The number of children and young people aged 0-24 is approximately 146,0000, a 3% decrease from the 2011 figure of 150,100. Projections to 2043 suggest that the 0-24 population will rise by 4% to 152,000.

Comparison between 2011 and 2021 age splits within 0-24 are provided in **Figure 3**, showing a decrease in older age groups and increase in younger groups, except for 0–4-year-olds.

County Durham has an ageing population structure. This follows national and historical trends brought about by the post Second World War spike in births, followed by steadily decreasing birth rates until the start of the new millennium.

Figure 3: Population age pyramid for County Durham 2011 to 2021, ages 0 to 24 years. Source: Mid-year population estimates, ONS



Deprivation

County Durham is a large and diverse area. It is the 75th most deprived Local Authority in England (75/326) and as such is expected to have lower than average health outcomes.

Health inequalities remain persistent and pervasive. 47% of the population live in relatively deprived areas, and 49% of County Durham's Lower Super Output Areas (LSOAs) are in the 30% most deprived nationally. Levels of deprivation are higher than the England average. Life expectancy for men and women is lower than the England average. This variation is shown in **Figures 4 and 5**.

Figure 4: Map showing County Durham's most 30% most deprived LSOAs nationally. Source: ID2019, Department for Communities and Local Government (DCLG).

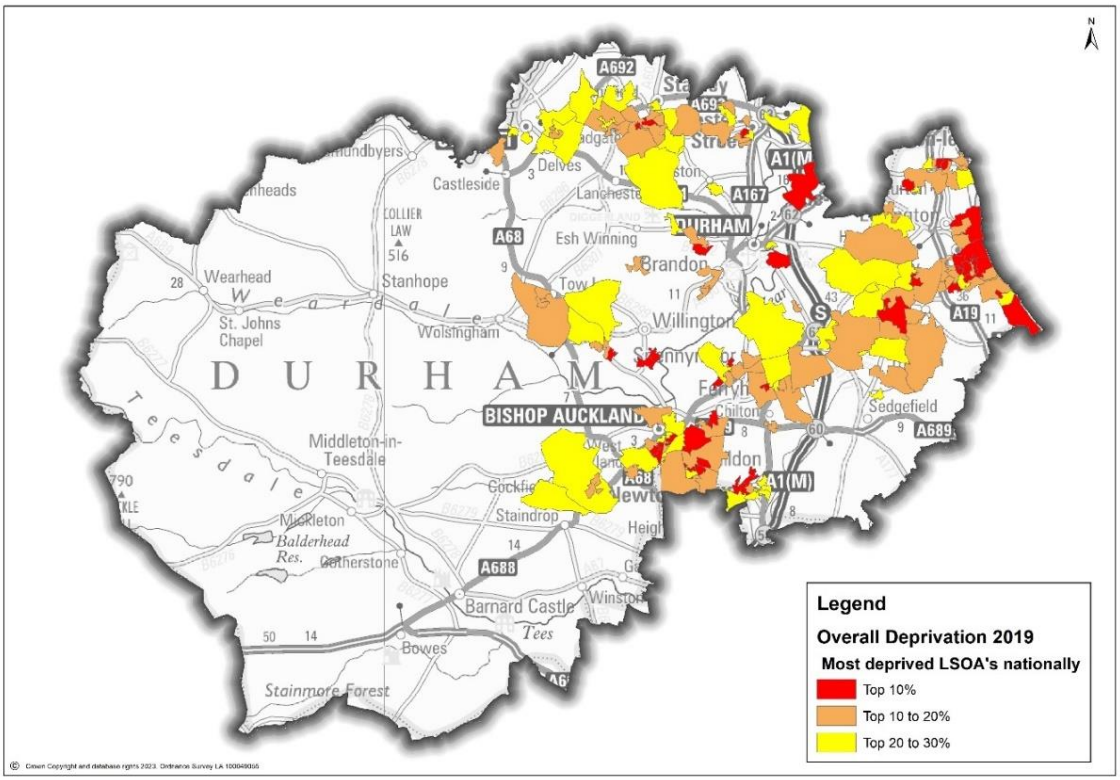
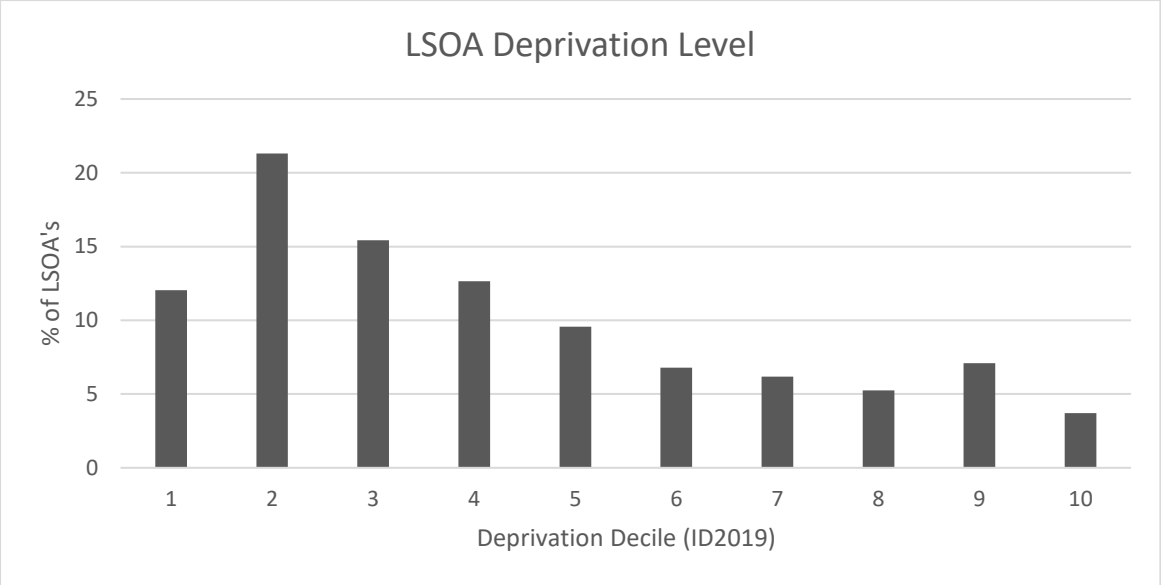


Figure 5: Percentage of LSOAs by national deprivation deciles (Overall Rank, Index of Deprivation 2019), County Durham, DDES CCG and North Durham CCG. Source: ID2019, DCLG, Durham County Council Public Health Intelligence (DCCPHI).



Health Needs of Children and Young People

Child health and wellbeing in County Durham is generally worse than the England average, with some measures worse, others showing improvement from previous assessments, and others better. County Durham is not in the worst decile (10%) for any child health and wellbeing key indicators nationally. The 2023 Child Health Profile is included in the data annex to this report.

Children with a good level of development at the end of reception and average Attainment 8 score for children in care and not in care are like the England average. The number of 16- and 18-year-olds not in ETE sits at 5.3%, similar to the England average.

First time entrant to the YJS rate per 100,000 sits at 146.2, similar to the England average. The number of children living in absolute low-income families is higher than the England average at 20.9% and rate of children in care per 100,000 population is significantly higher than the England average at 99 compared to 70.

Admission to hospital for alcohol-specific conditions for under 18's is higher than the England average and admissions due to substance misuse between 15-24 are similar to the England average.

Admissions to hospital for mental health conditions for those under 18 are significantly higher than the England average at a rate of 186.9 per 100,000 population compared to just 99.8. Similarly, the rate of hospital admissions linked to self-harm between 10-24 is higher than the England average at 591.2, compared to 427.3. however, coding differences between areas have been flagged as a contributor to these disparities, so figures should be interpreted with caution.

Chapter 3: Understanding Young People Who Offend in County Durham

Chapter 3 outlines available data on young people who offend in County Durham in terms of their offending behaviour, identified health and wellbeing needs, interventions offered, and service delivery model. Additional data is available in a separate data annex.

Number of Offences and Offenders

In 22/23, a total of 932 offences (resulting in a pre-caution disposal, out of court disposal, or imposed court conviction) were committed by 382 young people, shown in **Figure 6.** Between 16/17 and 22/23, a 13.5% decrease in the number of offences (1077 to 932) was observed and a 24.1% decrease in the number of young people offending (503 to 382) shown in **Figure 6.**

22/23 saw a significant increase from 21/22 in number of offences, up 81% (515 to 932) and number of young people offending, up 45.8% (262 to 382). This is thought to be due to a reduction in crime figures during the COVID-19 pandemic and the increase represents a return to levels seen before.

In 2022, there were 68 first time entrants to CDYJS compared to 333 in 2010 due to changes in recording practice. The rate of first-time entrants, 146.2 per 100,000, is not statistically significantly different to the England rate of 148.9/100,000 shown in **Figure 7**.

Figure 6: Number of offences and number of young people offending, 2016/17 – 2022/23, County Durham. Source: CDYJS Systems – CareDirector and ChildView

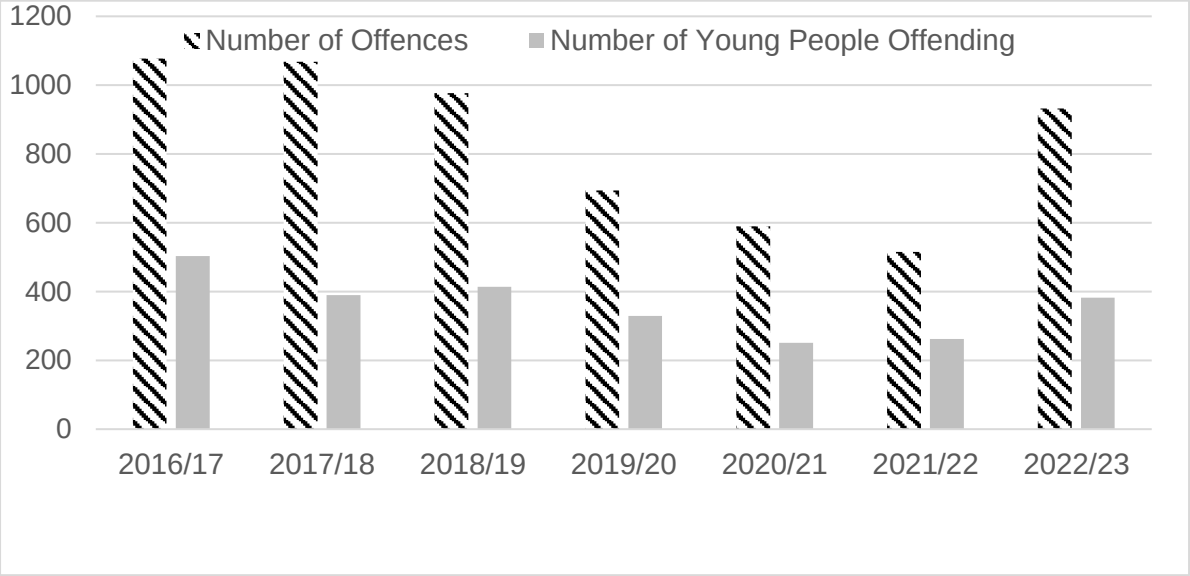
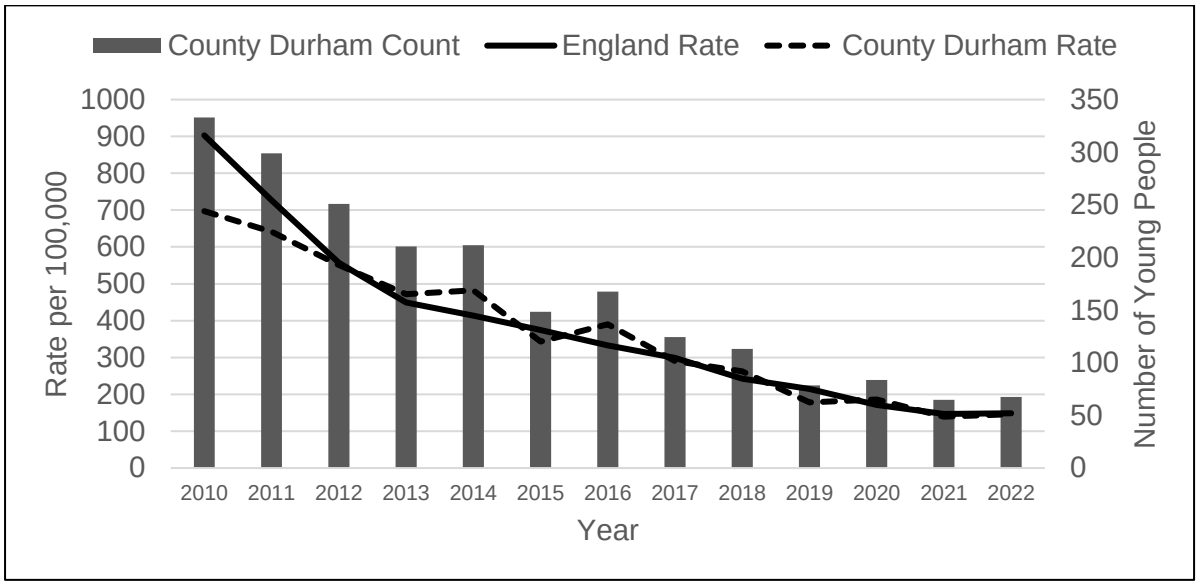


Figure 7 Rate of first-time entrants to the YJS rate per 100,000 and numerical count, County Durham compared to England, 2010-2022. Source: PHOF, Fingertips, PHE.



Distribution of Offenders

The majority of CDYJS clients are from the most deprived areas in County Durham, and in 22/23, 67% came from the 30% most deprived Middle Super Output Areas (MSOAs) nationally, shown in **Figure 8.**

Distribution of young people who offend is unevenly distributed, shown in **Figure 9**. 22% were resident in Derwentside, 19% in Easington and 19% in Sedgefield, with 18% from The Dales, 14% from Durham and 7% from Chester-le-Street.

