

The Health of Children and Young People in Secure Settings

Final Report to the Department of Health
October 2007

Ann Mooney, June Statham and Pamela Storey



THOMAS CORAM RESEARCH UNIT
Institute of Education, University of London

Acknowledgements

We gratefully acknowledge the financial support of the Department of Health for this study, although the views expressed in this report are those of the authors and not necessarily those of the Department of Health.

We would like to thank the key stakeholders and interviewees who contributed to the case studies for their willingness to talk to us and share their views and experiences, which are reflected throughout the report. We would also like to thank the Office for Standards in Education (Ofsted) for providing copies of the inspection reports for secure children's homes.

TCRU's responsive research programme

This study was carried out as part of the Thomas Coram Research Unit's programme of responsive research for the Department of Health. This provides a facility for government policy makers to request small-scale, exploratory studies on issues of immediate policy relevance. Such work is carried out by experienced researchers in accordance with sound research principles, and outputs are independently peer reviewed. It is important when reading and using reports from responsive programme studies, however, to bear in mind the limited time and resources available for each piece of work. Responsive programme studies are particularly useful in bringing together diverse evidence, 'scoping' a new field, and providing a basis for more substantive in-depth research where this appears to be necessary.

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Executive Summary

1 Introduction

This small-scale descriptive study was commissioned by the Children and Young People's Public Health team within the Department of Health, in partnership with Offender Health, in order to inform preparation and implementation of an Offender Health Strategy document for children and young people. The overall aim was to review what is currently known about healthcare for children and young people in the secure estate, covering all three types of setting (Young Offender Institution, Secure Training Centre and Secure Children's Home) and all aspects of health, but with a particular focus on physical health since more is already known about mental health and substance misuse among young people in secure settings.

The study took a multi-method approach involving a focused overview of relevant literature, interviews with key stakeholders, analysis of the most recent full inspection report (obtained for 42 of the 45 institutions holding young people under 18), and case studies of promising practice. It did not include primary research in secure settings, and a number of important caveats concerning the available data are discussed in the report. The strength of the report is that it brings together in one place information about healthcare for children and young people in the secure estate, and begins to identify key issues that need to be addressed. However, further research is needed to validate the conclusions of this study.

The summary of findings below is organised under the chapter headings used in the main report.

2 Characteristics and health needs of children in the secure estate

- Boys far outnumber girls in secure settings, but more girls than boys are placed in secure children's homes (SCHs) for welfare reasons. Around a quarter of juveniles in Young Offender Institutes (YOIs) are from a Black or minority ethnic background.
- Children placed in secure children's homes for welfare reasons usually do not know when they will leave or where they will go and, according to interviewees, this leads to high levels of anxiety and challenging behaviour.
- There is a high level of learning disabilities and difficulties among young offenders, and up to 60 per cent have specific difficulties with speech, language and communication.
- A high proportion of both boys and girls in secure settings have mental health needs and substance misuse issues. Rates of post traumatic stress are higher among minority ethnic offenders, and rates of self-harm are especially high for young women in custody.
- There is comparatively little information about physical health problems among children in any sector of the secure estate, although respiratory complaints/asthma appear to be relatively common.

3 Health education and promotion

- The custodial period presents an opportunity for health education and the promotion of healthy lifestyles in a situation where young people can be removed from risky health damaging behaviour such as smoking and alcohol and drug abuse.

- Inspection reports describe a range of health promotion activities across the estate, which were usually delivered through themed events, regular programmes or on a one-to-one opportunistic basis. However, health promotion materials which met the needs of the age range and learning needs of the population were not always available according to interviewees and inspectors, although some establishments had developed their own.
- Given the transience of the population held in secure settings, the high levels of poor literacy and learning difficulties, and often poor experiences and mistrust of formal education, as evidenced by all three sources of data, an individual, less formal and opportunistic approach to health promotion would seem to be an important one.
- Some establishments are taking a whole setting approach to health promotion as seen from the inspection reports and case studies, but such an approach requires that all staff have the knowledge and skills to promote health education and to exploit opportunities for delivering health-related messages.
- Inspection reports and case study data suggest that some secure establishments are beginning to recognise the importance of promoting emotional health and well-being and, for example, are providing relevant training and support for staff, particularly residential staff, in this area. However, empirical evidence shows that the experiences of BME boys and those held in dedicated juvenile establishments may negatively impact on emotional well-being.
- Recent research would appear to point to a shift in focus towards substance misuse treatment programmes at the expense of substance misuse education. Although there were examples of promising practice in substance misuse education across the estate, few education or treatment programmes have been evaluated.
- The promotion of sexual health care and family planning relied on staff having the necessary experience and training to provide this service. Inspection reports and interviewees indicated that this was not available in all establishments, although there were several examples of what appeared to be promising practice across the estate.
- Over the past four years the availability of smoking cessation programmes has significantly increased. It is important to acknowledge that whereas many young people may welcome the opportunity to stop smoking, it can cause additional stress for those coming into custody. Some establishments offered nicotine replacement therapy and acupuncture to help young people give up smoking.
- Inspection reports suggested that not all settings were providing a health promoting environment by offering healthy food. In those that were, residential staff were guiding and monitoring young people's choice of food, catering staff worked with young people and healthcare staff to develop healthy and appealing menus, taught cooking skills and involved young people in food preparation. Not all canteen lists offered healthy snacks and fresh fruit.
- Inspection reports also showed that opportunities for physical activity varied due to availability of outdoor space and facilities for exercise. However, some establishments with restricted facilities had nevertheless developed programmes to provide regular exercise sessions that were well supported by young people and staff. There appear to be differences between male and female establishments in access to physical activity.

- All sources of data for this review indicate that some young people entering custody need help with personal hygiene, but the limited access to showers in some establishments and IEP (Incentive and Earned Privilege) regimes can hinder rather than promote personal hygiene.

4 Meeting healthcare needs

- Data, primarily from inspection reports and interviews, suggest that although health-related services are improving, there is significant variability in the level and quality of services across the estate. Some variability is attributable to the training and expertise of the healthcare professionals, and the number and length of sessions they provide.
- All establishments undertook risk and health assessments with each young person on admission, but the quality and scope of these assessments varied. This was partly attributable to screening procedures and the expertise of those undertaking the assessment. The evidence suggests that assessments that are effective in identifying health needs depend on adequate screening procedures, appropriately qualified staff and access to a reliable medical history for the young person.
- New assessment processes were being piloted for the juvenile estate which may improve initial risk and health assessments. Those undertaking the assessments may need to take account of the raised anxiety levels among many young people entering custody and the impact this may have on assessment results.
- Research shows that the number of young people entering custody with learning disabilities is increasing, yet adequate assessment and identification of this group is often overlooked according to interviewees who thought that health, education and residential staff sometimes lack the necessary skills and training to care for this group and to meet their needs.
- It is known that poor vision and/or hearing can impede educational progress and although not standard practice across the secure estate, some establishments tested all young people on admission.
- Analysis of inspection reports shows that:
 - It was common practice to identify inoculation needs at initial assessment and an inoculation programmes were generally in place across the estate.
 - Not all SCHs had a comprehensive health care plan for each young person as required by National Standards, but homes where the health care plan was in place and accompanied the young person on release or transfer were seen as examples of promising practice.
 - The availability of specialist clinics for physical conditions such as asthma and diabetes, and access to specialists such as chiropodists and physiotherapists, varied depending on the size of the establishment and the skills of the healthcare staff.
- Although custody provides the opportunity for young people to access healthcare services that they may have previously missed out on in the community, the short duration of the typical stay in custody combined with long waiting lists for services such as dentistry may mean that routine

treatment is not completed.

- Evidence from inspections and other reports suggests that substance misuse treatment has improved as the YJB's Juvenile Substance Misuse Programme is implemented. However, recent research has identified gender and ethnic differences in attitudes towards and take-up of treatment.
- Sexual health and family planning services were patchy, though there is indication of an increase in the number of establishments offering clinics. Inspection reports indicate that in many establishments the quality of the service depended on having appropriately trained specialists and nursing staff. Escorting young people to outside clinics could cause embarrassment and risk of breaches of confidentiality.
- A national review conducted in 2005, and before many services were transferred to PCTs, concluded that mental health needs were not well met in many establishments. There is some evidence from recent inspection reports and key stakeholders of improvements in mental health provision but also of considerable variability in the level and availability of mental health services.
- Inspection reports reveal that few secure settings had access to a Forensic CAMH service and the availability of psychologists and psychiatrists was very varied. Often the role of such specialists was to support other staff to work with young people with mental health problems, rather than working directly with young people themselves.
- Some establishments had in-patient units where those with complex or mental health problems could be treated, but inspection reports and interview data suggest a general lack of secure mental health beds leading to lengthy delays in transfer to a psychiatric unit.
- According to interviewees, bereavement and loss is a significant issue for many young people in the secure estate, a perception supported by the research literature. However, inspection reports suggest that this is only just starting to gain recognition in terms of support.
- Although there are examples of good practice in preventing suicide and self-harm, the inspection reports suggest that there is a need for a more multi-disciplinary approach.
- There is minimal provision of specialist support for speech and language difficulties as evidenced by inspection reports despite the high levels of communication difficulties reported in the literature. Two YOIs had access to a therapist through a two-year funded project, and three secure children's homes located in the area covered by the Community Homes Health Team could access and receive support from a speech and language therapist.
- Inspection reports show that practices for transferring medical information and ensuring follow-up on release varied across the estate. These included making arrangements for follow-up appointments or by writing to home GPs. Other practices included health care plans and transfer summary sheets to accompany young people or sent to YOT health workers; healthcare teams undertaking follow-up of the young person for up to three months post release, and the young person being accompanied by a health worker when transferring to another secure setting.

5 Provision of healthcare in different settings: a review of inspection reports

- In attempting to provide an overview of inspectors' assessments of health services across the three types of secure setting, the limitations of this data source need to be borne in mind. For example, the level of detail on health needs and provision differs between types of setting; inspections are only able to provide a snapshot view of each service; and different standards, which are often non-specific and open to interpretation, apply to each type of setting.
- However, the overview of inspection report findings on health care in the three types of secure setting suggests the following broad conclusions:
 - Secure children's homes assessed by inspectors against the ECM outcomes (earlier inspections did not use this framework) were mostly judged to meet the minimum standards comprising the 'Being Healthy' outcome, and the majority were assessed overall as 'good' at helping children to 'be healthy'.
 - In looking at the strengths, weaknesses and recommendations for healthcare for the four secure training centres, only one secure training centre (STC) appears to be performing poorly.
 - Inspection reports for YOIs illustrate considerable variability in provision of health care services. Many institutions are described as 'improving' in relation to various aspects of health care. One institution was judged as seriously inadequate on health care, but at an inspection which took place two years ago, so the situation may have since improved.
- Although there appeared to be no discernable pattern across inspection reports to suggest that size of the establishment and staffing ratios made a difference to healthcare, nevertheless key stakeholders believed that SCHs may be in a better position to tailor health services to individual need and to offer a more therapeutic approach because they are smaller, have higher staffing ratios and are welfare-based.

6 Improving healthcare services

- This chapter draws largely on the views of key stakeholders whose suggestions for improving healthcare services need to be validated by further in-depth research.
- A joined-up approach to health care was thought to be needed that took account of what happens to young people pre- and post-custody, as well as the often short time spent in custody, which limits what can realistically be achieved. Any benefits derived from health promotion and treatment whilst in custody may be lost if there is no follow through on release, such as resettlement plans that support young people with any post-release problems.
- Greater integration and collaboration between health, education and care was called for to avoid each group of professionals competing for the young person's time, and to facilitate the development of good relationships between healthcare staff and young people which was considered a necessary starting point for effective health promotion.
- A number of establishments are trying to take a more integrated approach to their health work, but this can sometimes be hindered by issues of confidentiality and the unwillingness of some staff to move beyond their professional boundaries. The Healthier Inside Project and the Healthy Schools approach adopted by some establishments encourage a whole setting approach and a more holistic view of health, and may help to bring about a shared common

understanding between different professional groups.

- To provide services that meet the health needs of young people requires a healthcare team with the appropriate range of skills and expertise in working with this age group. Difficulties in recruiting and retaining staff in the complex and sometimes challenging environment of the secure estate means that not all establishments have achieved the level of staffing required.
- The transfer of responsibility to PCTs for commissioning health services is perceived by some to be improving the skill base of healthcare staff and providing staff with the support of community health professionals working within the PCT. Nevertheless, difficulties can arise when PCTs are unwilling to provide a specialist service to a young person who lives outside their region.
- Given the scale of the health needs of young people in secure settings combined with limited resources and the limitations placed on healthcare by the custodial environment, it would seem advantageous to explore the role that residential staff, with adequate training and support, could play in promoting health and responding to young people's health needs.
- Information about and records of young people's health need to be readily accessible to relevant personnel, notwithstanding the confidentiality issues that may arise. This would avoid asking young people for the same information several times when identifying health needs and effective treatment. Likewise, information about health assessments and treatments during custody needs to be effectively communicated on transfer or at release.
- In considering ways to improve health services, interviewees highlighted the limitations imposed by the custodial environment such as the physical accommodation for healthcare, limited access by healthcare staff to residential units in some establishments and the need for escorts to accompany young people to clinic appointments.
- There is growing recognition of the importance of involving young people in the development of health services that will meet their needs both in and out of custody

7 Conclusions

- The concluding chapter returns to the research questions outlined in chapter one. Specifically:
 - What do we know about the health and well-being of children and young people in secure settings?
 - What do we know about the health status of particular sub groups?
 - To what extent are services perceived to be meeting needs?
 - What initiatives are underway to bring about improvements in health in secure settings?
 - What is the evidence base for effective interventions for this group?
 - What is the potential for bringing about improvements?
- Some aspects of young people's health needs in secure settings have been relatively well researched, such as mental health and substance misuse. Much less is known about physical health needs or health promotion activities. The evidence is strong regarding high levels of mental health illness and substance misuse and problems related to learning disability among children in custody and, compared with the general population, there is a significantly higher rate of mental health problems and substance misuse. There is little comparative data

regarding physical health, but self-report data from surveys of young people in YOIs suggest that respiratory complaints are common.

- Studies have highlighted specific health needs among some groups of young people in custody such as the higher rates of substance misuse, sexual health problems and self-harming among girls compared with boys. There is a need for further research to improve the understanding of the needs of different groups among the population of children and young people in custody.
- The review found that although services are improving to meet the needs of children in custody, there exists significant variability in the level and quality of services across the estate as evidenced from all sources of data: literature review, inspection reports and stakeholder interviews. National initiatives such as the Juvenile Substance Misuse Programme and the recent focus on mental health needs are helping to improve health services in these areas.
- Custody is often for a short period and the importance of systems, such as a care programme or pathway approach, to take account of healthcare both before and after custody becomes a significant factor in addressing health needs, according to interviewees and the research literature.
- A number of initiatives to improve health and well-being for children in custody, both at national and local level, are described in the report, but evaluation of their effectiveness is often lacking. Health education and promotion to improve young people's lifestyle choices and to teach them how and when to access health care in the community; developing links between the health care young people receive before, during and after custody; and promoting a 'whole setting' approach whereby health specialists work with other staff such as prison officers, education staff and residential workers to address children's health needs are likely to be key areas upon which to focus attention for improvement, but further research is required to substantiate this view .
- The evidence base for effective health interventions in secure settings is weak, partly due to the problems associated with evaluating effectiveness among a transient population. Long-term outcomes may be difficult to assess, but short-term outcomes such as changes in clinic attendance for sexual health, increased take-up of tests for blood-borne viruses or improvements in health literacy, might provide evidence of effectiveness of those interventions.
- Evidence-based approaches that have been shown to work with young people generally, and may be relevant to promoting health in secure settings, include the use of behavioural techniques to prevent depression, a focus on helping young people with stress and anxiety rather than an explicit focus on suicide prevention, and increasing the availability of healthy foods.
- Holistic approaches to meeting the health needs of children and young people in custody were emphasised by interviewees and inspection reports and highlighted by HMCIP in the conclusions of a 1997 thematic review of young prisoners. Although taking a 'whole setting' approach may be challenging for some staff within the secure estate it may be one means by which to improve how settings meet the health needs of young people in custody.

1 Introduction

This report presents the findings from a scoping study drawing together what is known about the health needs of children and young people in the secure estate, and how well their health needs are met. The study focused on children aged under 18 in Young Offender Institutions (YOIs), Secure Training Centres (STCs) and Secure Children's Homes (SCHs). It has been commissioned by the Children and Young People's Public Health team within the Department of Health, in partnership with Offender Health, in order to inform preparation and implementation of an Offender Health Strategy document for children and young people. It is primarily a descriptive study, based on desk research, and needs to be complemented by more in-depth study within secure settings, including the views of young people themselves.

