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# Cheshire Youth Justice Services Health Needs Assessment – full technical report

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This full technical report provides findings from the in-depth Health Needs Assessment (HNA). This report sits alongside a short executive summary report, which details the key findings.

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# Contents

# 1. Introduction

Preventing children and young people's engagement in crime and violence are key public health issues at local and (inter)national level. In 2020/21, over 15,000 children (aged 10-17 years) were cautioned or sentenced across England and Wales (Youth Justice Board, 2021). The Youth Justice System (YJS) works to prevent offending and reoffending by children (aged 10-17 years), through providing a child-centred service, that is trauma-informed and focuses on assessing the needs of the child and supporting better outcomes for them. The YJS aims to work with children to help them to lead a life free from crime and reduce crime in the local area. The YJS is a statutory partnership that takes a holistic approach to working with children and young people. As such the partnership comprises several specialties such as police, probation, children's social care, health, education, and wider support services (e.g., substance misuse, mental health, housing). Local YJS partnerships/boards enable a place-based approach to supporting children. Across Cheshire, the YJS covers all four local authorities - Cheshire East, Cheshire West, Halton, and Warrington.

The Public Health Institute (PHI), Liverpool John Moores University (LJMU) were commissioned to undertake a Health Needs Assessment (HNA) for Cheshire Youth Justice Services (YJS). The HNA aimed to assess the health and wellbeing needs of the youth offender population across Cheshire East, Cheshire West, Halton, and Warrington. The key objectives included:

- Identify the health and wellbeing needs of children, and key factors that influence these needs.
- Map out the health service provision for children during (and prior to) their engagement with the YJS.
- Examine the impact of children's engagement with the YJS on their health and wellbeing (and wider outcomes relating to the social determinants of health).
- Identify key leverage points and mechanisms for supporting young people's health and wellbeing, prior to, during, and following YJS engagement (focusing on primary prevention and a life course approach).

# 2. Methodology

Health needs assessment (HNA) allows us to identify needs and assets for review, to help determine priorities to improve the health and wellbeing needs of young people involved in the criminal justice service. For the Cheshire YJS needs assessment, the HNA framework developed by the National Institute for Health and Care Excellence (NICE, 2005) was used. This incorporated the cyclical five step methodology:

1. Getting started and the establishment of a project steering group.
2. Identifying health priorities through a desktop analysis of data and through engagement with the target population.
3. Assessing a health priority for action through a comprehensive review of all relevant literature.
4. Planning for change through the development of a series of evidence-based recommendations.
5. Moving on and review through the delivery of this report to allow providers and commissioners to learn from the findings and action plan for change.

## 2.1 Literature review

A literature review was undertaken to provide context to the research and aide the interpretation of research findings and development of recommendations. Existing documentation, data and information produced or collated by partners that detail the policies, processes, and support mechanisms in place for children at risk of, and/or engaged with the YJS, and/or the health and wellbeing needs, were also collated and explored to inform this HNA.

## 2.2 Secondary data analysis

Data from YJS case records were extracted from the Cheshire YJS system to identify the health and wellbeing needs of children in contact with the YJS. A data sharing agreement was developed with strict data protection processes to adhere to GDPR legislation. The secondary data sample included the full client caseload and included data on:

- Demographics - age; gender; ethnicity; responsible local authority; education profile (including any exclusions, and special educational needs).
- Neurodiversity and other needs - neurodiverse conditions; speech and language needs; difficulties with social skills; having had a traumatic brain injury.
- Health needs - physical health needs; mental health needs.
- Health risk behaviours - drug, alcohol, and tobacco use.
- Vulnerability and victimisation - social care needs; child exploitation; missing from home incidents; relationships with family; adverse childhood experiences (ACEs); violence victimisation; risk of future adverse outcomes and victimisation.
- Offending and violence perpetration, including the risk of future offending.

Data was extracted from completed Assetplus assessments for statutory cases. The sample included 122 young people, of these 97.5% had a completed Assetplus assessment at the time of extraction (November 2022). Assetplus assessments are comprehensive, containing data on all the above factors in the form of both drop down boxes and free text spaces.

Data was extracted from completed DIVERT assessments for DIVERT cases. The sample included 92 young people, of these 89.1% (n=82) had a completed DIVERT assessment at the time of extraction (November 2022). DIVERT assessments are less comprehensive than Assetplus assessments,

containing data on most of the above in the form of free text spaces primarily, however, tick boxes were used in the same fashion as the Assetplus assessment for data on physical and mental health outcomes, and for educational, social, and speech and language needs. DIVERT assessments did not contain some of the variables that were included in the Assetplus assessments, such as information on qualifications, numeracy and literacy levels, AUDIT assessment for alcohol use, and the Youth Offending Group Reconviction Scale (YOGRS) score.[1] Some young people did not have an assessment completed as data extraction was performed on a live system, as such at the time of extraction the young person was awaiting assessment.

Available national and local data was used as a comparison between the YJS cohort and young people in the general population, highlighting where different needs were overrepresented in the youth justice sample. The values for different variables in the youth justice sample were compared to the expected values that would be present if the YJS data matched data nationally or locally. National and local data sources included for example, surveys of young people and government data sets.

Some variables are based on case notes (e.g., ACEs) and not formally assessed or measured so they represent the minimum prevalence (i.e., a child might have had ACEs but if this does not come up in discussions then it won't be recorded). This is even more relevant for DIVERT cases where the formal Assetplus assessment is not conducted.

## 2.3 Engagement with stakeholders

Semi-structured interviews and focus groups were carried out with 43 key stakeholders, this included 26 staff members involved in the management and delivery of services at Cheshire YJS, and 17 wider stakeholders involved in the commissioning and delivery of services across Cheshire that support young people and their families.

Engagement with YJS colleagues (n=5 focus groups, n=4 one-to-one interviews, and n=1 paired interview) included case managers, support workers (including both DIVERT and statutory), child and adolescent mental health services (CAMHS), speech and language therapies (SLT), and substance use workers. Wider partner engagement (n=1 focus group and n=16 one-to-one interviews) included a geographical spread across Cheshire (Cheshire East n=2, Cheshire West n=6, Halton n=2, Warrington n=2, and Cheshire wide n=5). Stakeholders included strategic and commissioning, managerial, and operational positions, which focussed on early help, mental health, sexual health, community safety partnership, substance use, health protection, education, youth services, and health services. Interviews and focus groups were carried out using MS Teams and explored views on the health and wellbeing needs of children engaged in the YJS and key risk and protective factors, processes for, and outcome/impacts of identifying and responding to children's health and wellbeing (and wider) needs (both prior to and during engagement with the YJS). Further exploration focused on the key leverage points and mechanisms for supporting children's health and wellbeing, prior to, during, and following YJS engagement (focusing on primary prevention and a life course approach); and areas for transformation (at policy and/or practice level) to enhance children's health and wellbeing and prevent offending and reoffending.

## 2.4 Engagement with young people and parents

The research team have engaged with seven individuals. This includes four young people and three adults, comprising of three paired interviews with a young person and parent, and a one-to-one interview with a young person. The young people who have engaged in the needs assessment so far

[1] The Youth Offending Group Reconviction Scale (YOGRS) uses an algorithm to estimate the probability that youth offenders will be re-sanctioned for any recordable offence within two years of sentence, or release if sentenced to custody. This provides a percentage estimate of re-sanctioning compared to a similar cohort of individuals.

have all been male and aged 10, 15, and two aged 17. They were engaged with Cheshire YJS through DIVERT (n=2) and statutory requirement (n=2), and represented Warrington, Chester, and Halton. Case managers and support workers supported the recruitment and facilitation of the interviews. Interviews were carried out using MS Teams or via telephone. Discussions explored views of the health needs of young people engaged in, or at-risk of engagement with the YJS, approaches to addressing and/or preventing these health needs (including prior to YJS engagement), and views on the YJS support and interventions, and the outcomes and impacts for health and wellbeing (and wider outcomes as relevant).

## 2.5 Stakeholder workshop

An online multi-agency workshop was held towards the end of the HNA to share key findings and facilitate a discussion around shaping the recommendations. The workshop was attended by 33 key partners from across the Cheshire footprint, including representation from Halton, Cheshire East, Cheshire West and Chester, and Warrington. A range of services and strategic and operational roles were represented including the YJS, Local Authority, Public Health, Safeguarding Children Partnership, Children's Services, Early Help, Integrated Care Partnership, CYPMH, CAMHS, and SEND service. The key findings and draft recommendations were presented to the group and discussions focused on:

- Do the key findings reflect your experiences?
- Are there further examples of best practice?
- What are the challenges?
- Are there any gaps within the HNA?
- Are the recommendations feasible?
- How do the findings/recommendations relate to the local children's strategies?

## 2.6 Analyses

All qualitative interviews were recorded, transcribed, and analysed using thematic analysis. Quantitative data was shared via a secure SharePoint and through secure access to the Cheshire YJS case management system and analysed using SPSS. All research activities were subject to ethical approval through the LJMU Research Ethic Committee (approval reference 22/PHI/011).

# 3. Findings

## 3.1. Assessing a health priority for action – literature review

### *3.1.1 Risk factors (and health and wellbeing risk factors) for young people becoming involved in criminal justice system/youth justice*

The Minimum Age of Criminal Reasonability (MACR) within England, Wales, and Northern Ireland is one of the youngest in the world, at 10 years old (Parliament, 2020). In Scotland, the MACR was recently raised to 12 years of age, with plans to rise again to 14 years (Scottish Government, 2019). Across the UK, there is a strong argument to increase the MACR to 14 years old, with research suggesting that 10 years is developmentally inappropriate. Additionally, it contravenes regulations introduced by the United Nations Convention on the Rights of the Child (UNCRC) (United Nations, 2008) and can have potentially harmful effects, as it had been found that early contact within the YJS can lead to negative cycles of criminality. Early contact with the YJS can lead to stigmatisation, discrimination and differential treatment from schools, peers, the police, and the judiciary, which increases the likelihood of future crime involvement and re-offences (Local Government Association, 2022; Youth Justice Board, 2021).

In the year ending March 2021 in England and Wales there were 38,518 offences committed by children aged 10-17 years old, with 15,751 children sentenced or cautioned. The number of children receiving a caution or sentence has decreased by 17% compared to the previous year, and 82% from 2011. The majority (87%) of those sentenced or cautioned were boys, 82% were aged 15-17 years old, and 70% were White. There were 8,800 first time entrants to the YJS, falling 20% from the previous year, and 81% from 2011. Of first-time entrants to the YJS, 85% were boys, and 76% were aged 15-17 years old, the reoffending rate fell by 3.6% to 34.2% (Youth Justice Board, 2022).

Historically, numerous risk factors have been identified as precursors for youth involvement within the YJS and these can be seen on an individual, family, peer, and social and community level (Murray and Farrington, 2010). Whilst risk factors are often used to detect (and may increase) the likelihood of offending (adopting delinquent behaviours) and reoffending, this does not make offending a certainty, with many youths with multiple risk factors never exhibiting offending behaviours (Shader, 2001, 2003; Fergusson et al., 2007). Risk factors are observed to have a cumulative and interactive effect (meaning that no single risk factor leads to offending behaviour). Those exposed to several risk factors across multiple domains, however, are often considered to be at an elevated risk of embarking on a life path leading to delinquent behaviour and involvement within the YJS[2] as well as other negative life outcomes (Stouthamer-Loeber, 2002; Wasserman, 2003; Loeber et al., 2008; Vanderbilt-Adriance and Shaw, 2008; PHE, 2019). Neurodiversity is one such example whereby risk factors may cluster, and therefore have a greater cumulative effect than for any risk factor alone. For example, those with neurodiversity, such as attention deficit hyperactivity disorder (ADHD) or autism spectrum disorder (ASD), are more likely to have ACEs and poorer health, wellbeing, and social outcomes that can track across the life course (Kirby, 2021; Gajwani and Minnis, 2022). Neurodiversity is one risk factor that is disproportionately present in young people in the criminal justice system (CJS), with one in six in the general population having some form of neurodiversity, whereas in the YJS, this is around one in three, with many of these yet to be identified (Kirby, 2021).

In recent years, there has been a growing recognition placed on the importance and effectiveness of adopting a risk-centred approach to youth's involvement in offending and, subsequently, the YJS. Such an approach shifts its attention towards understanding the personal traits, characteristics of the

[2] https://youth.gov/youth-topics/juvenile-justice/risk-and-protective-factors

environment, or conditions in the family, school, or communities that are linked to youth's likelihood of engaging in offending and other problem behaviours (Murray and Farrington, 2010). Crucial to such an approach is the consideration that risk factors are not always static, with their predictive value changing according to not just the context and setting in which they happen, but also when they occur in a young person's development (Vincent, Guy and Grisso, 2012; Ragnarsdottir et al., 2017).

### *Mental Health*

Research investigating the intersection between mental health concerns and offending has found that youth involved with the YJS have received at least one positive psychopathological diagnosis or meet the criteria for such diagnosis (Perron and Howard, 2008; Vaughn et al., 2008; Whitt, Garland and Howard, 2012; Schubert and Mulvey, 2014; Teplin et al., 2015). Various other studies have sought to investigate the prevalence of specific psychopathological and psychiatric disorders in youth involved with the YJS, with some revealing conduct disorders tend to be extremely prevalent amongst delinquent youths (Grisso, 2008; Yampolskaya and Chuang 2012; Barrett et al., 2014). For those with mental ill-health (diagnosed or undiagnosed), persistent cycles of antisocial behaviour, impulsivity, and extreme aggression associated with conduct disorders may be precursors to criminal offending (Lahey, Moffitt and Caspi, 2003; Farrington, 2009; Murray and Farrington, 2010).

Studies have sought to specifically outline how impulsiveness or an inability to regulate self-control can be one of the most crucial risk factors for YJS involvement. Meta-analyses carried out on the topic reveal that impulsiveness is strongly associated with youth offending due to quick decision-making processes whereby consequences are not carefully weighted before acting, making young people more likely to participate in high-risk behaviours including criminal offending (McLeod, 2018). Focus has also been shown towards ADHD, stating that its impulsive nature as well as hyperactivity are strongly associated with offending. In the UK, the most comprehensive study about the link between ADHD and youth offending was carried out in the Aberdeen Prison in Scotland (Young et al., 2009). The aim of the study was to investigate predictors of offending among prisoners from official records after controlling for age at first conviction and antisocial personality disorder (ASPD). This study observed that those prisoners who met the criteria for childhood ADHD[3] (whether fully symptomatic or in partial remission of their symptoms), had 'significantly more aggressive incidents and were more functionally impaired in terms of their behaviour than those participants who were symptom free, after controlling for ASPD [anti-social personality disorder]' (Young et al., 2009, p.265). This study also found that those with symptomatic ADHD were more likely to enter the justice system at an earlier age, have a greater number of convictions, and engage in substance use (drugs and alcohol) when compared to others (Young et al., 2009; Young, Wells and Gudjonsson, 2011). Additionally, other studies have raised their concerns about the link between conduct disorders, ADHD and the risk for offending, by finding that the comorbidity of both disorders is linked to chronic and repeat offending during adolescence (Brennan, Mednick and Mednick, 1993; Klinteberg et al., 1993; Young et al., 2010; Philipp-Weigmann et al., 2017).

Personality and psychological concerns, which are not considered as diagnosable in the DSM, have also been noted to impact a young person's risk of offending and involvement with the YJS. These include: low self-esteem (Dogar et al., 2010), social skill deficits (van der Put et al., 2012), cognitive-intellectual development (including poor academic achievement, language and communication deficits/impairments, special educational need (SEN) and Neurodivergence), substance use, runaway

[3] 198 prisoners completed Diagnostic Statistical Manual (DSM) IV screen for child and adult attention-deficit hyperactivity disorder (ADHD) symptoms and the Millon Clinical Multiaxial Inventory III for Axis I and Axis II disorders.
The DSM is the handbook used by healthcare professionals as the authoritative guide to the diagnosis of mental disorders. DSM contains descriptions, symptoms and other criteria for diagnosing mental disorders.

and missing cases (Shalev-Greene 2011), and perinatal risk factors such as pregnancy and birth complications and intrauterine exposure to tobacco, drugs, and alcohol (Conseur et al., 1997; LaPrairie et al., 2011; Oskarsson et al., 2022).

### *Adverse Childhood Experiences (ACEs)*

ACEs are also identified as a risk factor. Across a wide range of studies, child sexual abuse has been suggested as a precursor to criminal and deviant behaviours in adolescence. Studies conducted with young women and girls involved with the YJS have shown that a high proportion of such young women have reported having a history of sexual abuse or sexual violence (Baglivio et al., 2014). Other studies such as that of Senn, Carey and Coury-Doniger (2012) and Zahn et al. (2008) have sought to outline the association between child sexual assault and youth offending, whereby they reveal that sexual assault often leads to the externalisation of psychopathology and psychological disturbances, which leaves young individuals engaging with multiple negative behaviours and outcomes, including substance abuse, runaway episodes and erratic behaviour (Child Exploitation and Online Protection Centre, 2011). Ultimately, it is these very same behaviours that lead such young adolescents at high-risk of offending and becoming involved with the YJS (Cockbain and Bayley, 2012). Interestingly, it has also been suggested that sexual abuse confers differential risk for offending, with studies comparing multiple types of childhood trauma revealing that sexual abuse is one of the most salient predictors of high-risk behaviour and criminal offending in young people (Wareham and Dembo, 2007; Feiring, Miller-Johnson and Cleland, 2007; Begle et al., 2011).