Offending rates were highest in the former District area of Sedgefield at 31 per 1,000 compared to the lowest in the former District of Chester-le-Street at 8.7 per 1,000 (not tested for statistical significance) shown in **Figure 10.**

Average offences stood at 2.4 per young person in 22/23. Offences are split unevenly between male and female offenders, with 301 male (78.8%) and 81 female (21.2%). Split by gender, young women have an average number of 1.9 offences (16.6% total offences) and young men, 2.6 offences per person (83.4% total offences) in 2022/23 shown in **Figure 11.**

Figure 8: % Distribution of County Durham Youth Justice Service clients by national deprivation decile, County Durham, 2022/23. Source: CDYJS Case Management System – ChildView.

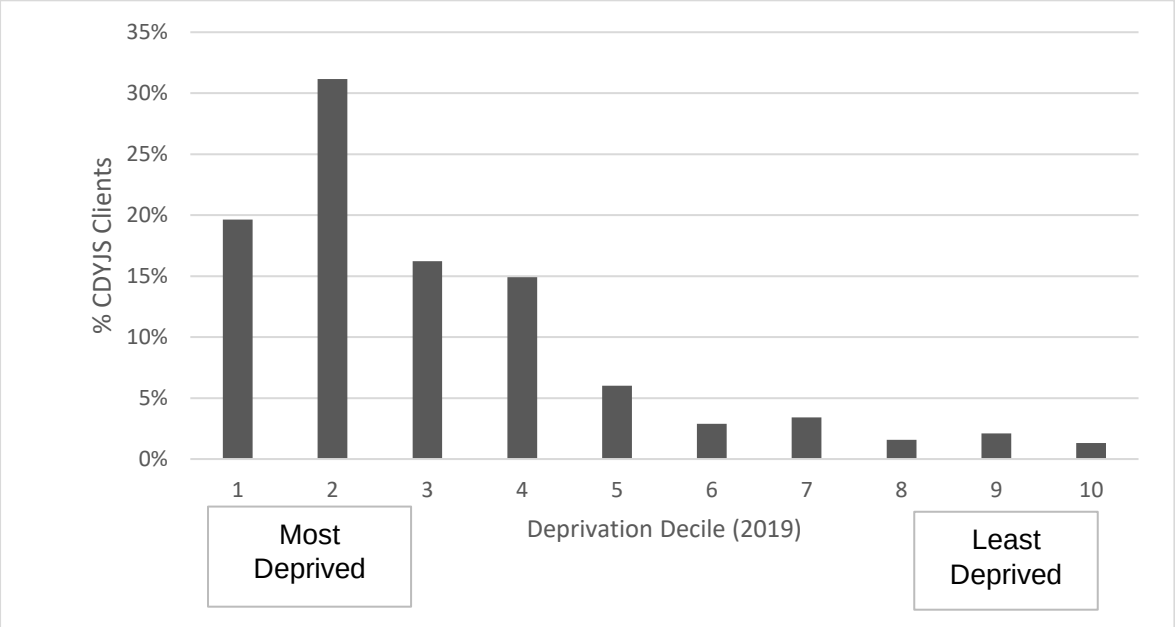
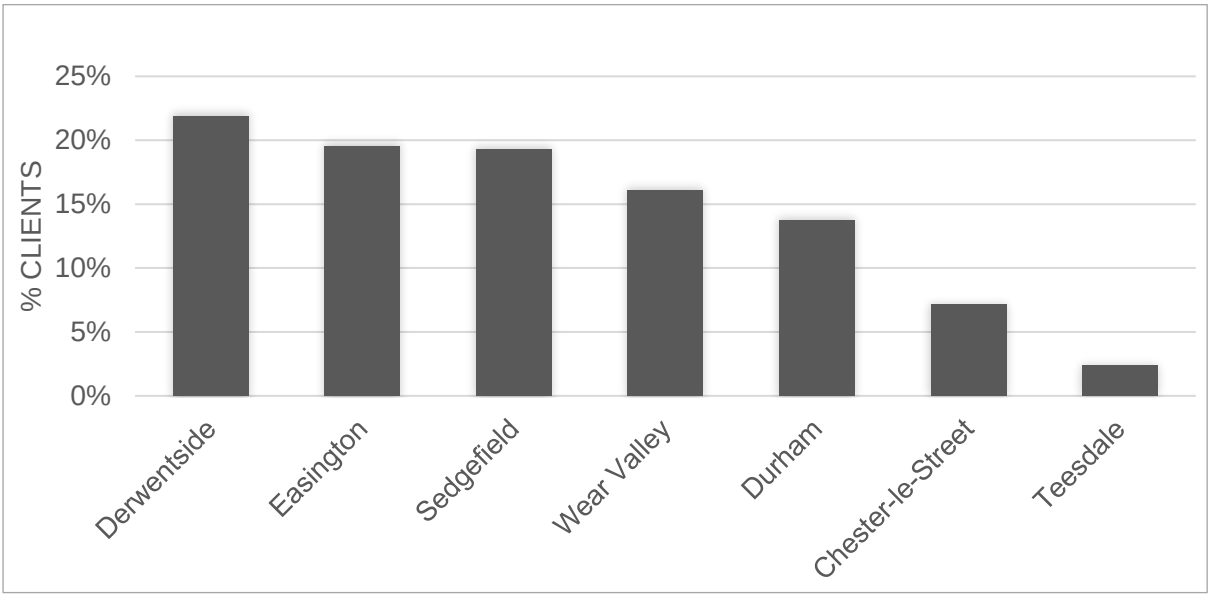


Figure 9: Proportion of young people offending by former district (identified by last known postcode), April 2022 – March 2023. Source: CDYJS Case Management System – ChildView. Distribution



* Due to the low numbers of young people residing in Teesdale, for the purpose of the remainder of the report in relation to offending, this will be combined with Wear Valley and called ‘Wear / Tees’.

Figure 10: Number of offences by type and former district, 22/23. Offences Source: CDYJS Case Management System - ChildView. Population Source: Based on DCC estimates using 2021 Census.

	Chester-Le-Street	Derwentside	Durham	Easington	Sedgefield	Wear/Tees	Num of offences	% of all offences	% change from 21/22
Violence	14	28	31	42	58	48	221	23.8%	23.5%
Damage	6	20	19	40	29	36	150	16.2%	50.0%
Motoring/ Vehicle	*	34	21	5	38	48	149	16.1%	217.0%
Acquisitve	*	44	23	18	29	21	136	14.7%	257.9%
Other	7	23	13	27	22	13	105	11.3%	16.7%
Breach		*	5	*	58	5	71	7.7%	294.4%
Sex Offences	6	17	5	5	19	*	55	5.9%	323.1%
Drugs	*	13	6	10	5	*	41	4.4%	36.7%
Former District num. offences	40	180	123	149	258	178	932		80.2%
& of all offences	4.3%	19.3%	13.2%	16.0%	27.7%	19.1%			
Offences per 1,000 population	8.7	20.9	16.5	17.1	31.0	21.4	20.3		81.0%

** Suppressed due to numbers less than 5*

Figure 11: Offences by category and gender. Source: CDYJS Case Management System - ChildView.

Offence Category	2021/22 % of Offence Category		2022/23 % of Offence Category	
	Male	Female	Male	Female
Acquisitive	97.4%	2.6%	93.4%	6.6%
Breach	89.5%	10.5%	100.0%	0.0%
Damage	87.9%	12.1%	74.8%	25.2%
Drugs	96.7%	3.3%	92.7%	7.3%
Motoring / Vehicle Theft	97.9%	2.1%	98.7%	1.3%
Other	77.5%	22.5%	73.2%	26.8%
Sexual Offences	100.0%		98.2%	1.8%
Violence	70.0%	30.0%	67.1%	32.9%
TOTAL OFFENCES	**82.3%**	**17.7%**	**83.4%**	**16.6%**

Offence Types

Violent crimes

Violent crime remains the most frequently committed offence following the same trend as the preceding 6 years, accounting for almost 25% of all offences, shown in **Figure 11.**

Violence accounted for 48% of all female offences and 19% of male offences in 2022/23. Female violent offending accounted for 32.9% of all violent offending, a higher percentage than any other category comparing male and female offending, and following trends seen in 21/22, shown in **Figure 11**.

Despite the significant increase in the overall number of offences, violent offences did not increase at the same rate between 2021/22 and 2022/23 and saw a reduction when shown as a proportion of all offences, 35% down to 23.8%. Other offence categories saw much larger increases and therefore had a bigger impact on the overall number of offences than violent offences, shown in **Figure 11**.

Common assault/Assault (ABH)/Assault by beating were the most prevalent offences in 2022/23 accounting for 58.4% of violent offences compared to 48.3% in 2021/22. If assaults on Police or other emergency workers were added this figure would rise to almost 75% of all violent offences during 2022/23, shown in **Figure 12.**

Figure 12: Violent offence types. Source: CDYJS Case Management System - ChildView.

Violent Offence	Number of Offences	% of all Violent Offences
Common Assault / Assault (ABH) / Assault by beating	135	58.4%
Assault / Beating of a PC / Emergency Worker	38	16.5%
Possess knife blade / sharply pointed article / offensive weapon / imitation firearm	28	12.1%
Obstruct / resist a constable in execution of duty	8	3.5%
Robbery / Attempt Robbery	7	3.0%
Violent Disorder	5	2.2%
Racially / religiously aggravated assault / beating	<5	n/a
Stalking / Harassment (Fear of Violence) / Intimidate a witness	<5	n/a
Wound / inflict grievous bodily harm without intent	<5	n/a
Manslaughter	<5	n/a
Section 18 - wounding with intent	<5	n/a
Cause / Administer poison / noxious thing with intent to injure / aggrieve / annoy	<5	n/a
TOTAL NUMBER OF VIOLENT OFFENCES	**231**	

Alcohol-related Crimes

Alcohol-related offences fell by 35.6% between 2016/17 and 2022/23, shown in **Figure 13.**

Variation was observed at former District level; however, this was affected by number of offences in each area. Only Derwentside saw an increase in the number of alcohol-related offences committed (13 to 33), also seeing the highest rate in the area with 3.8 alcohol related offences per 1,000 10–17-year-olds shown in **Figure 14.**

14% of all offences committed by young people aged 16 or over were alcohol-related, and 48.5% of all alcohol-related offences were committed by those aged 16 or over, a reduction from 21/22's figure of 56.9%.

For 14–15-year-olds, 11.1% of offences were alcohol-related, and their share of total alcohol-related offences fell from 41.3% in 21/22 to 38.8% in 22/23.

In contrast, the 10-13 age group had 6.2% offences classified as alcohol-related, but their share of total alcohol-related offences rose from 1.8% to 12.6%. Shown in **Figure 14.**

Figure 13: Number of young people offending and young people committing alcohol related offences in County Durham, by gender, 2016/17 to 2022/23. Source: CDYJS Case Management System - ChildView.

	Males		Females		Persons		% of All Offenders committing Alc Related Offences
	Alcohol related	All offenders	Alcohol related	All offenders	Alcohol related	All offenders	
2016/17	73	415	31	88	**104**	**503**	**20.7%**
2017/18	47	301	18	89	**65**	**390**	**16.7%**
2018/19	85	335	29	79	**114**	**414**	**27.5%**
2019/20	49	272	16	57	**65**	**329**	**19.8%**
2020/21	42	198	22	53	**64**	**251**	**25.5%**
2021/22	43	203	16	59	**59**	**262**	**22.5%**
2022/23	47	301	20	81	**67**	**382**	**17.5%**
Reduction 16/17 to 22/23	**-35.6%**	**-27.5%**	**-35.5%**	**-8.0%**	**-35.6%**	**-24.1%**	

Figure 14: Number and Percentage of Alcohol Related Offences by Area and Age Group (2022/23) Source: CDYJS Case Management System - ChildView.

	10-13 yrs		14-15 yrs		16+ yrs		Num of Alc Related Offences
	Num of Alc Related Offences	% of former District Total	Num of Alc Related Offences	% of former District Total	Num of Alc Related Offences	% of former District Total	
Chester-le-Street	*	20.0%	*	30.0%	5	50.0%	**10**
Derwentside	8	24.2%	13	39.4%	12	36.4%	**33**
Durham		0.0%	7	41.2%	10	58.8%	**17**
Easington		0.0%	11	57.9%	8	42.1%	**19**
Sedgefield	*	25.0%	*	37.5%	*	37.5%	**8**
Wear / Tees	*	6.3%	*	18.8%	12	75.0%	**16**
Alc Related County Total	**13**	**12.6%**	**40**	**38.8%**	**50**	**48.5%**	**103**
TOTAL Num of Offences	211		359		358		928
% of All Offences that were alc related	6.2%		11.1%		14.0%		11.1%

** Suppressed due to number less than 5*

AssetPlus Assessments – Health Needs, Vulnerabilities and Risks

Where a young person received more than one assessment in the period, only the latest assessment has been used for the purposes of this analysis to avoid bias. In 2022/23, 152 young people (88.2% male,11.8% female) had an AssetPlus assessment completed with breakdown shown in **Figure 15.**

Figure 16 outlines health needs identified in assessments, showing a significant number of young people with SLCN and mental health needs. In contrast, **Figure 17** shows the number of young people with a *diagnosed* condition when assessed, demonstrating the disparity between needs and diagnosis and the number of young people accessing mental health services with no diagnosis.

Figure 18 demonstrates additional factors in assessment linked to vulnerability and risk. The above figures demonstrate disparities between nationally recorded statistics on levels of need and those identified through CDYJS and the wide range of vulnerabilities of young people in relation to offending.