1.1 Background

Around 3,000 children and young people¹ are held in the secure estate, and they are entitled to a health service of a similar standard to that provided for children in the community (Youth Justice Board, 2004). Standard 1 of the Children's National Service Framework (NSF) states a requirement that 'Primary Care Trusts have arrangements in place to ensure access to appropriate local health services for juveniles and work in partnership with the Local Authority and the Prison Service to improve standards of health care and access for young offenders, including health promotion'.

Standard 4 of the NSF refers to the need for Local Authorities and Primary Care Trusts (PCTs) to ensure that children in 'special circumstances' have access to high quality care. Standard 5 specifies that all agencies working with children and young people living away from home have a responsibility to protect them from abuse and exploitation. Prisons and secure establishments themselves have a responsibility to 'build the physical, mental and social health of each young person as part of a whole prison approach to promoting health; and to help each young person to adopt healthy behaviour that can be taken back into the community and that will also help prevent deterioration of their health during or because of custody' (HM Prison Service, 2006, p12). A Juvenile Health Development Programme is helping to build the capacity of prisons to support the *Every Child Matters: Change for Children* agenda. This involves the creation of dedicated posts within prisons holding children under 18 to co-ordinate and champion work to promote their health and well-being, and initiatives such as the National Children's Bureau's 'Healthier Inside' project.

The number of 15-17 year olds in prison has more than doubled over the last 10 years. Although a relatively small group in absolute terms, young people who spend time in secure settings are an important group in terms of implications for public health and achievement of Government targets. A high proportion have a background of severe social exclusion. Over half of under 18s in secure settings have a history of being in care or social services involvement, and nearly six in ten left school or were excluded before the age of 16 (Galahad SMS Ltd., 2007). The incidence of mental, physical and sexual health problems is high, with drug and alcohol abuse being major problems. In the next chapter, we provide a more detailed analysis of the population of young people held in the different parts of the children's secure estate and their health needs.

¹ Young people between the ages of 15 and 17 are referred to as 'juveniles' by the Prison Service and Youth Justice Board, with the term 'young offender' reserved for those aged 18-21. In this report, we have also used the terms 'children' and 'young people' interchangeably.

1.2 The children's secure estate²

There are 45 establishments in the children's secure estate in England and Wales – 19 Young Offender Institutions which are part of HM Prison Services; four Secure Training Centres run by private operators; and 22 Secure Children's Homes (formerly Local Authority Secure Units), almost all run by local authorities. The vast majority (over 82%) of children are held in YOIs. All establishments can receive children from any part of England and Wales, with the result that many children end up far from home.

The SCHs all hold children placed on welfare grounds, for the protection of themselves or others (section 25, Children Act 1989). Seven sites are used for welfare placements only. The 15 that hold children who have offended do so under a contract with the Youth Justice Board (YJB). Five of the homes are single sex (3 units for boys only and 2 for girls). The majority of the homes accommodate between 10 to 20 young people. STCs are larger, with between 58 and 87 places, and all cater for both boys and girls.

There are 19 YOIs accommodating young people under the age of 18 of which 14 are male-only and 5 are female-only units. Some YOIs hold young offenders up to the age of 21, with those under 18 held in a separate juvenile wing, whilst others are children-only institutions. Just over half (53%) of young people aged 15-17 resident in January 2007 were in children-only sites, while 47 per cent were in juvenile wings. The YOIs for males are much larger institutions compared with either SCHs or STCs, with 11 of the 13 having 150 or more places and the largest 400 places. In contrast, the female juvenile units are much smaller with the largest having just 26 places.

The time that children spend in secure settings is often very short. Most (82%) of children in secure children's homes have been there for less than six months (Department for Children, Schools and Families, 2007), although they may move from one home to another, or move back and forth between periods in the community or non-secure children's homes and time in secure settings. The majority of young people aged between 15 and 17 in YOIs and STCs are serving a Detention and Training Order (DTO). These last from a minimum of four months to a maximum of 24 months, with half of the term spent in custody and half in the community. The average length of stay in custody is 84 days, including time spent on remand. Reconviction rates are high, with approximately 70 per cent re-offending within 12 months (Department of Health, 2007).

1.3 Aims of the study

The overall aim of the study was to provide a high level review of what is currently known about healthcare for children and young people in the secure estate. The scope was defined to include all three types of setting, and children placed for welfare as well as youth justice reasons in secure children's homes. All aspects of their health were to be considered, although with a particular focus on identifying information relevant to physical health needs and how well these are met, since more is already known about mental health and substance misuse among young people in secure settings.

² Information for this section has mostly been taken from the Department of Health 2007 report '*Promoting mental health for children held in secure settings: a framework for commissioning services*', including further analysis of Appendix A : *Children under 18 in secure settings*.

Specifically, the study set out to address the following research questions:

1. What do we know about the health and well-being of children and young people in secure settings? (addressed particularly in chapter 2)
2. What do we know about the health status of particular subsets of young people within these settings e.g. girls and young women, ethnic minorities? (chapter 2)
3. To what extent are services and the care of young people perceived to be meeting need? (chapters 3, 4 and 5)
4. What initiatives are underway to bring about improvements in their health and well-being? Are there readily accessible examples of good or promising practise? (chapters 3, 4 and 6)
5. What is the evidence base for effective interventions with this group? (chapters 3 and 4)
6. What is the potential for bringing about improvements in this area? (chapter 6)

1.4 Methodology

The study took a multi-method approach involving a focused overview of relevant literature, interviews with key stakeholders, analysis of inspection reports and case studies of promising practice.

1.4.1 Literature review

Given the limited time and resources available for this review, a decision was made in consultation with the commissioners of the review to draw wherever possible on existing overviews and key studies rather than to undertake a systematic search for all relevant material; and to focus on UK studies that had specifically considered health issues for young people aged under 18 in secure settings. This means that the following types of literature were not included, even though they may well contain potentially useful messages for developing health services for young people in the secure estate:

- Literature on 'healthy prisons';
- Studies of the health of young offenders in community rather than custodial settings, although some comparative research has been included;
- Studies which focused on young offenders (aged 18-21) rather than juvenile offenders or those in secure children's homes and secure training centres. In practice, studies undertaken in Young Offender Institutions often did not report findings separately for any juveniles that might have been involved.

The literature review draws particularly on an overview of the health needs of young offenders carried out by the National Primary CRDC at the University of Manchester, which covered young offenders in the community as well as in secure settings (Macdonald, 2006); a review by the National Children's Bureau of the literature on improving the health and well-being of young people in custody (Cox and Lewis, 2005); and two studies for the Youth Justice Board: one on the health needs of young women in YOIs (Douglas and Plugge, 2006) and the other a recently submitted report on substance misuse across the secure estate by Galahad SMS Ltd., which was unpublished at the time of this review. Both of these include overviews of relevant literature. These key texts were supplemented by others identified through searches of relevant bibliographic databases (including Social Care Online, PubMed, Applied Social Sciences Index and Abstracts, CSA Social Services Abstracts, National Electronic Library for Health and the Social Science Citation Index) and internet searches (Google and Google Scholar). Search terms used included health, healthcare and health promotion combined with young or juvenile offender, youth justice, secure estate, custody, secure children's home, young offender institution and secure training centre. Websites such as the Youth Justice Board, Howard League for Penal Reform, NACRO and the Prison Reform Trust were also searched for relevant material.

As others have also found (Macdonald, 2005; Douglas and Plugge, 2006) there is a very limited literature focusing specifically on health issues (aside from mental health and substance misuse) for the group we are concerned with: young people under 18 in secure settings. Studies in Young Offender Institutions often include those aged 18-21, who form the majority of the YOI population. There are particularly few published studies of children in Secure Children's Homes or Secure Training Centres, and where all three types of setting are included, results may not be presented separately. Evidence is lacking on the effectiveness of interventions to address the health needs of children in secure settings.

1.4.2 Key stakeholder interviews

We sought the views of key stakeholders at national level, as agreed with DH within the scope of the project, on the health needs of young people in the secure estate and how they are met. Interviews were undertaken with senior managers (e.g. directors and heads of policy and research) from the following ten organisations: Butler Trust; HM Prison Inspectorate; HM Prison Service; Howard League; National Association for the Care and Resettlement of Offenders; National Children's Bureau 'Healthier Inside' Project; Prison Health (now Offender Health); Prison Reform Trust; Secure Accommodation Network and the Youth Justice Board. We were unsuccessful within the timeframe of the study in securing interviews with a representative from the Association of Managers of Youth Offending Teams and from Ofsted who from April 2007 took over the inspection of SCHs and STCs from the Commission for Social Care Inspection (CSCI).

Although the interviewees did include a senior public health physician, local commissioners and providers (e.g. PCTs and LAs) were not represented among the stakeholders interviewed since within the scope of the study it was not feasible to include the views of stakeholders at local level. However, PCT representatives were interviewed for the case studies of promising practice (see 1.4.4 below).

A topic guide outlining the main areas to be covered in the interview was sent to interviewees in advance. Interviewees were asked about the health needs of children and young people, the key issues of concern, how health needs were met and the challenges therein, how services could be improved and examples of promising health-related practice. Interviews took 45 minutes on average and were digitally recorded with the interviewee's permission. Following the interview, the researcher wrote a note of the interview under the topic themes highlighting the main issues raised. Although interviewees were primarily providing information from the perspective of the organisation they represented, it is inevitable that interviewees occasionally spoke from personal experience.

1.4.3 Review of inspection reports

All secure settings are inspected on a regular basis: Secure Children's Homes and Secure Training Centres by CSCI/Ofsted, and Young Offender Institutions by HMI Prisons. YOIs are generally inspected at three to five year intervals whereas STCs and SCHs are inspected annually, though the reports are less detailed than those from HMIP. Inspection reports cover the whole range of activities within these establishments, including information relevant to each setting's ability to assess and meet the mental and physical health care needs of young people. Some reports also identify initiatives to promote health and well-being and provide examples of good or promising practice.

Inspection reports were obtained for 42 of the 45 secure settings accommodating young people under 18 (21 SCHs, 4 STCs and 17 YOIs³). We used the most recent inspection report available for each

³ One SCH report was not available, one new unit for 17 year old girls (Foston Hall) had not yet been inspected, and one small male YOI (Woodhill) was not included as it had only four juvenile offenders (all Category A) at the time of inspection and very little information was provided on their healthcare.

setting, which ranged from January 2004 to March 2007: some therefore pre-date significant changes to the secure estate, such as the transfer of prison health funding to PCTs and the introduction of the Young People's Substance Misuse Service (YPSMS) for juveniles. Inspection reports also contain recommendations for improvement, so it could be expected that some of the shortfalls identified have been rectified since the report was published though we were unable to verify if this was the case.

Relevant data was extracted from the sections covering health and safety, as well as the overall summaries, and tabulated under the following headings:

- Assessments on arrival
- Mental health and well-being (including suicide and self-harm)
- Substance misuse
- Primary health care
- Pregnancy and maternal health
- Health promotion
- Healthy diet
- Physical exercise
- Staffing
- Post custody healthcare

1.4.4 Case studies of promising practice

The purpose of the case studies was to provide illustrative examples of promising practice in meeting the health needs of young people in secure settings and to identify issues arising from this work. Drawing on suggestions from key stakeholders three examples of promising practice were selected, at Wetherby⁴ and Huntercombe YOIs, a SCH, and the Community Homes Health Team which provides healthcare services to a number of secure children's homes. From inspection data, annual reports from the relevant PCT and telephone interviews with key figures including Healthcare Managers and PCT representatives, short synopses of promising practice were drawn up and these have been incorporated into the report.

1.5 Limitations of the data

It is important when reading this report to be aware that it is based on a small-scale scoping study. We did not undertake primary research in secure institutions⁵, and a number of limitations inherent in each of the data sources should be kept in mind when reading this report:

- Inspection reports vary in their level of detail and in the aspects of healthcare which they address, especially between types of institution. This makes it difficult to make direct comparisons and provide an overview, although we have attempted to do so. Inspection reports also provide only a snapshot view of provision, which may at the time of inspectors' visits be experiencing a particularly difficult time, or alternatively be undergoing a period of exceptionally positive management and resourcing. The situation may have improved (or deteriorated) since the inspection was undertaken although verification of significant change since the inspection was beyond the scope of this study.

⁴ Wetherby, Huntercombe and the Community Homes Health Team agreed to being identified.

⁵ A project currently being undertaken by Mace Ltd will include visits to SCHs and STCs.

- Published literature presenting research evidence on healthcare needs and effective services to meet them is thin on the ground, especially outside of the two key areas of mental health and substance misuse.
- Interviews with key stakeholders reflect their views and perceptions rather than 'hard' evidence – although these views are based on valuable knowledge and experience which needs to inform policy development.
- The case studies of promising practice provide examples of new ways of working, which could have the potential to significantly improve health outcomes for children in secure settings although their effectiveness needs to be evaluated.

The main aim – and strength - of this report is that it brings together in one place information about healthcare for children and young people in the secure estate, and begins to identify key issues that need to be addressed.

1.6 Structure of the report

The rest of the report is organised as follows. Chapter Two outlines key characteristics of the population held in the three types of secure setting, and presents a broad overview of their health needs, highlighting where possible any differences in health need for specific groups. Chapter three examines how secure establishments promote health and provide health education for the young people in their care while Chapter four focuses on the delivery of health care and how well this meets identified health needs. Chapter five provides an overview of healthcare in the three types of setting and Chapter six considers how improvements could be made. Throughout, promising practice examples are highlighted in text boxes. Chapter seven concludes the report by addressing the research questions which the study set out to answer, highlighting particular issues for consideration.

2 Characteristics and health needs of children in the secure estate

2.1 Who are the children in secure settings?

Around three thousand children are held in secure establishments at any one time, and nearly three times as many pass through each year (Department of Health, 2007). In this chapter we provide a more detailed breakdown of the population in the children's secure estate.

2.1.1 Gender

In all three types of setting, boys form the majority - 98% of those in YOIs, 61 per cent in STCs and 68 per cent in SCHs (Table 1). Among children placed for welfare reasons in children's homes, however, there is a different pattern. More girls are placed than boys, and this has been attributed to 'gendered interpretations of when a young person is at risk, as well as the fact that many troubled and troublesome boys end up going through the youth justice system earlier and faster than girls' (Held, 2006, p7; see also O'Neill, 2001). Concerns that led managers in the Held study to use SCHs for girls were mainly linked (though not always consciously or explicitly) to the risk of sexual abuse or exploitation. Boys were more often placed due to behaviour that posed a threat to others or because they were likely to abscond from a non-secure home and become involved in offending behaviour.

2.1.2 Age

Children in YOIs are aged between 15 and 17, although female-only units are now used only for 17 year olds. Secure Training Centres take children aged between 12 and 17, although the majority are aged 13-15. Secure children's homes accommodate children aged 10 to 17. The most recent figures, for March 2007, show that nearly two thirds (64%) of children in SCHs were aged 14 or 15, with 22 per cent aged 16 or 17 and just 12 per cent aged 13 or under.

2.1.3 Ethnicity

A report by the Social Exclusion Unit (2002) estimated that approximately 10 per cent of young people under the age of 18 in prison were from a black or minority ethnic (BME) background, but more recent information suggests this figure is far too low. In response to a parliamentary question in March 2007, it was reported that 28 per cent of the population in YOIs (including 18-21 year olds) was from a BME background. Surveys carried out by HMIP in every juvenile prison between 2004 and 2006 found that 23 per cent of both boys and girls were from BME groups (Worsley, 2007). The same proportion (23%) was found among 73 young women in YOIs who completed a health questionnaire (Douglas and Plugge, 2006). No national figures were found describing the ethnic background of children in secure children's homes.

2.1.4 Young parents

Statistics are not routinely collected on the number of young parents in custody, although it is thought that they are more likely to be parents than other young people of their age (Sherlock, 2004). One study found that 51 per cent of young men and 79 per cent of young women under the age of 23 in custody were parents (Katz and Sherlock, 2003), and in another study, 13 per cent of boys under 18 in custody had children of their own (HMIP, 2005a).

2.1.5 Learning disabilities

Various studies have identified a high level of learning disabilities and difficulties among young offenders (e.g. Tunnard et al., 2005; Chitsabesan et al., 2006). Research involving boys (mean age 14.9) in four secure children's homes assessed 27 per cent as having an IQ of less than 70, and 43 per cent as having an IQ of between 70 and 85 (Kroll et al., 2002). A similarly high rate has been found in YOIs, with 28 per cent of young offenders reported as having a learning difficulty, although juveniles were not reported separately (Borrill et al., 2003). Among juvenile homicide offenders, almost a quarter had attended special schools and learning disabilities were noted in over a third (Dolan and Smith, 2001). The disrupted schooling of many of those in secure settings may well be a factor in low IQ scores: a survey of juveniles in custody found that 41 per cent of male respondents reported being under the age of 14 when they last attended school (HMIP, 2005a).