### *Poverty*

There is now considerable literature on the strong and direct relationship between socio-economic status and offending, particularly in respect of childhood poverty and the effects it has on youth offending. Nonetheless, despite the wealth of evidence and studies on the matter, it becomes evident that the relationship between income, economic disadvantage, and youth criminality, though showing some clear patterns, may sometimes be far from straightforward, encompassing and affecting other factors in a youth's life as a result (Galloway and Skardhamar, 2009; Webster and Kingston, 2014; Kingston and Webster, 2015). Longitudinal studies that have followed children growing up in poverty highlight how the longer a young person lives in poverty, the more likely they are to engage in delinquent behaviour (Jarjoura et al., 2002; Fergusson, Swain-Campbell and Horwood, 2004). Low-socio-economic situations have been described as placing constraints on an individuals' life chances by reducing the availability and range of resources young individuals can make use of to fulfil their goals (Bjerk, 2007; Hay et al., 2007; Belfast City Council, 2017). Other studies add on this argument by outlining that when there are fewer financial and cultural resources at hand, children are left at a disadvantage, especially when compared to cohorts from affluent backgrounds (Kingston and Webster, 2015; Chan, 2019). Others also argue that youths from socio-economically deprived backgrounds may also be at higher risk of getting involved in delinquent acts because of the anger and frustration felt by perceived wider injustices against them and their financial position (Agnew, 1992).

Several studies have also factored in the family's role, arguing that family economic problems, such as parents or guardians on low-income or who are facing job disruptions, facing high debt and similar economic problems may, in turn, affect individual distress through the daily strains or pressures they create (Conger et al., 1994; Sampson and Laub, 1994; Davies et al., 2012). These studies argue that the link between family economic problems and youth offending is an indirect one, whereby, because of financial struggles, it becomes increasingly difficult for parents to provide the standard of living required and/or desired by their children (Galloway and Skardhamar, 2009). Studies argue that such situations may lead to conflict between family members and also, hostility and aggressive behaviour shared between the family (Raver et al., 2015). Hence, the parents' aversive behaviour towards their

children may increase the children's risk of conduct problems and offending because of coercive behaviour exhibited within the family. In some instances, the relationship between long-term poverty and youth offending has been described almost in terms of a self-fulfilling prophecy. Whereby children become involved with criminal behaviour due to a lack of resources and general opportunities, but that, in turn, a criminal record acts as a significant barrier to the young person's ability to move up the socio-economic ladder, even decades after an offence has taken place (Stacey, 2018).

Emerging research conducted across different regions globally has revealed a strong link between economically disadvantaged neighbourhoods or communities and higher youth offending rates (Sariaslan et al., 2013; Rotger and Galster, 2017). Several studies have specifically found that areas of high poverty concentration are characterised by lower levels of informal supervision and reprimanding of children and young people (Kim et al., 2018) as well as higher levels of population turnover which may undermine feelings of community attachment (Swart, Ismail and Seedat, 2022). Transferred to a British context, Wikström et al.'s (2012) study of youth crime in Peterborough has outlined that a lack of community attachment leads to a lack of willingness of residents to intervene and exercise informal social control, if needed for the common good of the neighbourhood, because of a lack of mutual trust in the community. The study found that young people's involvement in crime was linked to reductions in social cohesion and control coupled with residential instability and social disadvantage.

#### *Looked after children*

It is estimated that between 37% and 50% of children in custody have been in care at some point in their lives (Prison Reform Trust, 2016). A Health Needs Assessment report of young offenders involved in the YJS in Merseyside highlighted numerous 'wider' health needs, placing particular focus on suitable accommodation (among other things) (Lewis and Scott-Samuel, 2013). As part of widespread national efforts to curb these numbers, in 2018, the Department of Education launched a 'National Protocol on Reducing Unnecessary Criminalisation of Looked-after Children and Care Leavers' to ensure that cared for children and care leavers are deterred from the CJS wherever possible through alternative strategies. Aiming to follow and deliver such recommendations, Cheshire has developed its own multi-agency protocol that aspires to reduce the unnecessary criminalisation of Cheshire's cared for children and care leavers in an ethical and proportionate way while taking the needs of the area into context. Such aims are set out to be reached, by multi-agency partnerships that focus on restorative justice practices (Cheshire Youth Justice Services et al., 2021). The protocol names such practices as mediators that can achieve the appropriate balance between the rights, responsibilities and needs of the young person. Although in Cheshire, the rates of young individuals involved with the YJS who are in care or have a care leaver status equates to 20% (HM Inspectorate of Probation, 2021). The protocol recognises that children in care in the area are disproportionately disadvantaged when it comes to risks of offending and that their safety needs to be continuously monitored and promoted through recovery, resilience, and wellbeing practices.

### *3.1.2 Health and wellbeing needs for young people involved in criminal justice system/youth justice*

When exploring the health and wellbeing needs for young people involved in the CJS/YJS, many of the areas covered are similar to those explored within the risk factors for becoming involved in criminal activity. Namely, these needs include/focus upon; social, emotional, and mental health; education; neurodiversity; being a looked after child (LAC) under the care of the local authority; access to adequate and appropriate housing; criminal and sexual exploitation (being a victim of crime); substance use; access to support services (including GP etc.); and local community (Youth Justice Board, 2021). It has been recognised that early identification and intervention are key, as is effective

health screening and assessment of young people entering the YJS to ensure that they get the help and support that is needed (Lennox and Khan, 2012). Many of these needs require a multi-disciplinary approach to the provision of support. Some examples of these key health and wellbeing needs are provided below.

### *Criminal and sexual exploitation (being a victim of crime)*

It has been identified that often, children who are criminally exploited or are involved in county lines operations, are seen as criminals rather than victims, and that their significant levels of vulnerability and needs are not always being met, with a range of adverse outcomes arising due to county lines involvement (Public Health England, 2021). In 2019, the Home Office recognised the need to commit to tackling county lines and launched The County Lines Programme, expanding a National County Lines Co-ordination Centre, and shifting towards supporting victims, with 4,000 vulnerable young people receiving safeguarding support, and investing £145 million over three years (The Home Office, 2022). Under the Children's Act (HM Government, 2004), local authority councils have a responsibility to work with other key statutory partners (such as police and health) to safeguard and protect children, across all levels from strategic through to delivery level. Other key policies have been released since then, including the Tackling Child Sexual Abuse Strategy (HM Government, 2021) which set out the requirement for a multi-agency response to tackling child sexual exploitation and abuse, prioritising bringing offenders to justice and safeguarding and protecting children. With the government committing to the principle that safeguarding children is the responsibility of everybody, The Working Together to Safeguard Children plan (HM Government, 2018) sets out the responsibilities and requirements of each organisational body that works with children in their role for collaborating to safeguard children. It states that 'children who are encountered as offenders… are entitled to the same safeguards as any other child'.

### *Social, emotional, and mental health*

In the 2012 Chief Medical Officer Directorate report (Lennox and Khan, 2012), there was a focus on the health, wellbeing, and social needs of detained young people in England and Wales. Communication needs were identified as one of the largest areas of need for this group, with 60% having speech and language needs, and 43% of those on community orders had emotional and mental health needs. Those involved with the CJS were also seen to have suicide rates higher than the general population and be more likely to be looked after children (LAC). One in ten girls had been sexually exploited, 39% had been on the child protection register or experienced neglect or abuse, one in eight young people had experienced parental death, 40% had been homeless, and over half had themselves been victims of crime. This report stressed the importance of both individual and environmental protective factors to prevent youth offending, with youth offending teams further identified as a key area for developing protective factors and enhancing the prospects of young people who have committed offences. A further review study (Lennox, 2014) of those aged 10-17 who were detained in England and Wales concluded that in some instances, mental health needs developed because of detainment itself.

Lennox and Khan (2012) identified several protective factors in childhood are associated with prevention of offending and other adverse outcomes. These include individual characteristics (social skills, attachment to family, independence, problem solving skills), parents and parenting style (competent, stable care, healthy attachment, clear boundaries), family factors and life events (family harmony, positive and supportive relationships) and community factors (positive bond with peers, teachers, community members, access to positive opportunities, participation in community activities and safe neighbourhood).

### *3.1.3 Youth Justice Services*

Punitive and formal prosecutions of young people who have committed low-level offences or who have offended for the first time, can have devastating negative impacts on not just the prospects of such youths remaining secure and achieving positive outcomes, but also their prospects of achieving long-term ambitions by virtue of having to disclose formally recorded sanctions years after an offence has originally taken place (Jacobson and Kirby, 2012; Crown Prosecution Service, 2020). With such a strong evidence-base, there is a need to adopt strategies that aim not to create or foster the labelling of young people as simply 'criminals', but to divert them away from the CJS in the first place and to protect those who are already involved through early interventions. As such the Youth Justice Board for England and Wales in its 2021 plan promoted their Child First vision, aiming to better the outcomes of young people who have committed offences through a holistic approach. The Child First vision works constructively with young people using a strengths-based approach to improving outcomes and preventing reoffending (Youth Justice Board 2021).

**Box 1: Summary of the role of a YJS partnership**

Upon initial engagement the YJS assesses the needs of the child (using routine assessment tools) to identify factors relating to the person's offending behaviour, risk they may pose to others, and their vulnerability. The assessment aims to guide the implementation of interventions to support the child and reduce the likelihood of reoffending. Support will come directly from the YJS team (e.g., through regular meetings with a supervising officer) and where relevant wider support services as relevant to the child's needs. The YJS also manage court orders issued and support Restorative Justice processes aiming to help repair any harm resulting from the young person's behaviour, and/or enable the young person to give back to their community through reparation projects.

Statistical publications by the UK government highlight the likely impacts of the COVID-19 pandemic upon the YJS (Box 1). Figures in the year ending March 2021, demonstrate that 15,800 children (those aged 10-17) were cautioned or sentenced, this is a 17% reduction on the current year. Additionally, the number of first-time entrants to the YJS has fallen by 20% since the previous year to 8,800 individuals. These large decreases in arrests, cautions, and sentences are likely to be driven in part by the COVID-19 pandemic due to extended periods of lockdown restrictions, leading to many children being home-schooled for large parts of the year, as well as changes to people's behaviours, including a reduction in social contact (Youth Justice Board, 2022). However, it is important to note that in addition to the positive impacts the pandemic seems to have had upon proven and committed offences, there has already been a downward trend in many areas in recent years and therefore, reduction in youth offences is not solely attributed to the pandemic alone.

### *3.1.4 Context about the Cheshire area and needs*

Cheshire borders, and has exceptional transport and commuting links, to large cities such as Manchester, Liverpool, and Birmingham and their surrounding local authorities, making it a focal location for some of the county lines issues plaguing the UK (Kirwin, 2022; Merseyside Police, 2022). Despite county lines operations taking place in Cheshire, no figures have thus far been released on the involvement of young people in such acts specifically in the area. Nonetheless, in a report detailing an inspection on Cheshire YJS, it is outlined that the service often works with the vulnerabilities associated with specific offenses such as county lines involvement or exploitation from drugs dealers in the area (HM Inspectorate of Probation, 2021). From March 2020 to March 2021, Youth Justice Board Data published as part of the annual Youth Justice Statistics reveals that in Cheshire there have

been 438 proven offences committed by youths aged 10-17 and 242 cautions and sentences given to youths of the same age (Youth Justice resource hub UK, 2021).

### *Halton*[4]

In Halton, the proportion of children achieving a good level of development at age 2-2.5 years (84.1%; 2021/22) is significantly better than the England average (81.2%). Whilst achieving the expected levels of communications skills at this age is significantly worse compared to England (83.9% compared to 86.5%; 2021/22), and the expected level in personal social skills (91.3%; 2021/22) is not significantly different than the England averages (91.2%). The percentage (60.1%) of children are achieving a good level of development at the end of Reception year (age 5; significantly worse than the England average, 65.2% - 2021/22), and those who receive a free school meal (49.8%) are achieving a good level of development at the end of Reception (significantly worse compared to the England average, 49.1% - 2021/22). Pupil absence for children aged 5-15 years is 5.31%, significantly worse than the England average (4.62%; 2020/21), and the rate of first-time entrants to the YJS is not significantly different to the England average (107.0/100,000 aged 10-17 years compared to 146.9 respectively; 2021).

The rate of hospital admissions in children (aged 0-14 years) caused by unintentional and deliberate injuries is significantly worse than the England average (106.6/100,000 compared to 75.7; 2020/21). The percentage of LAC whose welfare is a cause for concern is significantly better than England average (5.6% compared to 36.8%; 2020/21).

In comparison to other Cheshire local authorities, Halton is ranked the most deprived area (Warrington Council, 2021). The percentage of children (all dependent children aged 0-19 years) in low-income families is significantly worse than the England average (19.4% compared to 17.0%; 2016). Although the Northwest of England has above national average incidents of children living in poverty, with 23.5% of children under 16 living in low-income households, Halton has the fourth highest rate of child poverty in England (Halton Borough Council, 2018a). Figures continue to outline that the two policing units at Halton, the Runcorn and Widnes police units, are more affected than other parts of Cheshire for serious crime, child safeguarding, and domestic related crime and offenses (Halton Borough Council, 2018b).

### *Cheshire East*[5]

The percentage of children achieving a good level of development at age 2-2.5 years (81.2%; 2021/22) is not significantly different to the England average (81.2%), whilst achieving the expected levels of communications skills at this age (89.8%; 2021/22) and also the expected level in personal social skills (95.3%; 2021/22) are significantly better than the England averages (86.5% and 91.2% respectively). Similarly, to West Cheshire, 66.1% of children in East Cheshire are achieving a good level of development at the end of Reception year (age 5; not significantly different to the England average, 65.2% - 2021/22). However, for those who receive a free school meal (44.0%) are achieving a good level of development at the end of Reception (significantly worse compared to the England average, 49.1% - 2021/22). Pupil absence for children aged 5-15 years is 4.29%, significantly better than the England average (4.62%; 2020/21) and the rate of first-time entrants to the YJS is significantly better than the England average (73.1/100,000 aged 10-17 years compared to 146.9 respectively; 2021).

[4] https://fingertips.phe.org.uk/static-reports/public-health-outcomes-framework/at-a-glance/E06000006.html?area-name=Halton

[5] https://fingertips.phe.org.uk/static-reports/public-health-outcomes-framework/at-a-glance/E06000049.html?area-name=Cheshire%20East

The rate of hospital admissions in children (aged 0-14 years) caused by unintentional and deliberate injuries are not significantly different to the England average (94.7/100,000 compared to 75.7; 2020/21). The percentage of LAC whose welfare is a cause for concern is not significantly different to the England average (39.1% compared to 36.8%; 2020/21). Female adolescent drinking has been identified as a concern in Cheshire East. The What About In Cheshire East in particular, highly patterned variations of child maltreatment (abuse/neglect) may be noted. Although in the year 2016/2017 there have been 4,663 children placed on Child in Need and Child Protection (CP) plans, Crewe, Macclesfield, and Congleton, some of the most deprived areas in Cheshire East, have the largest portion of children placed under such plans (Cheshire East Council, 2018).

Youth data shows that 76% of girls in Cheshire East have had an alcoholic drink in comparison to the England average of 65% or to 70.3% of boys who participated in Cheshire East. Figures on the number of youths who regularly drink alcohol have also shown that more young people aged 14-17 in Cheshire East drink alcohol once a week and binge drink compared to the rest of the Northwest as well as the rest of the country (Cheshire East Council, 2018).

The percentage of children (all dependent children aged 0-19 years) in low-income families is significantly better than the England average (10.0% compared to 17.0%; 2016). Ellesmere Port and parts of Chester, Crewe, and Macclesfield, some of the most deprived areas in East and West Cheshire, were outlined as the areas where children and young people are likely to have a higher occurrence of mental health needs. In these areas the occurrence of mental illness in children is up to 50% higher than in other parts of Cheshire. Similarly, the highest referral rates to CAMHS were reportedly from Ellesmere Port, Macclesfield, Poynton, and parts of Crewe, Chester, Winsford, and Wilmslow (Cheshire East Council, 2016). Cheshire East has experienced a 33% rise in the number of Cared for Children since 2015, with the rise not owing itself to general population increases (Cheshire East Council, 2019).

### *Cheshire West and Chester*[6]

Exploring the wider determinants of health, the percentage of children achieving a good level of development at age 2-2.5 years (84.4%; 2021/22), achieving the expected levels of communications skills at this age (89.0%; 2021/22) and the expected level in personal social skills (93.7%; 2021/22) are all significantly better than the England averages (81.2%, 86.5%, 91.2% respectively). At the end of Reception year, 67.1% of children are achieving a good level of development (age 5; significantly better than the England average, 65.2% - 2021/22). However, for those who receive a free school meal, only 43.3% are achieving a good level of development at the end of Reception (significantly worse compared to the England average, 49.1% - 2021/22). Pupil absence for children aged 5-15 years is 4.62% (not significantly different to the England average; 4.62%; 2020/21) and the rate of first-time entrants to the YJS is significantly better than the England average (104.0/100,000 aged 10-17 years compared to 146.9 respectively; 2021).

The rate of hospital admissions in children (aged 0-14 years) caused by unintentional and deliberate injuries are significantly higher than the England average (94.7/100,000 compared to 75.7; 2020/21). The percentage of LAC whose welfare is a cause for concern is not significantly different to the England average (36.1% compared to 36.8%; 2020/21).