Figure 15: AssetPlus assessments by gender. AssetPlus Reports 2022/23 source: CDYJS Case Management System – ChildView

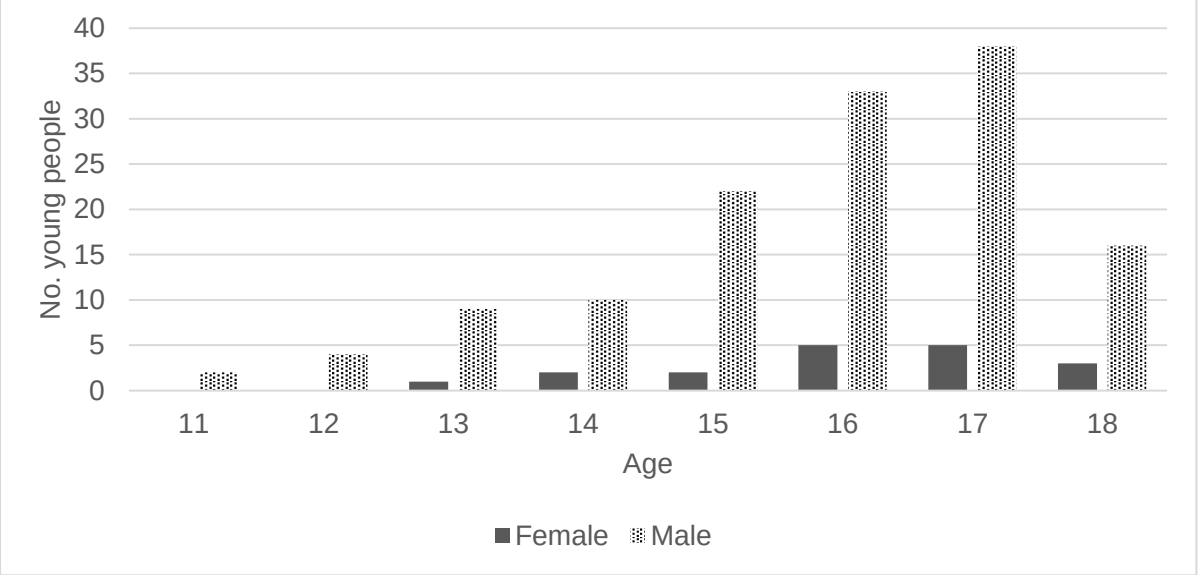


Figure 16: Health needs/concerns identified on AssetPlus assessments. AssetPlus Reports 2022/23 source: CDYJS Case Management System – ChildView

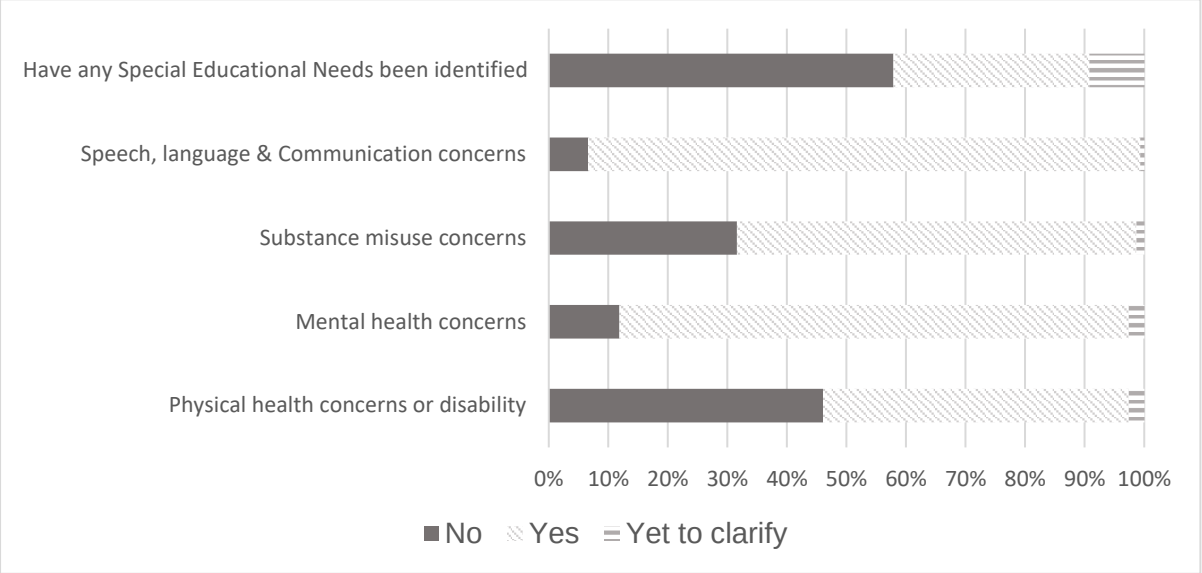


Figure 17: AssetPlus assessments showing diagnosed social/health conditions and contact with mental health services. AssetPlus Reports 2022/23 source: CDYJS Case Management System – ChildView

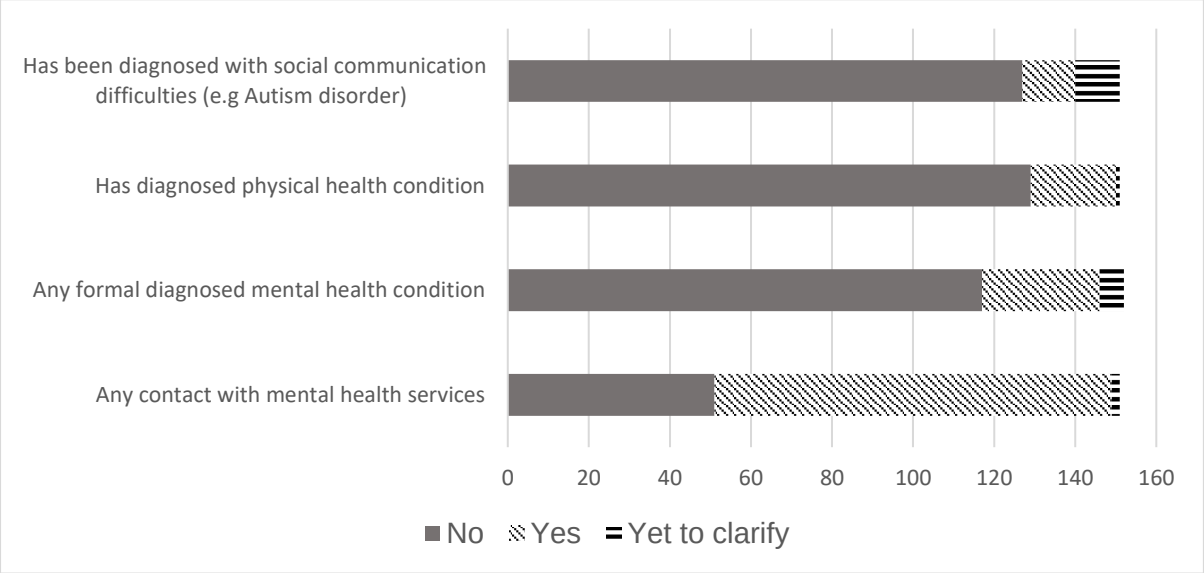
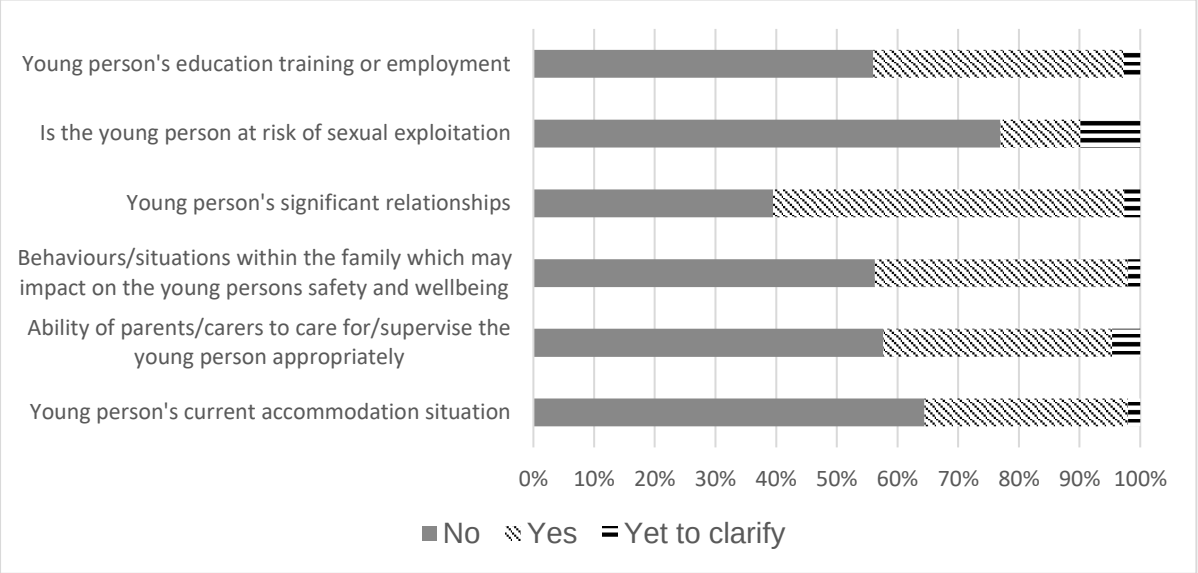


Figure 18: Additional Concerns Identified about the Young Person. AssetPlus Reports 2022/23 source: CDYJS Case Management System – ChildView



Risks to Re-offending

In CDYJS assessments case managers assess factors that increase a young person's risk of re-offending on a scale from 'potential' to 'strong' risk. **Figure 20** shows assessment scores, with 60% of assessments naming emotional development and mental health as a risk factor for re-offending and 29% assessments identifying this as a 'strong' risk.

Other risk factors included attitudes towards offending, thinking and behaviour, parenting care and guidance and features of lifestyle (including factors such as gambling and use of technology). The distribution of assessed risks to re-offending are different from those observed nationally, with fewer children having learning and ETE and engagement participation identified as a risk. However, they are similar to findings from assessments on health needs.

The CDYJS provides access to a number of interventions internally and externally to address risk factors for re-offending, keep young people safe from risk of harm, and improve their health. **Figure 21** outlines interventions referred to by Case Managers in 22/23.

Figure 20: Risk of Re-offending, AssetPlus Reports 2022/23 (Source: CDYJS Case Management System - ChildView):

Re-offending/Desistance Factor	Strong Risk		Identified Risk- any level	
	Number of Assessments (Number of people)	% Assessments	Number of Assessments (Number of people)	% Assessments
Emotional development and mental health	140 (53)	29%	293 (87)	60%
Attitudes of Offending/Behaviours	126 (46)	26%	257 (73)	52%
Thinking and behaviour	123 (48)	25%	258 (84)	53%
Parenting Care and Supervision	113 (41)	23%	174 (49)	36%
Features of Lifestyle	111 (41)	23%	248 (76)	51%
Learning Education Training & Employment	78 (32)	16%	176 (53)	36%
Family and wider networks	70 (31)	14%	161 (50)	33%
Social and community/neighbourhood	63 (28)	13%	132 (42)	27%
Substance misuse	60 (34)	12%	162 (59)	33%
Engagement & Participation	58 (18)	12%	88 (23)	18%
How the young person relates to others	58 (22)	12%	123 (40)	25%
Speech Language Communication & Neuro-disability	49 (21)	10%	100 (33)	20%
Care History	41 (20)	8%	79 (29)	16%
Living arrangements housing and financial considerations	28 (13)	6%	62 (19)	13%
Resilience and goals	8 (2)	2%	12 (3)	2%
Self-identity	8 (6)	2%	12 (8)	2%
Physical Health & development	5 (2)	1%	8 (4)	2%

Figure 21: Number and type of interventions delivered by CDYJS, 2022/23. (Source: CDYJS case management system - ChildView)

Intervention Type	Number of Interventions
Prevention	245
Victim Awareness	126
Consequences of Offending / Tackling Offending Behaviour	125
Healthy Relationships	77
Tackling Violence	76
Car Crime	32
Alcohol / Substance misuse	26
Emotional Resilience	3
Tackling Racism	3
Fire Setting	2
Firearms	2
Respecting Young People Programme	2
Firebreak Course	1
Joint working as 2/1	1
Personal Development	1

Health Team Screening, Assessment, and Interventions

Figure 2 outlines the health screening, assessment, and intervention process. New entrants to the CDYJS are first screened by searching System One and Cito health databases to identify potential health needs. Cases are then discussed at the weekly multi-disciplinary health team meeting to plan how to assess and support young people's needs appropriately.

Discussion at the health management team meeting may result in a full HNA being undertaken by the PHN, allowing proactive identification and intervention for unmet health needs, or direct referral to specific members of the health team, to the speech and language therapist, health and wellbeing workers, or substance misuse workers. Referral to external agencies for specialist treatment or advice are also made following full HNA. Case Managers can refer young people for assessment at any time.

392 screenings were undertaken in 21/22, increasing 68% to 642 during 2022/23. A quarterly breakdown of this activity is shown in **Figure 22**. Total number of referrals for interventions has remained consistent but the percentage of screenings undertaken that result in referrals has varied over time, **Figure 23**.

Figure 24 show the proportion of referrals to each health team destination following screening, with the most common referral being to the PHN for full HNA. In 2023/24, 177 young people were allocated a specific health worker, with 253 allocations in total due to some young people having more than one specific need identified.

Figure 25 shows the reasons that a young person's screening result was referred for HNA from the PHN, with physical health the main reason and mental health another common issue. This can be expected when screening using medical records as they are more likely to record physical health issues than wider outcomes such as undiagnosed neurodiversity or learning disability.

Figure 26 shows the actions taken as a result of HNAs, showing that a broader range of needs are identified through HNAs than identified by screening young people's medical records; for example, the number of young people supported with smoking, vaping and substance misuse as a result of the HNA is higher than the number identified through screening.

