

The health needs of Young Offenders

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1. List of Abbreviations

CAMHs	Child and Adolescent Mental Health Services
GPs	General Practitioners
LASCH	Local Authority Secure Children's Home
NHS	National Health Service
NSF	National Service Framework
PCTs	Primary Care Trusts
PHImP(s)	Prison Health Improvement Partnership(s)
PHRN	Prison Health Research Network
STC	Secure Training Centre
UN	United Nations
YJB	Youth Justice Board
YOI	Youth Offending Institutions
YOT	Youth Offending Teams
WHO	World Health Organization

2. Introduction

This report is a scoping review of the health needs of young offenders in prisons in England and Wales.

The research on which the report is based is one of three projects commissioned by the Primary Care section of the newly-established Prisons' Healthcare Research Network (PHRN) <http://www.phrn.nhs.uk/> to investigate various aspects of the healthcare and welfare of prisoners.

The other research areas are:

- Peri-natal healthcare
- Chronic disease & care of older people

This report presents findings from research into adolescent health in the general population, primary care services in relation to young people and adolescent health needs, and health care provision in Youth Offending Institutions (YOIs). It ends by making recommendations about health care for adolescents and young people in prison, and identifies what further research is needed.

2a. Acknowledgements

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3. Executive Summary

Background

In April, 2006 the responsibility for commissioning health services was transferred from the Prison Service to Primary Care Trusts (PCTs), and for education services to the Department of Education and Skills and the Learning and Skills Council. The intention of the government is that health care provision in secure estates should, as far as possible, be equivalent to services in the community. In order to support this reform, the Department of Health (DH) has funded the development of the Prison Health Research Network to build an academic and research base for prison healthcare.

This report focuses on issues relating to healthcare for adolescents, findings from research into adolescent health and primary care services and the health needs of young offenders, and makes recommendations for future development.

Conclusions

Adolescence is a time of exploration and experimentation, and the behaviours and attitudes adopted during this period are often continued into adulthood.

Health professionals who provide care for adolescents have the opportunity to influence the knowledge, attitudes, and behaviours of adolescents by providing them with accurate information.

In general adolescents view health care providers as credible sources of health-related information but often do not discuss health issues of greatest concern to them in consultations with health care providers. Their health concerns are often not adequately addressed by healthcare professionals.

There is a need for training of primary health care providers in the particular challenges of adolescence.

Young people value confidentiality. Other aspects of care that are important are the perceived attitudes of reception staff; privacy of the reception area; difficulty getting an appointment; waiting times before being seen; duration of the consultation; attitudes of the doctor and other health care professionals; and fear of embarrassment.

Young offenders have much higher levels of health need than the general population of adolescents and they tend to utilise services in times of crisis rather than using them in a primary or preventative way.

Recommendations

The stigma of adolescent healthcare provision, where young people are seen as a difficult group that requires specialist provision should be tackled. This is particularly the case for young offenders. There should be specific provision for these young people that takes into account developmental stages, the high prevalence of risky behaviours associated with this group, their health attitudes and beliefs and their need for services that are accessible, confidential and delivered in a non-judgemental way.

Care needs to be flexible, adequately resourced, with a listening culture amongst staff encouraged, and skills development and training for staff. Any service changes should involve young people in the development and evaluation.

Recognition of health problems needs to be improved, probably through additional training of all primary care professionals, although it is noted that the new Youth Justice Board (YJB) screening tool currently in development may address some of the current problems.

Given the high levels of need amongst young offenders careful screening is clearly extremely important in order to improve recognition of health needs. Health care provision in Youth Offending Institutions (YOIs) will need to be well developed and resourced if these needs are to be addressed.

While children are detained there is the opportunity to detect, diagnose, and treat health problems in a group that is often not engaged with health services. PCTs and the YJB need to work together to ensure that the needs of these vulnerable and needy children are met. There is currently a shortage of appropriate services for adolescents generally, let alone young offenders, so planning for service provision will need to address funding and resource issues in the development of health care in secure estates.

Health care teams based in YOIs may be able to provide the kind of flexible, skilled care that could have an impact on the health and well-being of children and adolescents whilst they are in custody and may also impact on long-term health.

The use of a care plan which grants a health professional overall management of a young person could be helpful in meeting the needs of young offenders and ensuring that they receive the necessary help from appropriate agencies and professionals.