The percentage of children (all dependent children aged 0-19 years) in low-income families is significantly better than the England average (12.6% compared to 17.0%; 2016). Indices of multiple deprivation indicate that there are four areas within Cheshire West and Chester that are ranked in the

[6] https://fingertips.phe.org.uk/static-reports/public-health-outcomes-framework/at-a-glance/E06000050.html?area-name=Cheshire%20West%20and%20Chester

5% most deprived areas in England, 16 areas ranked in the 10%, and 34 areas ranked in the 20%. Health deprivation and disability is the type of deprivation that is most prevalent within Cheshire West and Chester, with 51 areas, averaging a total of 78,465 residents all together, being marked as health deprived (Cheshire West and Cheshire Council, 2020a). Cheshire West and Chester are also marked by high levels of income disparity, with the least deprived neighbourhood estimated to have just 1.5% of its population income-deprived, as opposed to the most deprived neighbourhood, of which 41% of people are considered to be going through income deprivation (Office for the National Statistics, 2021).

*Warrington*[7]

In Warrington the proportion of children achieving a good level of development at age 2-2.5 years (87.2%; 2021/22) is significantly better than the England average (81.2%), whilst achieving the expected levels of communications skills at this age (87.5%; 2021/22) and also the expected level in personal social skills (92.1%; 2021/22) are not significantly different than the England averages (86.5% and 91.2% respectively). The percentage of children (69.5%) are achieving a good level of development at the end of Reception year (age 5; significantly better than the England average, 65.2% - 2021/22), and those who receive a free school meal (54.5%) are achieving a good level of development at the end of Reception. This is significantly better compared to the England average, (49.1% - 2021/22). Pupil absence for children aged 5-15 years is 4.07%, significantly better than the England average (4.62%; 2020/21), and the rate of first-time entrants to the YJS is not significantly different to the England average (115.5/100,000 aged 10-17 years compared to 146.9 respectively; 2021).

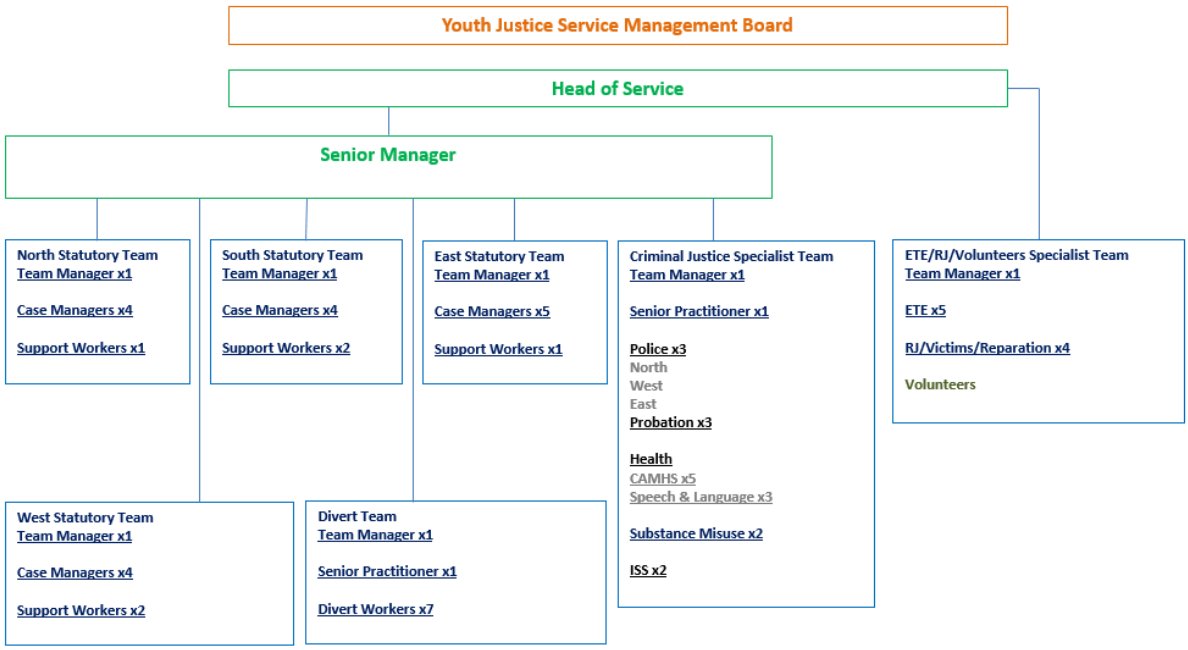
The rate of hospital admissions in children (aged 0-14 years) caused by unintentional and deliberate injuries is significantly worse than the England average (124.4/100,000 compared to 75.7; 2020/21). The percentage of LAC whose welfare is a cause for concern is not significantly different to the England average (40.3% compared to 36.8%; 2020/21). The percentage of children (all dependent children aged 0-19 years) in low-income families is significantly better than the England average (11.5% compared to 17.0%; 2016).

## 3.2 Cheshire Youth Justice Services operational model

Information in this section is derived from documentation and engagement with stakeholders. The YJS is a multi-disciplinary team that is made up of the Police, education workers, CAMHS (CAMHS practice nurses and practitioners employed by Cheshire and Wirral Partnership NHS Foundation Trust (CWP) but fully seconded to YJS), speech and language therapy (SLT) (this is a new element), and probation workers (transition to YJS to probation if a court order). Each young person will have a support worker and a case manager (some of whom are qualified social workers). They provide holistic support around the young person and their family. It was seen to be very important that the team around the family (whether statutory or diversionary) remains as consistent as possible so that the young person and their family can build up relationships of trust. It was also acknowledged that young people do not like change, with an example being given around trying to keep the team of support the same even where a young person may move out of area and where cases are complex. The organisational structure of the Cheshire YJS is shown in Figure 1.

[7] https://fingertips.phe.org.uk/static-reports/public-health-outcomes-framework/at-a-glance/E06000007.html?area-name=Warrington

**Figure 1: The organisational structure of Cheshire Youth Justice Services**[8]




Those staff from the YJS who took part in interviews and focus groups spoke about the importance of identifying individual needs of children and young people in their care. It was considered that staff are good at asking the right questions and from there delivering relevant and appropriate interventions to support the young person, whilst also linking into other support where needed such as social workers, substance use services (e.g., CGL), health (e.g., children's nurse team), prison etc.

Staff felt that they were well supported by their management team and spoke about using a trauma-informed approach to the support they provide. They spoke about developing a programme of interventions to meet the needs of the young people they are working with. These focused around relationship-based models and outreach (incl. home visits) and highlighted the importance of developing relationships as a base for engaging young people and their families. Staff are guided by what is available in each area in terms of the provision of support, but also commented that they plug the gaps where services are not available. They felt that generally the YJS are proactive and forward thinking, so will try and fill any gaps themselves. Creativity was seen to be vital as was being able to constantly evolve to meet needs, looking at what works well and what can be developed. Participants from one focus group however, commented that Children's Services and others use the YJS as a 'fixing service'. When looking at how the YJS are resourced, it was commented that monies come from different sources in different areas and that this impacts upon the support available. Within the YJS, there are two main routes for referral. This includes a statutory and diversionary route.

### *3.2.1 Statutory*

Following sentencing, if a young person is given a statutory (mandated) order, they will work with the YJS as part of this order for the length of time set out as part of the sentence. The YJS is pan Cheshire, so children and young people who are currently in, or may be placed into the care of Cheshire East, Cheshire West and Chester, Halton, or Warrington Local Authorities. The YJS support children and young people from arrest, being charged with an offence, and possibly going on remand and being

[8] Organisation structure November 2023. Key: ETE: Education, Training and Employment; RJ: Restorative Justice; ISS: Intensive Supervision and Surveillance; CAMHS: Child and Adolescent Mental Health Services

convicted and sentenced through to release. Whilst working with the YJS, a young person will be assigned to a case manager and if necessary, also a support worker (e.g., if subject to intensive supervision and surveillance court order). Where identified through assessment, they may also work with specialist staff with a mental health, substance use, or speech and language therapy role as part of the health offer at Cheshire YJS. The Joint Procedures and Practice Guidance for Children in Care and the Criminal Justice System[9] follow the service needed for children and young people during each stage of their involvement with the CJS. Some examples are provided below:

- For those children and young people aged under the age of 18 who are under the care of the local authority and are arrested, the local authority social care team with responsibility for the care of the child should ensure that the child has the support of an appropriate adult as well as access to appropriate legal support. Where a child or young person has been arrested and/or charged, it is good practice to consider reviewing the child's Care Plan or Pathway Plan to ensure that appropriate measures are in place to address the causes of offending. That review includes input from YJS who can advise on prevention, risk reduction, and offender management programmes.
- Where a child or young person who is in care is charged with an offence the social worker or another representative will attend court with them and if already allocated, the YJS worker works with the relevant Children's Social Care (CSC) to identify suitable bail support programmes so that all viable alternatives to custody are explored.
- Where a child in care is convicted of an offence, the YJS case manager will liaise with the local authority social worker and the YJS complete the AssetPlus (YJS assessment tool) with the young person.[10] The YJS are also responsible for preparing the young person's Pre-Sentence Report (PSR), with the YJS case manager consulting with the child's social worker over its content and the recommendations to the court. Within this report is also detail around the interventions and support that would be made available to the child or young person if they received a community disposal order. The role of the YJS case manager is also to prepare the child or young person and his/her family (where they are not estranged) by explaining what will happen and how the child will be supported and supervised during and after the period of custody.
- Where there are any safeguarding concerns whilst a child or young person is being detained (reported through the Assessment, Care in Custody, and Teamwork [ACCT] care-planning system), the YJS will risk assess the situation and where necessary request a YJS High Risk Review Meeting – this is also attended by a member of the Local Area Safeguarding Partnership.
- YJS case managers develop remand or sentence plans that plan the activities the child or young person will engage in during their time in custody and, for sentenced children, on release into the community. The primary aim of this is to reduce the risk of offending.
- The YJS work with housing and social care to ensure that all young people who have been remanded or served a custodial sentence are provided with suitable accommodation upon their release.

### *3.2.2 Diversionary*

The diversionary route promotes the use of community resolutions to avoid formally recorded sanctions for low-level offences and first time (low-level) offences for first time entrants to the CJS.

[9] https://www.proceduresonline.com/halton/cs/user_controlled_lcms_area/uploaded_files/PAN%20Cheshire%20Children%20in%20Care%20in%20the%20Criminal%20Justice%20System.%20Final.pdf

[10] This is an assessment and planning interventions framework developed by the Youth Justice Board (YJB) and aims to provide a holistic end-to-end assessment and intervention plan, allowing one record to follow a child or young person throughout their time in the youth justice system - https://www.gov.uk/government/publications/assetplus-assessment-and-planning-in-the-youth-justice-system/assetplus-assessment-and-planning-in-the-youth-justice-system

The DIVERT team at Cheshire YJS manage out of court disposals. It is a way of supporting children and their families who have committed low-level crimes or low-level police incidents. It is aimed at not criminalising children and young people.

As part of this diversionary function, following arrest and referral, Cheshire YJS provide an additional health offer of triage, assessment, and health screening for mental health and communication difficulties. This model provides an opportunity to identify any unmet needs for the young person and identify if these unmet needs have or could contribute to the risk of offending (Dooks, 2022). The case is then screened by a senior in the team and if it is appropriate, the case will be distributed to one of the DIVERT team support workers. Once the referral has been accepted, the allocated worker will contact the family. Whilst this is happening, they will complete a children's services check – if the child or young person has a social worker they will contact them and see if they are open to early help, which will support the assessment and allow the sharing of knowledge. Staff spoke about families being given three chances to complete the initial appointment and get signed up to the scheme. If they do not engage, however, their case will be sent back the Police where they then may end up having to appear in court. The DIVERT offer is voluntary and provides 12 weeks of support working with a DIVERT support worker, and where identified, specialist health staff as highlighted above for those on a statutory order. For both statutory and DIVERT cases, the YJS works alongside local early help and prevention services across Cheshire.

### *3.2.3 Health offer within Cheshire Youth Justice Services*

A health assessment is offered to all children to explore their physical, emotional, and mental health. This assessment is open to all children and young people who are in touch with the YJS and is used to identify support needs and if any interventions are needed. As part of the health offer all young people who come through the YJS can access an in-house assessment and support for young people (statutory and DIVERT) with identified and previously unidentified needs relating to their physical, emotional, and mental health as well as SLT. In addition to case managers and support workers, Cheshire YJS has specialist staff from CAMHS, substance use services, and SLT with representation in each of the four areas. One example was provided of the holistic support provided by SLT where they provide support within the young person's school as well as engaging with the other professionals who are working with the young person. A second example was provided relating to accessing substance use services. One member of staff spoke about working across the four areas of Cheshire from 'low-level community resolutions' to divert children and young people away from the CJS and courts. This would involve a maximum three-month intervention plan that would be linked to their incident or offence and identified needs; after which time they young person's care would be transferred over to an external voluntary provider.

Cheshire YJS work alongside a range of partners, both inside the YJS model and with external partners including children's services and services within the voluntary sector. Further details around areas of best practice and areas for transformation are provided within section 3.4, which explores the experiences of YJS staff, wider stakeholders, and young people and their parents. The DIVERT team are qualified to Level 2 Substance Misuse Support and can provide support around this. However, it is important to note, that anything clinical will be reported to the allocated specialist substance use worker, and those requiring longer-term support beyond their engagement with YJS will be referred to specialist services with the community (via local authority and voluntary services).

In terms of identifying and responding to health and wellbeing needs, there are several screening tools which are utilised. These have specific focuses upon SLN, communication, and physical and mental health. Those under the care of the DIVERT team are also asked whether they have a GP and dentist and are supported to register/access/attend these services, as well as other short-term, simple

signposting (e.g., sexual health [STIs and contraception], sleep hygiene, anxiety and stress, anger). They also have access to the youth offending team (YOT) specialist health team.

It was acknowledged that for some young people there is a long-term therapeutic partnership for the duration of the order that may involve the young person undertaking therapy (e.g., CBT, EMDR for PTSD). This support may also continue after the order is complete if there is still work to be completed with the young person, or they will be referred to mainstream CAMHS for further support. It was highlighted that it can take time after initial contact with YJS CAMHS for a young person to offer up details about their trauma and that for most young people they will only be able to access three or four sessions whilst they are on DIVERT. The DIVERT team, however, work with other professionals to risk assess the young person and whether they carry risk (to themselves or others) and need further intervention (e.g., for self-harm, suicidal ideation/suicide attempts) etc. As well as case workers, the DIVERT team is comprised of a team of support workers who support the case managers in several vital ways. That includes delivering interventions, referring children and young people into other services, court attendance (there is a duty rota during the week and at the weekends), referral order panel reports, and reparation in the community (e.g., gardening projects); all elements are risk assessed.

Some of those who took part in research spoke about being Intensive Supervision and Surveillance (ISS) officers who work at the higher end of youth offending. This involves dedicated work with young people for 25 hours per week, which will include 15 hours of education where they will take them to/pick them up from e.g., Pupil Referral Unit (PRU), as well as sign off with the Police at Police stations. Their role also involves elements of support worker role tasks. Staff also spoke about undertaking training in aspects outside of their areas of expertise and that this helped them to gain a greater, holistic understanding and awareness of the needs of the young people they are supporting.

## 3.3 Identifying health priorities – secondary data analysis

### *3.3.1 Sociodemographics (statutory cases)*

The statutory sample included 122 young people, of these 97.5% (n=119) had a completed Assetplus assessment. The sociodemographics of the young people are described in Table 1.

The Assetplus assessment includes information about a young person's current and past living conditions and family history, education, social care needs, health and wellbeing needs, substance use, offending history, and future offending and adverse outcome assessments. It does not always include when young people have been diagnosed or assessed for conditions, or if there are concerns about the young person having a condition but being undiagnosed.

- Most young people were male (90.2%).
- Two thirds (67.2%) were aged 15-17 years, 13.9% were aged 10-14 and 18.9% were 18.
- The majority were White British (88.4%).
- There was a relatively even split between local authorities. Cheshire East had the largest proportion of cases (28.8%) and Warrington the least (20.3%).
- Two thirds (65.5%) lived at home.
- Over half (56.3%) lived with their parents.
- One in twenty (5.0%) were a parent or expecting a child.

**Table 1: Sociodemographics (statutory cases)**

| Demographics | % (n) |
|---|---|
| **Gender** | |
| Male | 90.2 (110) |
| Female | 6.6 (8) |
| Other | 3.3 (4) |
| **Age group (years)** | |
| 10-14 | 13.9 (17) |
| 15-17 | 67.2 (82) |
| 18 | 18.9 (23) |
| **Ethnicity** | |
| White British | 88.4 (107) |
| Other ethnicity | 11.6 (14) |
| **Responsible Local Authority** | |
| Cheshire East | 28.8 (34) |
| Cheshire West and Chester | 24.6 (29) |
| Halton | 26.3 (31) |
| Warrington | 20.3 (24) |
| **Current accommodation** | |
| At home | 65.5 (78) |
| Residential unit/supported | 24.4 (29) |
| Foster care placement | 2.5 (3) |
| Detention facility | 5.9 (7) |
| Other | 1.7 (2) |
| **Living arrangements** | |
| Living with parents | 56.3 (67) |
| Not living with parents | 43.7 (52) |
| **Parental status** | |
| Has/expecting child | 5.0 (6) |
| No child | 95.0 (113) |

### *3.3.2 Education, Employment, and Training (statutory cases)*

#### *Not in Education, Employment and Training (NEET)*

- 35.6% were not in any form of educational, employment or training (NEET). Of young people aged 16-17 years old, 40.6% were NEET, which is higher than the national prevalence of 2.8% for the same age group.[11] Furthermore, prevalence of NEET 16-17 year-olds was higher across all local authorities amongst statutory cases compared to the local general population of 16-17 year-olds. The prevalence of NEET amongst all statutory cases differed by local authority with the lowest prevalence in Cheshire West and Chester (24.1%) and highest amongst cases in Warrington (45.8%; Figure 2).
- There were significant associations between NEET and age (10-14 years old, 12.5%; 15-18 years old, 39.2%; $p<0.05$), not living with parents (50.0%; living with parents, 24.2%; $p<0.01$), and not having qualifications (51.1%; qualifications, 26.9%; $p<0.01$).
- There were no significant associations between being NEET and health conditions, needs, or neurodiversity.