2.1.6 Language and communication difficulties

Sixty per cent of young men in one YOI screened over a six month period by a speech and language therapist on arrival at the institution were identified as having specific difficulties with speech, language and communication (Bryan et al. 2005). This reinforces the findings of an earlier study, where around half of 15-17 year old male juvenile offenders in a YOI had specific problems of language and literacy (Snowling et al., 2000). More recently, between a half and two thirds of juvenile offenders screened at a male YOI were in the 'poor' or 'very poor' group on a range of language tests, and nearly two thirds had not reached Level 1 in literacy (Bryan et al., 2007).

Although communication difficulties may sometimes be linked with a low IQ, this is not always the case. An Australian study, comparing male juvenile offenders in the community with non-offending controls, rated just over half of the young offenders as 'language impaired'. However, although they performed significantly worse than the controls on measures of language and social skills the difference could not be accounted for on the basis of IQ (Snow and Powell, 2007).

2.1.7 Vulnerability

As well as providing a secure placement for children who are aged under 15 and for 16 year old girls, STCs or SCHs are also used for 15-16 year old boys who are judged to be particularly vulnerable. Most SCHs accommodate two different groups of children – those who are on welfare placements and those who are on remand or serving a sentence. Interviewees stressed that the circumstances of these two groups can be very different. Welfare placements are usually young people who are in care, have been moved several times, usually with no 'home' base and do not know when they will leave or where they will go. These circumstances were said to lead to anxieties and behaviours that are particularly challenging. Another interviewee working in the youth justice system drew a distinction between those young people on remand and those serving a sentence. Those on remand were described as more anxious because they do not know what will happen next and this "accelerates all their other problems and the risk of self-harm". Research evidence has identified remand status as increasing vulnerability to self harm and suicide (Goldson, 2002).

Table 1: Characteristics of children resident in secure settings, 2007⁶

	Juvenile YOI ^a	STC ^a	SCH ^b
Children resident	2370	259	305 190 YJB 30 LA criminal justice 80 LA welfare
Gender	98% boys	61% boys	68% boys (overall) ^b YJB: 81% boys ^a LA welfare : majority are girls ^c
Age	15-17 (15-16 year old girls now in STC or SCH)	12-17 Majority aged 13-15	10-17 Under 13: 12% 14-15: 64% 16-17: 22%
Ethnicity	Black: 16% ^d Asian 6% Mixed: 6% Chinese/other: 1%	N/A	N/A

Sources:

- a) Ministry of Justice (2007) *Children in Custody, monthly tables*. June 2007 England and Wales. www.justice.gov.uk
- b) DCSF (2007) *Children accommodated in secure children's homes, year ending 31 march 2007, England and Wales*. SFR 23/2007. www.dcsf.gov.uk/rsgateway/DB/SFR/ In 2007, 'type of placement' was introduced to replace the previous 'legal status' category.
- c) Held, J. (2006) *Qualitative study: the use by local authorities of secure children's homes*. DfES Research Report RR749. www.dcsf.gov.uk/research
- d) Hansard (2007) *Young Offender Institutions: ethnic groups*. Commons Hansard, vol 458, no. 69 (27 March), col. 1456-1460W

⁶ Figures relate to either 31 March or 31 July 2007. Providing accurate comparative statistics is difficult for a number of reasons. It was necessary to use different data sources in order to obtain information on the various characteristics and types of setting. These figures were collected at slightly different times, and the rapid turnover of children in secure settings means numbers can fluctuate from one week to the next. However, the overall patterns are evident from the table.

2.2 What are the health needs of children in secure settings?

A number of existing reviews provide a good overview of the health needs of children in custody (e.g. Cox and Lewis, 2005; Macdonald, 2006). This brief section builds on this literature by focusing on more recently published material, or material which was not included in the earlier reviews; and on disaggregating (as far as possible) information on the health needs of different groups within the juvenile population, such as girls and young women or ethnic minorities. It also draws on interviews with key stakeholders.

Although needs are presented under separate headings, in practice many of the health needs and problems of young people in custody are linked, and so are unlikely to be effectively treated in isolation from each other. For example, a study of drug misuse among juveniles in custody (Galahad SMS Ltd., 2007) found that young people often used substances for reasons related to their emotional state, indicating a link between mental health needs and substance misuse. It is also important that the health needs of young people in custody are not viewed in isolation from the needs of juvenile offenders in the community, although we have tried to focus on the former in this study. There is considerable movement in and out of custodial settings, and the extent to which health needs are identified and treated in the community will affect the services needed by young people in custody.

2.2.1 *Mental health*

The high level of mental health needs among young people held in secure settings has been well documented, with well above average rates of psychosis, self-harm and suicide (Lader et al., 2000, Harrington and Bailey, 2005). For example, in a survey carried out at the end of 1997, at least 95 per cent of young people (aged 16 to 20) in custody were assessed as having one or more mental health disorder, with conduct disorders and oppositional disorders the most common (Lader et al., 2000). This compares to around 13 per cent of boys and 9 per cent of girls in the general population who suffer from some form of mental disorder (Meltzer et al., 2003), although this is based on younger children up to the age of 15. Staff surveyed in 17 YOIs at the end of 2004 judged most children in their care to have some form of mental health problem (Tunnard et al., 2005).

Differences between groups within secure settings include a higher number of mental health needs among females than males, and higher rates of post-traumatic stress among minority ethnic offenders (Chitsabesan et al., 2006; Harris, Hek and Gordon, 2007). Rates of self-harm are particularly high among young women in custody, with one study finding that over a third of 17 year old girls in YOIs had engaged in self harm in the previous month (Douglas and Plugge, 2007). Key stakeholders interviewed in the current study also believed that although there are far fewer girls than boys in the secure estate, their needs were more complex, with higher levels of co-morbidity and self-harming.

Bullying is widespread in institutions for juvenile offenders (Ireland, 2002) although those in secure children's homes appear to feel safer, possibly because of the smaller size or the different ethos in such settings (HM Prison Service, 2003). Sexual victimisation does not appear to be a major health problem for juvenile offenders. Interviews with almost a thousand 15 to 17 year olds in YOIs, both male and female, found that whilst bullying was endemic among this population, the incidence of sexual victimisation, at least as reported to the researchers, was very low (McGurk et al., 2000).

2.2.2 *Substance misuse*

A very high proportion of both boys and girls in custody have a history of substance misuse. An assessment of the health needs of 17 year old young women held in YOIs (Douglas and Plugge, 2006)

reported high levels of smoking, harmful drinking and illegal drug misuse. A YJB study of 14- to 17-year-olds held in the secure estate found that 83 per cent were regular tobacco smokers at the time of their arrest, over a quarter had used ecstasy more than a few times a week and more than one in eight had used crack regularly (YJB, 2004). A pilot drug testing scheme at one YOI, which screened all young men on entering the prison, revealed a positive rate of 80 per cent (HMIP, 2005b). Such rates of substance misuse are much higher than those reported for young people in general. For example, 30 per cent of young men and 22 per cent of young women aged 16 to 24 had drunk heavily on at least one day in the previous week (Self and Zealey, 2007) and 24 per cent of young people aged 16 to 19 smoked regularly (Goddard, 2006).

Young people often do not view drug or alcohol use as a problem: the *Juveniles in Custody* survey (Challen and Walton, 2004) found that 15 per cent of young people admitted to alcohol problems when they arrived in custody (with just over a third of these saying that they received help in their YOI) and 28 per cent reported drug problems, either on arrival or at some time in the past (with nearly a half of these saying that they had received help in custody).

A recent comprehensive study for the YJB of substance misuse among young people in the secure estate (Galahad SMS Ltd., 2007) covered all three types of secure setting and was based on surveys or interviews with 486 juvenile offenders (408 held in YOIs, 64 in STCs and 14 in SCHs), and with staff in all three types of secure setting. Unfortunately, information about health needs or provision is not presented separately for young people in SCHs, STCs and YOIs, but the report does discuss gender and ethnic differences in substance misuse. Young women were as likely overall as young men to use drugs, and were more likely than the young men to disclose heroin and crack use. Levels of reported substance misuse (both illegal drugs and alcohol) were lower among Black and Asian juvenile offenders than among those from a white or mixed ethnic background, but since clinical measures showed no significant differences by ethnicity, it is suggested that this could be due to cultural differences in willingness to disclose.

Among interviewees in the current study, alcohol abuse was considered to be one of the biggest problems, often more so than misuse of illegal drugs. The experience of one interviewee representing the secure children's home sector was that self-reporting of drug use was often unreliable: "there is a lot of bravado in there – we get services lined up for detoxification only to find there isn't a need".

2.2.3 *Physical health*

As other reviews have noted (Cox and Lewis, 2006), there is relatively little published information about the physical health needs of children in any sector of the secure estate. Physical health needs such as asthma, epilepsy and diabetes were also mentioned less frequently than mental health or substance abuse as a cause for concern by the key stakeholders whom we interviewed, and there was some disagreement about how prevalent such illnesses were among children in custody. Some interviewees thought that they were chronic within this population, while others suggested that most of these conditions do not affect this age group any more than the rest of the population as "they are usually fit and healthy".

Turning to the research evidence there is a limited UK literature on physical health needs in custody. The Macfarlane review found evidence of young offenders in the community having low rates of routine health checks and immunizations despite high rates of substance and alcohol misuse, accidents/injuries and hospital admissions and contact with GPs, suggesting that they only accessed health services in times of crisis (Macfarlane, 2006). A survey by HMIP (2005a) found that 14 per cent of boys and 12 per cent of girls in custody during 2003 to 2004 reported that they had health problems

that needed to be dealt with as soon as they arrived in custody, although these health problems were not specified. The most frequently quoted study, based on analysis of 1997 ONS survey data on around 600 young people held in YOIs (Lader et al., 2000), found that about a quarter of male and a third of female young offenders reported a longstanding physical complaint. Among the young men, respiratory complaints were the most common (reported by 10 per cent of remand and 11 per cent of sentenced young offenders) followed by musculo-skeletal complaints (mentioned by 7 per cent and 4 per cent respectively). Among young women, respiratory problems were also the most common (reported by 18 per cent) followed by nervous system complaints (6 per cent) and skin complaints (5 per cent). About a tenth of the young men and two fifths of the young women interviewed were taking some form of medication that acts on the central nervous system such as hypnotics, anxiolytics or anti-depressants.

Unpublished data on the health of 500 young men entering one YOI over a six-month period in 1996 found that 82 (17 per cent) were receiving medical treatment, of whom 42 (8 per cent of the total sample) were prescribed inhalers for asthma, 36 (7 per cent) were taking a short course of specific treatment such as antibiotics, and 6 (just 1 per cent) were on long-term medical treatment for conditions such as diabetes, epilepsy or depression (cited in Macfarlane, 1997). We were unable to find data on the prevalence of conditions such as asthma and diabetes among this age group within the general population for comparison purposes (Office of National Statistics, 2004), but the fact that nearly one in ten of young men entering a YOI used an inhaler suggests that respiratory complaints are common in this group.

Another source of information on physical health needs among young offenders is the health care needs assessments undertaken during 1999/2000 by prisons and health authorities, in preparation for the sharing of responsibility for prison healthcare. These needs assessments were reviewed by researchers at the University of Birmingham in 2001, including those from ten YOIs. The main health problems identified, although again the information relates to young offenders aged 18 to 21 as well as to juveniles, were mental health (mentioned by all ten YOIs), asthma (8), dental health (7), blood-borne viruses such as hepatitis B and C (6), sexually transmitted diseases (6), epilepsy (6) and drug and alcohol misuse (5). Health problems mentioned in less than half of the YOI health care needs assessments included diabetes, self-harm, suicide, dermatology (including acne), smoking, allergies, minor illnesses, injuries/wound care, respiratory infections and family planning/genito-urinary medicine (Piper, 2002).

In the next two chapters, we provide an overview of how the health needs of young people in the secure estate are being addressed, starting with health promotion and education to promote positive health behaviours, followed by services to treat health problems once they arise.

3 Health education and promotion

This chapter looks at how health education and health promotion are delivered within the SCH, STC and YOI estates. It identifies the types of promotion activities undertaken and specific programmes to engage young people to improve health, such as promoting positive mental health and reducing substance misuse. This chapter also looks at other aspects of the secure regime that play an important part in promoting good health such as diet, access to physical exercise and opportunities for personal care. Information about healthcare treatment is covered in the next chapter, although in practice health education/promotion and the provision of healthcare are closely intertwined and difficult to separate. Inoculation to prevent communicable disease or advice regarding risky behaviours such as substance misuse, for example, could have been included in either chapter.

The information below presents the views of key stakeholders, evidence from the literature review and data from the review of inspection reports.

3.1 Health promotion activities

Inspection reports described health promotion activities being undertaken in a variety of ways within the establishments. One-off themed events, regular programmed sessions within healthcare and/or within education, and individual opportunistic health promotion were all reported as a means of delivering health messages.

The inspection reports for the four STCs illustrate the range of health promotion activities as well as the variation in what is available to young people. Three of the centres had some links between health promotion services and education departments. At Medway, for example, the healthcare team was responsible for a comprehensive health education and health promotion programme with education managers regularly reviewing the programme to ensure that the teaching material was age appropriate. This contrasted with Oakhill where the contract between the centre provider and the PCT did not include delivery of a formal programme of health education, which was provided informally on an individual basis by the nursing team during routine clinic sessions. Inspectors said that these *ad hoc* arrangements fell short of the standard required.

Themed events relating to health promotion, sometimes linking into national health promotion topics, were described by inspectors at several YOIs, such as a 'Health Fayre' at Werrington and a 'health week' at Thorn Cross. In addition, many YOIs reported regular sessions either based in healthcare or education. Programmes for sessions tended to be themed around topics including sexual health, diet and fitness, and were arranged on a drop-in basis to take account of the problems in engaging this group of young people in more formal educational activities. At Downview, good links with the PCT health promotion adviser enabled a nurse specialist in nutrition to run a weekly weight watchers clinic with an occupational therapist. These sessions also provided opportunities for young people to ask about general or specific health problems, and offered information on a wider spectrum of health topics.

Health education and promotion in SCHs took a similar format to that at YOIs with themed events and sessions. Staff in education departments provided health education in their Personal, Social and Health Education (PSHE) sessions, sometimes supported by nursing staff.

The reports suggested that many establishments throughout the sector were working towards widening the scope of health promotion and engaging the whole setting in health promotion activities. By providing training, staff beyond the healthcare department were being skilled to provide informal advice and support. Themed health weeks or events provided the opportunity to include all staff and raise

awareness of health issues throughout the whole establishment. Locating programmed sessions within education, rather than isolated within healthcare, was reported to help widen access to health promotion. In addition, these activities helped provide healthcare staff with more opportunities to be seen working outside the healthcare unit, again conveying the message that health was an important part of daily life. At Hassockfield STC, for example, work to promote healthy lifestyles across the whole site had resulted in the centre gaining the 'Healthy Heart Award'.

The two case studies of YOI establishments both emphasised the importance of informal health promotion and education. Young people in custody had often had poor experiences of formal educational settings and little contact with health services. One healthcare manager reported that many young men were more receptive to opportunistic health promotion messages than those offered by a classroom approach. The need to provide opportunistic support, responding to young people when they were receptive to health messages, was perceived to be a more effective way of conducting health promotion in such cases than a 'classroom' approach. Both YOIs were working towards empowering all establishment staff to respond to openings by young people, as opportunities arose.

The 'Up Front' health promotion project at Wetherby* YOI

A community based health promotion project, Up Front, which had been successfully operating in local high schools, was extended to Wetherby at the suggestion of the project's steering committee. The project aims to promote positive attitudes towards health and covers a range of topics such as aromatherapy, reflexology, massage, anger management, skin problems and drug and alcohol misuse.

Courses for the project are offered as part of the education curriculum, giving the organisers access to young men in a safe location, without prison officers in attendance. In this way healthcare is integrated with the education programme.

The course runs as a rolling programme of two sessions per week for six weeks, with young men choosing which sessions they wish to attend. During the sessions there are opportunities to raise confidential issues privately with staff and for sexual health screening, the taking of blood pressure and the calculation of body mass index.

Poor literacy is addressed through the use of visual images, such as photographs, and, with the organisation of games to convey health messages, staff avoid using materials that require reading skills.

The structure of the sessions permits discussion to develop on wider issues. For example, a session on massage led on to further discussions about appropriate touching, homophobia, aggression and domestic violence.

* Most of the 'promising practice' examples in this chapter are drawn from Wetherby YOI, since this institution was selected as the case study to illustrate positive health promotion activities.

3.2 Health promotion materials

Several interviewees mentioned the poor availability of suitable health promotion materials, covering the health risks for this group in language appropriate to the literacy levels and high level of learning disability of this population. Interviewees felt that whereas improvements had been made to materials and literature to accommodate the age range held in secure settings, further efforts were needed to address the needs of those with learning disabilities. Establishments aware of this need had produced

their own materials, using appropriate language and media. Hindley YOI, for example, had involved young people in developing its sexual health promotion information, and Wetherby YOI had developed a health promotion project that made use of visual images and games rather than written materials.