Recommendations for future research

There is a lack of research addressing the development and implementation of appropriate health care services for young offenders. Future research should seek to identify examples of existing good practice in YOIs. These models of service provision need to be evaluated and research should seek to demonstrate where these models succeed and also where they fall short to provide appropriate levels of care and interventions for what is clearly a population of young people with high levels of needs. Health care provision in YOIs in the future should be based on models that have been proven to be effective but should also take account of the local context and pay attention to what is already known about particularly vulnerable groups of young people within the young offender population generally (i.e. females, those from ethnic minorities, and young people who have been in care). Research should also involve young people in the development and evaluation of services as they can be a rich source of information and ideas about existing services and the ways in which they could be improved.

4. Adolescent Health

In order to place the needs of young offenders within the context of adolescent health more generally this report has drawn upon findings relating to health needs of adolescents.

Adolescents make up a significant proportion of the population; in the UK, along with most developed countries, young people between the ages of 10 and 20 account for 13-15% of the total.

Mortality among adolescents, in contrast to almost all other age groups, did not fall during the second half of the twentieth century (Blum, 1987). Accidents and self-harm are the main causes of mortality in this age group (Coleman, 2001; Adolescent Health Chartbook, 2000; University of Liverpool, 1998). Health needs appear to be greater amongst adolescents than children (5 to 12 years) or young adults. Morbidity mainly arises from mental health problems and chronic illness. Existing Child and Adolescent Mental Health services (CAMHs) are a poor relation to other services in terms of resources (Audit Commission, 2000) although young people with mental health problems have the highest morbidity and mortality of any group of patients (Royal College of Paediatrics, 2003). Type 1 diabetes has a peak of onset in adolescence and control is poorer in this age group than any other (Greene, 1996). Health issues of immediacy that impact on peer relations are the focus for young people and include weight, problems with skin, appearance, emotions and sexual health (Kurtz and Thornes, 2000; Gleeson, Robinson & Neal, 2002). Illnesses that have impacted on appearance or sexual and reproductive function in childhood or adolescence generate particular challenges for young people as they grow up (Royal College of Paediatrics, 2003).

Use of health care by 12 to 19 year-olds is about half that of children aged 0 to 14 years but their use of hospital beds grows during adolescence (Viner, 2001). There is evidence that although nearly all have seen a GP within the previous twelve months their consultations are shorter than average and many will have seen other health professionals (Coleman, 2001; Jacobson et al. 2000). Adolescents also have a number of concerns about how services are provided (Finlay, 1998; Opong-Odiseng & Heycock, 1997; Jones, 1997; Burack, 2000; Norwich Union, 2001; Wilson, 2001; Brook, 1998; Teenage Pregnancy Unit, 2001). These will be highlighted below in the section on adolescent use of health services.

Adolescence is a stage with significant change and maturation and this phase is not universally problematic. However, a number of problems which have been less apparent in earlier years may become more visible. Acting out behaviours may become problematic (because of changes in growth and strength), particularly in boys, while anxiety and depression, particularly in girls, may become more obvious (Venables, 2001; Stanway and Cotgrove, 2001). 'Looked after' children are also associated with a dramatic increase in the prevalence of teenage pregnancy, health disorder and involvement in crime (McCann et al. 1996).

Young people have diverse needs influenced by gender, ethnicity, social and educational disadvantage, family breakdown and sexual orientation (Royal College of Paediatrics Child Health, 2003). Young Bangladeshi and Pakistani people under the

age of 20 form a significantly larger proportion than the host population in the UK (Office for National Statistics, 2000; Stationery Office, 2000). These young people are at increased risk of certain health problems and are over-represented in families who suffer socio-economic and health disadvantage (Spencer, 2000).

There are a number of health problems in young people that are of concern: high rates of sexually transmitted diseases (PHLS, DHSS&PS and the Scottish Collaborative Group, 2001; Burns et al., 2002), particularly in teenage girls; and the rise in suicide in young men (Rutter and Smith 1999). There is strong and growing evidence of the inter-relationship between physical, social and mental health (McClure, 2001; Bennett and Bauman, 2000, Ramrakha et al, 2000) and problems in young people in any of these domains indicate the likelihood of long term adverse health and social outcomes (Kurtz and Thornes, 2000).