**Figure 2: Prevalence of NEET amongst all statutory cases, statutory cases aged 16-17 years, and local general population aged 16-17 years, by local authority**


#### *Educational attainment*

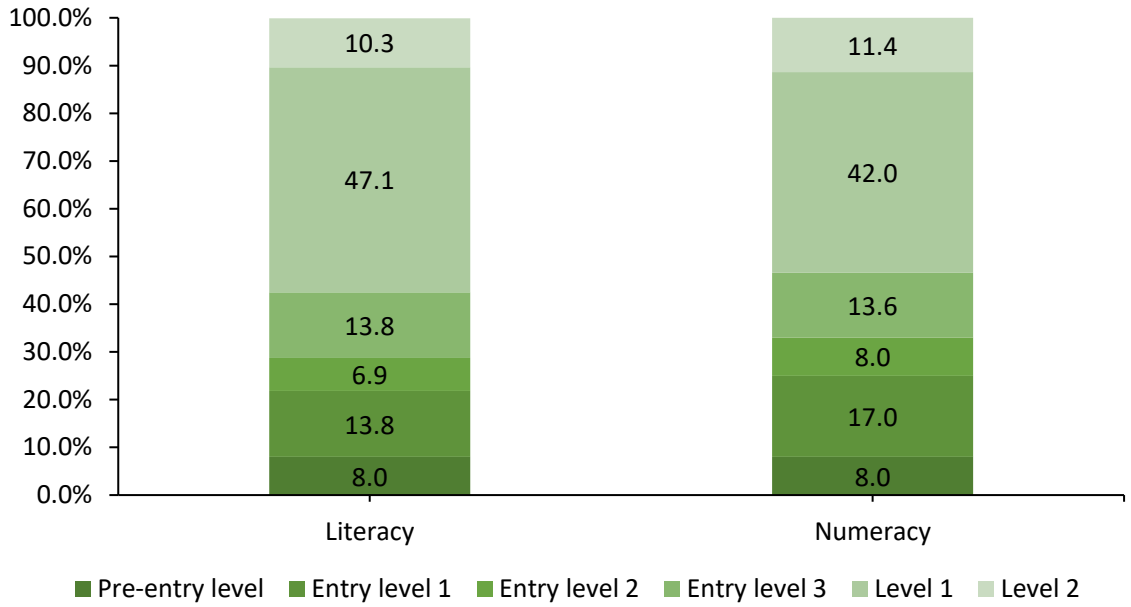
- One quarter (24.6%) of young people were in mainstream school, 21.2% were in alternative education provision, and 2.5% were engaged in both education and some form of employment or training.
- Overall, almost six in ten (58.3%) young people had, or were currently working towards, some form of qualification.
- The average weekly hours engaged in education was 17.6.[12].
- Of young people in education, half (50.0%) had either participation or attendance issues.

[11] National and local prevalence statistics for young people aged 16-17 who were not in education, employment or training NEET were obtained from routinely collected data by the National Client Caseload Information System https://www.gov.uk/government/publications/neet-and-participation-local-authority-figures

[12] This includes only individuals in education, those involved in both employment and education were included in the employment and training section.

- Of young people in education, there were no significant associations between young people having participation or attendance issues and health conditions, needs, or neurodiversity.
- Of young people in education, a higher proportion of those with no qualifications had participation or attendance issues (77.8%) than those with qualifications (36.4%; p<0.01).
- Levels of basic literacy and numeracy ranged from pre-entry level to level 2.[13] Over half of individuals had level 1 or above ability in literacy (57.4%) and numeracy (53.4%; Figure 3).

**Figure 3: Prevalence of levels of literacy and numeracy amongst statutory cases**




*School exclusion*

- Half (50.4%) of individuals had experienced some form of school exclusion. This is significantly higher than the 4.3% national prevalence of school exclusions[14] (4.25% suspensions; 0.05% permanent exclusions; p<0.001).
- There were no significant associations between exclusions and sociodemographics.
- A higher proportion of those with speech and language difficulties had ever been excluded (58.9%), compared to those without speech and language difficulties (37.0%; p<0.05).

*Special educational need*

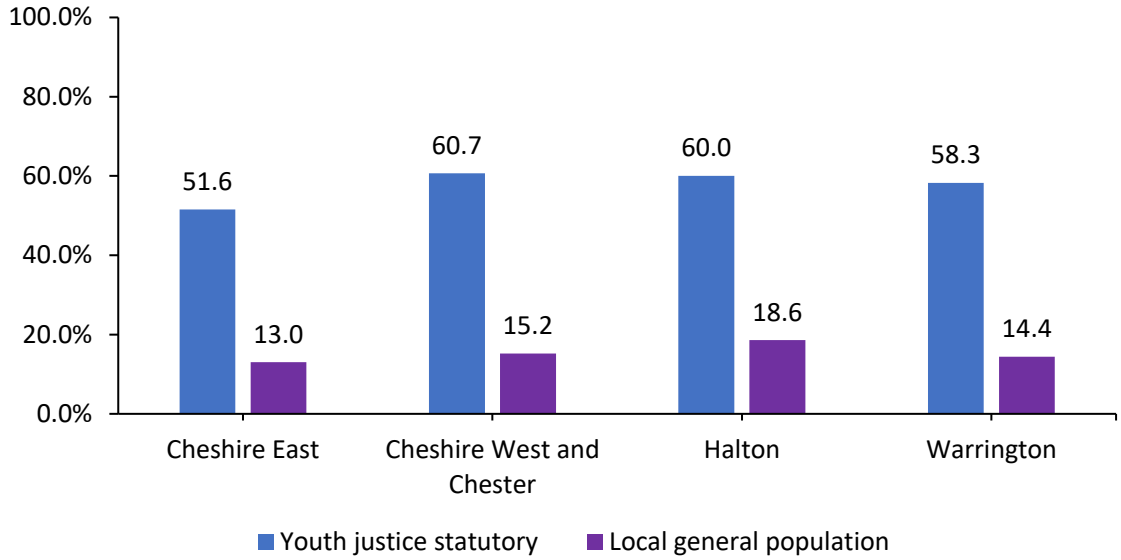
- Approximately seven in ten (67.8%) had some form of SEN.
- There were significant associations between SEN and: not living at home (80.0%; living at home, 61.5%; p<0.05); not living with parents (78.4%; living with parents 59.7%; p<0.05), and having no qualifications (89.4%; qualifications, 52.2%; p<0.001).

[13] Levels of basic numeracy and literacy range from entry level 1 – denoting that an individual understands information given by numbers, and the literacy level of a 5-7 year-old; up to level 2 – denoting that an individual can understand mathematical information used for different purposes and can independently select and compare relevant information from a variety of graphic, numerical, and written forms, and the literacy level of GCSE A*-C grade. Individuals who do not meet entry level 1 standards are described as pre-entry level. https://www.nationalnumeracy.org.uk/what-numeracy/what-do-adult-numeracy-levels-mean; https://literacytrust.org.uk/parents-and-families/adult-literacy/what-do-adult-literacy-levels-mean/

[14] Permanent exclusions and suspensions in England. Data collected by the school census. https://explore-education-statistics.service.gov.uk/find-statistics/permanent-and-fixed-period-exclusions-in-england

- Of those with SEN, 70.0% had speech and language needs (no SEN, 42.1%; p<0.01); 75.0% had social difficulties (no SEN, 23.7%; p<0.001); and 58.8% had neurodiversity (no SEN, 21.1%; p<0.001).
- Of those with SEN, this had been identified or diagnosed for the majority (82.3%).
- Overall, 56.0% had an identified SEN. This is significantly higher than the 16.5% national prevalence of identified SEN[15] (p<0.001). Further, across all local authorities the prevalence of SEN was higher amongst clients compared to the local general population of young people (Figure 4).

**Figure 4: Prevalence of SEN amongst statutory cases and general population, by local authority**




*Employment and training*

- Over one in ten (15.3%) young people were in some form of employment or training, and a further 2.5% were engaged in both education and some form of employment or training.
- The average weekly hours engaged in employment or training was 24.3.[16]
- Of young people in employment, over half (54.5%) of individuals had either participation or attendance issues.
- Of young people in employment, a higher proportion of those with no qualifications (100.0%) had participation or attendance issues compared to those with qualifications (37.5%; p<0.05).
- Of young people in employment, there were significant associations between having participation or attendance issues and: having speech and language difficulties (75.0%; no speech and language difficulties, 30.0%; p<0.05); having social difficulties (75.0%; no social difficulties, 30.0%); and SEN (75.0%; no SEN, 30.0%; p<0.05).

### *3.3.3 Neurodiversity and other needs (statutory cases)*

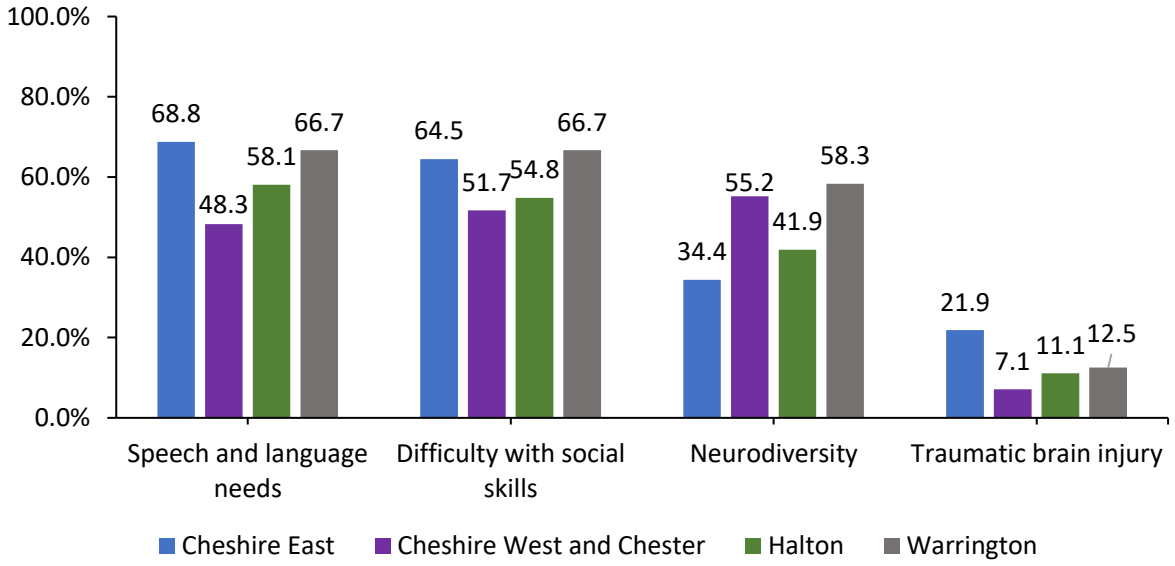
- 46.2% of young people had a formal diagnosis of neurodiversity, with a further 13.4% awaiting a referral or diagnosis.
- Six in ten (61.3%) young people had some type of speech and language needs.
- Just over one in ten (13.2%) young people had a traumatic brain injury.

[15] Special educational needs and disability: an analysis and summary of data sources. Department for Education. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1082518/Special_educational_needs_publication_June_2022.pdf

[16] This includes those involved in both employment and education.

- Six in ten (58.5%) young people were assessed as having social skills difficulties.
- Six in ten (62.3%) individuals who had social skill difficulties also had a formal diagnosis of neurodiversity (most commonly multiple neurodiversities or ADHD), while a further 15.9% were awaiting a diagnosis or referral.
- There were no significant associations between speech and language needs, having a diagnosis that would impact social skills (such as ASD), neurodiversity, or traumatic brain injury, and sociodemographics.
- There were significant associations between social skills difficulties and not living with parents (70.6%; living with parents, 49.3%; $p<0.05$), and no qualifications (72.3%; qualifications 47.8%; $p<0.01$).
- Prevalence of neurodiversity and other needs amongst young people differed across local authorities, with Warrington in general having higher levels of need across the four types (Figure 5).

**Figure 5: Prevalence of neurodiversity and other needs amongst statutory cases, by local authority**




- Of those with neurodiversity, 78.2% also had speech and language needs (no neurodiversity, 46.9%; $p<0.001$); 78.2% had social difficulties (no neurodiversity, 41.3%; $p<0.001$); 85.5% had SEN (no neurodiversity, 52.4%; $p<0.001$); and 13.0% had a traumatic brain injury (no neurodiversity, 13.3%; NS).
- Of those with speech and language needs, 80.6% had social difficulties (no speech and language needs, 23.9%; $p<0.001$); 77.8% had SEN (no speech and language needs, 52.2%; $p<0.01$); 58.9% had neurodiversity (no speech and language needs, 26.1%; $p<0.001$); and 21.4% had a traumatic brain injury (no speech and language needs, 0.0%; $p<0.001$).
- Of those with social difficulties, 84.1% had speech and language needs (no social difficulties, 28.6%; $p<0.001$); 87.0% had SEN (no social difficulties, 40.8%; $p<0.001$); 62.3% had neurodiversity (no social difficulties, 24.5%; $p<0.001$); and 16.4% had a traumatic brain injury (no social difficulties, 8.7%; NS).
- Of those with a traumatic brain injury, 100.0% had speech and language needs (no brain injury, 55.6%; $p<0.001$); 73.3% had social difficulties (no brain injury, 57.1%; NS); 73.3% had SEN (no brain injury, 66.3%; NS); 46.7% had neurodiversity (no brain injury, 47.5%; NS).

### *3.3.4 Health (statutory cases)*

#### *Physical health*

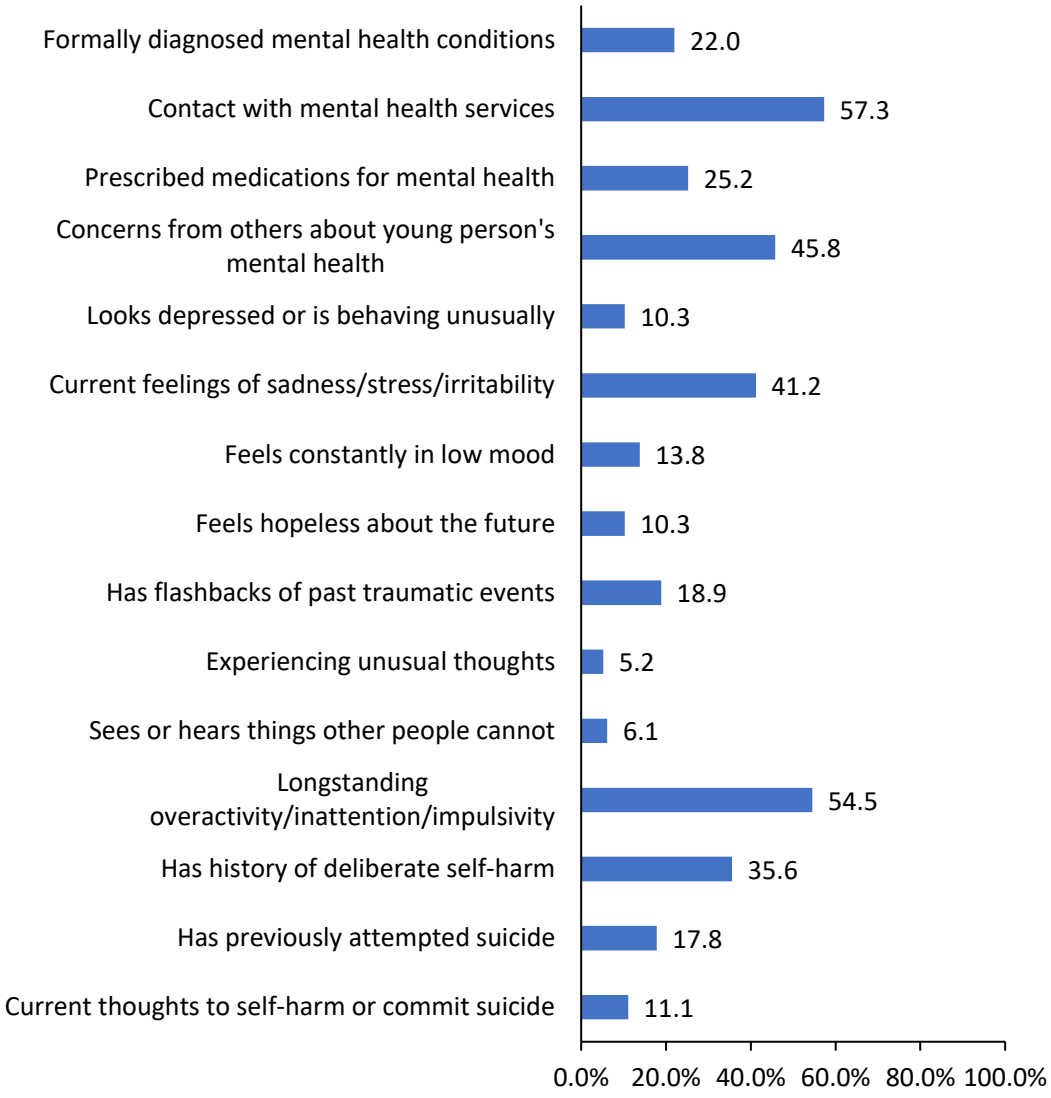
- One in ten (10.9%) individuals had a diagnosed long-standing physical health condition, while 2.5% had current poor physical health symptoms. Prevalence of long-standing physical health conditions differed across local authorities, with the highest prevalence amongst young people from Cheshire East (21.9%; Warrington, 12.5%; Halton, 6.5%; Cheshire West and Chester, 3.4%).
- Of those with a long-standing health condition, 15.4% were currently experiencing poor physical health symptoms, compared to just 0.9% of those without a long-standing physical health condition.
- There were no significant associations between being diagnosed with a physical health condition or having current physical health symptoms, and sociodemographics.