The range of actions taken including large numbers referred for 'liaison with professionals' highlights the complexity of needs of young people known to the CDYJS and reflects health team time taken working collaboratively with other agencies to support young people's health.

A large number of interventions are undertaken by the wider health team posts, speech and language therapist, health and wellbeing workers, and substance misuse workers. **Figure 27** shows the number of young people referred to health team staff member caseloads in 23/24, showing the demand across the health team.

Many young people are allocated to multiple health team specialisms due to complexity of their needs, and the health team works collaboratively across organisations and roles, with non-health CDYJS staff and external health services to flexibly meet young people's needs.

Similarly, **Figure 28** shows the number of referrals made to both internal health team members and external agencies following HNA, so that a young person can access specialist services without disadvantage where their needs cannot be met within CDYJS.

Again, this shows the broad range of specialist needs young people entering CDYJS present with and reflects wider challenges in accessing healthcare for vulnerable population groups – for example, the number of young people referred for dentistry.

One example of interventions that the CDYJS health team deliver is work to reduce self-harm rates and identify risk of suicide by collaborative working across the whole team to support young people; for example, through targeted support by health and wellbeing workers in partnership with substance misuse workers or case managers. Data on self-harm and suicide is shown in **Figure 29.**

Figure 22: Number of CDYJS screenings by quarter, Q1 2021/22 to Q2 23/24. Source: Health Team data, CDYJS.

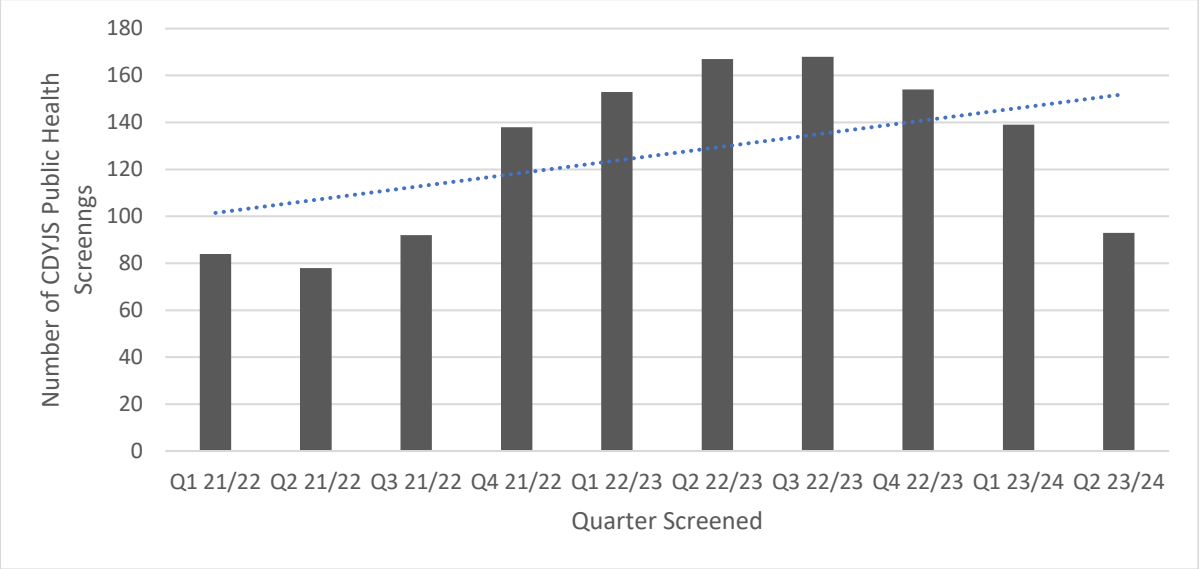


Figure 23: Referrals as a percentage of screenings Q2 21/22 to Q2 23/24. Source: Health Team data, CDYJS.

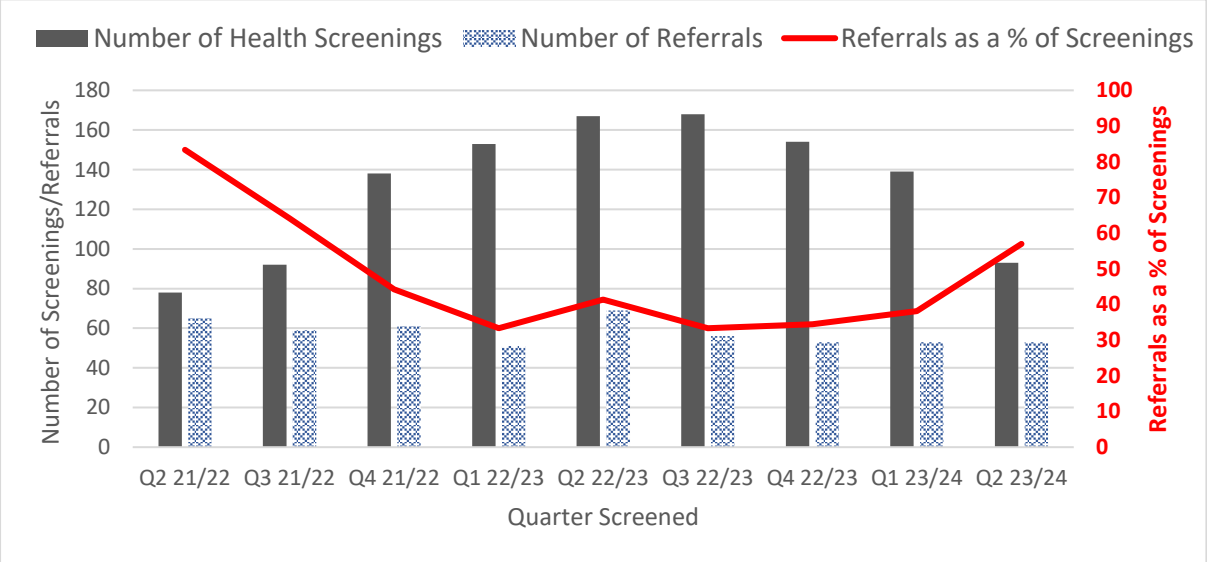


Figure 24: Distribution of referrals (proportion) to internal CDYJS health team destinations following CDYJS screening, by quarter, Q2 2021/22 to Q2 23/24. Source: Public Health Nurse, CDYJS.

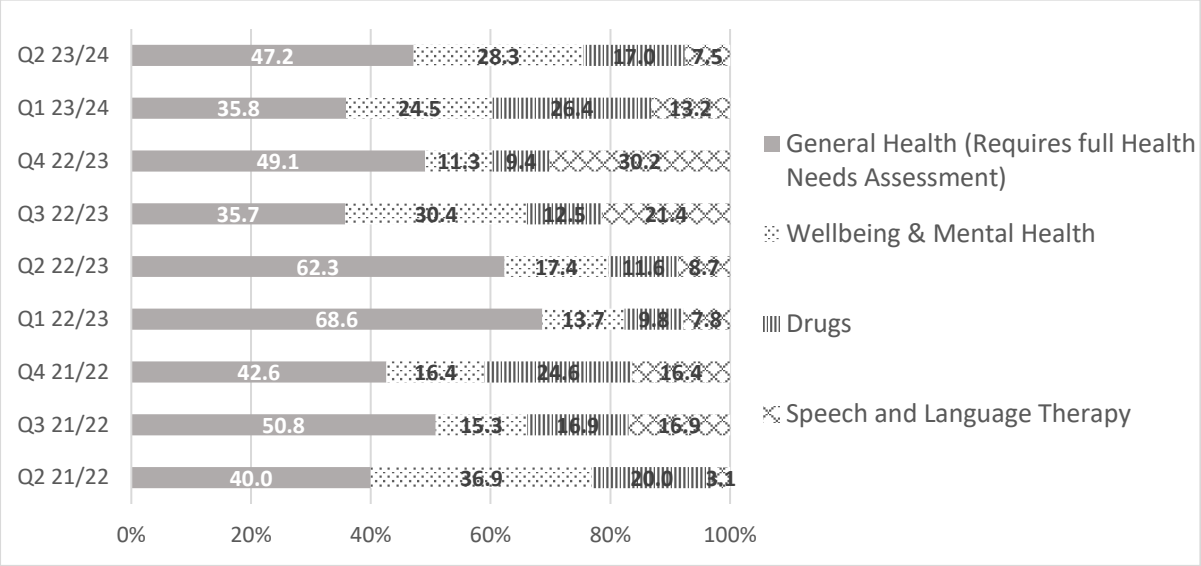


Figure 25: Health Need as a Reason for Referral to CDYJS for HNA by %, 2022/23. Source: Public Health Nurse, CDYJS

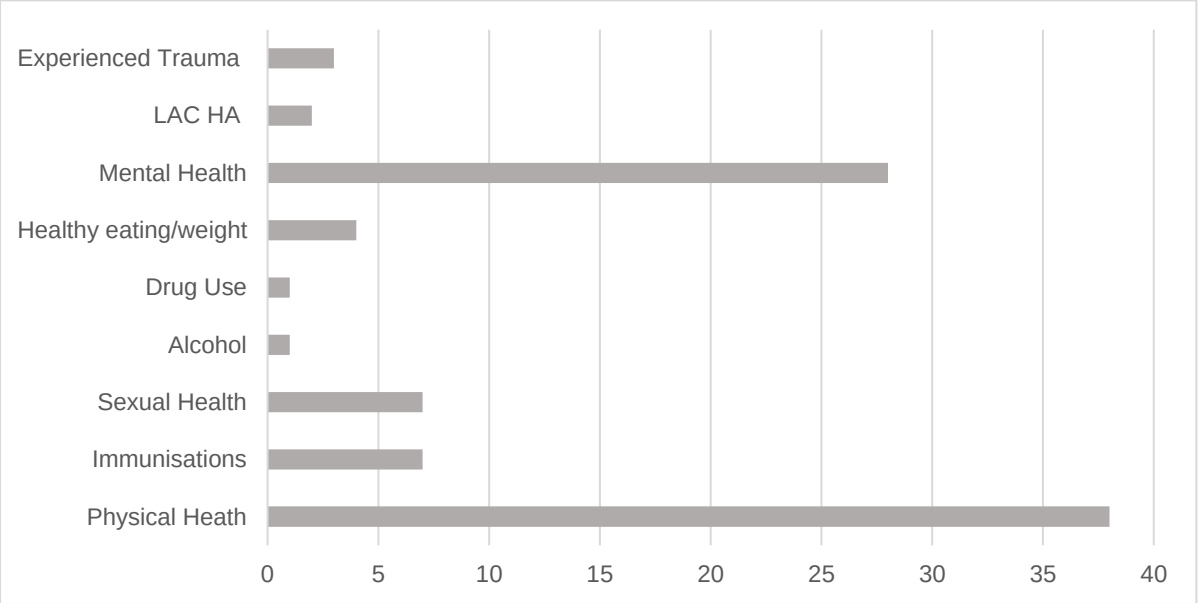


Figure 26: Actions following CDYJS PHN HNA 2022/23. Source: Public Health Nurse, CDYJS

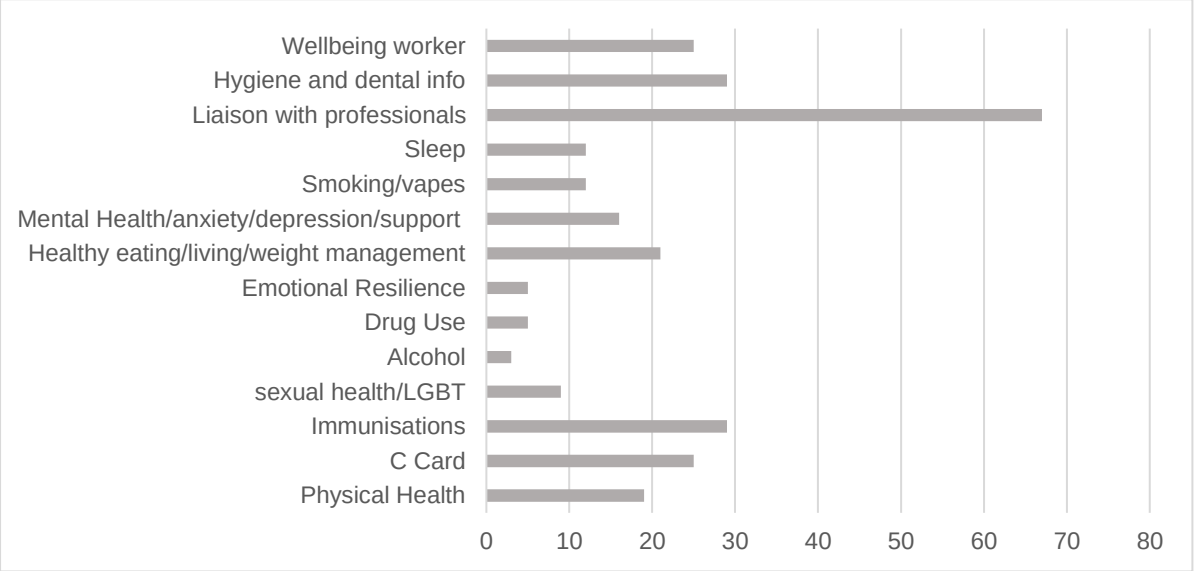


Figure 27: Number of young people allocated to CDYJS health team professionals for internal interventions in 23/24. Source: CDYJS