Health behaviours established in adolescence have been shown to persist into adulthood - for example, smoking (US Department of Health and Human Services, 1994), substance misuse (Fonagy et al., 2002; Rohde et al., 2001), eating disorders (Fonagy et al., 2002; Wentz et al, 2001), physical activity (Biddle et al, 1998), obesity (Steinberger et al, 2001), and sexual risk taking (Johnson et al, 1994). Living in relative poverty, family breakdown, poor parenting, and being looked after by the local authority are often associated with a higher risk of unhealthy behaviours (Royal College of Paediatrics, 2003).

4a. Adolescent mental disorders

Prevalence rates of mental disorders were investigated by a large scale survey of over 10,000 children up to the age of 15 in the United Kingdom (Meltzer et al, 2003). This survey identified 4% as having emotional disorders such as anxiety, depression and Post Traumatic Stress Disorder (PTSD) and 1% had hyperactivity problems such as Attention Deficit Hyperactivity Disorder (ADHD). 5% of the sample had conduct disorders. Including conduct disorders, the study found that 10% of the sample had at least one type of mental disorder. This study also found that the prevalence rates for all types of disorder tended to increase into adolescence (i.e. from the age of eleven onwards). This study examined the prevalence of mental disorders in a number of different ways. Prevalence of all disorders (including conduct disorder) was marginally greater amongst boys than girls although girls were slightly more vulnerable to emotional disorders. Rutter and Smith (1995) found that conduct disorder and substance misuse problems were more common amongst boys but that girls were more vulnerable to depression. The prevalence of disorders appears to increase with age; boys over the age of 10 have a 30% increased likelihood of a mental health problem compared to their younger peers (Meltzer et al, 2003). This study found that children of lone parents were almost twice as likely to have mental disorders compared to those with married or co-habiting parents. Prevalence of mental disorders increases as family income reduces and is also a negatively correlated with the educational qualifications of the principle carer.

An American study (Costello et al, 1996) screened 4,500 nine to thirteen year-olds, using the Child & Adolescent Psychiatric Assessment (CAPA), and identified prevalence rates for any DSM-III-R disorders at 20.3%. 5.7% had anxiety disorders, 3.3% had conduct disorder and 1.9% had hyperactivity. A study in the Netherlands

(Verhulst et al, 1997a) used the Diagnostic Interview Schedule for Children (DISC) to generate DSM-III-R diagnoses on a sub-sample of 780 adolescents who had been screened from a sample of 5,900 using the Child Behaviour Check List (CBCL). This study identified an overall prevalence rate for any disorder of more than 21% with rates of up to 4.4% for overanxious/generalised anxiety, up to 6% for conduct disorder and up to 2.6% for hyperactivity.

Longitudinal studies suggest that the overall prevalence of mental health problems amongst adolescents is likely to be greater than that revealed at a single time point by a cross sectional study (Costello et al, 2003) and also suggest that the nature of the disorder may vary with age with significant continuity from depression to anxiety and vice versa, and from anxiety and conduct disorder to substance abuse. Such studies also indicate that mental disorders during adolescence are a major risk factor for adult mental health disorders: Retrospective assessment of adults within a longitudinal cohort diagnosed with a mental health disorder revealed that over 70% had received a diagnosis before 18 years of age and 50% had received a diagnosis before 15 years of age (Kim-Cohen et al, 2003).

4b. Primary care services for young people

A survey carried out by the Royal College of Paediatrics (2003) found that dedicated services within general practice primary care for young people are rare. Outside of general practice there are a number of specialist clinics which aim to offer user-friendly and confidential services for sexual health (McMorrow and Kell, 2002) and mental health (Kurtz et al, 1994).

There is some evidence to suggest that many physicians feel uncomfortable in consultations with adolescents as they feel under-trained in adolescent healthcare. Veit et al (1995) found that as many as 82% of GPs did not fully understand the developmental stages of adolescence, 75% had concerns about their ability to provide appropriate adolescent healthcare, and 91% said they had little or no training in this area. In a study of Swiss paediatricians there was a discrepancy between their high rating of topics relevant to adolescent health care and their lack of training and knowledge in such areas (Stronski et al. 1999).