#### *Mental health*

- One fifth (22.0%) of young people had a formally diagnosed mental health condition. Nationally in 2021, 17.7% of young people aged 11-16 years had a 'probable' mental health condition.[17] Prevalence of mental health conditions differed across local authorities with the highest prevalence amongst young people from Cheshire West and Chester (27.6%; Halton, 25.8%; Cheshire East, 18.8%; Warrington, 17.4%).
- There were no significant associations between having a formally diagnosed mental health condition and sociodemographics.
- A higher proportion of those with educational needs had been diagnosed with a mental health condition (29.1%), than those without educational needs (7.9%; $p<0.05$).
- Overall, 57.3% of young people were accessing mental health services. Of those with a diagnosed mental health condition 100.0% were accessing mental health services.
- One in five (18.9%) young people had flashbacks to past traumatic events.
- Overall, a third (35.6%) of young people had a history of deliberate self-harm.
- There were significant associations between having ever self-harmed and ethnicity (White British, 39.8%; other ethnicities 7.1%; $p<0.05$); not living at home (53.7%; living at home, 26.0%; $p<0.01$); and not living with parents (50.0%; living with parents, 24.2%; $p<0.01$).
- A higher proportion of those who had difficulties with social skills had ever self-harmed (45.6%), compared to those without difficulties with social skills (22.4%; $p<0.05$).
- Over four in ten (41.2%) young people had current feelings of sadness, stress, or irritability.
- There were significant associations between current feelings of sadness, anxiety, stress, or irritability and not living at home (61.0%; living at home, 30.8%; $p<0.01$); and not with parents (55.8%; living with parents, 29.9%; $p<0.01$).
- There were also significant associations between having current feeling of sadness, anxiety, stress, or irritability and: social skills difficulties (52.2%; no difficulties, 24.5%; $p<0.01$); educational needs (47.5%; none, 26.3%; $p<0.05$); and neurodiversity (52.7%; none, 31.3%; $p<0.05$).
- The mental health needs of young people are described in Figure 6.

[17] Mental health of children and young people in England 2021 – wave 2 follow up to the 2017 survey https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2021-follow-up-to-the-2017-survey

**Figure 6: Prevalence of mental health needs of statutory young people**




### *3.3.5 Health risk behaviours (statutory cases)*

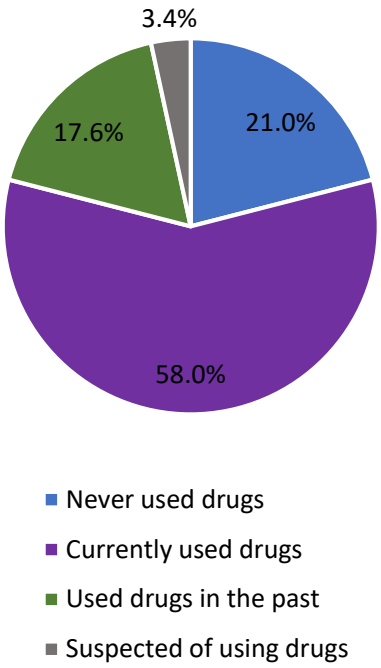
*Drug use*

- The majority (79.0%) of young people had ever used drugs in their lifetime. For 11-15 year-olds in the sample, 70.4% had ever used drugs. This is significantly higher than the 24.0% national prevalence of drug use amongst 11-15 year-olds[18] ($p<0.001$).
- Almost six in ten (58.0%) young people currently used drugs, 17.6% used drugs in the past, while 3.4% had suspected (but not confirmed) drug use (Figure 7).
- Of those who had ever used drugs (current and past use), over half had used multiple substance (53.2%), 45.7% had only ever used cannabis, and 1.1% had only ever used a non-cannabis drug.
- Of those who currently used drugs, over half use multiple substance (56.5%), and 43.5% only use cannabis.

[18] National figures for drug, alcohol, and tobacco use amongst young people aged 11-15 years were obtained from a national survey conducted in 2018 on 13,664 secondary school aged young people https://digital.nhs.uk/data-and-information/publications/statistical/smoking-drinking-and-drug-use-among-young-people-in-england/2018/introduction

- Of those who had used drugs in the past, over half (57.1%) had only ever used cannabis, whilst 42.9% had used multiple substances.
- The mean age at which individuals first started to use drugs was 13.3 years old.
- There were significant associations between ever having used drugs and not living at home (92.7%; living at home 71.8%; p<0.01); not living with parents (90.4%; living with parents 70.1%; p<0.01); NEET (92.9%; being in some form of EET 71.1%; p<0.01); and no qualifications (91.7%; qualifications 73.1%; p<0.05).
- There were no significant associations between having ev er used drugs and any type of health conditions, needs, or neurodiversity.

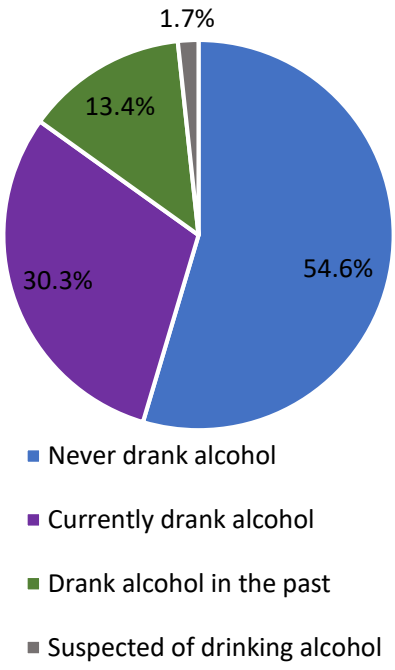
**Figure 7: Prevalence of drug use amongst statutory cases**




*Alcohol use*

- Over four in ten (45.4%) young people aged 10-18 years in the sample had ever drank alcohol. For 11-15 year-olds in the sample 33.3% had ever drank alcohol. This is not significantly lower than the 44.0% national prevalence of lifetime alcohol consumption amongst 11-15 year-olds.[19]
- Three in ten (30.3%) young people currently drank alcohol, 13.4% drank alcohol in the past, while 1.7% had suspected (but not confirmed) drinking of alcohol (Figure 8).

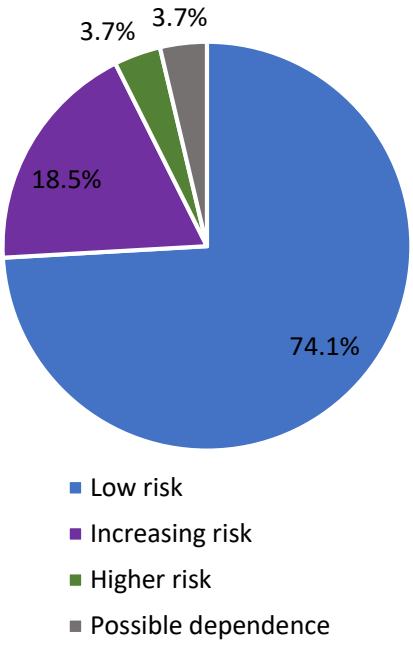
**Figure 8: Prevalence of alcohol use in statutory cases**




[19] National figures for drug, alcohol, and tobacco use amongst young people aged 11-15 years were obtained from a national survey conducted in 2018 on 13,664 secondary school aged young people https://digital.nhs.uk/data-and-information/publications/statistical/smoking-drinking-and-drug-use-among-young-people-in-england/2018/introduction

- The mean age at which individuals first drank alcohol was 13.8 years old.
- A higher proportion of those who were living not with their parents had ever drank alcohol (57.7%), compared to those who did not live with their parents (35.8%; p<0.05).
- There were no significant associations between having ever drank alcohol and any type of health conditions, needs, or neurodiversity.
- Of those who ever used alcohol the majority (74.1%) had alcohol use that was considered low risk, 18.5% increasing risk, 3.7% higher risk, and 3.7% had possible dependence on alcohol (Figure 9).[20]

**Figure 9: AUDIT drinking risk among statutory young people**




*Tobacco use*

- Three in ten (31.1%) young people aged 10-18 years in the sample had ever smoked tobacco. For 11-15 year-olds in the sample 22.2% had ever smoked tobacco. This is not significantly higher than the 16.0% national prevalence of lifetime tobacco use amongst 11-15 year-olds.[21]
- Over one quarter (26.1%) of young people currently smoked tobacco. For 11-15 year-olds in the sample 18.5% currently smoked tobacco. This is significantly higher than the 5.0% national prevalence of current tobacco use amongst 11-15 year-olds (p<0.001).
- There were no significant associations between lifetime tobacco use and sociodemographics.
- A significantly higher proportion of those who had a traumatic brain injury had ever smoked tobacco (53.3%), compared to those without a traumatic brain injury (27.3%; p<0.05).

### *3.3.6 Vulnerability and victimisation (statutory cases)*

*Involvement with social care services*

- Three quarters (75.4%) of young people were currently or had previously been identified as a child in need.
- 15.3% were currently identified as a child in need. This is significantly higher than the 3.2% national prevalence of all children (aged 0-18 years) in need for the year 2021[22] (p<0.001). Further, across all local authorities, except Cheshire West and Chester, the prevalence of current child in need was higher amongst youth justice young people compared to the local general population of young people (Figure 9). Prevalence of current children in need differed

[20] The full Alcohol Use Disorders Identification Test (AUDIT), measures how harmful an individual's alcohol consumption is using 10 questions scoring from 0-4 for each, the score for each question is then totalled to give an overall score ranging from 0-40. Scores can be categorised as: 0-7 low risk; 8-15 increasing risk; 16-19 higher risk; and 20+ possible dependence. The AUDIT was only performed on young people who had ever (currently or previously) used alcohol.

[21] National figures for drug, alcohol, and tobacco use amongst young people aged 11-15 years were obtained from a national survey conducted in 2018 on 13,664 secondary school aged young people https://digital.nhs.uk/data-and-information/publications/statistical/smoking-drinking-and-drug-use-among-young-people-in-england/2018/introduction

[22] Characteristics of Children in Need. Data obtained from local authorities by the Department for Education. https://explore-education-statistics.service.gov.uk/find-statistics/characteristics-of-children-in-need/2020#dataBlock-6bbdf6de-2b08-4cb9-b62e-2c0b555f308c-charts

across local authorities with the highest prevalence amongst young people from Halton (25.8%; Warrington, 25.0%; Cheshire East, 12.9%; Cheshire West and Chester, 0.0%).

- A higher proportion of those with no qualifications were ever identified as a child in need (85.1%) than those with qualifications (68.7%; p<0.05).
- There were significant associations between ever being a child in need and educational needs (82.5%; none, 60.5%; p<0.01); and neurodiversity (87.3%; none, 65.1%; p<0.01).

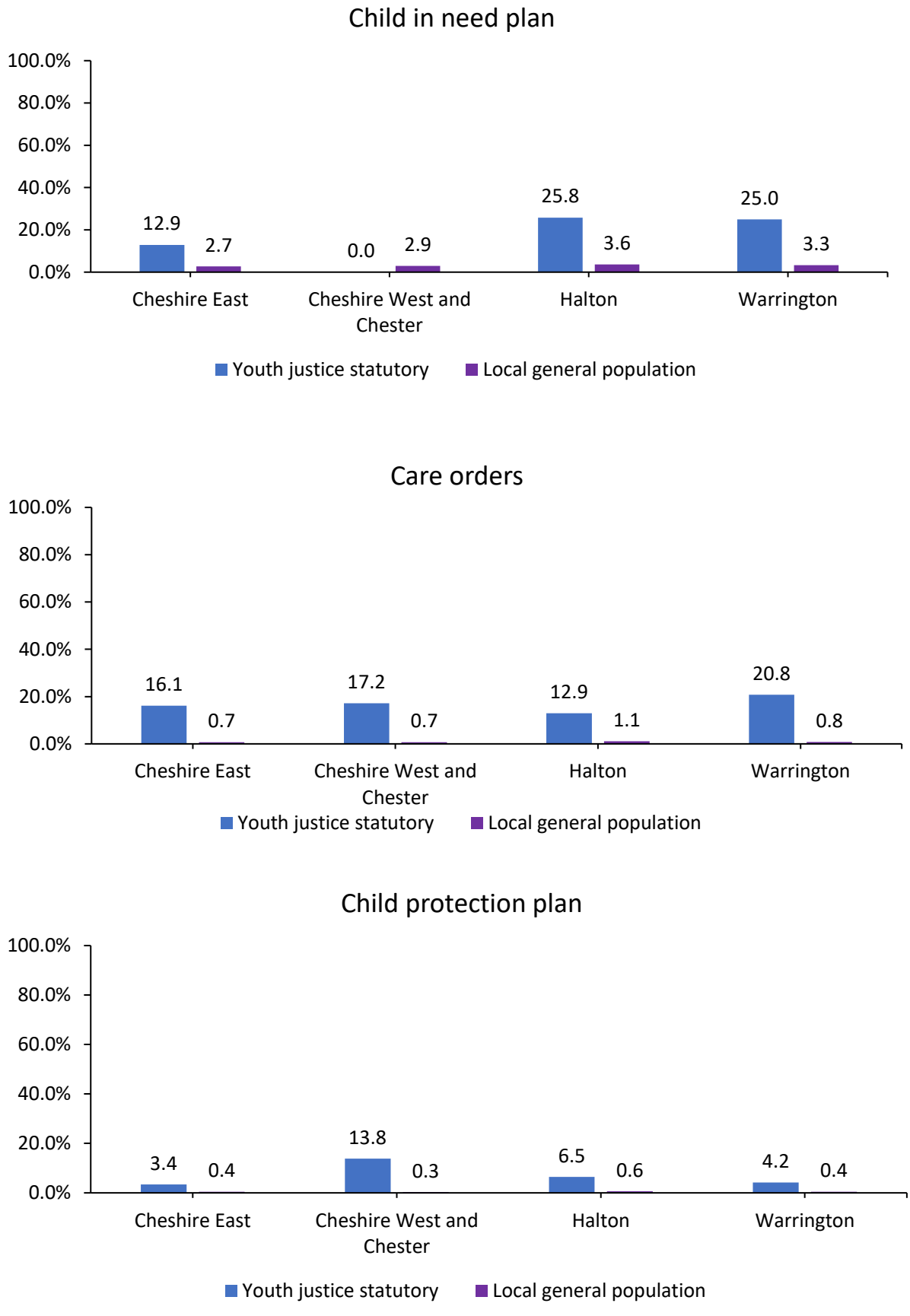
- One fifth (22.0%) of young people were currently or had ever been subject to a care order.
- Over one in ten (16.1%) were currently subject to a care order. This is significantly higher than the 0.7% national prevalence of all children (aged 0-18 years) subject to a care order for the year 2021[23] (p<0.001). Further, across all local authorities the prevalence of current care orders was higher amongst clients compared to the local general population of young people (Figure 9). Prevalence of children currently subject to a care plan differed across local authorities with the highest prevalence amongst clients from Warrington (20.8%; Cheshire West and Chester, 17.2; Cheshire East, 16.1%; Halton, 12.9%).
- There were significant associations between having ever been subject to a care order and: gender (females, 50.0%; males, 18.9%; p<0.05); not living at home (45.0%; living at home, 10.3%; p<0.001); and, not living with parents (39.2%; living with parents, 9.0%; p<0.001).
- There were significant associations between having ever been subject to a care order and having educational needs (27.5%; no educational needs 10.5%; p<0.05).

- Four in ten (41.4%) young people currently or had ever had a child protection plan.
- Less than one in ten (6.9%) currently had a child protection plan. This is significantly higher than the 0.4% national prevalence of all children (aged 0-18 years) subject to a child protection plan for abuse or neglect for the year 2018[24] (p<0.001). Further, across all local authorities the prevalence of child protection plans was higher amongst clients compared to the local general population of young people (Figure 9). Prevalence of child protection plans differed across local authorities with the highest prevalence amongst clients from Cheshire West and Chester (13.8%; Halton, 6.5%; Warrington, 4.2%; Cheshire East, 3.4%).
- There were significant associations between ever having had a child protection plan in place and: not living at home (57.9%; living at home, 33.3%; p<0.05); not living with parents (57.1%; living with parents, 29.9%; p<0.01); and no qualifications (53.2%; qualifications, 32.3%; p<0.05).
- A higher proportion of those with educational needs had ever had a child protection plan in place (49.4%) than those with no educational needs (24.3%; p<0.05).