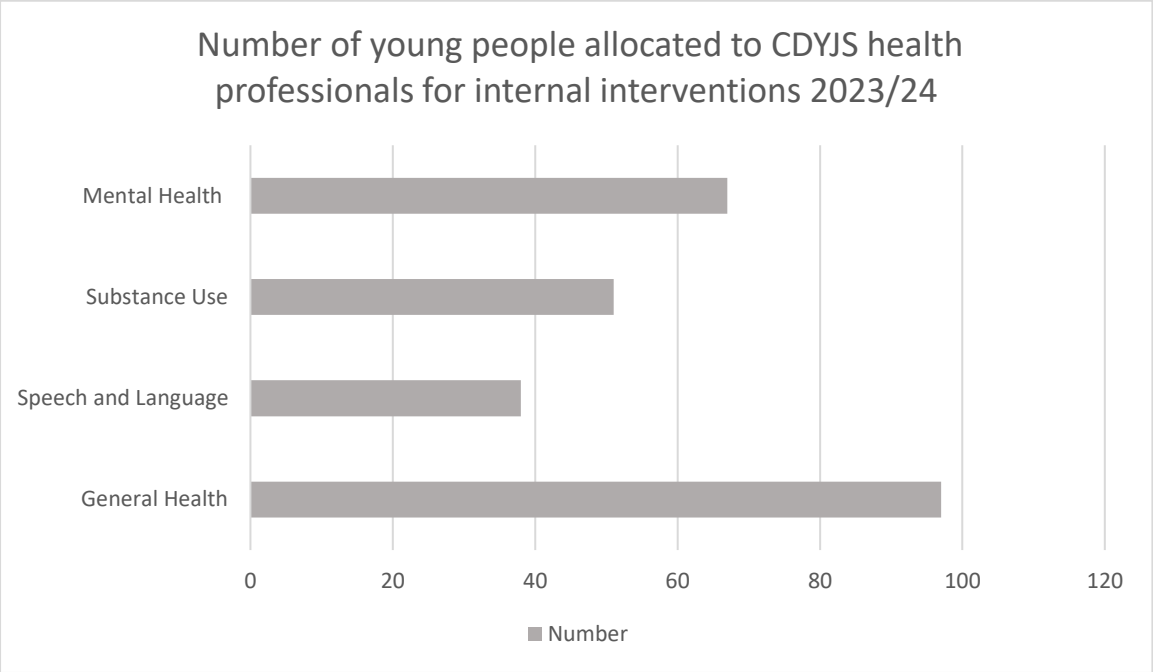


Figure 28: Number of referrals made to internal health team and external agencies following CDYJS PHN HNA 2022/23. Source: Public Health Nurse, CDYJS

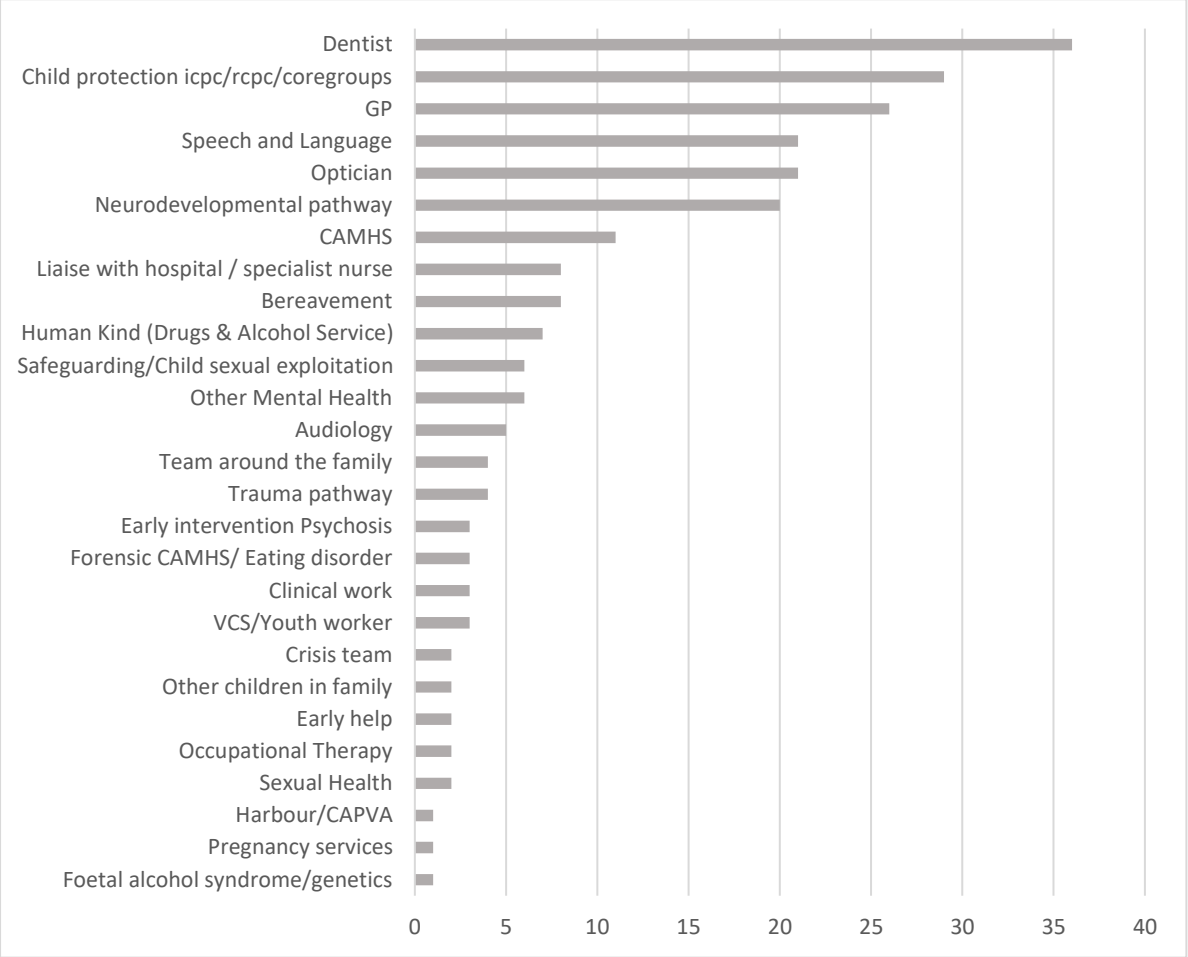
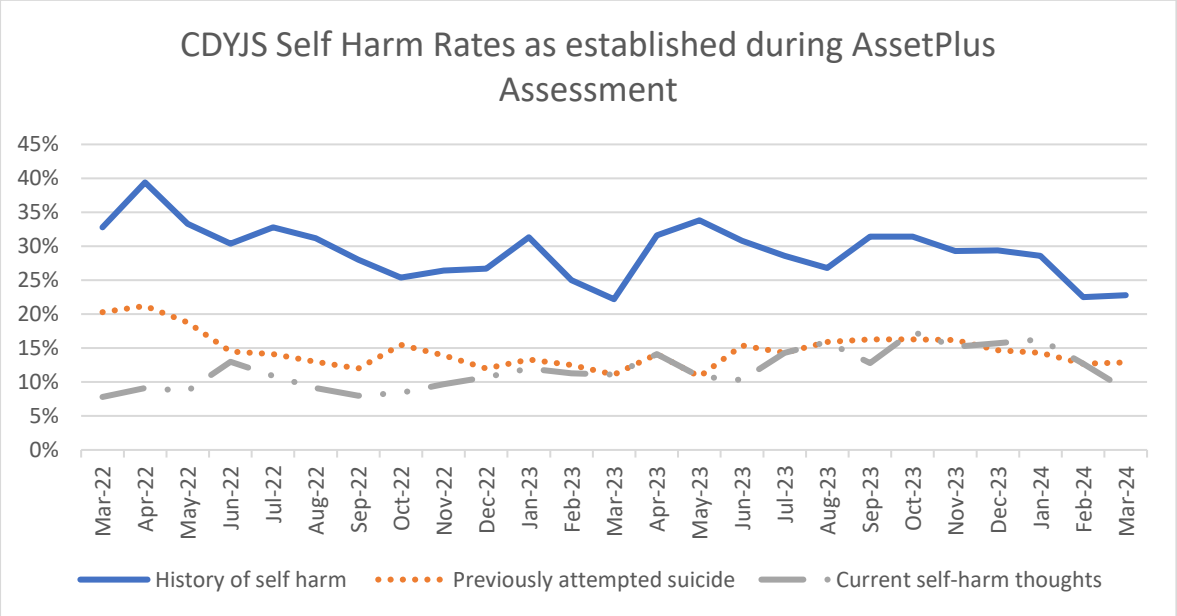


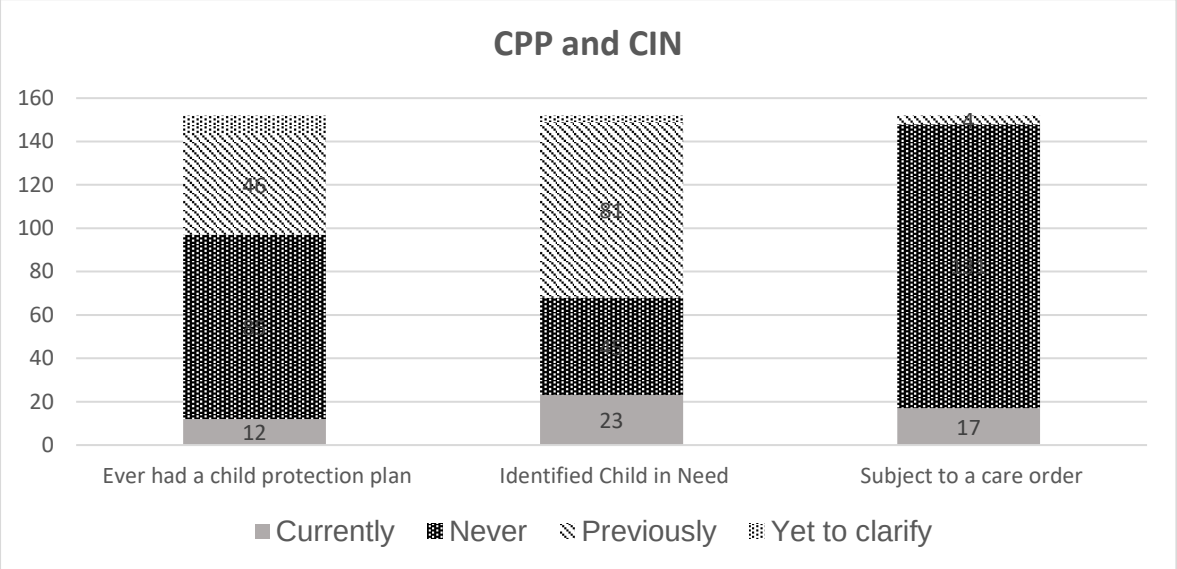
Figure 29: Self-reported self-harm and suicide attempt rates identified in AssetPlus assessments for interventions 23/24. Source: CDYJS



Looked After and Child Protection Status

In 22/23, 68.4% of young people who offended were either currently or previously identified as a 'child in need' (n=104 from 152 AssetPlus assessments). In addition, 38% or 58 of the 152 AssetPlus assessments identified that a young person had been on a CPP in the past or at the point of offending, shown in **Figure 30.** The majority of all CPPs were linked to experiencing neglect (62%).

Figure 30: Breakdown of looked after and child protection status of young people known to the CDYJS, 2022/23. Source: CDYJS Case Management System - ChildView



Education, Employment and Training

School exclusion

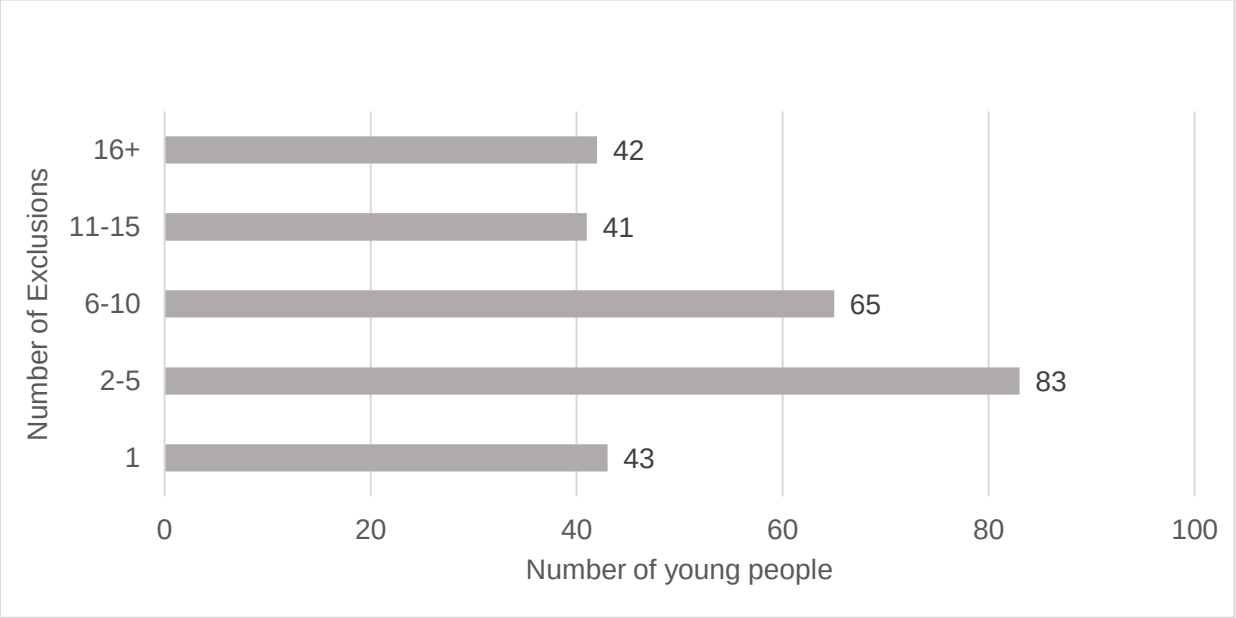
Exclusions are common for young people known to the YJS. In 22/23 274 of the 377 young people (for whom data was available) had been excluded from school on a permanent or fixed-term basis a total of 2173 times, an average of 7.9 exclusions per child. Males were more likely to have been excluded than females.