Over six hundred 13 and 15 year-olds were surveyed about their expectations and experiences of consultations with their GP, particularly with regard to confidentiality (Rutishauser et al 2003). Of these adolescents, 33% of 13 year-olds and 52% of 15 year-olds said that seeing the doctor alone for some of the consultation was important to them but only 18% of the 13 year-olds and 20% of the 15 year-olds were given the choice. Although 79% of the younger students and 90% of the older adolescents said that confidentiality was a significant issue, and 64%/78% (13 year-olds/15 year-olds) wanted assurances of confidentiality even with regard to their parents, only 26%/27% of the doctors explicitly assured the young people of confidentiality with regard to parents. With regard to gender, the opportunity to talk to the doctor alone, be assured of confidentiality generally and specifically with parents and see a female doctor was significantly more important for girls than boys.

A study by Jacobson et al (2000) found that the main reasons for dissatisfaction with primary care amongst the young people in their study were insufficient information

from the GPs and a lack of improvement in their condition. Other reasons were a perceived lack of care, embarrassment or an issue related to the gender of the GP. The authors suggest that there is still a need to change the perceptions of young people as well as improving services.

Studies have demonstrated that young people also find other aspects of primary care important, for example the perceived attitudes of reception staff, privacy of the reception area, attitudes of the doctor, duration of the consultation and fear of embarrassment (Donovan et al 1997; Kari et al. 1997; McPherson, 1996).

Pregnancy rates in under 16-year-olds and sexual risk-taking are both increasing (Burack, 2000). The findings from a survey of sexual health services offered by GPs showed that, although the majority of young people in the survey were aware of sexual health services in general practice (68%) and 75% were positive about the content of the consultation, 54% believed they had to be over 16 years old to be eligible to use the services and 58% were concerned that confidentiality would not be assured. Some (30%) were also concerned that the GP would not have the necessary skills or time to help them with their problems. The study suggests that work is needed to improve young people's access to, and use of primary care services (Burack 2000).

4c. Adolescent use of health care services

Adolescent's intentions to use health care for different types of health issues have received relatively little attention. However, studies of adolescents have revealed that they are more willing to seek health care and disclose their concerns if the doctor assures confidentiality (Cheng 1993; Ford et al 1997; Proimos, 1997). Adolescents welcome friendly staff of both genders with personal experience and professional expertise, confidentiality and flexible hours, and some prefer drop-in facilities rather than a more formal set up (Hewitt, Roose and John, 2004).

In a study of adolescent health beliefs (Marcell & Halpern-Fisher, 2005) using age and gender-specific health case scenarios found that most adolescents believed all health care problems except for planning to initiate sex were serious. They believed that physicians were most effective in diagnosis and treatment for pneumonia, followed by cigarette use, depression, and sex. Their intention to seek help was greatest for physical as compared to risk behaviour or mental health problems. When they considered physicians to be effective they were more likely to seek help for cigarette use, sex, and depression. The authors concluded that adolescents who report not seeking health care are also less knowledgeable about services available to them and physicians need to be trained in how to reach adolescents. Ginsberg et al (1995) found that teenagers seek providers who are competent, warm, compassionate, unpretentious, non-judgemental and willing to respect confidentiality.

Klein and Wilson (2002) used the Commonwealth Fund Survey of the Health of 6728 adolescent boys and girls and found that there was a discrepancy between what young people wanted to discuss with service providers and what they actually talked about. Young people mainly discussed diet, weight, and exercise but most frequently wanted to discuss drugs, smoking and diet. Of those who reported at least one of eight potential health risks, 63% did not speak to their doctor about them. Common risk

factors were high stress (37%), alcohol use (34%), smoking (27%), low exercise levels (21%), and having sex without using contraception (18%).

4d. Mental health services

Young people's attitudes and knowledge (or lack of it) are significant factors in their decisions whether or not to use mental health services. Research within the general adult population (Jorm, 2000; Regier et al, 1998) suggests that their understanding and beliefs are very different from those of mental health professionals. The findings with younger people are very similar (Armstrong et al, 1998). Nabors et al (1999) examined adolescents' satisfaction with school-based mental health services and found that students valued the therapeutic relationship and the 'catharsis' associated with therapy consistent with findings from previous research (Brannan et al, Garland and Besinger, Shapiro 1997).