[23] Children looked after in England including adoptions. Data obtained from routine data collection by local authorities. https://explore-education-statistics.service.gov.uk/find-statistics/children-looked-after-in-england-including-adoptions/2021#dataBlock-c4302ddd-306f-4c83-93f2-a685e64bf417-tables

[24] Children subject to a child protection plan for abuse or neglect statistics. https://fingertips.phe.org.uk/profile/MH-JSNA/data#page/0/gid/1938132920/pat/6/par/E12000002/ati/102/are/E06000008/yrr/1/cid/4/tbm/1

**Figure 10: Social care needs for statutory young people by local authority**



*Child criminal and sexual exploitation*

- Six in ten (59.5%) young people were considered vulnerable to criminal exploitation.
- Of those vulnerable to criminal exploitation, there were concerns for 71.2% that they were involved in county lines activities. In total, 38.2% had concerns that they were involved or at risk of being involved in county lines activities.
- There were significant associations between being vulnerable to criminal exploitation and: not living with parents (72.0%; living with parents, 49.2%; $p<0.05$); being NEET (78.0%; being in EET, 49.3%; $p<0.01$); and no qualifications (77.8%; qualifications, 46.8%; $p<0.01$).
- There were significant associations between being vulnerable to criminal exploitation and having educational needs (67.6%; none, 43.2%; $p<0.05$); having speech and language needs (67.6%; none, 46.5%; $p<0.05$); and having difficulties with social skills (68.2%; none, 46.7%; $p<0.05$).
- One in ten (11.3%) young people were considered vulnerable to sexual exploitation.
- There were significant associations between being vulnerable to sexual exploitation and: gender (females, 75.0%; males, 4.9%; $p<0.001$); not living at home (25.6%; living at home, 3.9%; $p<0.001$); not living with parents (20.0%; living with parents, 4.6%; $p<0.05$); and being NEET (20.0%; being in EET, 6.8%; $p<0.05$).
- A higher proportion of those with difficulties with social skills were vulnerable to sexual exploitation (16.4%) than those without difficulties with social skills (4.3%; $p<0.05$).

*Missing children*

- Over one third (37.0%) of young people had at least one instance of being recorded missing.
- A higher proportion of those who lived not at home had ever been missing (51.2%) than those who lived at home (29.5%; $p<0.05$).
- A higher proportion of those with neurodiversity had ever been missing (47.3%) than those without (28.1%; $p<0.05$).

*Relationships*

Four in ten (44.4%) young people had caregivers who had underlying issues impacting the quality of care they provided for the young person. Of these young people, 54.2% had caregivers with multiple issues impacting their caregiving, 12.5% had mental health concerns only, 10.4% had substance misuse concerns only, while 22.9% had another type of concern only.

- There were no significant associations between caregivers' issues affecting the quality of care they provided and young people's sociodemographics, or health conditions, needs, or neurodiversity.
- Over half (51.3%) of young people had incidents involving their current caregivers that risked the young person's safety and wellbeing.
- There were significant associations between young people having had incidents involving their current caregivers risking the young person's safety and wellbeing and: age (10-14 years old, 87.5%; 15-18 years old, 45.5%; $p<0.01$); gender (females, 87.5%; males, 47.6%; $p<0.05$); and being NEET (65.9%; being in EET, 44.0%; $p<0.05$),

There were no significant associations between ever having had incidents involving their current caregivers and health conditions, needs, or neurodiversity.

- Seven in ten (70.4%) young people had a concern noted about their significant relationships.
- There were significant associations between a concern being noted about young people's significant relationships and: age (10-14 years old, 93.8%; 15-18 years old, 66.7%; $p<0.05$); not

living at home (87.5%; living at home, 61.3%; p<0.01); and, not living with parents (80.0%; living with parents, 63.1%; p<0.05).

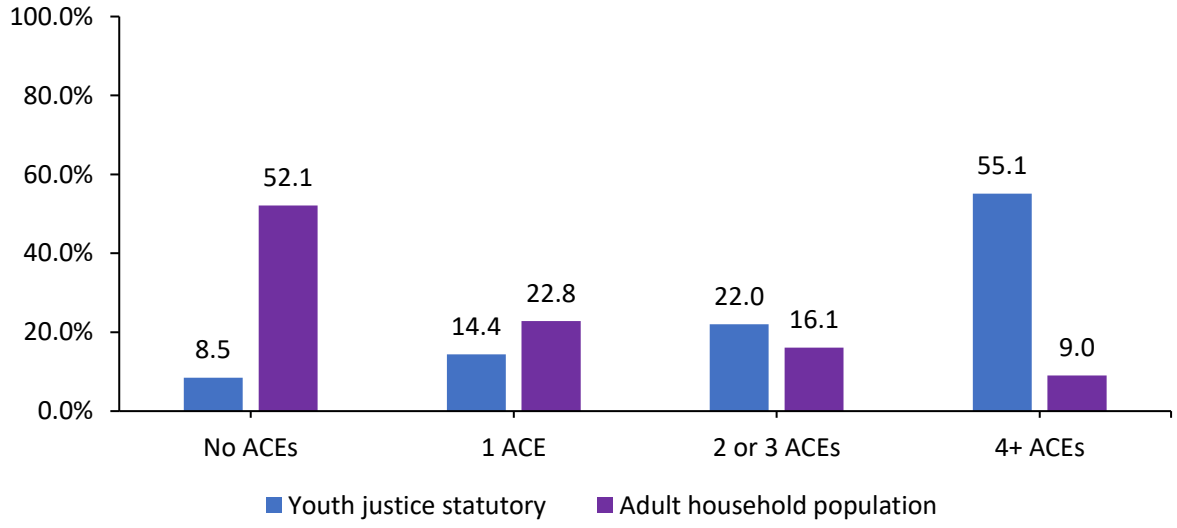
- A higher proportion of those with educational needs had a concern noted about their significant relationships (77.2%) than those with no educational needs (55.6%; p<0.05).

*Adverse childhood experiences*[25]

ACEs can have significant impacts on development and wellbeing during childhood and can be critical in shaping future health and social outcomes. Ten ACEs were recorded from the data which included: physical, verbal, and sexual abuse; physical and emotional neglect; parental separation; witnessing domestic violence; parental mental illness and substance misuse; and parental incarceration.

- The majority (91.5%) of young people had at least one ACE, compared to nationally whereby 47.9% of adults had experienced at least one ACE.
- Over half (55.1%) had experienced 4+ ACEs. This is significantly higher than the estimated 9.0% prevalence of 4+ ACEs from a national retrospective study of adults in England (p<0.001).
- Whilst prevalence decreased as the number of ACEs increased for the nationally representative sample of adults, the reverse was true for the sample of young people on statutory, with prevalence increasing as the number of ACEs increased (Figure 11).
- The number of ACEs amongst young people ranged from 0 to 9. The mean number of ACEs was 3.7.
- There were significant associations between experiencing four or more ACEs and age (10-14 years old, 87.5%; 15-18 years old, 50.0%; p<0.01); gender (females 87.5%; males 50.9%; p<0.05); not living at home (75.0%; living at home, 44.9%; p<0.01); not living with parents (72.5%; living with parents, 41.8%; p<0.001); and, NEET (69.0%; being in some form of EET, 48.0%; p<0.05).
- There were no significant associations between having four or more ACEs and any type of health condition, needs, or neurodiversity.

**Figure 11: Prevalence of ACEs amongst statutory clients/nationally representative population of adults in England**

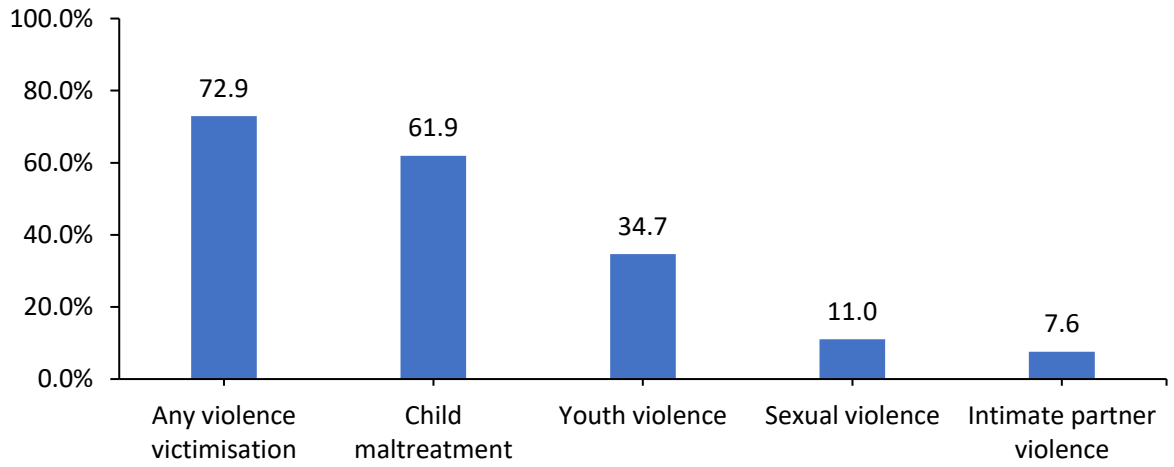



[25] National data and information for ACEs came from a representative household survey of people aged 18-69 years old (n=3885) undertaken in England in 2013 - https://bmcmedicine.biomedcentral.com/articles/10.1186/1741-7015-12-72

*Violence victimisation*

- Nearly three quarters (72.9%) of young people had experienced some form of violent victimisation (Figure 11).
- There were significant associations between ever experiencing violent victimisation and age (10-14 years old 93.8%; 15-18 years old 69.6%; $p<0.05$); not living at home (95.0%; living at home 61.5%; $p<0.001$); not living with parents (92.2%; living with parents 58.2%; $p<0.001$); and no qualifications (83.0%; qualifications 65.7%; $p<0.05$).
- There were significant associations between ever experiencing violent victimisation and having difficulties with social skills (82.6%; no difficulties with social skills 59.2%; $p<0.01$); and having educational needs (81.3%; not having educational needs 55.3%; $p<0.01$).
- Six in ten (61.9%) experienced child maltreatment (Figure 11).
- Of those who experienced child maltreatment, 39.7% experienced multiple types of child maltreatment, 38.4% experienced neglect only, 12.3% experienced physical violence only, 6.8% experienced emotional violence only, and 2.7% experienced sexual child maltreatment only.
- Over one third (34.7%) experienced youth violence (Figure 12).
- Of those who experienced youth violence, 34.1% experienced multiple types of youth violence, 34.1% experienced bullying only, and 31.7% experienced physical youth violence only.
- One in ten (11.0%) experienced sexual violence (Figure 11).
- Just under one in ten (7.6%) experienced intimate partner violence (Figure 11).
- Of those who experienced intimate partner violence, 44.4% experienced physical violence only, 33.3% experienced multiple types of intimate partner violence, and 22.2% experienced sexual intimate partner violence only.

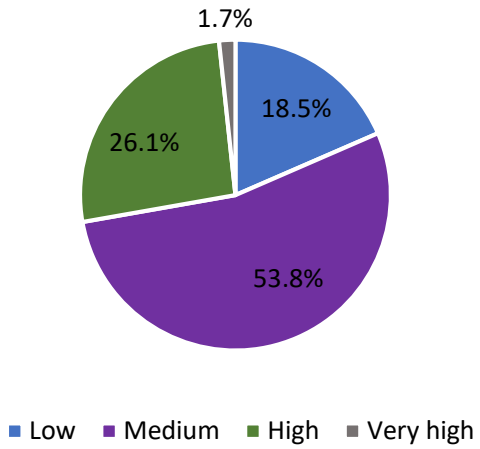
**Figure 12: Prevalence of violence victimisation amongst statutory young people**



*Risk of future vulnerability and victimisation*

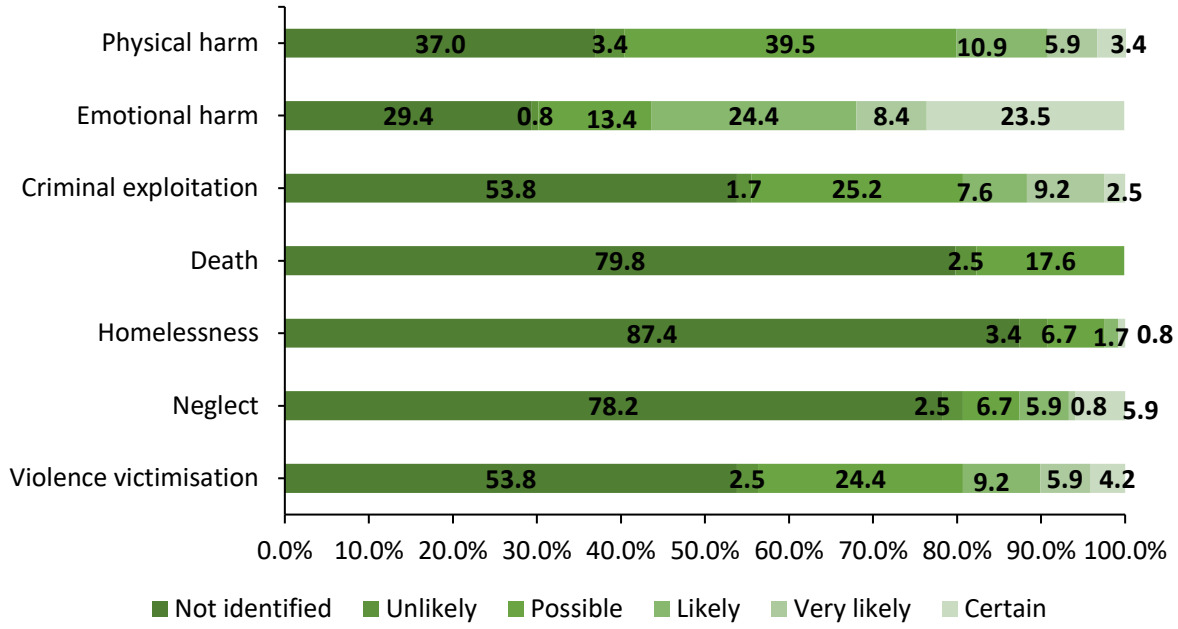
- Over one quarter (27.8%) of statutory young people were assessed as having high (26.1%) or very high (1.7%) concerns for their safety and wellbeing (Figure 13).
- There were significant associations between safety and wellbeing ratings and: not living at home (48.8% high; living at home, 16.7% high; p<0.001); not living with parents (46.2% high; living with parents, 13.4% high; p<0.001); NEET (42.9% high; EET, 19.7%; p<0.01).
- There were no significant associations between safety and wellbeing risk level and health conditions, needs, or neurodiversity.

**Figure 13: Safety and wellbeing risk level for statutory young people**




- The number of types of identified adverse future outcomes for young people ranged from 0 to 11, with a mean of 3.7 identified adverse outcomes.
- 59.7% were identified as being potentially (i.e. possible to certain) at risk of physical harm (Figure 14).
- 69.7% were identified as being potentially at risk of emotional harm (Figure 14).
- 44.5% were identified as being potentially at risk of criminal exploitation (Figure 14).
- 17.6% were identified as being potentially at risk of death (Figure 14).
- 9.2% were identified as being potentially at risk of homelessness (Figure 14).
- 19.3% were identified as being potentially at risk of neglect (Figure 14).
- 43.7% were identified as being potentially at risk of violence victimisation (Figure 14).

**Figure 14: Adverse outcomes for statutory young people**

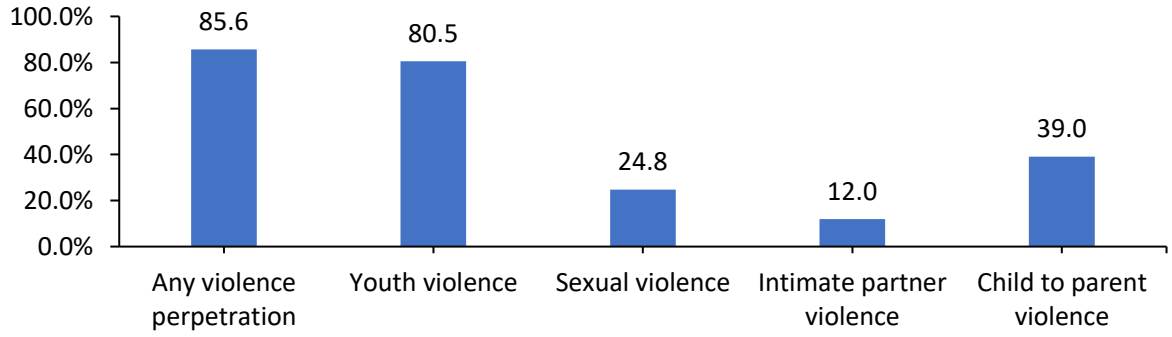


### *3.3.7 Offending and violence perpetration (statutory cases)*

*Violence perpetration*[26]

- The majority (85.6%) of young people had perpetrated some form of violence (Figure 15).
- There were significant associations between violence perpetration and: living not at home (100.0%; living at home, 78.2%; p<0.01); not living with parents (98.0%; living with parents, 76.1%; p<0.001).
- There were significant associations between violence perpetration and having speech and language needs (91.7%; no speech and language needs 76.1%; p<0.05); having difficulties with social skills (92.8%; no social skills difficulties 75.5%; p<0.01); and having neurodiversity (92.7%; no neurodiversity 79.4%; p<0.05).
- Eight in ten (80.5%) had perpetrated youth violence (Figure 15).
- Of those who perpetrated youth violence, 46.3% perpetrated multiple types of youth violence, 44.2% perpetrated physical youth violence only, 4.2% perpetrated emotional youth violence only, 4.2% perpetrated sexual youth violence only, and 1.1% perpetrated bullying only.
- A quarter (24.8%) had perpetrated sexual violence (Figure 15).
- Over one in ten (12.0%) had perpetrated intimate partner violence (Figure 15).
- Of those who perpetrated intimate partner violence, 57.1% perpetrated multiple types of violence, 21.4% perpetrated physical violence only, 14.3% perpetrated emotional intimate partner violence only, and 7.1% perpetrated sexual intimate partner violence only.
- Four in ten (39.0%) had perpetrated child to parent violence and abuse (Figure 15).
- Of those who perpetrated child to parent violence and abuse, 50.0% perpetrated multiple types of violence, 28.3% perpetrated emotional abuse only, and 21.7% perpetrated physical abuse only.