Inspection reports for some establishments stressed the need for health promotion advice and materials to be readily accessible throughout the buildings, in the residential units and in education blocks rather than displayed or available only in the healthcare unit to which young people had restricted access.

3.3 Promoting positive mental health

Stress, lack of family contact and uncertainty about the future may impact negatively on the well-being of young people in the secure estate. There is increasing recognition of the importance of work to promote the emotional health and well-being of young people in such settings, but there has been little research into this compared to research on mental illness, self-harm and suicide in custody. An evaluation of a campaign in the late 1990s to promote mental health in all YOIs in England found that mental health promotion, as opposed to treatment of mental disorders, was regarded by both health care staff and prison officers as the 'soft' end of health care, and peripheral to their day-to-day work (Caraher et al., 2000). This campaign was judged not to have been successful, partly because of staff attitudes and partly because the materials used (a postcard and factsheets) did not take account of the differing ages, literacy levels and circumstances of young offenders (see above).

Key stakeholders interviewed in the current study also raised concerns that mental health services within establishments tended to focus their limited resources on young people with more serious mental health problems, with the consequence that the needs of those with 'low level' mental health problems were not being adequately met. Providing more opportunities for young people to talk through what might be troubling them or how they might cope would, it was thought, be beneficial to their mental well-being. Inspection reports identified a number of ways in which establishments were working to address this unmet need. These included the use of the training package, *Improving Emotional Health and Well-being*, developed by the National Children's Bureau, and providing mental health awareness training at staff induction. Inspectors also cited examples of healthcare staff supporting residential staff to understand and manage young people with mental health problems, to improve their awareness of different therapies and to identify those who might benefit.

The CAMHS team at Wetherby YOI

The recently established CAMHS team within the prison has been working with staff and officers to raise awareness of mental health problems and to improve understanding of mental health issues. This was initially a difficult area and was met with some reservation. Initially the role of the CAMHS team was misunderstood, and young men were referred inappropriately, for example for being disruptive in the classroom.

The team therefore devised a new training package, working with a range of materials used for offenders and for community provision. The approach for young people focused on promoting their well-being, rather than the emphasis on mental health in standard packages designed for adult prisoners. The training is not yet mandatory, but newly appointed officers spend time in the department during their induction. The CAMHS team believes that the training has resulted in more appropriate referrals, with more staff contacting the team to discuss potential referrals and to seek advice.

The literature suggests that young people themselves stress the importance for their emotional well-being in prison of good relationships with prison staff, being treated with respect, and having someone such as a key worker they can trust and rely on (Lyon et al., 2000). There were some clear differences related to ethnicity in the experiences reported by juvenile offenders surveyed by HMIP between 2004 and 2006 (Worsley, 2007). Black and minority ethnic boys reported higher levels of victimisation by staff, poorer experiences of the reception process and higher levels of the use of force against them. The HMIP surveys also found differences in the experiences of young people held in dedicated juvenile establishments and those in split or mixed sites, which are likely to impact on emotional well-being. Those in dedicated establishments were less likely to have experienced physical restraint and more likely to be able to take outside exercise every day. However, they were also more likely to report feeling unsafe and to have experienced victimisation by other young people (Worsley, 2007).

3.4 Substance misuse education

The need for substance misuse education or treatment is generally assessed during the induction period. Whilst some young people have problematic use that requires treatment on their entry to secure settings (see Chapter 4), many report relatively low-level use. For those, education and advice may be the most appropriate support to provide. Almost all institutions in the secure estate offer drug and alcohol awareness programmes as part of PSHE, but to provide a standard service across YJB establishments, the National Specification has begun to be phased in and is leading to an improvement in substance misuse services overall (Galahad SMS Ltd., 2007). However, there appears to have been a shift in focus towards higher level interventions at the possible expense of substance misuse education, with fewer institutions offering Tier 1 services in 2006 than in 2005, although more were offering services at Tiers 2 and above. There was also a significant disparity between the 76 per cent of institutions that stated they offered non-targeted substance misuse education, and the much smaller proportion (37%) of juveniles who said that they were offered drug and alcohol education classes (Galahad SMS Ltd., 2007).

Inspection reports showed that the substance misuse work was generally undertaken by a substance misuse team, education team, residential staff and/or the CAMHS team. Substance Misuse Programmes (SMPs) generally involved both individual and group work and included programmes and courses on drug and alcohol awareness, developing coping strategies and identifying the factors that had triggered the use of drugs.

One interviewee questioned whether those delivering the programmes were adequately trained and whether such interventions were effective. Most substance misuse programmes offered to young people in secure establishments have not been evaluated to assess effectiveness (Galahad SMS Ltd., 2007). One of the few prospective studies, which followed the progress of boys placed in a secure children's home, found a significant *increase* in substance misuse on average two years later, once they were back in the community (Harrington et al., 2005).

Inspection reports from YOIs, SCHs and STCs provided examples of apparently promising practice in relation to substance misuse education. At Ashfield YOI, inspectors noted that, uniquely in the juvenile estate, all the discipline staff had been trained in drug awareness and counselling skills, working jointly with the YPSMS and taking part in weekly reviews. At two women's YOIs, Downview and Cookham Wood, substance use awareness and education were delivered on a one-to-one basis through the 'better choices' intervention pack, although inspectors noted that this had not yet been adapted to the particular needs of young women. The Open College Network (OCN) drug awareness and alcohol awareness courses were also in use, along with daily individual work and a range of group workshops including yoga and PE initiatives. At Rainsbrook STC, the Substance Misuse Team (SMT) worked with

the education department to deliver a drug awareness offending behaviour programme and the YJB programme 'Never Going Back'. Within a SCH⁷, a drugs worker from the 'E's Up' project worked with individuals and groups, and in another, with the highest rating against national standards, the local drug counselling group and support workers routinely provided sessions three times a year.

Substance misuse work in a Secure Children's Home

This SCH enhanced its substance misuse work by purchasing the services of Odd Theatre who have worked alongside Drugs Scope to design a creative and pragmatic substance awareness project. A two day workshop highlights the implication of drug use, working from the premise that it neither denies the attraction or devastation of drugs. The ultimate aim is to reduce both consumption and harm to all participants upon their release.

Odd Theatre also developed a staff training package so that staff within an organisation can be trained to deliver this work. The SCH purchased two training sessions and anticipates working with two other SCHs to train more staff. The aim is to develop a core staff group to provide substance misuse workshops as a regular programme.

3.5 Sexual health and family planning

Interviewees highlighted the need for sexual health promotion to be widely available in custodial settings, since "young people entering the secure estate are less likely to be aware of the issues". All SCHs have a school on site, and sexual health education is to some extent covered in the PSHE curriculum. In these establishments sexual health awareness and family planning advice is tailored to the individual, and the young person's key worker will work with them on 'work packages' which include this topic. Sexual health and family planning can be sensitive areas and, as one interviewee highlighted, require particular skills on the part of teaching and residential staff.

Within the YOIs, sexual health promotion work appeared to be undertaken during themed events such as a contraceptive awareness week at Thorn Cross; as part of formal programmes of health education, including the use of packages such as 'Talking Balls'; and opportunistically at sexual health screening clinics. However, sexual health clinics and promotion relied on healthcare staff having the necessary background and training to provide this service.

There were several other examples of good practice across the three types of settings. As well as the regular PSHE input in SCHs, regular screening clinics, close links with specialist juvenile sexual health clinics in the local community, well women clinics, and teaching self-examination for testicular cancer were also noted in inspection reports from across all types of setting. Links with the local sexual health promotion team at Hassockfield STC gave children regular access to a specialist nurse for sexual health advice. Cookham Wood YOI held a clinic providing information and support on family planning and sexual health to young women, screening for sexually transmitted disease where appropriate, and encouraging them to check their sexual health.

⁷ We were given access to the inspection reports for SCHs on the understanding that they would not be named.

Sexual health promotion at Wetherby YOI

Although screening for Sexually Transmitted Diseases (STDs) is offered to all new arrivals, not all take it up at that time. There are regular sexual health clinics, but young men are sometimes unable or unwilling to attend, so staff undertake screening as and when opportunities occur to engage young men.

Arrangements have been made for young men before their discharge to be registered with a community scheme which enables them to collect free condoms from local health centres and youth centres on release.

3.6 Smoking

Support for smokers placed in no-smoking settings varied. SCHs and STCs are no smoking as most placements are aged under 16. Several YOI establishments including Werrington operated a complete no-smoking policy even before 2007. One inspection report noted that many young people welcomed the opportunity to stop smoking, but that others found that it added to the stress of arriving in custody. During the time this report was being prepared, several more YOIs were known to introduce a ban in advance of the October deadline, when it will be an offence to sell tobacco or cigarettes to anyone under 18 years of age.

Back in 2003/4, very few smoking cessation programmes were available across the juvenile secure estate, and some health professionals complained that they could not prescribe nicotine replacement therapy to under 16 year olds (YJB, 2004). By 2005, just over half (52%) of institutions within the children's secure estate provided smoking cessation programmes, and by 2006 this had risen to 80 per cent of those surveyed (Galahad SMS Ltd., 2007). The inspection reports suggest that establishments without smoking cessation courses generally provided one-to-one help as required, and some offered auricular acupuncture.

3.7 Healthy diet

A nutritional analysis of menus in a YOI found that the meals were broadly in line with current dietary recommendations, but that food choices made by young people resulted in wide variation in dietary intakes, with high fat consumption (largely from items bought in the prison shop), and vitamin D intake below that recommended for people with limited exposure to sunlight (Eves and Gesch, 2003). In the *Juveniles in custody* report (Challen and Walton, 2004) food came in for considerable criticism from young people themselves, although on the grounds of portion size and quality rather than the healthiness of the food provided. Only 15 per cent of young men and 14 per cent of young women described the food as good.

Both the stakeholder interviews and inspection reports highlighted variability in the degree to which settings offered young people a healthy, nutritious diet. Several settings, SCHs, STCs and YOIs, had achieved the Healthy Schools Award (which includes meeting criteria on healthy eating), but although some settings were creative in providing and using fresh produce, this was by no means uniform across the secure estate.

Over half of the SCHs and two of the four STCs were reported by inspectors to be offering healthy meals and a good diet. Eleven YOIs (8 male and 3 female units) were reported to be providing healthy options on daily menus, though these were not always promoted or identified, for example by a 'traffic

light' system. Only at ten YOI establishments did inspectors specifically mention the daily availability of fresh fruit with the availability of five daily portions of fruit and vegetables identified only at two. One catering manager reported that a substantial increase in budgets would be required to provide the 'five a day' ration.

Inspection reports pointed to factors which facilitated or impeded attempts to encourage healthy eating, such as having a qualified chef to produce healthy menus in consultation with a nutritionist or the healthcare team. Some establishments found it difficult to recruit catering staff, and not all settings took nutritional advice. Producing healthy and appealing meals required consulting with the young people, and most YOIs and SCHs were reported to consult regularly on the menu content. Consultation on menus was only mentioned in one STC report

Inspectors identified several barriers to improving diet. Sweets and unhealthy snacks featured on canteen lists, some of which failed to offer fresh fruit or tinned products as healthier snack options. Staff in daily contact with young people were sometimes observed to be failing to provide support to develop healthier eating habits, by either not advising on healthier menu options or monitoring individual eating habits. This lack of support was seen in part to be a consequence of staff themselves not being confident or having the knowledge to offer guidance on healthy eating. Another counterproductive practice, according to one interviewee, was the introduction of 'breakfast bags'. These were generally given out in the afternoon for the following morning, but many were believed to be eaten well before breakfast time.

One interviewee pointed to the importance of the involvement of young people in food preparation and in teaching cooking skills, a practice that would help in encouraging a healthier lifestyle and one that she thought was rare. There were several examples of young people participating in food preparation, for example at Rainsbrook STC where a weekly cookery club offered children the opportunity to prepare food alongside catering staff. The teaching of cooking skills was mentioned at eight YOIs and the involvement of young people in food preparation was mentioned at four SCHs.

Having easy access to drinking water was problematic in some YOIs, though this rarely featured in the STC and SCH inspection reports. This had been overcome in several establishments by providing water bottles so that young people could carry water with them during the day and during periods of lock up.

Ensuring access to drinking water

A Good Practice conference had highlighted the need and the advantages of access to drinking water in the day, not just in hot weather. At Wetherby YOI, young men did not have access to water unless they happened to be near a tap or fountain and had no means of carrying water with them within the prison. The Leeds PCT public health department was persuaded to fund the provision of sport drinking bottles bearing the PCT and YOI logos. Each new entrant is given one so that they can fill it up during the day and take it with them as they work in the garden, visit the gym and or undertake building work and other active training exercises.

3.8 Physical exercise

As with other health topics, the level of detail provided about physical exercise differed across the inspection reports, with greater detail found in the YOI reports. Despite these limitations it was

apparent from both inspection reports and interview data that there was considerable variation between institutions in access to, type and frequency of physical activity. This was attributed variously to space and facilities, staffing levels, and Incentive and Earned Privileges (IEP) regimes.

Across the SCHs facilities for physical exercise varied widely, with some having a full range of indoor and outdoor facilities while at two the outdoor space was very limited. Two of the larger homes had swimming pools and most had fitness centres and gyms, although the use of equipment could be restricted due to a lack of trained staff. The frequency and amount of physical activity was rarely mentioned in inspection reports unless assessed as particularly inadequate.

Most of the young men's YOIs were reported to have adequate or good PE facilities, although only three offered outdoor facilities for a full range of activities. Access to the gym was sometimes reported to be limited for operational reasons, but most juvenile units for males appeared to be offering a minimum of three hours gym each week. In contrast, at the female unit at Eastwood Park the gym was in the main prison and staffing difficulties there limited visits to a maximum of twice a week. Outdoor exercise was not offered every day and was cancelled completely for safety reasons when the outdoor pitch was wet. Research in this area also highlights variation in access and frequency of physical activity related to gender (Challen and Walton, 2004). Surveys of juveniles in custody show that, among young women, 44 per cent had access to the gym only once or twice a week whereas almost all young men had this level of access and almost a quarter could use the gym more than five times a week. On the other hand, fifty per cent of young women reported that they could go outside for exercise every day compared with 18 per cent of young men, and seven per cent of young men said that they did not go outside at all. Opportunities for outside exercise were generally better in dedicated juvenile establishments compared to split or mixed age sites (Worsley, 2007).

An interviewee remarked that it was difficult to motivate young people to engage in sports and physical activity when the space and facilities were poor. Another suggested that young people could be reluctant to participate because of bullying and although some settings were believed to have tackled this issue well, others had yet to do so.

Some YOIs encouraged young people to engage in physical activity by assessing personal fitness during induction and arranging a programme of planned activities. Around one third of YOIs offered accredited sports courses as an incentive to participate, and some provided tailored sessions for vulnerable groups. For example, at Huntercombe, those identified as obese or at risk of obesity were encouraged to attend bespoke sessions, which developed individual fitness and lifestyle programmes.

Opportunities for less formal exercise varied between YOIs with a few offering a range of additional activities in the evenings and at weekends. At Feltham, wing staff received training from the PE department to support weekend sport. Similarly, at Downview, PE staff organised a recreational hour every evening developing a successful programme of well attended sessions to build confidence and teamwork skills. At Huntercombe, 'catch up' sessions in the gym in the evening were provided for young men who could not go to PE or the gymnasium at the scheduled times because of legal visits or healthcare appointments.

Inspection reports identified the IEP system in some settings as restricting opportunities for physical activity. For example, at Medway STC, a programme of recreational and sporting activities could be accessed by those who had achieved a higher status under the rewards and incentive scheme. At Oakhill STC, young people on 24- and 48-hour basic privileges were subject to an activity ban which prevented them leaving the unit and getting fresh air, a rule that inspectors said should be amended.

3.9 Personal care

Several interviewees identified the problem of young people entering custody with little basic knowledge of how to take care of themselves, partly attributed to not knowing what constituted 'normal' behaviour in terms of hygiene and personal care. An investigation of health needs among young women in YOIs reported that professionals working with them commented that 'life skills' were often lacking in relation to self care, manifested in inadequate nutrition and poor personal hygiene (Douglas and Plugge, 2006). Personal care or life skill classes were not generally mentioned in YOI inspection reports, perhaps reflecting the fact that this work is undertaken on a one-to-one basis as required. At Downview YOI, young women were encouraged and enabled to shower daily. Inspectors were impressed by the general message to staff and young people, in the form of a poster 'how we expect you to behave' that specified that: 'whether you live or work on the unit, keep your room or work area clean and tidy and dress appropriately' provided a strong signal about the expected standards. At one SCH, inspectors commented on the good support for personal health care.