A recent paper (Jacobson, et al 2002) examining the recognition of mental illness during adolescence argued that there are several deficiencies in the primary care system, namely a lack of identification of teenage distress, a lack of training for GPs in adolescent health, a lack of an evidence base, a lack of resources and also a lack of information from adolescents who have experienced difficult emotional experiences and who could otherwise give useful insights into their difficulties.

5. Juvenile Offenders

5a. Key facts about juvenile offenders

The following information was taken from the Audit Commission report Youth Justice (2004).

- There are nearly five and a half million 10-17 year-olds in England, around one-quarter of whom have committed a criminal offence of some kind in the last 12 months (MORI, 2003).
- In 2002/2003 nearly 268,500 juveniles were arrested for notifiable offences (Simmons and Dodd, 2003). At around 5% of the age group, young people are at a disproportionately high risk of becoming involved in the criminal justice system and of being the victim of crime when compared with older people (Cabinet Office, 2000).
- Overall level of crime and police recorded crime has fallen since the early 1990s (Simmons and Dodd, 2003); the number of young offenders peaked in 1992 and fell by 14% between 1995 and 2001 (Home Office, 2001).
- However, there has been a steady rise in violent crime since 1991 and the number of juveniles cautioned or convicted for drug offences, robbery and violence has also risen (Home Office, 2001).

- There are almost 3,000 young people in prison, half as many again as there were ten years ago, although the numbers have remained fairly constant since 1997 (Simmons and Dodd, 2003).
- A school survey undertaken by MORI annually since 1995 (MORI 2003) shows that the self-report offending rate for 11-16 year-olds has remained relatively stable. A separate sample of excluded children aged 11-16 also showed little fluctuation, although the numbers of young people admitting to offending is much higher than those in education (MORI 2003).
- Between 1991 and 2001, the percentage of young offenders in school saying that they have been caught by the police after offending has fallen from 28% in 2001 to 21% in 2003 (MORI, 2003). As the overall rate of youth offending has not declined, this suggests that a smaller number of young offenders are being arrested.
- Those young people at risk of, or involved in criminal offences, are often engaged with a wide range of agencies and individuals. Critical to these agencies' success in meeting the many and diverse needs of troubled young people, and preventing offending and re-offending is the degree to which they are supported, resourced and configured.

5b. The Youth Justice Board

- The YJB was created in 1999 to:
 - 'monitor the operation of the youth justice system and the provision of youth justice services';
 - multi-agency Youth Offending Teams (YOTs) were established 'to co-ordinate the provision of youth justice services for all those in the authority's area who need them'
 - make changes to pre-court interventions and court sentences.
- The YJB oversees the youth justice system which comprises secure estates, YOTs, youth courts and the police. YOTs are multi-disciplinary with representatives from social services, probation, education, police and health and have a YOT manager. The aims of the YJB are to:
 - prevent crime and the fear of crime
 - identify and deal with young offenders; and
 - reduce re-offending.
- Youth justice services have changed considerably since the creation of the YJB, the youth justice reforms of 2000, and the establishment of YOTs. Delays in bringing persistent young offenders to justice have been reduced; final warnings and reprimands have replaced police cautioning; and new orders and programmes have been introduced.

- The Audit Commission (2004) examined the economy, effectiveness and efficiency of the reformed youth justice system and measured success against primary aims. The key findings from this research were:
 - 'the new arrangements are a significant improvement and a good model for delivering public services;
 - the current positioning of YOTs, enabling joint working between criminal justice, health and local government services, is critical to effective performance;
 - court time and resources could be freed up to focus more on the most persistent and serious offenders by keeping more minor offences out of court;
 - sentencing could be more cost-effective by increasing the courts' and the public's confidence in community disposals, especially Intensive Supervision and Surveillance Programmes;
 - and schools and mainstream agencies should play a more central role in meeting the needs of young offenders and preventing offending by targeting those most at risk.'

5c. Children Placed in Custody - the legal framework

Of relevance to young people was the judgement by Mr Justice Mumby, in November 2002, that children in custody are entitled to the same services under the Children Act 1989 as any child in the community, subject to the requirements of imprisonment. This means that the duties imposed on local authorities to safeguard and promote the welfare of children in need, and to make enquiries in cases where it is suspected that a child is suffering, or is likely to suffer significant harm, apply to these children. The Children Act 2004 specifically requires the Governor of a prison or Secure Training Centre to ensure that they discharge their functions, having regard to the need to safeguard and promote the welfare of children.