**Figure 15: Violence perpetration of statutory young people**



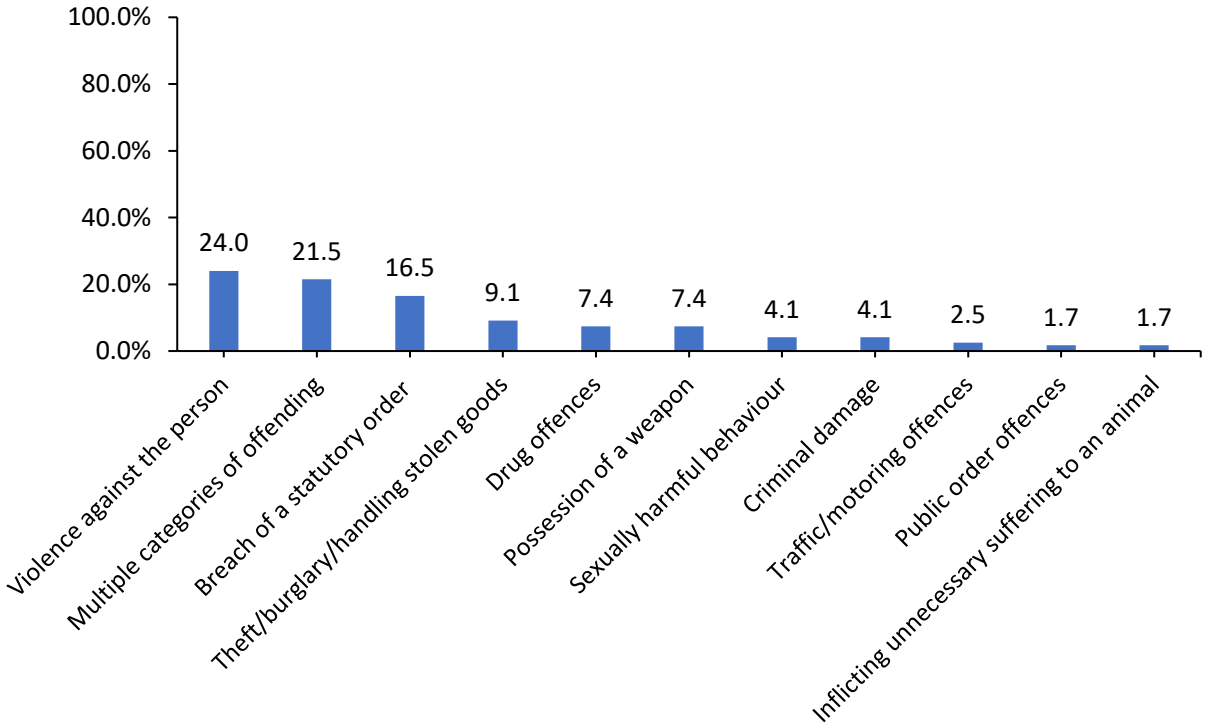

[26] WHO. World report on violence and health. https://apps.who.int/iris/bitstream/handle/10665/42495/9241545615_eng.pdf
Youth violence – physical, verbal, or sexual violence committed by the young person against an individual known or otherwise, outside of the family context. Examples include physical assaults – with or without weapons, gang-related violence, and bullying.
Sexual violence - any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work.
Intimate partner violence - any behaviour within an intimate relationship (including a dating relationship) that causes physical, psychological or sexual harm to those in the relationship. This may include acts of physical aggression, name calling, and controlling behaviours.
Child to parent violence – any physical, psychological, or sexual acts perpetrated by the young person against their parent or primary caregiver (not including staff in care environments) causing harm. This may include acts of physical aggression, name calling, and controlling behaviours.

*Offending history*

- The most common category of most recent offence was violence against the person (24.0%), followed by multiple categories of offending (21.5%), and breach of a statutory order (16.5%; Figure 16).
- Ages of most recent offence ranged from 11.8 years to 18.3 years with a mean age of 16.0 years.
- The seriousness of the most recent offence ranged from 2.0 to 8.0 with a mean seriousness of 3.8.
- There were significant associations between mean seriousness of the most recent offence and male gender (3.7; females, 3.1; $p<0.05$), and older age (15-18+, 3.8; 10-14, 3.2; $p<0.05$). There were no significant differences in the mean seriousness of the most recent offence by health conditions, needs, or neurodiversity.
- Ages of first offence ranged from 10.0 years to 17.6 years with a mean age of 14.2 years. Those with educational needs had a younger mean age of first offence (13.8 years) than those without educational needs (15.4 years; $p<0.01$). There were no significant differences in the mean age of first offence by health conditions, needs, or neurodiversity.
- Seriousness of the first offence ranged from 2.0 to 8.0 with a mean seriousness of 3.3. Those in the older age group (15-18+) had a higher mean seriousness of the first offence (3.3) than those in the younger age group (10-14, 2.9; $p<0.05$). Those with speech and language needs had a higher mean seriousness of the first offence (3.5) than those without (2.9; $p<0.05$).
- The total number of offences ranged from 1 to 131, with a mean of 7.7 for total offences. Six in ten (61.2%) committed five or fewer offences (one offence 19.0%; two offences 14.0%; three offences 13.2%; four offences 5.0%; five offences 9.9%). Over three quarters (77.7%) committed ten offences or fewer.
- The number of separate incidents of offending[27] ranged from 1 to 28 with a mean of 4.1 incidents. Three quarters (75.0%) had five or fewer incidents of offending (one incident 36.7%; two incidents 15.0%; three incidents 12.5%; four incidents 8.3%; five incidents 2.5%). The majority (90.0%) had ten incidents of offending or fewer.
- Those who lived not at home had a higher mean number of offences (12.7) than those who lived at home (5.2; $p<0.05$). Those who lived not with their parents had a higher mean number of offences (11.9) than those who lived with their parents (4.5; $p<0.01$).
- There were no significant differences in the mean number of offences by health conditions, needs, or neurodiversity.
- Those who lived not at home had a higher mean number of incidents of offending (5.8) than those who lived at home (3.3; $p<0.05$). Those who lived not with their parents had a higher mean number of incidents of offending (5.7) than those who lived with their parents (3.0; $p<0.01$). Those without qualifications had a higher mean number of incidents of offending (5.4) than those with qualifications (3.5; $p<0.05$).
- Those with a physical health condition had a smaller mean number of incidents of offending (2.5) compared to those without a physical health condition (4.4; $p<0.05$). Those with educational needs had a higher mean number of incidents of offending (4.9) compared to those without educational needs (2.8; $p<0.05$).

[27] Incidents of offending relate to the event of offending and may contain multiple separate offences within the one incident of offending, whereas offences relate to each individual offence that takes place.

**Figure 16: Categories of most recent offence for statutory young people**




*Risk of future offending*

The Youth Offending Group Reconviction Scale (YOGRS) uses an algorithm to estimate the probability that youth offenders will be re-sanctioned for any recordable offence within two years of sentence, or release if sentenced to custody. This provides a percentage estimate of re-sanctioning compared to a similar cohort of individuals.

- YOGRS scores for young people ranged from 12.0% to 79.0%, with a mean YOGRS score of 46.3%.
- Mean YOGRS scores were higher for:
    - Males (47.6%) compared to females (36.9%; $p<0.05$).
    - Those without qualifications (50.2%) compared to those with qualifications (44.3%; $p<0.05$).
    - Those with educational needs (49.5%) compared to those without (39.9%; $p<0.001$).
    - Those with neurodiversity (49.9%) compared to those without (43.1%; $p<0.05$).
    - Those with a traumatic brain injury (56.0%) compared to those without (45.2%; $p<0.01$).
    - Those with a diagnosed mental health condition (52.5%) compared to those without (44.3%; $p<0.05$).
- Three in ten (29.4%) young people were assessed as having a high likelihood of reoffending (Figure 17).
- There were significant associations between likelihood of reoffending and: not living at home (46.3% high; living at home, 20.5%; $p<0.01$); not living with parents (44.2% high; living with parents, 17.9% high; $p<0.01$); and no qualifications (43.8% high; qualifications, 20.9% high; $p<0.01$).
- There were significant associations between likelihood of reoffending and: social skills difficulties (37.7% high; those without social skills difficulties, 16.3% high; $p<0.05$) and having educational needs (37.5% high; those without educational needs, 10.5% high; $p<0.01$).

- Over one quarter (27.1%) of young people were assessed as posing a high risk of serious harm to others (Figure 18).
- There were significant associations between risk of serious harm to others and ethnicity (White British, 23.3% high; other ethnicities, 57.1% high; $p<0.01$); not living at home (45.0% high; living at home, 17.9% high; $p<0.01$); not living with parents (45.1% high; living with parents, 13.4% high; $p<0.001$); and no qualifications (38.3% high; qualifications, 20.9%; $p<0.05$).There were significant associations between risk of serious harm to others and: having speech and language needs (34.7% high; no speech and language needs, 15.2% high; $p<0.05$); having difficulties with social skills (36.8% high; those without social skills difficulties, 12.2% high; $p<0.01$); and having educational needs (34.2% high; those without educational needs, 10.5% high; $p<0.01$).

**Figure 17: Likelihood of reoffending for statutory young people**

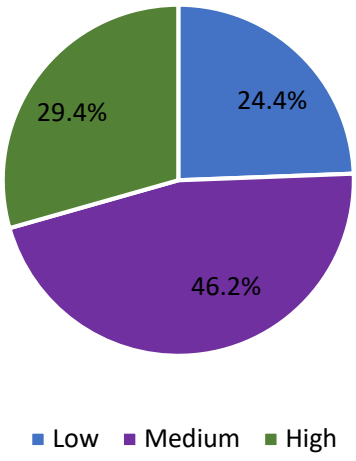
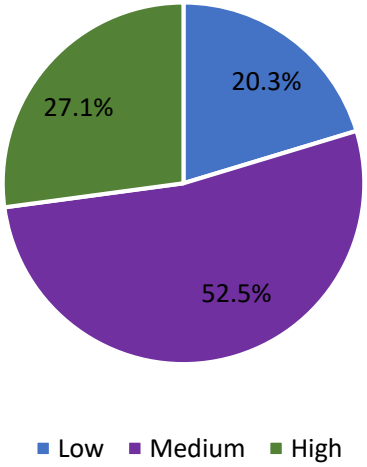



**Figure 18: Risk of serious harm to others for statutory young people**



### *3.3.8 Sociodemographics (DIVERT cases)*

The divert sample included 92 young people, of these, 89.1% (n=82) had a completed DIVERT assessment. The demographics of the young people are described in Table 2.

The DIVERT assessment includes similar information to the Assetplus assessment however is less detailed and mostly uses free text rather than tick boxes in the Assetplus. The divert does miss some information if it is not entered in free text such as qualifications could not be ascertained, and the DIVERT assessment does not calculate a YOGRS score.

- Seven in ten (70.7%) young people were male.
- 59.8% were aged 15-17, while 39.1% were aged 10-14 and 1.1% were aged 18.
- The majority were White British (89.2%).
- Most young people were split between Cheshire West and Chester (40.0%) and Cheshire East (35.6%).
- The majority (87.8%) lived at home.
- The majority (80.5%) lived with their parents.
- 1.2% were a parent or expecting a child.

**Table 2: Sociodemographics (DIVERT cases)**

| Demographics | % (n) |
|---|---|
| **Gender** | |
| Male | 70.7 (65) |
| Female | 27.2 (25) |
| Other | 2.2 (2) |
| **Age** | |
| 10-14 | 39.1 (36) |
| 15-17 | 59.8 (55) |
| 18 | 1.1 (1) |
| **Ethnicity** | |
| White British | 89.2 (74) |
| Any other ethnic backgrounds | 10.8 (9) |
| **Responsible Local Authority** | |
| Cheshire East | 35.6 (32) |
| Cheshire West and Chester | 40.0 (36) |
| Halton | 8.9 (8) |
| Warrington | 15.6 (14) |
| **Current accommodation** | |
| At home | 87.8 (72) |
| Residential unit/supported | 6.1 (5) |
| Foster care placement | 6.1 (5) |
| **Who young person lives with** | |
| Parents | 80.5 (66) |
| Not with parents | 19.5 (16) |
| **Parental status** | |
| Has or is expecting a child | 1.2 (1) |
| No child | 98.8 (81) |

### *3.3.9 Education, Employment, and Training (DIVERT cases)*

#### *Not in Education, Employment and Training (NEET)*

- 8.5% of young people were NEET. Of clients aged 16-17 17.9% were NEET, compared to 2.8% nationally.[28]
- There was a significant association between being NEET and age (10-14 years old 0.0%; 15-18 years old 14.3%; $p<0.05$).
- A higher proportion of those with a traumatic brain injury were NEET (37.5%) than those with no traumatic brain injury (4.8%; $p<0.01$).

#### *Educational attainment*

- 54.9% of young people were in mainstream school, while 29.3% were in an alternative education provision, and 1.2% were engaged in both education and some form of employment or training.
- Of young people in education 53.6% had either participation or attendance issues.
- Of young people in education there were no significant associations between young people having participation or attendance issues and demographics.
- Of young people in education a higher proportion of those with social skills difficulties had participation or attendance issues (63.6%) than those without social skills difficulties (36.8%; $p<0.05$).

#### *School exclusion*

- Four in ten (41.5%) individuals had faced some form of school exclusion. This is significantly higher than the 4.3% national prevalence of school exclusions[29] (4.25% suspensions; 0.05% permanent exclusions; $p<0.001$).
- There were no significant associations between having been excluded and sociodemographics or health conditions, needs, or neurodiversity.

#### *Special educational need*

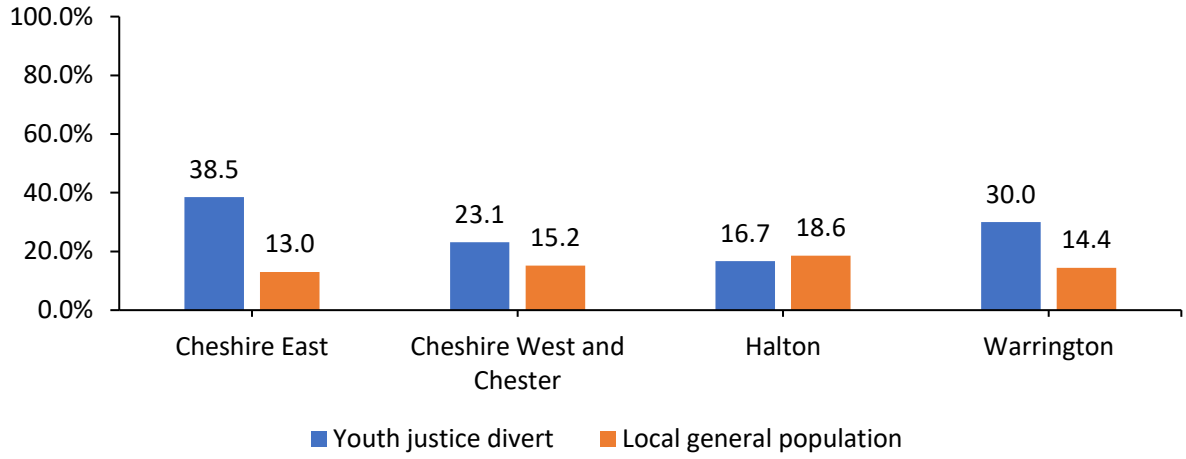
- 56.2% had some form of SEN.
- There were no significant associations between having some form of SEN and sociodemographics.
- Of those with SEN 75.6% had speech and language needs (no SEN, 58.1%; NS); 78.0% had social skills difficulties (no SEN, 50.0%; $p<0.05$); 50.0% had neurodiversity (no SEN, 15.6%; $p<0.01$); and 15.4% had a traumatic brain injury (no SEN, 6.7%; NS).
- Of those with a SEN, 51.3% had this need identified or diagnosed.
- Overall, 28.6% had an identified SEN. This is significantly higher than the 16.5% national prevalence of identified SEN[30] ($p<0.05$). Across all local authorities except Halton, the prevalence of SEN was higher amongst clients compared to the local general population of young people (Figure 19).

[28] National and local prevalence statistics for young people aged 16-17 who were not in education, employment or training NEET were obtained from routinely collected data by the National Client Caseload Information System https://www.gov.uk/government/publications/neet-and-participation-local-authority-figures

[29] Permanent exclusions and suspensions in England. Data collected by the school census. https://explore-education-statistics.service.gov.uk/find-statistics/permanent-and-fixed-period-exclusions-in-england

[30] Special educational needs and disability: an analysis and summary of data sources. Department for Education. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1082518/Special_educational_needs_publication_June_2022.pdf

**Figure 19: Prevalence of SEN amongst DIVERT cases and general population, by local authority**



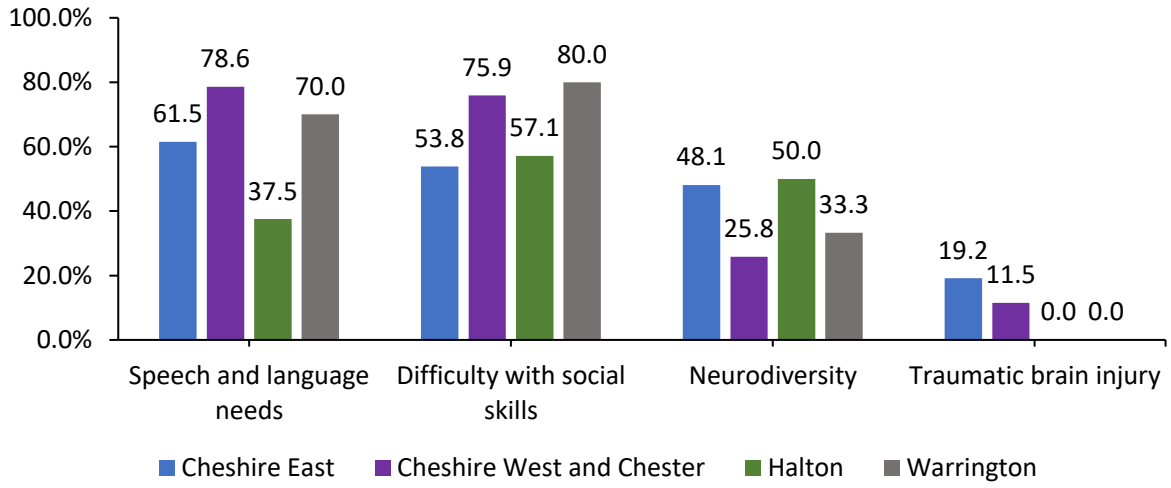

*Employment and training*

- 6.1% of young people were in some form of employment or training, and 1.2% were engaged in both education and some form of employment or training.
- 0.0% of individuals in employment had either participation or attendance issues.