Accommodation and establishment practices can impact detrimentally on maintaining personal care. Inspectors had recommended the immediate cessation of limiting young people's access to underwear as part of the rewards and sanction system at Oakhill STC. At Stoke Heath YOI, the inspectors noted that juveniles on the basic IEP regime could shower only once a week. Young people themselves reported differing levels of access according to gender: the majority of girls surveyed by HMIP said they were able to take a daily shower, but this fell to just over half (57 per cent) of the boys (Worsley, 2007). Although some establishments had en suite facilities so showers were readily available, other establishments had limited access, and only seven reports for young men's YOIs indicate daily showers available. Since showers in many establishments are generally made available during the evening association time, this is sometimes restricted by operational strictures, or because young people prefer or need to make telephone calls or take part in other activities.

4 Meeting healthcare needs

Evidence from interview data and the literature suggest that health problems, especially mental health problems, among this group of young people often remain undiagnosed or untreated before they enter custody (see below). Interviewees attributed this in part to a lack of consulting and non-attendance at clinic appointments, a consequence of the often chaotic lifestyles led by the young people and their families. Custody therefore provided the opportunity for routine health checks, diagnosis of need, and appropriate treatment.

Provision of services to YOIs was undergoing substantial change over the period covered by the inspections reports used in this review. The two YOI case studies suggest that the transfer to PCT commissioning and provision is improving the delivery of healthcare services. In both cases, the change was reported to have widened the skill base of healthcare staff and to have promoted closer links with community services in the PCT, which benefited staff working within the closed community of the secure estate. Since some of the inspection reports and research studies contributing to the following analysis were written before the introduction of PCT commissioning, the possibility of improvements since this transfer needs to be kept in mind.

This chapter describes the extent to which secure establishments are meeting the needs of young people in terms of the services delivered as described in inspection reports, interviews with key stakeholders and the literature review. In relying on these data sources, expressed need – the views of young people in custody – was not included. Whilst YOI inspection reports often include the results from surveys of young people in prison (see 5.4), these tend to focus on access to healthcare services rather than their views about their specific health needs. This chapter looks firstly at how initial health assessments are conducted, and then at how specific health needs are met.

4.1 Health assessments and care plans

As many young people arrive in custody with no comprehensive accompanying medical history, a thorough assessment of their health needs is required to inform decisions about what interventions and support they will need during their time in a secure establishment. In a study commissioned by the YJB, the most common reason for unmet need with respect to mental health was the failure to adequately assess and review the needs of a young person (YJB, 2005). Initial screening should include assessment of physical and mental health and details of any substance misuse. All establishments across the secure estate undertook health and risk assessments, as required by national standards, but the quality and scope of these assessments varied, with inspectors commenting on the need for improvement in some establishments.

Initial assessments were generally undertaken by a healthcare nurse. In some settings, a doctor routinely completed a follow-up assessment, whilst in others this only happened if the initial screening indicated a specific need for a medical assessment. The inspection reports suggest that over time, each establishment developed its own induction and reception procedures, usually in conjunction with ASSET⁸ documentation if this was available. Some healthcare units explored a range of potential sources of information to gain a medical history, including contacting parents where possible, or the young person's GP if this was known, but this did not appear to be widespread.

⁸ The 'ASSET' assessment profile is a national tool developed by the YJB for use with juvenile and young offenders in community and custodial settings.

Both stakeholder interviews and the research literature identified a number of issues around relying on ASSET assessment to identify health needs. Two interviewees felt that physical health needs were likely to be underestimated in such assessments, since the health section of the ASSET form assesses health primarily in relation to offending behaviour. One interviewee gave the example of poor dental care, “which is a big health related issue but not related to a young person’s offending”. Mental health needs may also be underestimated: Harrington and Bailey (2005) found that ASSET identified mental health problems in only 15 per cent of a sample compared with 31 per cent identified through a fuller assessment.

Interviewees also reported that those undertaking the ASSET assessment varied in their experience and expertise, so completion of the form could be relatively subjective. A further complexity for initial assessment is that young people entering custody, perhaps for the first time, are likely to have raised levels of anxiety in their new situation, exacerbating any existing problems of anger or depression. Reliance on an ASSET assessment conducted weeks, or perhaps months, beforehand takes no account of these changes or their impact on needs.

Another interviewee believed that self-diagnosis arising from incomplete assessment resulted in young people sometimes describing conditions that they may not have, though within the short term of their sentence, verification was not always possible: “they will say they are asthmatic because they once got seen by the doctor when they were on the out and he said they might have a respiratory problem and their mum interpreted that as asthma, but then they are not in prison long enough to have all the work to find out if they have asthma or not”. A recent Australian study, though, suggests that juvenile offenders are as reliable as clinical and community samples of adolescents in their self-reporting of health-related behaviours and problems (Kenny and Grant, 2007).

The inspection report for Hindley YOI describes a new assessment process being piloted for the juvenile estate. This involves a reception questionnaire, which acts as an initial screen to identify urgent problems related to physical or mental health including any risk of suicide, self-harm or substance misuse; followed by a more in-depth social and medical interview and separate mental health and substance misuse interviews.

Under the National Minimum Standards for Children’s Homes, it is a requirement for each SCH to have a health care plan for every young person (there is no similar requirement for STCs and YOIs). At least 11 homes had individual health care plans for young people, though some of these were said by inspectors to lack detail. The remainder either had no plan or it was part of the young person’s overall care plan. In some homes the health care plan accompanied the young person on release or was forwarded to a YOT or the next placement, but this was not standard practice in all SCHs.

Several interviewees mentioned the increasing number of young people with learning disabilities entering the secure estate and the challenges this raised (see also Tunnard et al., 2005; Chitsabesan et al., 2006). Interviewees highlighted the stigma attached to illiteracy problems and the tendency for young people to conceal their disability by responding aggressively in some situations. There were fears that staff may lack the necessary skills to assess and identify learning disability and its impact on health needs. There is growing awareness and a focus on this issue, as evidenced by the appointment in some establishments of nurses with learning disability training or experience. Nevertheless, some felt that there was “a big gap in services” and that this area “will need particular focus over the next few years”.

4.2 Physical health

Analysis of inspection reports showed that regular specialist clinics such as for asthma, diabetes, epilepsy and dermatology were much dependent on the skill mix and training of healthcare staff. Some YOIs were addressing this lack of skill within their own healthcare staff by seeking PCT specialists to provide regular in-house clinics. Seven of the young men's YOIs offered regular asthma clinics and three held diabetes clinics, two provided epilepsy clinics and three offered special dermatological clinics. Such specialist clinics were not mentioned in the SCH and STC reports and it is likely that the size of these establishments meant that young people presenting with these conditions were treated on a case by case basis.

Most YOI establishments were reported by inspectors to have regular visits from opticians, although few young people surveyed thought they could easily access this service (Worsley, 2007). Seven YOIs had visiting podiatry or chiropody services, but only five reported scheduled sessions for physiotherapy. Given that poor vision (and hearing) can be a significant factor in impeding educational progress for some young people, as inspectors commented in one report, screening all young peoples' vision would seem to be good practice. Although not specifically referred to in every STC and SCH report it would seem that most establishments have access to an optician. It is unclear if this is standard practice throughout, but at least some give all new entrants a standard eye test (with one administering a hearing test too).

4.3 Inoculation and Immunisation

Most YOI establishments and some of the SCHs and STCs were reported by inspectors to offer regular inoculation screening or a routine clinic or programme to cover missed childhood immunisations such as MMR, BCG or Meningitis C. Hepatitis B inoculation was generally available too. Ideally, need was identified at the initial reception health assessment. Hindley YOI offered an accelerated course of childhood and hepatitis B immunisations to young people whose stay was expected to be short.

4.4 Minor Illness

All establishments had access to a GP, although access to a female GP was not always available in units accommodating girls and young women. YOIs, being larger, tended to hold daily, weekday GP surgeries. At SCHs the availability of a GP varied, although all establishments had an 'on call' service. Most establishments relied on out of hours services rather than their regular GP at weekends and these arrangements sometimes resulted in a lack of continuity in consultations and occasional irregularities in prescribing procedures.

Only five YOIs were reported to have a children's nurse on the team and only two reported nurses with formal triage skills. In SCHs, the nursing staff varied in terms of the hours they were available and the expertise they offered. For example, in two homes of similar size, one had two senior grade nurses available for two half days a week whilst the other had access to a school nurse just once a fortnight. Only a handful of SCH reports indicate that a LAC trained nurse either worked regularly in the unit or provided support to nurses.

The health facilities for young people and how to arrange to see a doctor were generally explained during the reception and induction period. At Thorn Cross YOI, new admissions were given an additional reception interview a few days after the initial induction because staff recognised that those new to custody often needed arrangements to be explained again in less stressful circumstances .

Arrangements for accessing primary care varied in male juvenile prisons, with most self-referring by completing a form on their residential wing. These applications were either collected by nursing staff on their daily visit to residential units or passed on by wing staff. Although this raised issues of confidentiality, some young people were said to be pleased to have wing staff involved to help them in completing the form.

One interviewee explained the effect of having to make a request through an officer: "For most of us going to see [a GP or a dentist] can be an uncomfortable experience. If you put those services within a prison and the security around those and... in a YOI you make a request through a prison officer, then those kind of experiences are even more uncomfortable, anxiety provoking and embarrassing. All those feelings will be exacerbated and for those going through adolescence - when you are not comfortable with determining what you should and should not be doing." Some YOIs had dispensed with formal application systems because of this. Instead, when nurses visited wings to administer medications several times a day, they made themselves available to discuss healthcare problems with young men, to give advice and arrange any necessary appointments.

4.5 Dental services

The literature suggests (Harvey et al., 2005) that the prison population as a whole demonstrates long standing neglect of dental health which, coupled with drug use, smoking and poor nutrition, further exacerbate dental problems. The main issue for young people was that their limited stay often prevented routine treatment being undertaken. Dental hygiene and dental health promotion work was often limited by lack of staff resources. Only a quarter of boys and less than one in six girls in custody reported that it was easy to access a dentist, with none at all saying this in two female establishments (Worsley, 2007). Lack of access to dentistry treatment was also a common complaint among young women in YOIs in the Oxford health needs study (Douglas and Plugge, 2006).

The inspection reports for YOIs suggest that dental provision varied substantially. Most YOI establishments reported that a dentist attended for one to two sessions every week, but waiting lists varied in length from one week or less to nine weeks, and few were able to offer advanced restorative work. Most units had access to an out-of-hours service and it was reported that emergencies were generally seen quickly. To address the problem of patients moving on before any routine work could be carried out, the dentist at Warren Hill YOI held pre-release clinics in an attempt to ensure young people were up to date with their treatment. However, several establishments were said to limit routine treatment to young people with at least six months to serve before release. This meant that many received only emergency treatment.

One interviewee questioned the practice at some establishments of not routinely giving all new admissions a dental appointment, but requiring young people to self-refer: "What child at the age of 16 is going to say 'I want to see the dentist'". Where dentistry was mentioned in the STC and SCH reports it appeared that all young people were given routine dental checks soon after admission, but as in the YOIs, could wait some time for treatment.

Only a limited number of reports mentioned that the dentist was accompanied by a dental nurse or that a dental hygienist attended. Exceptionally, at Hindley YOI, the hygienist attended for one session every week, dispensing toothbrushes and toothpaste as well as doing scraping and polishing work. At Brinsford YOI, where a dental nurse was available, this allowed the dentist more time to concentrate on clinical work, and the nurse provided weekly oral health promotion sessions.

4.6 Substance misuse treatment

Past research has highlighted a lack of support across the juvenile estate to meet young people's substance misuse needs, including poor access to rehabilitation and detoxification facilities (YJB, 2004). However, this area was perceived by interviewees to have received much attention and funding in recent years, resulting in a service that many now thought to be good. The introduction of the YJB's Juvenile Substance Misuse Programme was believed to have provided practitioners with a clear reference frame, and enabled workers to engage with young people with alcohol problems as well as those identified with drug problems.

Other research has identified gender and ethnic differences in attitudes towards and take up of treatment, even as the Substance Misuse Programme is being implemented. Young women are much more likely to receive detoxification services, which could reflect their higher need for this type of intervention or the better provision available in small female-only YOIs. However, they are less likely than young men to ask for help from substance misuse services and if they do, are less satisfied with what is offered (Galahad SMS Ltd., 2007).

In the same study, juvenile offenders from a Black or minority ethnic background were less likely than those from a white background to report receiving certain types of assistance such as an assessment of alcohol use, group work or counselling for personal problems - although this could be because they reported fewer needs in these areas. There was little evidence of BME specific programmes being made available or of systematic consultation with BME young people about the type of services needed, compared to practice in services to young offenders in the community (Galahad SMS Ltd, 2007).

Inspection reports indicate that not all YOIs have facilities to provide detoxification programmes. Young people entering custody who required more than symptomatic relief were usually transferred to an establishment that could provide that facility, for example Feltham YOI. Across all types of setting, inspection reports provided some examples of good practice in substance misuse treatment. One was the allocation of a key worker for young people after their initial assessment to provide individual counselling, highlighted in many reports as important to support those with high levels of substance misuse. Other examples of good practice included symptom relief such as acupuncture, and the involvement of all staff in helping young people with substance misuse problems.

4.7 Sexual health and family planning

A study carried out before the transfer of prison healthcare commissioning to PCTs found that less than half of YOIs in England and Wales held regular sexual health clinics run by specialists in Genito-Urinary Medicine (GUM), despite the high rates of partner changes and STDs reported by young offenders (Tang, 2003). Among female YOIs, there was limited availability of sexual health experts (Dougals and Plugge, 2006).

Interviewees expressed the view that sexual health and family planning services were patchy across the estate, with some establishments doing very well and others less so. Inspection reports for around half the young men's YOIs mentioned a regular sexual health clinic, an improvement on the Tang study. However, some establishments reported waiting lists for treatment, and few reported provision of a regular screening facility. In many establishments the quality of the service depended on having appropriately trained nursing staff.

Some establishments, for example, were trying to get Genito-Urinary clinics based in the setting, in order to maintain confidentiality. According to inspectors, a monthly GU clinic set up at Medway STC in 2005 'was successful in providing a much-needed efficient service to young people while removing the need for escorts and additional security during visits to external clinics'. At Ashfield YOI, a consultant in GUM held a fortnightly clinic in the unit, and nurse-led sexual health clinics were being introduced which included Chlamydia screening.

4.8 Pregnancy and maternal health

Although pregnant women in custody are entitled to the same healthcare as pregnant women in the community, research has shown that some pregnant women in custody face inadequate diet, limited access to antenatal provision and inadequate health provision (Sherlock, 2004).

Four of the YOIs were female only units as were two of the SCHs. Inspectors reported that all new arrivals to Downview YOI were offered a pregnancy test, and the Cookham Wood YOI team had established links with the local maternity unit to provide antenatal care if required, with a PCT midwifery liaison nurse providing on-site support as necessary.

At Rainsbrook STC, which had recently opened a mother and baby unit, separate and distinct protocols were in place for contact with the midwifery service, health visitors and specific GPs separate from those providing mainstream services at the centre. The healthcare manager confirmed in the inspection report that the young women in this unit had direct access to a named GP without reference to the centre's healthcare service.

4.9 Mental health

A national review for the YJB, based on interviews with key stakeholders in YOIs and SCHs (as well as in community settings), concluded that mental health needs were not being well met in many institutions (Harrington and Bailey, 2005). Provision of services was often dependent on the personal interest of mental health professionals and therefore vulnerable to changes of personnel and priorities. Mental health on admission frequently relied on previous assessments (ASSET forms) accompanying the child and these were often missing or (as previously mentioned) underestimated mental health needs. There was a lack of appropriate intervention packages available as well as resource problems in delivering the available interventions; and appropriate support and supervision for staff was lacking.

In a recent telephone survey of local authority managers responsible for purchasing 'welfare' places in secure settings, concerns were expressed about the lack of access to CAMH provision in secure children's homes, and the difficulty in continuing treatment a young person was receiving from their local CAMHS if they were placed at a distance from home (Held, 2006). Lack of dedicated CAMH provision on site in SCHs worried these managers as such placements were often used as the only way of achieving a safe setting for a young person with severe mental health problems when there was no Tier 4 CAMHS bed available. It was suggested that many young people were placed in 'welfare secure' after psychiatrists referred them on to social services. This referral was because the young person did not have a diagnosable or treatable mental health disorder, regardless of the behaviour disorders they might be exhibiting (Held, 2006). Similar concerns about the willingness of psychiatric services to offer treatment to young people with personality disorders were raised by representatives of campaigning organisations interviewed as part of the current study.

The limited resources available to meet mental health needs of young offenders can be illustrated by comparing the costs of mental health provision for young offenders (average age 15.7 years) in the

community and in custody (Barrett et al., 2006). Although costs were significantly higher among the secure facilities, this was mostly due to the high costs of accommodation and residential care. The amount spent directly on health services (mostly accounted for by contact with mental health professionals) was very similar, averaging £41 a month for those in custody and £42 for those in the community. This low figure suggests very limited availability of mental health provision, despite high levels of need.