A further important development was the publication of the Green Paper, Every Child Matters, and the companion document, Youth Justice - The Next Steps. The YJB Strategy for the Secure Estate for Children and Young People (2005) argues that the same key outcomes in the Green Paper used to measure services for children in the community should also govern custodial provision. The YJB is committed to ensuring that children and young people are cared for in secure establishments where they are:

- Kept safe and healthy in decent conditions
- Subject to coherent, rigorous, whole-sentence plans that address their offending behaviour
- Provided with effective education, training and recreational programmes
- Released into the community with practical support so that their education and training is extended, enabling them to gain employment and lead independent, fulfilled, and law-abiding lives

The age of criminal responsibility in England is 10 years. Children aged 12 to 17 years can be sentenced to custody under a Detention and Training Order. The length of the sentence can be between four months and two years. The first half of the sentence is spent in custody and the second half is spent in the community, under the supervision of the YOT (section 73, Crime and Disorder Act 1998). A child aged 10-17 years, if convicted of a serious offence (one for which an adult could be sentenced to 14 or more years in custody) can also receive a custodial sentence (sections 90 and 91, Powers of Criminal Courts (Sentencing) Act 2000).

Once a child is given a custodial sentence, the YJB decides where the child should be placed, having regard to their age and vulnerability:

- YOIs can accommodate children aged between 15 and 17 years. However, these institutions hold large numbers of young people and are therefore less able to address their individual needs. They are considered inappropriate accommodation for vulnerable young offenders.
- Another possible placement is in a Secure Training Centre (STC). An STC can hold young offenders from the age of 12 to 17 years and there are four such centres in the England. They hold fewer young people than YOIs and have a higher staff to young offender ratio.
- Finally, children sentenced to custody can be placed in a Local Authority Secure Children's Home (LASCH). These also cater for young people who are looked after (by the Local Authority) and need a secure placement, even if they have not committed an offence. Such homes also have a high ratio of staff to young people and are small in size. They are generally used to accommodate young offenders' aged 12 to 14, girls up to 16, and 15 and 16 year-old boys who are assessed as vulnerable.

5d. Health care needs amongst young offenders

It is well established that young offenders are a vulnerable group, with complex psychosocial and physical health needs (Bailey, 1999; Anderson et al., 2004). Health outcomes in later life include an increased risk of medical problems, sexually transmitted disease, tobacco or substance dependence, poorer self-reported health, lower body mass index, mental health problems and disorders such as depression, and early pregnancy in females (Bardone et al., 1998). Studies of young offenders have also established high rates of significant ill-health and injuries (Dolan et al., 1999; Rutter and Giller, 1984), infectious and parasitic diseases, poisoning and respiratory problems (Andre et al., 1994) substance and alcohol misuse (Goldson, 2000). Co-morbid psychiatric disorders have been established in different cultural groups (Papageorgiou and Vostanis, 2000), while substance misuse predicts a greater risk of co-occurring mental health problems (Kessler et al., 1995; Randall et al., 1999).

A recent study of young offenders attending YOTs found the reported health problems, routines, lifestyle, and social deficits of these young people were substantially different from the general population but similar to other groups of

vulnerable teenagers, such as those who are homeless or leave the care of the Local Authority (Bardone et al., 1998; Anderson et al., 2004). Stallard et al., (2003) found high rates of substance and alcohol misuse, accidents/injuries and hospital admissions and contact with GPs, in contrast with low rates of routine health checks and immunizations. These findings suggest that young offenders visit general health services in times of crisis, which may occur in conjunction with attendance at other agencies.

Epidemiological cross-sectional studies have revealed high levels of health and social needs (Lader et al, 2000) as demonstrated above. However, many of these studies have been small or have focused on specific populations - for example those in secure care (Kroll et al, 2000). There is a lack of studies that have investigated the needs of young people in the community, or compared them with the needs of those in secure care. Many have also concentrated on young male offenders, and had limited representation from ethnic minorities.

These young people frequently move within the youth justice system between community and secure sites, but there have been few longitudinal studies describing how their needs change. Such studies, although difficult to conduct, are vital when considering what mental health resources are necessary to meet their changing needs.