Breakdown of exclusions is shown in **Figure 31**. 43 young people received only 1 exclusion, but the majority (69.7%) received between 1 and 10 school exclusions, with 15.3% receiving 16 to 37 exclusions.

72.4% (273) young people have been excluded from school on a fixed term basis and 22.3% (84) have been permanently excluded from at least one school. 83 (98.8%) of these 84 had previously been excluded on a fixed term basis at least once.

Information sharing routes are in place between the CDYJS and the SEND casework team.

Figure 31: Exclusions of CDYJS young people in 22/23. Source: Social Care and Education systems, DCC



Participation in Post-16 Learning

The Department for Education defines priority vulnerable groups as those who are less likely to make a successful transition to post-16 learning due to the significant barriers they face or have faced, including young people who offend. Rates of participation in learning for all 16- and 17-year-olds varies between whole population and priority vulnerable groups, illustrated in **Figure 32.** Children supported by CDYJS had significantly lower participation levels than other 16–17-year-olds between 20/11-22/23.

The Progression and Learning Team in County Durham (incorporating DurhamWorks) co-ordinates the tracking of the education, training, and employment (ETE) destinations of young people aged 16-17, and up to 25 for those for whom an EHCP is maintained.

in December 2023, 94.3% of County Durham's overall 16- and 17-year-old cohort were engaged in ETE with 88.1% participating in full-time education, full-time training, or employment with accredited learning (including apprenticeships).

In contrast 54.8% of the YJS cohort were confirmed as engaged in ETE and 23.8% are participating in full time education, full time training or employment with accredited learning (including apprenticeships).

Figure 32: Participation in post-16 learning across priority vulnerable groups in County Durham. Source: Department for Education.

Participation in Learning %	2020/21	2021/22	2022/23
All 16-17 Year Olds	90.9	90.5	89.1
16-17 Year Olds with SEND (EHCP)	83.0	82.8	82.8
16-17 Year Olds Children Looked After/Care Leavers	74.5	64.8	60.7
16-17 Year Olds Supported by County Durham Youth Justice Service (CDYJS)	41.5	27.0	46.1
16-17 Year Olds with Parenting Responsibilities (Young Parents)	12.1	12.3	27.7
16-17 Year Olds with Caring Responsibilities (Young Carers)	27.4	68.6	61.8

CDYJS works to provide ETE opportunities for young people, for example, by acting as a delivery partner for the 'DurhamWorks' partnership between Durham County Council and colleges, employers, and other agencies with the aim of offering support to young people to develop skills and engage with ETE.

Analysis of all young people who completed a programme between April and September 2023 found that 108 orders/programmes were completed by 107 young people, with one completing two programmes. 17.6% of those completing an order/programme were not receiving any ETE by the time they completed, with 21.3% accessing ETE on a part-time basis and 61.1% on a full-time basis.38% of young people in this cohort were attending 'Alternate' provision, such is a Pupil Referral Unit (PRU) or special school.

Conclusion

The young people known to CDYJS are from the same population we would expect based on national data and research literature, and a similar population to that identified in 2017.

Though direct comparison is not possible due to significant changes in data collection, health needs identified are relatively similar to those identified in the 2017 HNA, with a greater focus on mental health and undiagnosed neurodiversity and SLCN, and a lesser focus on engagement in ETE. Health needs for young people who offend in County Durham are very similar to needs for other young people who offend across the country when compared to national statistics from the YJB[61] and those identified in HNAs from other Local Authorities between 2019-2024. They also align to needs identified in the literature review.

Young people known to CDYJS have high levels of need related to mental health, substance misuse, neurodiversity and learning disabilities. When compared to national indicators on the whole 10-17 population all needs are higher in this cohort and notably higher for mental health needs, SLCN, substance misuse and number who are care-experienced. Owing to challenges with national data not always reflecting the 'on the ground' level of need due to differences in how a *diagnosis* vs a *need* is recorded, needs may be higher in the whole 10-17 cohort, especially for mental health and neurodiversity, but it is likely that the needs for young people who offend are still significantly higher.

There is extremely high demand on the health team within CDYJS including an increase in health screening by 68% in 23/24, and a wider range of referrals are made to specialist services due to complexity of need. A large number of young people who offend have identified SLCN and are supported with this in a significant change from the 2017 HNA.

Needs identified around risk of re-offending that are not explicitly a 'health' need (and therefore not reflected on health screening) include high levels of concern around the family environment and lifestyle factors including supervision. However, limited information is collected about the environment and family of the child on statutory assessment tools, and few whole-family interventions are offered, or if they are, are not reflected in service data.

Other health needs identified generally match referrals recorded. Other new interventions including HWBWs has generated additional data about SEMH health needs. The way information is recorded across the YJS and wider partners, including lack of data collection and sharing on outcomes as a result of a referral or intervention makes it difficult to draw conclusions about the impact of some interventions on young people's health outcomes. For example, information is collected about needs and referral destinations for the cohort, but not about the outcomes from referrals, for example, if a child has stopped smoking.

The YJB guidance focuses on re-offending rates rather than health outcomes, and so there is available data on re-offending behaviour. However, it is not possible to link individual interventions to re-offending behaviour as it was identified in the literature review that risk factors compound to increase risk rather than specific needs causing offending. However, it is clear that a large number of needs are identified and addressed through the Health Team and delivery model in a clearer and more streamlined way than the 2017 HNA identified.

The above figures demonstrate the wide range of vulnerabilities young people have in relation to their health and offending behaviour and significant demand on the YJS to manage these needs.

Chapter 4: Perspectives from the Service and Young People

1. Engagement with staff

A survey was shared across CDYJS service staff, including the health team. 23 responses were received, approximately 50% of staff. Findings were discussed further with the CDYJS management team and staff teams to ensure the summary is reflective of staff thoughts.

Perceived health needs of young people

When asked "what is the most prevalent health concern amongst young people accessing the YJS?" staff said:

Mental health, anxiety, depression and low mood, self-harm, substance misuse, undiagnosed neurodiversity and learning disability, trauma, poor emotional wellbeing, poor self-esteem, and low support networks were the top concerns identified. Undiagnosed neurodiversity and learning disability were identified by most respondents.
Physical health of young people was perceived to be typically better than their mental health but increases in vaping and new diagnoses of asthma and respiratory conditions caused concern for staff, as do the lack of healthy lifestyle choices such as being physically active.

Staff reported that prior to being known to CDYJS young people have not always accessed mainstream health services when appropriate including the dentist, opticians, GP, sexual health services and vaccinations. Staff perceptions was that not accessing mainstream services was sometimes because of a lack of family support and other times the young person not wanting to engage, but in either case, the YJS often has to work to meet basic needs before tackling offending behaviour.

Figures 33 and **34** show the differences in how service staff rate the physical and mental health of young people known to the service. This shows a stark contrast in staff opinions of young people's physical health (91% rating 'fair' or 'good') vs mental health (100% rating 'fair' 'poor' or 'very poor' with 93% rating 'poor' or 'very poor'). However, staff felt the service was reasonably good in the support that it provides young people with both their physical and mental health.

Figure 33: Staff perceptions on physical health of young people engaged with YJS. Source: YJS HNA staff survey, 2024.

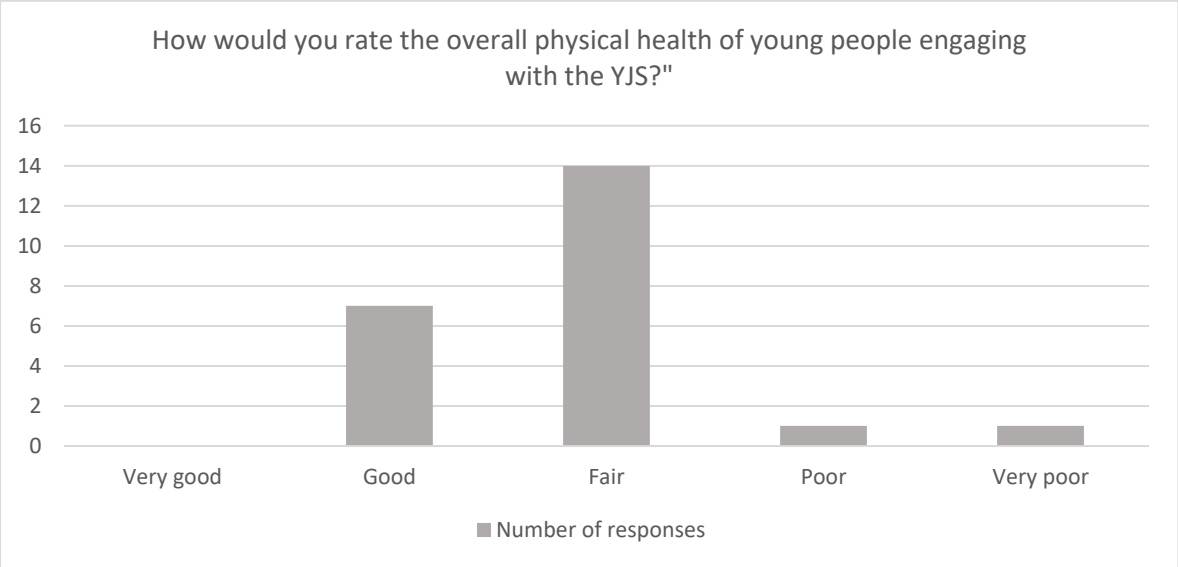
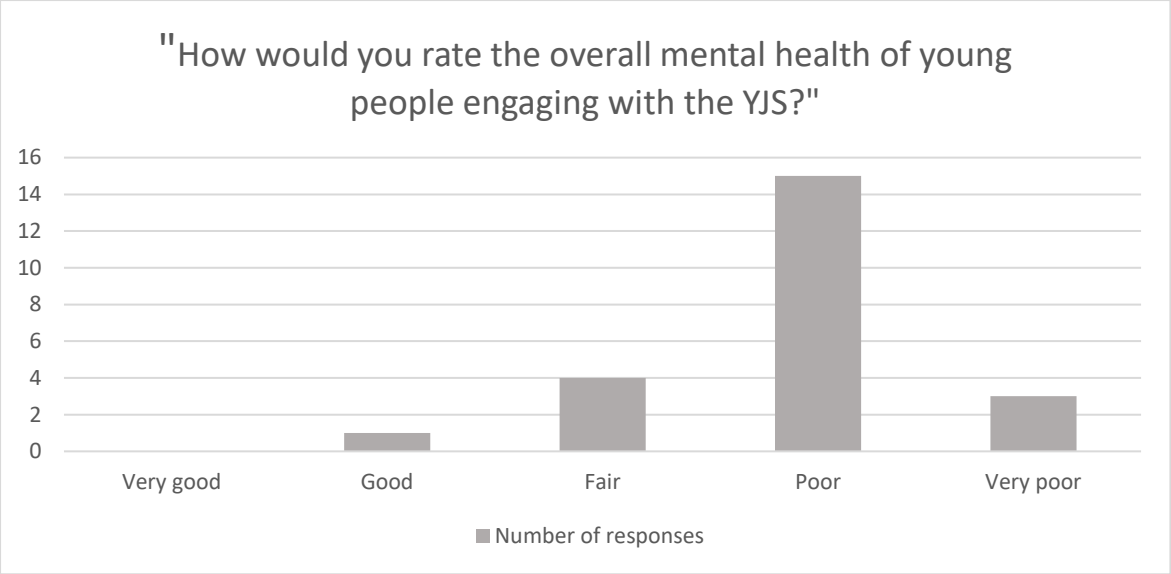


Figure 34: Staff perceptions on mental health of young people engaged with YJS. Source: YJS HNA staff survey, 2024.



Mental Health

Staff answered the questions “how effective (from your direct experience) is referring to mental health services in county Durham for young people?” “State any comments about referring to existing mental health services” and are there specific mental health services or interventions that could benefit young people accessing the YJS?”.

Figure 35 shows staff perspectives on how adequate access to mental health support is for young people known to CDYJS. Staff felt that waiting lists were exceptionally long for CAMHS and sometimes young people waited past the point where a diagnosis or support was helpful. This is a common challenge for all young people, not just those known to the YJS. Recently CAMHS have fast-tracked some neurodiversity assessments and CAHMS is moving to a needs-led culture where need will be met regardless of diagnosis.

Staff reported that some external and specialist services have referral criteria that were not always clear and that they did not always understand why referrals were rejected. Staff felt that some referral processes were lengthy and complicated. Staff said they felt there were gaps in provision; for example, a gap in services available for young people with mental health needs and substance misuse challenges and confusion on why this was.

Staff perception was that some external and specialist services do not always work in a way that best supports the young people known to CDYJS; for example, they have referral practices such as discharge after non-attendance, send complex information that young people cannot access, don’t provide the same worker to build up a relationship, or are not persistent enough in their pursuit of working with a young person.

Staff reported feeling frustrated at difficulties accessing external and specialist support and reported a sense that young people were being left behind with high pressure on CDYJS staff to deal with mental health challenges better met through specialist services.