Some of the literature reviewed above refers to the situation before the transfer of responsibility for commissioning health services to PCTs, and before it was possible for secure settings to act upon recommendations in the YJB report on mental health of young offenders (Harrington and Bailey, 2005). Both recent inspection reports and the views of key stakeholders suggest that the mental health needs of young people in custody are now beginning to be addressed more carefully, and further improvements are likely with the publication in March 2007 of a framework and good practice guide for commissioning mental health services for children held in secure settings (Department of Health, 2007).

It was evident from both the interview and inspection report data that although mental health provision is generally improving, there is still considerable variability in the services provided, with some settings having very good access to a CAMH service and a range of mental health specialists, whilst others struggled to get services in place. One interviewee described mental health treatment as a "post-code lottery". To some extent, variation in services might reflect differences in needs, since some establishments such as Thorn Cross YOI do not routinely accept young men with serious mental illness.

Inspection reports suggested that at most YOI establishments, primary mental health care needs were being addressed, for example at Thorn Cross YOI with weekly mental health clinics run by the healthcare manager, the only mental health trained member of staff. A mental health nurse at Brinsford YOI had designed a primary mental healthcare service which offered a mixture of one-to-one and group work covering anxiety and stress management, coping with mental illness and with self harming behaviour as well as substance use and dual diagnosis. This had involved engaging with local voluntary organisations such as Rethink, Alcoholics Anonymous and local drugs projects to be part of the programme

Inspection reports described both out-reach and in-reach models of service delivery within YOI establishments. At Hindley YOI, the mental health team provided an out-reach service to the wings, offering primary care interventions for common mental illnesses, such as depression and anxiety. Young people with higher levels of distress, but without a mental health diagnosis were similarly supported. Early intervention was provided for those with the early symptoms of more severe mental illness. At Lancaster Farms YOI, the team was described as in-reach, accessible by self-referral, or referral by wing or health services staff. By agreement with the GPs, the in-reach team and the establishment psychiatrist between them covered the full range of mental health problems, from emotional distress to severe mental illness. All the team activities were wing-based except for counselling, which took place in the health centre.

Few settings had regular access to a forensic psychiatrist or psychologist – just four of the YOIs, approximately seven of the SCHs and one STC. Most establishments had access to a psychiatrist and/or psychologist though often the role of such specialists was to support other staff to work with young people with mental health problems, rather than working directly with young people themselves. There was significant variation in the level of service. For example, an eight-bedded SCH had access to the local forensic CAMHS team with a psychiatrist visiting monthly and a psychologist weekly. Another, with twice as many places, had a psychiatrist visiting twice a month, but no access to a psychologist

and a CAMH service that only responded in emergencies, leading inspectors to conclude that the service did not meet the needs of the young people.

Links with a CAMH service were said to be poor or could be improved in five SCHs, one STC and three YOIs, two of which were female juvenile units. (However in one of the latter, the psychiatrist liaised with and was supported by the local CAMH team.) At the time of the inspection at Oakhill STC for example, the psychologist was working directly with two young people without, it was said, the capacity to develop and implement interventions for these young people and others identified as in need of therapeutic services and support. Better practice was observed at Rainsbrook STC, where an emphasis was placed on early interventions and therapeutic relationships. Here, a forensic psychologist with three assistants together with a psychiatrist held three clinics a week for young people.

Support for secure children's home staff from a forensic CAMHS team

The forensic CAMH service has been working in the SCH one day per week, involved not only in direct therapeutic work and psychological/psychiatric assessments with young people, but also consulting with staff about managing and working with individual children and providing staff training.

This indirect work through staff teams has been key in ensuring that the young people at the SCH have received a service which is tailor made to their individual mental health needs rather than simply dealing with the behaviour displayed. Consultation and training with staff has ensured that the staff have the confidence and knowledge to take a child centred approach to their work focusing on emotional and mental health needs as well as their behavioural needs.

Alongside this indirect work, the forensic CAMHS team has also been involved with the planning and delivery of emotional well-being training, based on the materials developed by the National Children's Bureau (Bird and Gerlach, 2005).

About three quarters of the young men's YOIs had the additional facility of in-patient units where those with complex or mental health problems could be treated. These varied in size from a three-bed unit at Parc to 22-bed unit at Feltham.

Interviewees identified several problems in locating suitable treatment for serious cases, including a lack of secure mental health beds for young people, leading to lengthy waits, sometimes for over a year, for transfer to a psychiatric unit. Despite more beds becoming available it was believed that these might still not be adequate to meet need.

The reports from the YOIs indicate a disparity of access across different establishments when transferring young people with severe mental health needs to appropriate facilities, with three mentioning good access and four highlighting delays, often of several months. Inspectors commended the input of the specialist adolescent forensic psychiatrist at Hindley YOI and the commissioning arrangements in place for young women in prisons⁹ as greatly assisting access to psychiatric secure accommodation. There was little specific mention of this issue in the STC and SCH reports, although in one SCH staff raised concerns about the shortage of inpatient facilities for young people nationally.

⁹ A weekly meeting of the Department of Health National Specialist Commissioning Advisory Group.

4.9.1 *Bereavement and loss*

Bereavement and loss was an area of children's emotional health which a number of interviewees considered to be overlooked within the secure estate, despite the fact that it was thought to be a significant issue. One interviewee cited a survey undertaken at a secure children's home showing that all the young people currently placed had at some time experienced significant loss and/or bereavement. Research by Boswell (1998) investigated the nature and frequency of child abuse and loss (bereavement and/or cessation of contact with someone important) among over 500 young offenders who had committed serious crimes, and the results provide strong confirmation of the prevalence of unresolved traumas in the backgrounds of young offenders. In this study, 91 per cent had experienced either abuse or loss, and 35 per cent had experienced both.

There were one or two examples of establishments addressing this issue, such as a secure children's home that had obtained funding from the Children's Bereavement Network to develop a service that provided a qualified bereavement counsellor, staff training and a library of resources. However, this was by no means common.

4.9.2 *Suicide and self harm (SASH)*

The risks of suicide and self harm within the secure estate are well documented (SCIE, 2005). YOI and STC inspections identified the value of a multi-disciplinary approach to SASH, to bring together information from risk assessments, suicide reduction records, handling strategies and intelligence gathering to inform an organised and effective system of identification and support of vulnerable children and young people. Case meetings were often not well attended, but some examples of positive practice were noted. Regular meetings, such as the morning staff meeting at Werrington YOI, attended by senior managers and representatives from all departments, were commended because they provided the opportunity to alert everyone of the need for additional support for those at risk.

The High Risk Assessment Team (HRAT) at Hassockfield STC offered another positive example, of a multi-disciplinary team which met at least twice a week to discuss young people on HRAT monitoring. This meeting brought together nursing staff, psychology staff, case managers, education and residential care staff to review and devise a support plan. At subsequent meetings, each department provided a written summary for each individual, and the decision to remove a young person from the HRAT monitoring procedure would only be made after discussion at the multi-disciplinary meeting. Rainsbrook STC took the precaution of placing all new receptions on a regular watch system for the first week as a preventative strategy, irrespective of any indication of need on their ASSET form.

At the time of the inspection reports, most YOIs had adopted the Assessment, Care in Custody, Teamwork (ACCT) system. ACCTs are opened when a prisoner has self harmed or may be in danger of harming themselves, and remain open until the risk has declined. Downview was praised for continuing to offer a programme of aftercare support for two weeks after closure of an ACCT. Not all establishments were able to provide in-patient units for supporting the vulnerable away from residential wings.

In addition to a formal monitoring system, most YOIs provided access to helplines, such as the Samaritans and Childline, but inspectors stressed the need for regular checking to ensure such lines worked, that numbers were well publicised and could be accessed free through the PIN phone system. They also identified instances of young people who spoke to the Samaritans being victimised by others on their wing.

Many establishments offered access to counselling, and peer support such as at Brinsford, where an officer-led 'Brinsford Crew' provided peer support for young people who were isolated and not participating in general activities. At Warren Hill, the chaplaincy adopted a proactive role in supporting young men, who were not engaging in activities, to attend a weekly support group.

Where information was provided in the inspection reports for SCHs, SASH procedures were variously described as good, needing to be put in place, or improved upon. Although there was evidence of SASH record books being opened and completed in some homes, the general picture was that staff were not sufficiently trained or encouraged to make comprehensive entries. Good practices were described in inspection reports however, including access to a sensory room at one SCH, which was considered to be a credible approach to reducing incidence of self-harm.

4.10 Speech and Language therapy

Inspection reports for only two YOIs referred to the availability of a speech and language therapist (SLT), and in both cases this service was provided as part of a two-year project funded by the Helen Hamlyn Foundation, and it was unclear whether the projects would continue after the charitable funding ended. Three secure children's homes were able to access speech and language therapy through the Community Homes Health Team (CHHT, see chapter 6). In the latter case, the therapist assessed, diagnosed and provided intervention either directly on a one-to-one or group basis, or indirectly by supporting key adults in the home to work with the young person. Where appropriate, the SLT also recommended environmental changes to support the young person's speech, language and communication difficulties. These examples provide the only instances of SLT described in inspection reports, suggesting that this support is not widely available, despite the high level of language and communication difficulties evident among juvenile offenders.

The SLT service provided through charitable funding at Werrington and Brinsford YOIs, as with the CHHT service to secure children's homes, involved the therapist working with other staff in the setting, as well as themselves identifying and treating young people with speech, language and communication problems. They aimed to increase the ability of non-specialist staff to identify communication difficulties and raise awareness of how these impact on young people's behaviour (Bryan et al., 2005). At Werrington YOI, the specialist SLT was seconded from the local PCT and was supported by a part-time Learning Support Assistant based in the education department. At Brinsford, a SLT was managed by the university overseeing the project and supported by an administrative assistant. Speech or language problems were picked up during the reception health screening and young people were referred to the therapist, or could refer themselves. Most sessions were one-to-one, but social groups were also arranged where required. The SLT project was highly valued by prison staff in the two institutions, who felt there was a real need for such support, and case studies illustrated positive benefits for young men who had been helped (Bryan et al., 2005).

The two therapists working in this project made onward referrals to community SLT services where appropriate, but ensuring young people had continued access once they were released proved difficult. Barriers included lengthy waiting lists for community services, young people falling through the gap between paediatric and adult services, appointments being sent in writing when the recipient could not easily read, young people's lack of motivation, or competing demands on their time from Youth Offending Teams. The custodial sentence appeared to provide a particular opportunity for addressing communication needs among young offenders and highlights the importance of discharge arrangements, to which we now turn.

4.11 Transfer and discharge

As important as obtaining accurate health information when young people enter a secure setting is the need to ensure that their health needs are fully communicated when they leave custody or are transferred to other custodial settings. A number of promising practices were noted in inspection reports, such as pre-release clinics where arrangements for follow-up were made; writing to home GPs; informing youth offending team health workers; health care plans which accompanied the young person; and discharge packs with health information for the young person including how to access services (although the information in such packs would likely prove challenging to those with poor literacy levels or learning difficulties). Inspectors commended the practice at one SCH whereby a nurse prepared a transfer summary sheet that was sent with each young person when they moved on.

Ashfield YOI was unusual in that the team followed up their clients for up to three months after their release, contacting the relevant Youth Offending Team or mental health team to ensure a smooth transition of care and attending reviews in the community. A member of the mental health team also accompanied all young men on their transfer to other prisons or secure accommodation.

Providing support to young people after their release from secure settings is particularly important for those with substance misuse problems. At Castington, members of the YPSMS were linked to specific geographical areas to maximise links with youth offending services, community drug teams, and the resettlement and aftercare programme teams. At Feltham, inspectors noted a number of challenges including the need for liaison with the remand management service and YOTs on release, and difficulty in ensuring appropriate follow-up in other establishments for transferees. Resettlement and aftercare provision (RAP), which provided structured community-based support of up to 25 hours a week to young substance users, was increasingly available and Feltham had established good links with all of the London RAP teams.

5 Provision of health care in different settings: a review of inspection reports

In this chapter we have attempted to provide an overview of inspectors' assessments of health services within each type of institution: SCH, STC and YOI. Supporting information is provided in Tables 1-3 in Appendix A. The overview gives an indication of the general strengths and weaknesses in health care provision at the time of the latest inspection. However, the caveats mentioned in previous chapters about drawing conclusions from inspection reports need to be kept in mind. Inspection reports may provide examples of apparently promising practice, and useful information about the health services offered and what young people think of them, but such reports do not provide evidence of effectiveness. Furthermore, some of the standards against which institutions are judged are non-specific and open to interpretation – for example, offering services that are 'equivalent to those available in the community' – rendering it difficult to make comparisons or benchmark institutions against each other or against other types of secure setting.

5.1 Secure children's homes

During the period covered by the inspection reports for SCHs, the CSCI re-organised the licensing standards and the National Minimum Standards for Children under the five *Every Child Matters* (ECM) outcomes¹⁰ for reporting purposes. Reports were structured around the five outcomes and settings were rated as to how well they were meeting each in terms of the National Standards. For the 12 homes inspected using this framework, the ratings for each of the three standards contributing to 'Being Healthy' and the overall assessment for this outcome are presented in Table 1 (Appendix A). It should be noted that the standards for this outcome relate to meals and diet, individual health care plans, policies and procedures for administering medicines and providing treatment, assessment and identification of health needs on admission and individual health care plans available to take away on discharge.

The table shows that there were differences between the homes in how well they were meeting the 'Being Healthy' outcome. However, in all homes the three standards making up this outcome were being met or almost met, and over half of homes were assessed as good overall at meeting the 'Being Healthy' outcome.

5.2 Secure Training Centres

Inspectors assess STCs against eight standards. Standard seven concerns healthcare, and stipulates that all trainees will be provided with health to NHS standards and with health education. There are seven criteria relating to this standard which cover the extent and quality of healthcare, including health promotion and education. STC inspection reports start with a summary of the key themes emerging from the inspection, which may or may not include health, and subsequent chapters detail the evidence which led to their conclusions and recommendations.

Table 2 (Appendix A) lists key strengths, areas for development and recommendations for healthcare identified by inspectors for each of the four STCs. It is difficult to draw general conclusions, other than that compared with the other three establishments of this type, Oakhill has fewer strengths and more areas of healthcare needing development and, consequently, more recommendations made for improvements.

¹⁰ The five outcomes are: Being Healthy, Staying Safe, Enjoying and Achieving, Making a Contribution, and Achieving Economic Wellbeing.

5.3 Young Offender Institutions

Inspectors assess YOIs against a healthcare standard that states that the health service assesses and meets the health needs of young people while in custody, promotes continuity of health on release, and that the standard of healthcare provided is equivalent to that which children and young people could expect to receive in the community. Table 3 (in Appendix A) provides an overview of inspectors' assessments of healthcare in YOIs, extracted from the summary and recommendations sections of the latest available HMIP inspection reports. As with secure children's homes, a key theme is the variability between institutions, and the difficulty in obtaining an accurate current picture given the different dates of inspections and the varying level of detail provided. However, the following general conclusions can be drawn.

Healthcare services in YOIs are generally improving, especially since the transfer of responsibility for commissioning healthcare to PCTs. Only one institution is judged as seriously inadequate on healthcare, and this inspection was undertaken over two years ago (May 2005) so the position may since have improved. Mental health services are variable, but more YOIs received positive than negative comments from inspectors on this aspect of healthcare in their latest report, suggesting that efforts to improve mental health services in YOIs are beginning to have some success.

Staffing issues are highlighted as a cause of problems with providing healthcare services in over a third of inspection reports, either due to inadequate staffing levels or lack of appropriate skill mix.

Although some YOIs are active in health promotion, others are lagging behind. Four institutions are specifically praised by inspectors for their work to improve young people's health and well-being, for example through relaxation therapy and exercise programmes, but the recommendations for another five suggest that health promotion activities and information need to be improved.

Dental care is more often judged to be a weakness than a strength, especially dental care for juvenile offenders in the last six months of their sentence. Occupational therapy and daycare facilities are often lacking in YOI healthcare services.

Inspectors' recommendations for improvements to healthcare in YOIs frequently refer to tightening up pharmacy procedures and improving the delivery of medication to young people.

5.4 Young people's views

We focus here on information obtained through the inspection process on young people's views about their access to health care services in prison. (Young people's views also inform section 7.5 on effective approaches to promoting health for young people). HMIP produces regular analyses of surveys of young people under 18, undertaken as part of formal inspection visits. The most recent report (Worsley, 2007) collates responses from 2500 15-18 year olds held in juvenile prisons inspected over a two year period between 2004 and 2006. An earlier HMIP report (Challen and Walton, 2004) was based on a random sample of over 1200 15-18 year olds in juvenile prisons inspected over 18 months between November 2001 and March 2003.