Many of the studies that have investigated mental disorders have historically used psychiatric diagnosis as a measure of need and some of the diagnostic tools used were developed for use with an adult population (Lader et al, 2000). The reliance on prevalence rates of psychiatric diagnoses - particularly from national studies - are often of limited value in planning health services and providing for juvenile offenders. For example disorders vary in prevalence between areas, depending on the level of deprivation locally. Also, the prevalence of a disorder does not necessarily equate with the level of services required, as this is influenced by a number of factors, including the availability of an effective intervention and a willingness to accept it (Harrington et al., 1999).

Increasingly needs assessment is seen as a more useful and meaningful measure of health problems in children and adults, including juvenile offenders (Marshall, et al., 2000).

In order to address some of the deficits in current research a recent study of health needs of young offenders in custody and in the community (Chitsabesan et al 2005) was carried out. A cross-sectional and longitudinal interview study of 301 young offenders (151 from YOIs and LASCHs and 150 from the community) was carried out to assess 17 areas of need including health, educational, and social needs. The study found that Asset (current YJB screening tool) was found to underestimate rates of mental health problems. There were high levels of needs in young offenders, not only in mental health but also within education and social relationships. A third of young offenders had a mental health problem. The most significant predictor of need was location; young offenders in the community presented with significantly higher needs than those in secure care, particularly within the areas of education, peer and family relationships, and risky behaviour. There was no difference in mental health need between the two groups. Female offenders were found to have significantly

higher levels of mental health needs while young offenders from ethnic minorities had higher rates of post-traumatic stress.

5e. Young offenders and health care services

Young offenders may not be registered with a GP (Dolan et al., 1999), and as a consequence it is more likely that their interactions with health services will occur at times of crisis rather than at a primary or preventative level.

Harrington et al (1999), discussing how future mental health services for young people should be developed, advocated the use of a needs-based model to enable impact on daily functioning and diagnosis to be considered together. Such an approach allows problems such as self-harm and factors such as psychological distress which do not readily fit into a diagnostic model to be taken into account. Grisso (2005), in a review of screening instruments for young offenders, pointed out the importance of taking overall functioning rather than just diagnostic criteria into account.

Currently the YJB are piloting the use of a new screening and assessment tool in six secure estates. The tool was developed, and is currently being evaluated, by Tarbuck and Bailey at the University of Central Lancashire. This tool is more comprehensive than the existing assessment tool and covers health care needs, substance misuse, and mental health. It is hoped that this will provide a clearer picture of the needs of this population and will therefore also give a clearer indication of the levels and type of service provision required to meet these needs.

Young offenders, rough sleepers, those involved in drug use, (Local Authority) care leavers and other marginalised young people present unique challenges in the provision of health care, particularly in terms of access. Young offenders are over-represented in all of these categories and although it is recognised that it may be difficult to engage these young people in regular health service provision because of their social exclusion, the cost to society of not meeting their needs may outweigh the expense of highly specialised services.

In a review of the literature, Dogra (2005) stated that “*young people want accessible services staffed by those they are able to trust who demonstrate an ability to listen; above all, young people want to be involved in the decisions made about them.*” The involvement of young people in their care and the services they receive is imperative in order to successfully address their health concerns. Services for young people should be provided in environments that show they are worthy of respect and that do not stigmatise them in any way. Through involving young people in the development of services, commissioners will find that young people can help guide service improvements, but this requires commissioners and services to be willing to examine and change their practices (Young Minds, 2006).

6. Recommendations

6a. Recommendations for care

Young people in YOIs should have access to health care services which are responsive and effective. Given the high level of needs in this vulnerable population health care provision in YOIs needs to be provided by a range of health care professionals and disciplines working in teams to ensure that this is achieved. In the case of mental health services and interventions, more needs to be done to ensure that there is a reduction in the stigma attached to the use of such services.

6b. Recommendations for new research

Future research should:

- Involve young people in the design, delivery and evaluation of services
- Pay attention to the particular needs of young people from ethnic minorities, females and others who are known to be at risk of physical and mental health problems
- Identify examples of good practice in relation to health services provision which would enable institutions to acknowledge and recognise where they are doing well and also to highlight areas where there is a need for improvement
- Ensure that research is disseminated in an accessible and meaningful way within the youth justice system to enable the system as a whole to build on successes and address weaknesses where they exist in current health care provision

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