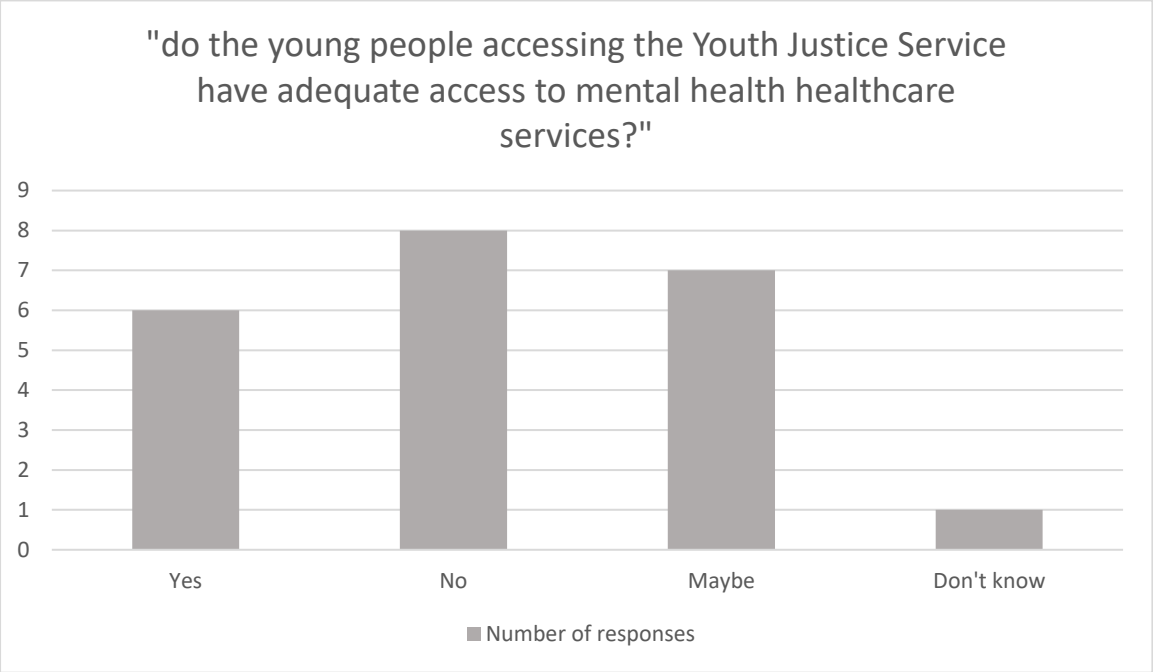
Staff made several suggestions for increasing CDYJS capacity to work with young people, particularly on their mental health, including recruiting additional workers like a psychologist,

additional emotional wellbeing workers, provision of talking therapies and counselling services and/or a mental health nurse. Staff felt it was important that these professionals or specialist interventions were provided by the CDYJS health team rather than provided externally in order to better meet the needs of young people.

Staff also made suggestions for improved access to neurodiversity assessment and support services and mental health crisis services; for example, through a fast-track model, improved waiting times for CAMHS, or named person responsible for CDYJS referrals, improved ways to discuss referrals before making them, and support to help young people while they wait for assessments. Suggestions also included clearer and more defined referral pathways to external services, for example, through standardised paperwork or reporting.

Staff shared opinions on the CDYJS health team being highly effective and skilled but under pressure as a result of the increased number of young people with complex needs, meaning that other non-health CDYJS staff were needed to support young people in ways they did not always feel equipped for; for example, supporting a young person while they waited for a specialist or external service.

Figure 35: Staff perceptions on access to mental health services for young people engaged with YJS. Source: YJS HNA staff survey, 2024.



Barriers to Health

When asked about young people's barriers to good health and accessing healthcare services staff shared a range of perspectives, including:

A perceived lack of family support to attend appointments, for example, no resources to transport a young person and family difficulty understanding verbal or written complex appointment information or not being able to provide information to external or specialist services. Staff reported that many families have additional challenges such as insecure housing that means that health appointments are lower on the agenda.

Staff highlighted specific issues where young people and their families believe they are on waiting lists for services when they are not, leading to confusion and distress for children and their families.

Staff reported that they felt young people were often disengaged from services owing to previous negative experiences with services and professionals where they felt judged or discriminated against. Staff said that some families had told them they felt like they had been lost in the system or help is coming too late.

Staff perceptions on barriers have been outlined, including service delivery, health literacy needs, appointments not meeting young people's preferences. An additional barrier was referred to as high staff turnover, both in the CDYJS and external or specialist services, reducing the ability of services to build trusting relationships with young people.

Drug and Alcohol Needs

When asked questions about young people's drug and alcohol use, staff reported the following. It should be noted that these responses are staff perspectives from their work with young people and are not necessarily supported by service data.

73% of staff said they felt referrals for drug and alcohol support were highly effective or effective. Embedded drug and alcohol workers in the CDYJS health team were highlighted as a positive, flexible, and person-centred service with good access and working arrangements with CDYJS to achieve the best outcomes for young people. Staff said the referral process is effective and new developments in automatic referral for drug and alcohol related crimes was positive.

Staff reported that drug and alcohol use was very high and felt like it had increased over the last year, especially in smoking cannabis. Staff felt most young people were upfront about their use, but others deny using drugs or alcohol which can make it hard to get them the right support.

Physical Activity and Healthy Behaviours

Staff said some young people were active but that it tended to be everyday activity like school PE. Staff thought fewer girls took part in physical activity than boys and that many young people tended to prioritise indoor activities like gaming, watching TV and seeing friends than spending time outdoors. Staff thought this could be a contributing factor to poor mental health for young people.

The YJS works to support healthy behaviours, for example, through the Positive Futures programme, which was highlighted by staff as a good initiative to support young people to try activities they may not otherwise get support to try. Other options offered by the YJS are free gym pass referrals and Skill Mill. However, staff said some young people are reluctant to take part. Generally, staff felt there were options to support young people to be more active, though these might not always meet everyone's needs; for example, girls may need different support or support was only available in school holidays.

Staff suggested improving access to social opportunities not just specifically for healthy behaviours, for example, a wider range of hobbies and activities available in the local community. Staff said they were not always sure what was available, or the best way to have conversations about opportunities, as young people typically did not want to engage in formal activities or those that seemed targeted towards vulnerable young people.

Integration and Collaboration

Staff were asked questions on the current integration, collaboration and partnership working of the YJS.

Staff said they felt the YJS works very well with the health team and embedded roles in other organisations and that they are an essential and integral part of the YJS. Staff were highly complementary about the difference the health screening process and interventions delivered by the health team and embedded roles makes for young people and noted that referrals between YJS and health team professionals/services such as drug and alcohol workers were seamless. Staff suggested it would be helpful to include health staff in case management meetings.

91% of staff said collaboration with partner agencies was 'extremely well' or 'well' done with 9% stating they were 'neutral'. Relationships with some agencies such as Humankind's embedded YJS roles were highlighted as good practice collaborative working that should be replicated elsewhere.

However, collaboration between the YJS and external and specialist services can be challenging. Staff shared examples about difficulties accessing data about clients, updates on referrals, or outcomes as a result of referrals. More informal information can also be difficult for staff to find such as reasons for a referral being rejected.

Staff suggested offering 'welcome to youth justice' training for external and specialist agencies to understand better how to work with young people and their specific needs, for example, for social workers, teachers, and other health professionals in CAMHS. This would help spread good practice from organisations such as Humankind and tackle some of the earlier perceived challenges of services not working in the best way to meet this cohorts needs.

Improvement Opportunities

Staff were asked “what additional health related support or services do you think would benefit the young people accessing the YJS?”. Staff suggested a diverse range of improvements, some of which have been outlined previously.

Generally, staff felt the health offer for young people in the service was very comprehensive, including mental health support offered by the CDYJS health team, but that the gap existed for young people with specialist needs that needed to be met by an external agency and that the whole service had difficulties meeting the demand from young people. Staff suggested expanding mental health capacity within CDYJS and working with external agencies to help them understand how best to support young people who offend, as outlined previously.

Staff suggested adding workers or a service to provide more support to young people on healthy behaviours, staying active, and life skills such as cooking, reading, writing, managing money. Staff thought these could be provided within CDYJS through an occupational therapist or dedicated life skills support worker.

Staff thought more opportunities to have conversations with young people about their health and wellbeing outside formal assessment process would be beneficial, such as having more conversations about physical activity, and more focus on helping young people to connect with their community and undertake hobbies and activities. Social prescribing type support may offer young people an opportunity to do this in line with their interests such as music production, fishing and boxing.

Staff thought improving data sharing across all agencies that support young people would help them to better understand the support being offered to a young person, for example, how referrals are progressing, how a young person is engaging and the health outcomes because of their service (both within the CDYJS health team and external or specialist services).

Staff suggested increased collaboration with young people using the service and following ‘the voice of the child’ in designing any service improvements. Some staff said that completing the HNA survey with young people was interesting and a useful way to understand their priorities and needs.

2. Engagement with Young People

30 survey responses were received from young people, approximately 15% of the cohort. The survey was made available online and in a hard copy and staff from CDYJS provided support to the young person to complete the survey where needed. Respondents were aged 13-18, attending a range of education and training, with some NEET. 24 respondents were male, with 5 females and 1 identified as ‘other’. Owing to the small number of responses and potential bias from self-reporting health status, findings have been interpreted as summaries and caution should be taken in interpreting results.

General Overview of Health Needs

Young people were asked several questions about themselves, their health, healthy behaviours, and their health needs.

General Wellbeing

Young people usually feel ‘happy’ or ‘neither happy nor unhappy’ on a day-to-day basis. Most respondents were able to name several things they do to help them feel better if they felt sad, anxious, or stressed: for example, speaking to CDYJS staff, talking to family and friends, hobbies, and activities, and getting outdoors.

Physical Activity and Hobbies

The vast majority of young people reported being physically active in the last week for more than 30 minutes; for example, going for a walk or going to the gym. Most young people reported their activity was part of being at school or college (walking to or from) or in a private gym or pool facility.

When asked about barriers to physical activity, young people named cost as their biggest barrier, and others said they had no time or nobody to go with.

Fewer young people reported having hobbies or interests, with the most popular being watching sports and gaming, both sedentary hobbies. Other young people said they spent time working or seeing partners.

When asked about barriers to hobbies, young people again named cost as their biggest barrier, and time and nobody to go with as other barriers, as well as mental health and mood stopping them from wanting to.

Smoking, Drugs and Alcohol

Less than a third of respondents reported smoking cigarettes, a mixture of smoking daily and smoking socially, with some reporting that they started at age 9. However much higher numbers of young people reported vaping, approximately two thirds, and of these, almost all vaped daily. Many young people said they bought vapes from other people and from shops.

Owing to the age range, no direct comparison was available for smoking or vaping rates across the general 10-17 population, but the number of young people vaping and vaping as a health concern is generally consistent with wider surveys and the CDYJS staff survey. More than half of respondents reported drinking in social situations, and none reported drinking daily, and the youngest age reported for starting drinking was 11.

Around a third of young people said they use illegal drugs, mostly cannabis and prescription drugs. The youngest reported age for trying drugs was 11.

Respondents said if they wanted to try and quit or reduce smoking, alcohol consumption and drug taking, that they would approach a range of people – including family, support services like Humankind, and the YJS/ their case manager. Similar to the staff survey, Humankind was positively commented on by young people. Barriers to getting this help included not wanting to and not feeling like they have an issue that needs addressing.

General Health Needs for Young People

When asked what they thought the most important health problem is for young people generally, the answers were strongly skewed towards mental health, substance misuse, vaping, and self-esteem and confidence. Several young people identified specific issues like waiting times for neurodevelopmental service assessments and the increase in vaping.

Own Health Needs

When asked what was important to think about in terms of their own health, young people said they wanted to improve their fitness, look better, stay out of anything illegal, get mentally healthier, improve their mood, improve their sleep, and that they want to look after themselves.

When asked if they had any worries about their own health, young people reported a range of concerns, from mental health, dealing with depression, anxiety, and low mood, waiting for diagnosis of ADHD/Autism and not having enough medicine for their ADHD diagnosis.

Young people said they had people they trusted to talk to about their health, with several naming their case manager, health team workers at CDYJS, their GP and their family.

Young people stated a range of preferences in terms of where they would like to go to get help with their health, including health appointments in school or at home. Young people did not report many barriers to accessing health appointments other than not wanting to talk to anybody.

Around a third of young people reported currently receiving health team support from CDYJS, with some making positive comments about the support received, with specific praise for the PHN and SLT. Lots of young people said they would take a CDYJS health appointment if they were offered it, including some young people who said they had a positive experience first time round, but others said they would not because they do not like speaking to people.

Family Health Needs

Young people's perceptions of their family were that they were quite healthy, but that parents suffered from stress because of their offending behaviour, and that they were worried about ageing relatives.

Conclusions from Engagement with Staff and Young People

Staff feel that young people have a wide range of health needs, with mental health needs more significant than physical, though there are some emerging health needs such as vaping that are consistent with wider concerns for children and young people's health.

Staff were very positive about the way YJS works with health team roles and specific areas of good, child-centred practice were highlighted, such as embedded drug and alcohol roles within Humankind, which could be replicated. Referrals to external and specialist agencies can be more challenging due to waiting times and referral criteria, and this has increased demand on CDYJS staff.

Barriers to accessing health services for include data sharing challenges as well as difficulties engaging young people and their families and services and external and specialist services offering support that meets young people's needs and preferences.

Staff felt there were opportunities to improve the way the CDYJS works with young people for their health, including better engagement and co-production opportunities within the service for continuous improvement and to ensure children's priorities are high on the agenda.

Young people had a range of perspectives on their health and wellbeing, priorities for themselves and other young people, and the services provided by CDYJS.

Their perspectives were consistent with those of staff and other research evidence and intelligence in this HNA and wider surveys and data available around young people's health and wellbeing.

Young people and staff were interested in future engagement and taking a co-production approach to service design and delivery with young people more routinely would be beneficial to ensure their specific needs are met.

Chapter 5: Conclusions and Recommendations

Summary of the Key Findings

Children known to the YJS have a range of needs that impact on their health and wellbeing which are linked to their risk of offending and re-offending behaviour. Key findings are summarised from research evidence, local and national data on the population and YJS service, and engagement with YJS staff and children and young people known to the service below.

Research evidence tells us that:

The research evidence base is relatively like that found in the 2017 HNA. Young people at risk of offending and who have offended have complex lives. They experience risk factors that contribute to offending and re-offending behaviour and poorer health and wellbeing outcomes compared to the general population of children and young people.