The most recent report shows that young people in custody are on the whole positive about the quality of healthcare overall: 56 per cent rated it as good or very good (Worsley, 2007). However, this ranged from 37 per cent in one institution to 83 per cent in another, Werrington, where inspectors noted that healthcare staff had managed to establish particularly good relationships with young people. Girls were more positive than boys about the overall quality of healthcare, and more likely to perceive themselves

as having good access to a nurse (79%). This suggests there has been considerable improvement in general healthcare facilities for girls since the earlier report, which showed that girls rated healthcare in their establishments as being significantly worse than did boys (Challen and Walton, 2004).

5.5 Difference in size and ethos of institutions

Compared with YOIs and STCs, SCHs are smaller in size and have higher staffing ratios. There was no discernable pattern across the inspection reports to suggest that size made a difference to the health-related services available. However, interviewees suggested that size and staffing ratios possibly could make a difference, allowing services to be tailored to individual young people. For example, smaller numbers and higher ratios mean that SCHs may be in a better position to tailor services to individual needs and, being smaller, they may be better able to track and monitor health needs compared with larger establishments. It was also thought that the newer all female units took a more therapeutic approach and that their smaller size facilitated closer working relationships between different professionals. One interviewee commented that "a large site does not preclude establishing effective partnerships, but it can be more challenging".

Some interviewees pointed to the differences between YOIs, STCs and SCHs in their genesis, philosophy and the needs of the young people accommodated, but again there was no consistent evidence in the inspection reports to suggest that this was reflected in the delivery of health services and ability to meet the health needs of young people in the secure estate. For example, SCHs were primarily set up to provide secure childcare and could therefore be expected to have a regime that is more welfare based - although qualitative research has suggested that the preponderance of young people placed in SCHs through the youth justice route has created 'a tendency for the welfare approach of local authority children's services to be marginalised whilst youth justice processes [take] centre stage' (Hart, 2006, p3). Despite this, in SCHs young people are called by their first name and residential staff do not wear uniforms. This has not generally been the case in YOIs, though there were examples from the inspection reports of establishments beginning to change their practice in this respect. Stakeholders representing campaigning organisations thought that STCs and YOIs needed to move more quickly than they were doing towards a more therapeutic and rehabilitative approach.

6 Improving health services in secure settings

This chapter draws largely on the views of key stakeholders to consider the potential for improving health services for young people in the secure estate. These suggestions for improvement need to be validated by further in-depth research, which was not possible within the scope of this study. We describe the ways in which interviewees believed health services in the secure estate could be improved but have made no attempt to prioritise these areas for improvement, as this was beyond our brief.

Key stakeholders were asked how health services could be improved to meet the needs of young people. Their views fell broadly into the following areas: the need to take a broader focus to look at health provision pre and post-custody; the need for greater integration and collaboration between health, care and education within the secure estate; improving the range of skills of the healthcare team; improving systems for sharing health information; overcoming the limitations imposed by the custodial environment; and giving greater prominence to the role young people have in the provision of health services. Where appropriate, we have supplemented these views with examples of promising practice, and with data from the literature review and inspection reports.

6.1 A pathway approach

A common view among interviewees was the need for a more joined-up approach: “[we] cannot divorce custody from what happens before and after [and it] needs a national strategy in terms of what types of services young people should get before, during and after custody”. Such an approach is supported within the literature on mental health needs and provision, where a care programme approach is recommended in order to promote continuity of care between services received before, during and after custody (YJB, 2005). This is particularly important because of the short time young people typically spend in custody. For example, in one 16 place SCH over the course of a year, a hundred young people were placed, staying on average just two months. Such short stays inevitably limit what can realistically be achieved in terms of promoting health or treating entrenched health problems, and reinforces the need to consider health in custody alongside what happens pre and post-custody. As one interviewee commented, “by the time [we have] received paperwork and had the meetings, [we have] probably just got time to get eyes and teeth checked and possibly inoculations”. The speech and language therapy project at Brinsford YOI found that over a quarter of those referred for treatment were transferred or released before the therapist was able to see them (Bryan et al. 2005).

Interviewees highlighted for attention a number of areas that in their opinion would help improve how well the health needs of this group of young people were met both before and after their time in custody. These included making more use of pre-custody court mental health diversion schemes¹¹, which had worked well in some parts of the country, and offering more continuity of care and support on release, such as resettlement plans that supported young people with any post-custody problems: “even the best efforts in terms of well-being and improving self-esteem [in custody] are doomed to failure if on discharge there is very little support”. Without adequate follow-up after release the benefits of health promotion and treatment in custody are likely to be lost.

Doing more to meet the health needs of young people before they came into the criminal justice system would, it was thought, be particularly beneficial for the young people whose health needs, especially mental health and substance misuse, were at the heart of the problem and who should be treated in the

¹¹ Where trained health workers are available to assess mental health needs of young people while still in police custody and divert the young person into some form of treatment if the offence is not serious or, if it is, into some form of secure health care rather than being sent to a YOI.

community rather than placed in custody. In fact, it was the view of interviewees mainly representing the campaigning groups that secure settings could potentially be harmful to a young person's health and well-being because of high levels of bullying and self-harm, together with practices such as strip-searching and the use of segregation: "...the physical environment is poorer [than in community settings] and [prison] is bound to make someone worse who has a psychotic illness or who is depressed".

Some interviewees believed that to raise the standards of health-related services both before and after custody required placing a statutory duty on service providers. One commented that "I know what a good discharge plan for a young person should look like and I know what should be provided, but [I] cannot insist on what local authorities and youth offending teams should provide while in custody or when they come out". It was suggested that this would help to raise the generally low expectations of what healthcare in the secure estate should provide and what a good service should look like. It was also suggested that a national resource for sharing good practice could help in addressing this issue whilst at the same time providing staff with an opportunity to share good practice, since "half the time you're trying to work something out that someone else has already done".

6.2 Integration and collaboration

The WHO *Health in Prisons Project* (World Health Organisation, 1996) highlighted the role of staff, families and the local community in promoting health, emphasising that health is a responsibility of the whole prison regime and not clinicians alone. This 'whole setting' approach also underpins the HM Prison Service guidelines on the care and management of young people held in the secure estate in England and Wales (HM Prison Service, 2006). However, such an approach may face particular challenges within the health environment of a closed secure setting compared to elsewhere in the community.

Key stakeholders interviewed for this study agreed that greater integration and collaboration between health, care and education was needed to improve services. Health has traditionally been viewed narrowly and tended not to include promoting and maximising good health, although several interviewees noted that projects such as '*Healthier Inside*' and award schemes such as Healthy Schools and Healthy Care, all of which take a whole setting approach, are encouraging the development of a more holistic view of health and a more integrated approach to providing healthcare services.

The need to integrate health with care and education was illustrated by interviewees with a number of examples. First, the pressure on different departments to fulfil their contractual requirements with the YJB could create a situation where departments seemed to be competing for a young person's time: "everyone wants to have their piece of the young person in order to do what they are required to do". This tended to be less apparent in establishments where health promotion was part of the education curriculum and good communication between the two departments had been fostered, as described earlier (see 3.1). Using opportunities during class time for health promotion meant that it was not 'squeezed' into the evening and week-end when young people may be less receptive.

Second, involving health staff in life on the residential units and wings can help to facilitate good relationships with young people. Advantage can also be taken of informal, opportunistic opportunities for health promotion, which are likely to be particularly valuable for young people who have had poor experiences of formal education and may be resistant to health messages delivered in a classroom setting. As one interviewee remarked referring to an all female unit: "health staff will involve themselves with the girls' activities during the evening... PCT's may find it difficult to justify their time being used in

this way, but it's an important means of establishing relationships, which are the precursor for health promotion." Several inspection reports comment on how well healthcare had been integrated within the establishment, but in one interviewee's experience marginalisation of PCT staff was more common: "Governors often don't want them to be [involved] and staff themselves are reluctant because they don't want to get involved in the 'nitty gritty' of prison life"

Moving towards greater integration is not without challenges, and can be hindered by a 'silo' mentality and a reluctance to take on board new ideas and ways of working. Differences between professional groups in terms of terminology and understanding can also create problems, although the training materials being piloted by the National Children's Bureau (NCB) may help to bring about a shared common understanding and reduce anomalies. Despite these challenges, some inspection reports noted that establishments were trying to take a more integrated approach to meeting young people's health needs, for example with multi-disciplinary meetings (see 4.9).

Given the scale of the health needs of young people in secure settings, the limited resources and the restrictions placed on healthcare by the custodial environment (see below), many interviewees pointed to the important role that could be played by residential staff who usually have most contact with young people. However, interviewees stressed that residential staff needed adequate training and support to enable them to play a role alongside health professionals in promoting health and responding to young people's health needs. In Chapter three, several examples were provided of residential staff receiving training in drug awareness and counselling skills. Staff need training not only to improve their knowledge of health issues, but also to develop their skills to promote positive relationships with young people, considered by one interviewee to be fundamental if young people "are going to open up and talk about their health".

In many establishments, residential staff supported by health professionals are working with young people on health issues, but they are often not regarded as part of the team and information which might assist them in caring for a young person is not always passed on to them. Notwithstanding the need to address issues of patient confidentiality and with whom information can be shared, the role that residential staff can play in helping to meet young people's health needs should be fully recognised.

Another aspect of integrated working necessary for effective service delivery is collaborative partnerships between secure settings and PCTs. According to interviewees, this requires PCTs to be interested and willing to provide services, and prison governors to believe that healthcare is important. Interviewees pointed to the difficulties that could be encountered, particularly when PCTs were unwilling to provide a specialist service to a young person who lived outside their region. Differences in policies and procedures between the two systems of health and prison service did not help and at times led to a duplication of effort. More joint policies were seen as one way to avoid this happening.

PCTs can sometimes be unaware of the health needs of young people in custody, and at Werrington YOI the healthcare manager has found that inviting Board members in for a tour of the establishment has proved to be an effective and powerful way to get the PCT 'on board'. The following two descriptions of contrasting examples of successful collaborative partnerships, at Huntercombe YOI and the Community Homes Health Team, which operates in the North West of England, are based on documentary material and interviews with key staff undertaken as part of the case study element of the current study.

Community Homes Health Team (CHHT)

The CHHT is a specialist multi-disciplinary team working with young people in both secure and open children's homes in the North West of England. The Team is funded and supported through joint commissioning by the participating establishments and a NHS Modernisation subsidy, hosted by the 5 Boroughs Partnership (a specialist Mental Health Trust).

A pilot project was initiated in 2000 to address the lack of mental health services to the secure estate – there were three SCHs in the region – and the idea to pool budgets was formulated. A successful bid was made to set up the service which now covers six sites.

In addition to the manager and administrative support, the Team comprises a clinical psychologist, a consultant psychiatrist, a forensic psychologist, a speech and language therapist, two registered mental health nurses, an art therapist and a music therapist. The Team is based in one of the SCHs where they have set up a specialist resource centre which all professional partners from across disciplines and sites can use.

Strengths of the CHHT

- Success of the service is attributable to the commitment of all those involved with the project including the managers of the homes who were convinced the service was needed and were willing to contribute financially.
- Economies of scale – young people can now access services which otherwise would have been unavailable to them.
- A more rounded, holistic approach to health and well-being.
- Good multi-disciplinary assessments. Although the number of children admitted with specific diagnosed disorders is small, the number leaving with such diagnoses after appropriate assessment has been undertaken is high, because engagement with the CHHT often provides the first comprehensive assessment and/or intervention for them.
- A Joint Agency Management Board involving all stakeholders reviews and oversees policy, budgets and operational issues. This direct relationship between customers and commissioners enables better tailoring of services to meet young people's needs, which was said to be a key advantage of the scheme, and giving customers 'ownership' of the service.
- As well as work with young people an important part of the service is the training offered to staff. This includes mental health awareness, anger management, self-injury, and working with young people with communication difficulties.
- Follow-up on release or transfer includes contacting YOI workers and forwarding copies of health reports, which may include referrals and/or recommendations to local services and receiving agencies.

Challenges of the CHHT

- Long waiting lists for CAMH services in the community often lead to delays in a young person being seen once released.
- Managing unrealistic expectations and demands on the service - CHHT capacity cannot meet demand.
- At first, convincing staff that health services have an important role to play.

Collaborative practice between Oxfordshire PCT and Huntercombe YOI

Oxfordshire PCT stresses the importance of engaging fully with the prison service to develop the concept of health as a prison wide service where all staff have a role to play, not just healthcare professionals and the NHS. Factors which have facilitated a collaborative partnership include:

- Identifying key priorities for the prison system and how they matched key priorities for health.
- Working initially on more readily achievable goals.
- Building on good relationships to take work forward by maintaining links between the service development officer with responsibility for prisons within the PCT and the YOI healthcare unit.
- An approach that demonstrated the PCT's willingness to embrace prison priorities.
- A Governor who supported health care work and ensured that initiatives were sustained even when there was staff turnover or a competing priority.
- Acceptance that the health unit is within the domain of the prison service and that the PCT is the second tier of the service.
- PCT Board members helping to raise awareness of the PCT's role in prison health, so that each PCT department considers this as part of their general work and not as a separate issue. When a public health issue is considered, how that is delivered in prison is now routinely included.

6.3 Extending the skills base of the healthcare team

We saw in Chapter four how the availability of specialist clinics was dependent on the skills base of the healthcare team. Although there were establishments with nursing teams that offered specialist knowledge covering women's health, genito-urinary medicine, children's nursing, school nursing, learning disabilities and mental health, this comprehensive skill mix was rare across the estate. Few establishments had a member of healthcare staff with a learning disability speciality, and there were still fewer occupational or speech therapists.

Not only is it important to have a team with a skills base that reflects the diverse health needs of this population, the importance of having a team with the appropriate skills for working with children and young people was also emphasised by interviewees. This might include RSCN nurses who have specific training related to children - only five YOIs for example reported a specialist children's nurse on the team – or a Forensic CAMH service with a consultant psychiatrist with paediatric or adolescent specific training or experience.

Working in the secure estate was noted to be very different and often more challenging and complex than working in a community setting, and interviewees stressed that it was not just about recruiting appropriately qualified staff, but motivating staff to stay. Wetherby YOI provides an example of promising practice in the recruitment of staff which has resulted in extending the skills base of the healthcare team.

Recruiting healthcare staff at Wetherby YOI

The transfer of healthcare to the PCT has had a positive impact on the recruitment of new staff to the healthcare unit at the YOI. The healthcare manager believes that since the unit became part of the PCT, health professionals have been more willing to consider working in the YOI. Applicants have been encouraged to apply for posts because these are supported by the PCT and the NHS and share the same governance arrangements, standards and expectations as posts in the wider community.

This has helped the unit to achieve its full complement of staff, after a period of considerable difficulty. The healthcare unit has gone from only four permanent staff at the time of the handover, with agency staff filling other posts, to 17 permanent appointments offering the full range of skills required for an establishment providing for male young offenders.

Shortages of staff, coupled with a lack of continuity in staffing had previously prevented the unit from widening its role within the prison. A full complement of permanent staff is now enabling the healthcare unit to extend its work to develop more health promotion activities.

In chapter four the importance of health staff having ready access to a reliable medical history for the young person was discussed. A key area of concern among interviewees was the difficulties associated with accessing medical records and information, particularly as accurate medical and social histories help in identifying need and effective treatment programmes. Where young people had a GP they could be contacted with the young person's consent, but transferring information could still take considerable time. Interviewees referred to the short time that many young people stay in custody and hence the importance of getting health information quickly: "here we have a chance to do something, but because of the lack of information and/or slowness in getting it, you don't get the work done straight away".

Improvements to how health information is accessed and shared would avoid having to ask young people several times for the same information and would reduce the number of assessments young people often experience when they enter custody. Suggestions for improving communication included holding information on a core file, having a health file for each young person that 'travelled' with them, and putting systems in place such as E-ASSET to support information sharing.

6.5 Limitations of the custodial environment

In considering how healthcare services can be improved to meet the needs of young people interviewees said that the limitations imposed by the custodial environment could not be overlooked. Certainly within the prison system, inspection reports highlight the specific problems that arise in trying to provide healthcare within the limitations of the operational issues that arise in custodial situations. For example, providing regular medication may be difficult when healthcare staff are only available or able to visit residential units at specific times of day. Clinical sessions may need to be shorter than in the community thus restricting the number of young people who can attend in one session. Where young people had to be taken to healthcare services rather than health professionals going to the residential units, there were sometimes problems with providing escorting officers to conduct young people to their appointments. At Huntercombe YOI, inspectors identified the additional problem of escorting officers waiting outside the clinician's room throughout the consultation, a practice that the inspectors reported to be intimidating for young people and to put medical confidentiality at risk.