Most research evidence focuses on risk factors for offending and health needs of young people who offend rather than interventions to address these risks before or after offending. However, most literature and national policy takes the position that any interventions to reduce offending behaviour or improve health outcomes are likely to be of net positive benefit to young people who offend and the communities they live in.

Research evidence on adapting health interventions to meet the needs of young people who offend is available. This mostly focuses on how each YJS can offer a child first, personalised approach, but also supports the argument that flexible health services are more effective than others in meeting the needs of young people who offend, and principles of the YJS approach can be applied to external and specialist health services to better meet the needs of young people.

Since the 2017 HNA national policy has changed, with a new strategic plan for YJS published in 2021. This plan does not include any requirements or recommendations related to health that differ significantly from previous iterations. One key difference is the recommendation supported by research evidence to take a 'child-first' approach to delivering youth justice services, seeing children and young people as an important and automatic partner in decision making. During the development of this HNA, Investing in Children and CDYJS have started to explore options to introduce more engagement and embed a 'child-first' approach across the service.

More detailed conclusions from research evidence can be found between pages 10-18.

Local and national data tells us that:

Demographics for young people who offend are similar to those found in the 2017 HNA and similar to the national picture of young people who offend. Boys living in deprived areas are more likely to offend than those living in less deprived areas.

New standardised assessment processes in the YJS introduced after the previous HNA means there is improved data available on risk factors for offending and health needs of young people, so the service is more able to understand and meet their needs.

Risk factors for offending are similar to those found in the 2017 HNA. Children who have experienced ACEs, those diagnosed or suspected of having a learning disability or autism, who are care-experienced or have experienced homelessness, with low educational achievement and mental health difficulties are more at risk of offending or re-offending than other children and young people.

The health needs of young people who offend are also similar to the 2017 HNA. There are some new health challenges due to an increase in number of young people vaping and increasingly complex mental health needs following the COVID-19 pandemic. High levels of need are observed in mental health, substance misuse, and diagnosed and undiagnosed neurodiversity and learning disability. There are differences in data between those 'diagnosed' with conditions and those identified as having a health 'need', which leads to disparities between local and national data.

After a steady decline in number of offenders and offences, in 22/23 figures have risen, and the CDYJS has experienced capacity challenges as a result, including in the health team and for the case management system. These capacity challenges are reflected in the wider health and care system, particularly in specialist mental health services for young people.

Systems within CDYJS have changed significantly since the last HNA, leading to a large increase in health team activity. Interventions offered to young people have expanded as a result of embedded roles in drug and alcohol services, embedded SLT role, and PHN screening and assessment process. Health needs identified in assessments generally match referrals recorded to the CDYJS health team and to external services. Demand across the health team to deliver interventions (all roles) is high.

Data on number of young people accessing health interventions has improved due to previously mentioned changes to systems, but there are barriers to monitoring outcomes across organisational boundaries for YJS health team roles hosted by TEWV and HDDFT, and with other external and specialist services. This is due to data sharing agreements between agencies not currently being in place.

This can make it difficult for CDYJS to understand the demand on their health team for interventions and outcomes as a result, and how well other services are doing at supporting their cohort. Improved data sharing would be beneficial to support understanding of how well the YJS health assessment, support and internal and external referral model is working to meet young people's health needs. Improved data sharing could also support the YJS to evidence impact in order to secure funding for service improvements, and support other YJS across the country by adding to the available evidence base for interventions.

Generally, there are many sources of data and intelligence about the needs of young people who offend, split across multiple systems. This can mean there are contradictions in local and national figures due to different case definitions. Increasing data availability through the Durham Insights dashboard is in progress, with the caveat that national data is usually based on diagnosed needs and this differs significantly from data on needs collected locally, so the dashboard should include both.

More detailed information from local and national data can be found in pages 19-41.

Engagement with staff and young people tells us that:

Staff perceptions of health needs generally match those highlighted in data and intelligence and research evidence and were consistent with wider health concerns for young people, such as the increase in vaping. Barriers raised to accessing health services or achieving good health outcomes included challenges engaging young people and their families and how other services approach working with young people. Young people named slightly different barriers, such as cost of activities.

Staff and young people highlighted positive relationships and flexible ways of working across CDYJS, health team and the organisations health team roles are hosted or employed by, such as Humankind. This could be replicated in other services to help them better adapt their offer to meet the needs of young people; for example, through building on the success of the SLT training model offered by CDYJS to support other services to understand the needs of young people who offend.

Staff shared the perspective that the service, whilst working hard to meet the needs of young people, could improve in terms of supporting young people to 'wait well' for specialist external health services particularly in mental health through providing early intervention, offering young people's mental health first aid, and other brief mental health interventions. Staff felt additional training could improve their feelings of confidence in supporting young people with their mental health given increased demand.

Supported by the literature review and data on service delivery, staff made suggestions on expanding capacity within the CDYJS to meet health needs of young people. These included increasing the number of existing roles to better meet demand for assessments and interventions, and also additional new roles, such as a mental health nurse.

The YJS has previously been successful in gaining funding for more specialist professionals provided in-house rather than relying on external and specialist services, for example, a psychologist to deliver a trauma-informed care pathway is currently commissioned for a limited number of young people using the Serious Violence Fund. However, this is not available to all young people. Expanding this pathway through additional roles would be likely to improve young people's outcomes, and there is an additional query about longer-term funding for trauma-informed care.

Increasing health team capacity to support specific unmet needs may also support specialist external services to adapt their offer to be flexible to meet the needs of young people who offend in the longer term, building on good practice offered by the SLT training model within YJS and supported by research evidence on differentiated and flexible service offers.

Staff and young people made other suggestions on how the service could be made better. Many suggestions focused on wider health and wellbeing rather than formal health 'needs' identified in assessments, such as being physically active, accessing more activities and hobbies for mental health and wellbeing, and being connected to the community. Building health promotion into all interactions through am evidence-based Making Every Contact

Count approach could provide additional opportunities for staff and young people to have healthy conversations outside of formal assessments and interventions.

Additionally, staff and young people identified that opportunities to engage in activities for wellbeing such as physical activity, hobbies, and other social opportunities can be limited as current service provision in the community does not always match their preferences or there are barriers such as cost or being available in the school holidays. Though community provision that young people do access was seen as high quality and positive for wellbeing, working with wider leisure services and other settings including education to influence or expand service provision may be beneficial to support young people's wellbeing.

Another staff suggestion was more dedicated staff resource to help connect young people with community assets to build confidence. No social prescribing service currently exists for young people in County Durham. Expanding YJS capability to offer support in building confidence and connecting with community assets could be undertaken, either through creating a dedicated young person's social prescribing role or service or upskilling existing staff to bridge the gap between provision and young people who offend.

Detailed information on findings from engagement with staff and young people can be found between pages 42-51.

Other Findings

Referral Pathways

Discussion with the service and engagement with staff and young people revealed that feedback loops are variable between agencies and often challenges arising in a young person's care such as a rejected referral, are addressed through individual case conversations.

Challenges with referrals to external and specialist services were highlighted through engagement with the service, but there is limited data available on number of referrals rejected, why they were rejected, and from which service they were rejected, so it is currently difficult to identify specific opportunities for improvements to referral pathways.

Undertaking an audit of referrals over a specified period of time would provide evidence needed to support necessary changes. Following the referral audit, options could be explored such as embedded professionals in other services building on success seen in the embedded drug and alcohol workers and other health service roles, fast tracked referral pathways, or single point of contact arrangements within specialist external services to follow up referrals.

Individual case conversations may not be the best way to tackle challenges common to more than one young person. One option to address this is to introduce a 'health panel' that mirrors the current YJS 'education panel' arrangement, where agencies involved in education and training for young people who offend come together monthly to discuss specific cases, unblock problems, and monitor common challenges that need escalation or additional input. Similar work is happening for the CYPMH pilot in Consett.

Creating a health panel gives YJS the opportunity to both discuss individual cases across organisations to improve their health outcomes, but also to gather more detailed evidence that can be used alongside an audit of referrals to support actions to improve multi-agency collaborative working and referral pathways.

Local Policy

Children and young people who offend are often included in wider definitions of children and young people deemed vulnerable or at-risk in local policies and strategies and in service delivery. This means that sometimes policies and strategies are not sufficiently detailed to understand how organisations and services are working to meet the unique needs of young people who offend.

Ensuring that young people who offend are specifically named as a priority group in local strategy and policy and how their unique needs will then be met by services will help to ensure continued focus on this cohort and reduce the risk of widening inequalities, aligned to the recommended NHS approach through the Core20PLUS5 framework for health inequalities for health services.

Recommendations

The HNA has identified several areas of relative strength in the YJS and wider health and care landscape for young people who offend. These are the collaborative working style across the YJS and embedded roles, including substance misuse workers, health and wellbeing workers, and public health nurses, and a sense of working together to support children and young people in the best way for them regardless of job role. Other strengths include high regard for substance misuse support, speech, language and communication support, and relationships with case managers and other staff. Areas for further development are around developing routine engagement with children and young people, availability of data between organisations, the wider health and care offer outside YJS for this cohort, and challenges in maintaining and retaining funding for elements of service delivery.

The following recommendations have therefore been formulated considering relative strengths and areas for further development and have been prioritised accordingly. Recommendations have been discussed with the CDYJS management board and public health senior management team. Recommendations relate to the findings outlined in the conclusion and are supported by evidence found in this HNA, and are priorities for ongoing improvement work, though other opportunities for improvement should not be disregarded if they arise.

Some recommendations are for the YJS to enact, and others rely on wider system working, which is facilitated by the CDYJS management board. Some recommendations are relatively short-term, where others are long-term pieces of work requiring collaboration across organisations. Organisations have been marked where appropriate.

The intention of this report and recommendations is to guide the CDYJS management board in developing a targeted action plan to deliver best value in terms of evidence-based improvements to the service, with the intended outcome of improved health and wellbeing for young people who offend in County Durham. It should be noted that recommendations assume current levels of service provision are not reduced below current levels.

The CDYJS management board should be accountable for the action plan and name specific organisations who are responsible for delivering actions. Therefore, the first recommendation is to address the need for a plan to deliver the recommendations.

Recommendations for the board and wider system

Recommendation 1: For the CDYJS management board to accept the report findings and recommendations and develop an action plan to enact recommendations, with the CDYJS remaining accountable for delivery, and organisations or people named as responsible for actions. The action plan should include timelines for delivery.

Recommendation 2: Disseminate findings of this HNA report proactively across partner organisations using mechanisms such as the CYP MH partnership board to improve knowledge of the specific vulnerabilities of young people who offend and make the case for other services to improve their support to this cohort.

Recommendations for the Service

Recommendation 3: Ensure a 'child first' approach is taken across the full YJS offer, aligned to YJB guidance. The approach should be embedded in the YJS service strategy and action plans. The service should monitor progress and impact.

Recommendation 4: Introduce engagement, co-production and co-design approaches with children and young people served by the YJS and their families to inform and improve the service. This should be aligned to the County Durham Approach to Wellbeing by using the wellbeing self-assessment framework[62] as a starting point, and the service should monitor progress and impact.

Recommendation 5: Take specific actions to create a service that meets the needs of neurodiverse young people, co-created with them, following the principles outlined in recommendations 3 and 4. Actions should be guided by available evidence in this HNA and utilise input from specialist services.

Recommendation 6: Develop an offer for the YJS to share their specialist expertise with other organisations and services through a wider systems approach so they can better meet the needs of young people who offend, building on success seen in the current model of sharing SLT expertise.

Recommendation 7: work with the public health team to increase the number and range of opportunities YJS staff have to support young people with their health and wellbeing and promote health beyond formal assessment processes and identified priority health needs, through introducing a making every contact count approach to interactions.

Recommendations for Commissioners

Recommendation 8: undertake a multi-agency audit of referral pathways to identify specific barriers to referrals and collaborative working and develop an action plan based on the audit findings to improve access to specialists through addressing identified barriers; for example, through expanding existing partnership working, creating new pathways, and changes to contracting arrangements.

Recommendation 9: Introduce a new joint working arrangement between agencies responsible for young people's care and support to both tackle individual case challenges and to gather further evidence on common challenges and barriers to support work to improve referral pathways outlined in recommendation 8.

Recommendation 10: Increase CDYJS staff expertise to meet current challenges faced by young people to help them wait well for specialist services through offering access to training on 'waiting well', early interventions, youth mental health first aid, and brief mental health interventions, working with mental health services.

Recommendation 11: Improve access to specialists through expanding capacity within the YJS health team to deliver trauma-informed care, and reduce demand elsewhere in the system, ensuring that the YJS is made aware of relevant funding opportunities. This recommendation includes specific exploration of the current commissioning and funding status for trauma-informed care pathways including funding a second public health nurse for this purpose.

Recommendation 12: Sustain areas of strength relating to commissioning arrangements for the health team identified in this HNA, including embedded substance misuse workers, SLT, public health nurses and health and wellbeing workers, using improvements to data and intelligence outlined in **recommendations 13 and 14** to build evidence of their impact.

Recommendations for Data and Intelligence

Recommendation 13: Set up a task and finish group to explore possibilities for improving data sharing across organisational boundaries on the youth justice cohort through data sharing agreements or changes to contracting and commissioning arrangements as appropriate. The aim of the task and finish group should be to improve the ability of the YJS to understand health outcomes achieved by their cohort.

Recommendation 14: Create a single source of information for monitoring and evaluation purposes and set out an ongoing plan for evaluation of the service in terms of health and wellbeing outcomes.

Recommendations for the wider system

Recommendation 15: Inform wider health, wellbeing, and activity service providers on the specific needs of young people who offend to influence provision of services to improve their offer to meet the needs of young people who offend.

Recommendation 16: Ensure the population of young people who offend are named in local health related policies and strategies, and sufficient detail on how their needs will be met is provided in order to monitor improvement.

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