The facilities that healthcare staff have available to them varied widely across the estate from modern, community like health suites to “grotty and shabby waiting areas and rooms”. One case study interviewee commented on the lack of suitable space to provide assessments and interventions as an inhibiting factor: “there is often no designated therapy space so we have to make do with dining rooms, meeting rooms etc., with frequent interruptions, difficulties of booking etc.” Another interviewee speculated that these differences in facilities were related to size, with larger establishments having more generous budgets and more facilities than smaller establishments. There was some evidence from the case studies of Wetherby and Huntercombe, both relatively large institutions, that the PCTs had been able to invest in improving facilities, both in the physical buildings and in equipment.

Limitations were often placed on the management of in-patient units when, for example, there was a need to restrict juvenile patients from associating with older patients. The high complexity of needs of some patients meant that the regime in in-patient units could be less comfortable and supportive than in the residential units, as for example at Brinsford YOI where patients had only one hot meal a day and had to eat in their cells. However, at Hindley YOI young people were able to spend more time out of their cells in the in-patient unit because the PCT had funded two additional discipline staff posts to support clinical staff. Nevertheless, where healthcare facilities were shared with an older population as in some YOIs, the need to limit access to protect juveniles from older prisoners remained.

6.6 Involving young people and their families

Interviewees emphasised the important role that young people could play in improving services, and described a number of different ways in which this could happen including peer support groups and peer mentoring. The *'Healthier Inside'* project materials were thought to be encouraging secure settings to engage more with young people.

As part of the wider approach to promoting children's health and well-being whilst in custody, the importance of maintaining family ties and finding ways in which families could be enlisted to provide support was stressed. The CHHT, one of our case studies, considered fostering early and ongoing links with a child's family to be an important area of their work. Whilst some YOIs have family contact officers who can facilitate contact between young people and their family, encouraging and facilitating family contact was, according to one interviewee, patchy across the estate and could be improved with benefits for children's emotional well-being.

7 Conclusions

The aim of this desk-based descriptive study was to review what is known about the health and well-being of children and young people in the secure estate (YOIs, STCs and SCHs) and how their health needs are met. The review brings together evidence from the literature, from interviews with key stakeholders and from recent inspection reports. We have tried to take account of the differences in weight between these three data sources, for example between interviewees' perceptions and empirical research, and to clearly identify the data source upon which conclusions are based.

In this concluding chapter, we re-visit the main research questions which the study set out to address. In attempting to answer these questions, the review identifies a number of recurring themes, most notably the lack of robust baseline data on the health of the children or on the effectiveness of interventions to address their health needs, and variability in the resources and health priorities within establishments.

This lack of evidence, particularly in evaluation of effectiveness of interventions may be partly because the number of children in custody has been historically lower throughout most of the twentieth century, with this population rising significantly in the past 15 years. In part too, the emphasis of the custodial setting is not health, so that the monitoring, rigorous data collection and analysis of health conditions of the children there has not been the principal priority of these establishments. There is also a disparity between the three groups of secure settings in how much is known of health needs and health provision, with more data from YOIs than from STCs and SCHs. This may be because YOIs provide more opportunity for data collection as more children are accommodated within them, and because a proportion of that population may stay within the secure estate for longer periods. It may also be attributable to the health care needs assessments undertaken in preparation for the transfer of funding to PCTs.

7.1 What do we know about the health and well-being of children and young people in secure settings?

There is relatively good research data on substance misuse and on mental health needs of children and young people in custody, but little comprehensive data on their physical health care needs. As discussed in chapter 2, we know that there is a significantly higher rate of mental health problems and of substance misuse among children in custody compared with the general population. There is little comparative data regarding physical health, but self-report data from surveys of young people in YOIs found respiratory complaints most common among both boys and girls, followed by musculo-skeletal complaints for boys and nervous system and skin complaints for girls.

This lack of comparative data makes it difficult to assess whether problems of physical health are higher among young people in the secure estate than among young people of a comparable age in the community. However, failure to address any long standing problems, such as asthma or tooth decay, may be more prevalent among young people in the secure estate because for some, interviewee and research data suggests that their chaotic home lives have reduced opportunities for routine health checks and treatments. The evidence is strong regarding the high levels of mental health illness, substance misuse and problems related to learning disability found within young people held in secure settings. These problems may have remained unrecognised or have been inadequately assessed and treated before custody and, according to some interviewees, may well have been related to the events which brought some young people into custody.

7.2 What do we know about the health status of particular sub groups?

The need for further research to improve understanding of the needs of different groups among the population of children and young people in custody such as females and black and minority ethnic groups has been highlighted (Chitsabesan et al., 2006). However, recent empirical studies have highlighted additional conditions or increased vulnerability within some groups. Examples include the complex needs of girls, with higher rates of substance misuse than boys, more sexual health issues and higher rates of self-harming. For minority ethnic offenders, higher rates of post traumatic stress disorder have been noted, and juvenile offenders from BME groups are more likely to report treatment by prison officers (use of force against them, perceived victimisation) that is likely to impact negatively on their emotional well-being. A further issue is the response of some sub groups to health interventions, with recent evidence suggesting gender and ethnic differences in attitudes to substance misuse programmes.

7.3 To what extent are services perceived to be meeting needs?

The review found that although services are improving to meet the needs of children in custody, there exists significant variability in the level and quality of services across the estate as evidenced from all sources of data: literature review, inspection reports and stakeholder interviews. In part, these differentials are starting to be addressed with the introduction of specific protocols, such as new assessment procedures to improve initial risk and health assessments, the YJB's Juvenile Substance Misuse Programme and the introduction of comprehensive care plans. However, inspection reports and interview data suggest that some of the variability is attributable to the training and expertise of the healthcare professionals in each establishment and the degree to which these can be supplemented, if necessary, with additional 'bought in' provision. Providing a prompt response to identified health needs is a significant issue in some establishments, if the length of a custodial stay is shorter than the waiting time for specific assessments and treatments. Where custody is shorter than the time required to complete treatment, then the importance of systems, such as a care programme or pathway approach, that link children into community healthcare at their release becomes an important factor in addressing their health need, particularly as some needs increase on discharge (Chitsabesan et al., 2006).

For those with ongoing health problems and with little previous or positive experience of seeking and receiving health advice and care, post custody may find them unwilling and unable to obtain the help they need in the community. Custody can provide a window for health education and promotion, and an opportunity to improve lifestyle choices and importantly, to teach children how to interact with healthcare professionals. There are examples of settings and programmes which are working to establish access to health and health care as an essential element of the framework for rehabilitation. However, if little continuity of support is provided to children who experience only a short period of custody, then the positive work undertaken in the secure setting may be wasted.

7.4 What initiatives are underway to bring about improvements in health in secure settings?

This report includes descriptions of a number of initiatives to improve health and well-being, drawn from inspection reports and case study interviews. Whilst some are universal initiatives, driven by a national campaign or target, others are locally based and *ad hoc*, such as the funding of a speech therapist or a programme of sexual health education. Evaluation of their effectiveness was often lacking. These initiatives have often developed because of the particular interest of a staff member with specific expertise or awareness of need, and whilst valued, they may lack sustainability if funding or staffing change. Within YOIs, according to interviewees, the move to PCT provision would appear to have helped widen the skill mix within healthcare teams and strengthened professional links with those

working in the community although it is too early to assess the full effect this move has had across the estate. Linking provision in secure settings with provision in the community is perceived to be lessening the differential between the two, with more opportunity for PCT initiatives within the community to be extended to the secure estate.

7.5 What is the evidence base for effective interventions for this group?

Overall, the evidence base for effective health interventions in secure settings is weak. In part, this is a consequence of the problems associated with evaluating effectiveness among a transient population which offers limited scope for assessing outcomes beyond the very short term, but also a lack of focus on undertaking rigorous studies, whether of process or outcome, in secure settings. In the past, much of the emphasis on 'outcomes' for children who have experienced custody has been in relation to re-offending behaviour post release. There has been little opportunity, or motivation, to maintain the contacts and data collection necessary to evaluate health outcomes. Additionally, to assess the effectiveness of health promotion interventions requires follow up over substantial periods since health messages to this age group may not produce any instant changes in lifestyle immediately on release. It would be possible, however, to look at short-term outcomes such as changes in clinic attendance for sexual health, increased take-up of tests for blood-borne viruses or improvements in health literacy, which might provide evidence of the effectiveness of those interventions.

Some guidance on effective approaches to providing health care to young people in secure settings may be obtained from reviews of evidence of 'what works' with young people in general. An overview of systematic reviews of interventions to promote young people's mental health, physical activity and healthy eating was undertaken by the Eppi-Centre at London University (Shepherd et al., 2002). This reports on barriers and facilitators in relation to factors in the community such as school, family and friends; so care obviously needs to be taken in transferring these messages to custodial rather than community settings. However, evidence-based approaches that have been shown to work with young people generally, and may be relevant to promoting health in secure settings, include:

- the use of behavioural techniques (such as modelling, role-play, feedback and reinforcement) to prevent depression, rather than simply providing information about how to recognise and deal with the symptoms;
- a focus on helping young people cope with stress and anxiety rather than an explicit focus on suicide prevention (some school-based suicide prevention programmes were found to increase the risk of harm);
- increasing the availability of healthy foods e.g. in the canteen. (Shepherd et al., 2002)

The way in which primary care is delivered matters to young people in general, and the same messages are likely to health care for young people in secure settings. These include confidentiality, the perceived attitudes of reception staff, privacy of the reception area, attitudes of the doctor, duration of the consultation and fear of embarrassment (Macdonald, 2006).

7.6 What is the potential for bringing about improvements?

In many ways, attempting to provide and improve the provision of health care to children in custody reflects many of the issues and problems that those tasks confront in the community. Indeed, the unevenness of services that this review highlights for children in secure settings reflects the situation of health services for vulnerable young people within the wider community. In part there is the additional problem of the stressfulness of the custodial setting, particularly for children on remand or for whom

there is uncertainty about where they will live following their release. More positively, custody may remove some from a risky and dangerous lifestyle and provide a short period in a more settled environment.

Key stakeholders and inspection reports highlighted the opportunities that custody offers to provide health care and to promote health and well-being in a group who may have traditionally been excluded from services or have higher levels of need than their counterparts in the wider community. At the same time, interviews and reports identified the need for holistic approaches. This echoes the conclusions of the 1997 thematic review of young prisoners by the Chief Inspector of Prisons, which stated that 'health promotion is a whole organisational matter affecting all departments, personnel and systems and is too all-embracing to be left solely to health care staff, however able' (HMCIP, 1997: 5.17). Embedding health care, health promotion and education within the ethos of secure establishments may require a significant change in attitudes for some staff, but a 'whole setting' approach whereby health specialists work with other staff such as prison officers, education staff and residential workers may be one way in which to improve how settings meet the health needs of young people in custody.

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Appendix A Overview of inspection reports

Table 1: How well are SCHs meeting the outcome 'Being Healthy'?

Home	Standard 10	Standard 12	Standard 13	Assessment
Atkinson	3	3	3	Good
Aycliffe	3	4	3	Good
Beechfield	2	2	3	Adequate
Lansdowne	3	2	2	Adequate
Leverton	3	3	4	Excellent
Lincolnshire	3	3	3	Good
Orchard Lodge	3	3	3	Good
Redbank	3	2	3	Good
St Catherines	3	4	3	Not rated
St Johns	3	2	3	Not rated
Swanick	3	3	2	Good
Vinney Green	3	3	3	Good

NB: This analysis is restricted to those SCHs inspected under the ECM outcome framework

Key:

Ratings: 4=Standard exceeded (commendable) 3=Standard Met (no shortfalls) 2=Standard almost met (minor shortfalls) 1 =Standard not met (major shortfalls)

Standard 10: Children enjoy healthy nutritious meals that meet their dietary needs. They have opportunities to plan, shop for and prepare meals.

Standard 12: Young people have a documented health care plan that identifies targets and how progress is to be reviewed by the secure unit

Standard 13: Children's health needs are met and their welfare is safeguarded by the home's policies and procedures for administering medicines and providing treatment

Table 2: Summary of CSCI inspection reports on healthcare in STCs

STC	Date inspected	Strengths	Areas for development	Recommendations
Hassockfield	Aug 2006	Nutritional and appetising food. Well integrated within establishment. Detailed healthcare plans etc forwarded to YOT on discharge. Good links with local HE team. Effective SASH procedures.	Needs distinct healthcare plan.	Healthcare department needs a separate and distinctive plan.
Medway	April 2006	Access to medical and nursing staff at all times Initial health assessment. Nurses responsible for HE and HP programme within academic timetable. SASH procedures good.	Health care passport for young people on discharge/transfer. More systematic approach to immunisation. Monitoring of access to dentist to ensure maximum use made of opportunity for remedial work.	None.
Oakhill	June 2006	Access to medical and nursing staff at all times. Evidence of progress in SMP in meeting health need.	Assessments variable in quality and content. Development of health care plans. Sharing of information held at centre with health staff. Developing more effective service for those with mental health problems. Review resourcing and support for those need therapeutic interventions. Considerable scope for development of integrated services. Not meeting special dietary needs. Need to develop integrated services. SASH procedures diffuse.	Review contribution of healthcare staff to HE programme. Review strategies for SASH management (priority). Standards set for assessments and plans which comply with CA and reflect models of good practice. Obtain agreement with PCT to share information held at centre with staff responsible for health and well-being (urgent).
Rainsbrook	Nov 2006	Improvement in meals. health well integrated within setting. Significant contribution to HE programme. Experienced and stable nursing force. Procedures for accessing specialist clinics.	None.	None.

Table 3: Summary of HMIP inspection reports on healthcare in YOIs

YOI	Date inspected	Strengths	Weaknesses	Overall healthcare assessment
Ashfield	Sept 2006	Good support from mental health team. Joint working between nursing staff, HCOs, LSAs. Eye tests.	No occupational therapist or daycare facilities. Pharmacy/medicines.	Good range of provision, well qualified and child-centred staff.
Brinsford	Feb 2005	Dental care.	Poor environment. Few nurse-led clinics. No appointment system. Limited inpatient regime. Pharmacy/medicines.	Improving but still scope for considerable development.
Castington	June 2006	Mental health services. Good relations with PCT.	Health promotion . Staff skill mix. OT and daycare facilities. Pharmacy/medicines.	Increasing range of facilities but inpatient unit not meeting needs.
Cookham Wood	Nov 2006	Health promotion. Informal drop-in service. Mental health counselling. Pre-release planning.	Staff shortages. Dental care.	Developing well.
Downview	June 2006	Relations between staff/patients. Health promotion.	Dental care. Mental health services. Lack of space.	Wide range of services but need for clinical psychologist and specialist juv. counselling.
Eastwood Park	March 2006*	Primary care services provided by 1 GP practice Good quality accomm. in new juvenile unit.	Poor communication between mental health (MH) inreach team and primary care team.	Significant progress in development of healthcare services.
Feltham	May 2005	Specialist mental health service.	Primary MH care. Provision for physical illness/ injuries . Staff skills. Dental service. Relationship with PCT. Pharmacy/medicines.	Healthcare services complex and a cause for serious concern. Focus on seriously mentally ill at expense of primary care.
Hindley	Aug 2006	Mental health. GP out of hours cover.	Staff skill mix. Health promotion (age appropriate). Pharmacy/medicines.	Continuing to improve.

Huntercombe	May 2006	Mental health in-reach team. Support from PCT.	Dental care (poor attendance). Health promotion. Information sharing between case worker and MH team. Pharmacy/medicines.	Improved significantly since 2005.
Lancaster Farms	Nov 2006	Health promotion. Smoking cessation & exercise programmes.	Use and staffing of inpatient unit. Pharmacy/medicines	Healthcare significantly better than average for juveniles.
New Hall	June 2006*	Active anti-bullying procedures.	SASH procedures (improved but scope for further development)	Healthcare improved since transfer to PCT.
Parc	Jan 2006	Dedicated young people's support nurse.	Strip searching on arrival.	Juveniles well catered for.
Stoke Heath	Jan 2005	Paediatric OT.	SASH procedures. Staffing levels. Health promotion.	Some aspects of primary care restricted due to poor staffing levels.
Thorn Cross	April 2005	Staff well qualified and motivated	PCT involvement in health needs assessment and planning. Sexual health services. Pharmacy/medicines.	Improved since 2002 especially for juveniles.
Warren Hill	Nov 2005	Specialist mental health support. Joint working with PCT.	Health promotion. Pharmacy/medicines.	Healthcare services in unsuitable temporary premises at time of inspection.
Werrington	Aug 2005	Joint working with PCT. Speech & language therapist. Health promotion and screening programme.	Staffing levels. Dental service. Pharmacy and mental health services ('being developed').	Change programme in place under new manager is leading to improvements.
Wetherby	July 2004	Mental health therapy-led service. Access to GP services. Staff skill mix (including learning difficulties). Range of nurse-led clinics.	Dental service. Poor access to CAMHS. Pharmacy/medicines.	Healthcare service 'safe and developing'.

*Unannounced follow-up visit. Most recent main inspection was undertaken before opening of juvenile unit.