### *3.3.10 Neurodiversity and other needs (DIVERT cases)*

- 36.3% of young people had a formal diagnosis of a neurodivergent condition, with a further 18.8% awaiting a referral or diagnosis.
- 67.6% of young people had some type of speech and language needs.
- Just over one in ten (11.4%) young people had a traumatic brain injury.
- Two thirds (66.2%) of young people were assessed as having social skills difficulties.
- Four in ten (41.7%) individuals who had social skill difficulties also had a formal diagnosis of a neurodivergent condition (most commonly multiple neurodiversities or ADHD), while a further 25.0% were awaiting a diagnosis or referral.
- There were no significant associations between speech and language needs, having difficulties with social skills, having a diagnosis that would impact social skills (such as ASD), neurodiversity, and sociodemographics.
- A higher proportion of those who were NEET had a traumatic brain injury (50.0%) than those who were in some form of EET (7.8%; $p<0.01$)
- Prevalence of neurodiversity and other needs amongst young people differed across local authorities, with Warrington in general having higher levels of need across the four types (Figure 20).

**Figure 20: Prevalence of neurodiversity and other needs amongst DIVERT cases, by local authority**




- Of those with neurodiversity 88.5% had speech and language needs (no neurodiversity, 55.3%; p<0.01); 80.0% had social difficulties (no neurodiversity, 58.3%; NS); 80.0% had SEN (no neurodiversity, 42.6%; p<0.01); and 16.7% had a traumatic brain injury (no neurodiversity, 8.9%; NS).
- Of those with speech and language needs 77.6% had social difficulties (no speech and language needs, 41.7%; p<0.01); 63.3% had SEN (no speech and language needs, 43.5%; NS); 46.9% had neurodiversity (no speech and language needs, 12.5%; p<0.01); and 17.0% had a traumatic brain injury (no speech and language needs, 0.0%; p<0.05).
- Of those with social difficulties 79.2% had speech and language needs (no social difficulties, 44.0%; p<0.01); 66.7% had SEN (no social difficulties, 36.0%; p<0.05); 41.7% had neurodiversity (no social difficulties, 20.0%; NS); and 10.9% had a traumatic brain injury (no social difficulties, 12.5%; NS).
- Of those with a traumatic brain injury 100.0% had speech and language needs (no brain injury, 62.9%; p<0.05); 62.5% had social difficulties (no brain injury, 66.1%; NS); 75.0% had SEN (no brain injury, 54.1%; NS); and 50.0% had neurodiversity (no brain injury, 32.8%; NS).

### *3.3.11 Health (DIVERT cases)*

#### *Physical health*

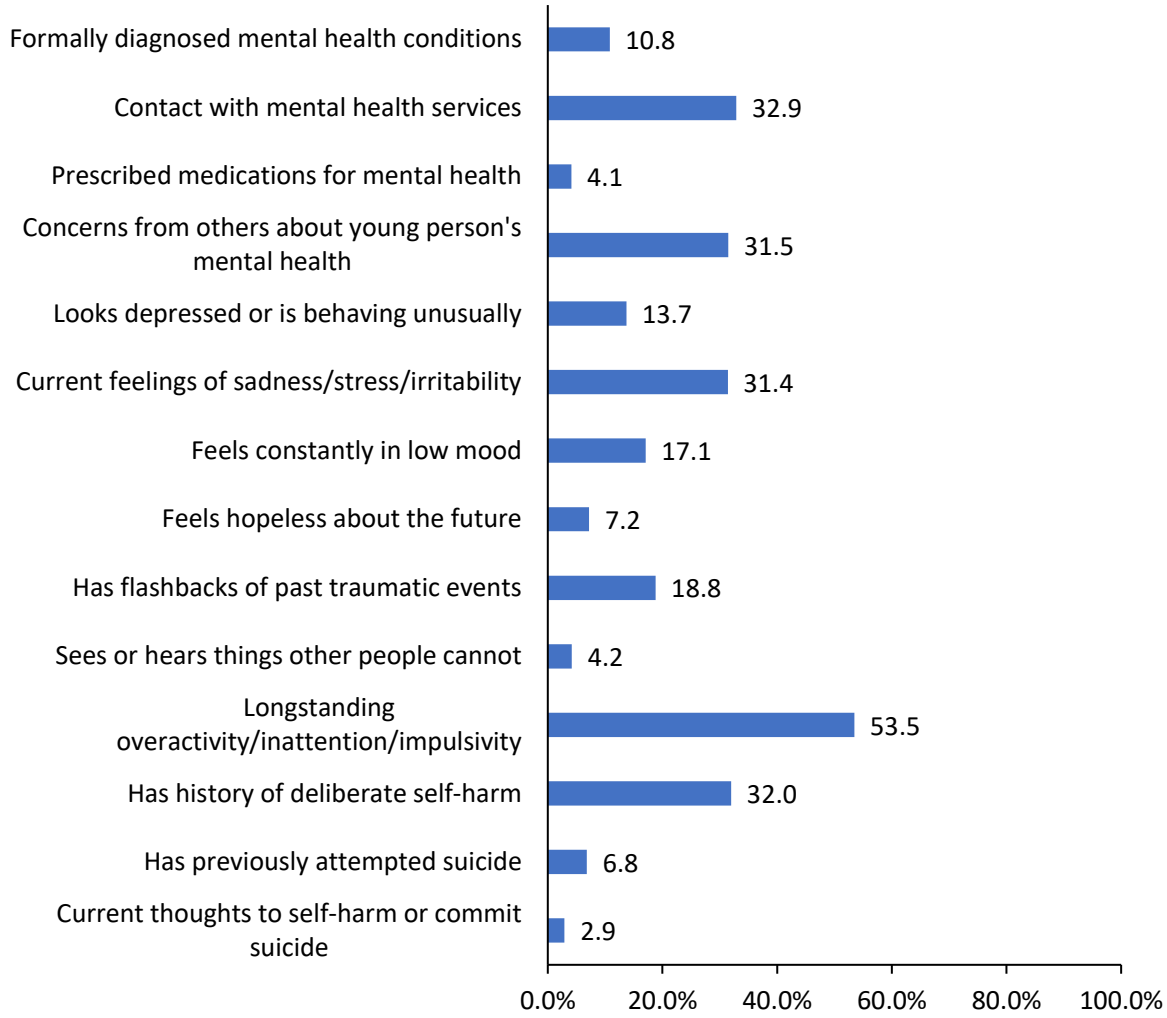
- One in ten (10.7%) individuals had a diagnosed long-standing physical health condition, while 6.8% had current poor physical health symptoms. Prevalence of long-standing physical health conditions differed across local authorities with the highest prevalence amongst young people from Warrington (20.0%; Halton 14.3%; Cheshire West and Chester 10.0%; Cheshire East 7.7%).
- Of those with a long-standing health condition, 14.3% were currently experiencing poor physical health symptoms, compared to 6.0% of those without a long-standing physical health condition.
- There were significant associations between having a diagnosed long-standing physical health condition and gender (females, 22.7%; males, 5.7%; p<0.05); not living at home (33.3%; living at home, 7.6%; p<0.05); and, not living with parents (33.3%; living with parents, 5.0%; p<0.01).
- There were no significant associations between having current physical health symptoms and sociodemographics.

*Mental health*

- 10.8% of young people had a formally diagnosed mental health condition. Nationally in 2021, 17.7% of young people aged 11-16 had a 'probable' mental health condition.[31] Prevalence of mental health conditions differed across local authorities with the highest prevalence amongst young people from Warrington (20.0%; Halton, 14.3%; Cheshire West and Chester, 10.3%; Cheshire East, 7.7%).
- There were no significant associations between having a formally diagnosed mental health condition and sociodemographics.
- There were significant associations between having a mental health condition and having a physical health condition (42.9%; no physical health condition 7.5%; $p<0.01$); having speech and language needs (16.3%; no speech and language needs 0.0%; $p<0.05$); and having social skills difficulties (16.3%; no social skills difficulties 0.0%; $p<0.05$).
- Overall, 32.9% of young people were accessing mental health services. Of those with a diagnosed mental health condition 87.5% were accessing mental health services.
- One in five (18.8%) had flashbacks to past traumatic events.
- A third (32.0%) had a history of deliberate self-harm.
- There were significant associations between ever having self-harmed and gender (females 65.0%; males 18.5%; $p<0.001$); not living at home (70.0%; living at home 26.2%; $p<0.01$); and not living with parents (53.3%; living with parents 26.7%; $p<0.05$).
- There were significant associations between ever having self-harmed and having a physical health condition (71.4%; no physical health condition 25.8%; $p<0.05$); and having speech and language needs (42.9%; no speech and language needs 8.3%; $p<0.01$).
- Over three in ten (31.4%) young people had current feelings of sadness, stress, or irritability.
- There were no significant associations between current feelings of sadness, anxiety, stress, or irritability and sociodemographics, or health conditions, needs, or neurodiversity.
- The mental health needs of young people are described in Figure 21.

[31] Mental health of children and young people in England 2021 – wave 2 follow up to the 2017 survey https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2021-follow-up-to-the-2017-survey

**Figure 21: Prevalence of mental health needs of divert young people**




### *3.3.12 Health risk behaviours (DIVERT cases)*

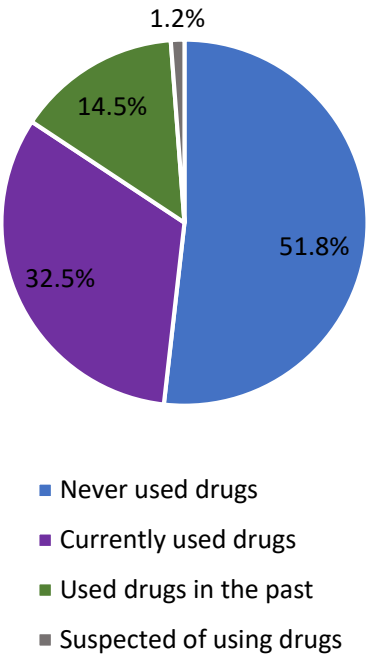
*Drug use*

- 48.2% of young people aged 10-18 years in the sample had ever used drugs. For 11-15 year olds in the sample 44.2% had ever used drugs. This is significantly higher than the 24.0% national prevalence of drug use amongst 11-15 year olds[32] ($p<0.001$).
- 32.5% of young people currently used drugs, 14.5% used drugs in the past, while 1.2% had suspected (but not confirmed) drug use (Figure 22).
- Of those who had ever used drugs (current and past use), a quarter had used multiple substances (22.5%), and 77.5% had only ever used cannabis.
- Of those who currently used drugs, three in ten use multiple substances (29.6%), and 70.4% only use cannabis.
- Of those who had used drugs in the past, 91.7% had only ever used cannabis, whilst 8.3% had used multiple substances.

[32] National figures for drug, alcohol, and tobacco use amongst young people aged 11-15 years were obtained from a national survey conducted in 2018 on 13,664 secondary school aged young people https://digital.nhs.uk/data-and-information/publications/statistical/smoking-drinking-and-drug-use-among-young-people-in-england/2018/introduction

- There were significant associations between ever having used drugs and age (15-18 years old 60.0%; 10-14 years old, 30.3%; p<0.01); not living at home (80.0%; living at home, 44.4%; p<0.05); and not living with parents (75.0%; living with parents, 42.4%; p<0.05).
- A smaller proportion of those with neurodiversity had ever used drugs (31.0%) than those without neurodiversity (60.8%; p<0.05). A higher proportion of those with a diagnosed mental health condition had ever used drugs (87.5%) compared to those without a mental health condition (48.5%; p<0.05).

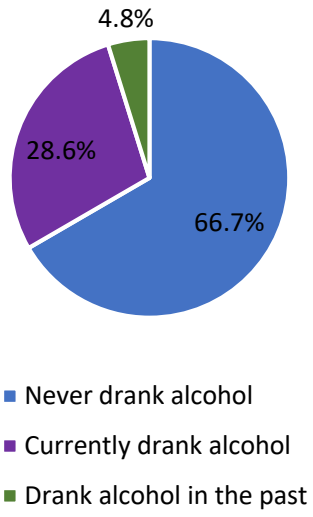
**Figure 22: Prevalence of drug use amongst DIVERT cases**




*Alcohol use*

- A third (33.3%) of young people aged 10-18 years in the sample had ever drank alcohol. For 11-15 year olds in the sample 26.4% had ever drank alcohol. This is significantly lower than the 44.0% national prevalence of lifetime alcohol consumption amongst 11-15 year olds[33] (p<0.05).
- 28.6% of young people currently drank alcohol, 4.8% drank alcohol in the past. Two thirds (66.7%) had never drank alcohol (Figure 23).
- There were significant associations between ever drinking alcohol and age (15-18 years old 45.1%; 10-14 years old 15.2%; p<0.01); and gender (females 60.9%; males 23.7%; p<0.01).

**Figure 23: Prevalence of alcohol use in DIVERT cases**




- There were no significant associations between having ever drank alcohol and any health conditions, type of needs, or neurodiversity.

[33] National figures for drug, alcohol, and tobacco use amongst young people aged 11-15 years were obtained from a national survey conducted in 2018 on 13,664 secondary school aged young people https://digital.nhs.uk/data-and-information/publications/statistical/smoking-drinking-and-drug-use-among-young-people-in-england/2018/introduction

*Tobacco use*

- 12.0% of young people aged 10-18 in the sample had ever smoked tobacco. For 11-15 year olds in the sample 11.5% had ever smoked tobacco. This is not significantly lower than the 16.0% national prevalence of lifetime tobacco use amongst 11-15 year olds.[34]
- Nearly one in ten (9.6%) young people currently smoked tobacco. For 11-15 year olds 9.6% currently smoked tobacco. This is not significantly higher than the 5.0% national prevalence of current tobacco use amongst 11-15 year olds.
- There were no significant associations between lifetime tobacco use and sociodemographics.
- A significantly higher proportion of those with a diagnosed mental health condition had ever smoked tobacco (50.0%), compared to those with no mental health condition (9.1%; p<0.01).

### *3.3.13 Vulnerability and victimisation (DIVERT cases)*

*Involvement with social care services*

- Three quarters (39.0%) of young people were currently or had previously been identified as a child in need.
- 19.5% were currently identified as a child in need. This is significantly higher than the 3.2% national prevalence of all children (aged 0-18 years) in need for the year 2021[35] (p<0.001). Further, across all local authorities (except Halton) the prevalence of current child in need was higher amongst clients compared to the local general population of young people (Figure 24). Prevalence of children currently in need differed across local authorities with the highest prevalence amongst young people from Cheshire East (25.0%; Cheshire West and Chester, 20.7%; Warrington, 9.1%; Halton, 0.0%).
- There were no significant associations between having ever been identified as a child in need and sociodemographics, or health conditions, needs, or neurodiversity.

- One fifth (23.2%) of young people were currently or had ever been subject to a care order.
- Nearly two in ten (19.5%) were currently subject to a care order. This is significantly higher than the 0.7% national prevalence of all children (aged 0-18 years) subject to a care order for the year 2021[36] (p<0.001). Further, across all local authorities (except Warrington) the prevalence of current care orders was higher amongst clients compared to the local general population of young people (Figure 24). Prevalence of children currently subject to a care plan differed across local authorities with the highest prevalence amongst clients from Halton (62.5%; Cheshire East, 20.0%; Cheshire West and Chester, 10.0%; Warrington, 0.0%).
- There were significant associations between having ever been subject to a care order and: not living at home (90.0%; living at home, 14.1%; p<0.001); and, not living with parents (80.0%; living with parents, 10.6%; p<0.001).
- A higher proportion of those with a physical health condition had ever been subject to a care order (71.4%) than those who had no physical health condition (19.4%; p<0.01).

[34] National figures for drug, alcohol, and tobacco use amongst young people aged 11-15 years were obtained from a national survey conducted in 2018 on 13,664 secondary school aged young people https://digital.nhs.uk/data-and-information/publications/statistical/smoking-drinking-and-drug-use-among-young-people-in-england/2018/introduction

[35] Characteristics of Children in Need. Data obtained from local authorities by the Department for Education. https://explore-education-statistics.service.gov.uk/find-statistics/characteristics-of-children-in-need/2020#dataBlock-6bbdf6de-2b08-4cb9-b62e-2c0b555f308c-charts

[36] Children looked after in England including adoptions. Data obtained from routine data collection by local authorities. https://explore-education-statistics.service.gov.uk/find-statistics/children-looked-after-in-england-including-adoptions/2021#dataBlock-c4302ddd-306f-4c83-93f2-a685e64bf417-tables

- Two in ten (21.3%) young people currently or had ever had a child protection plan.
- Less than one in ten (6.3%) currently had a child protection plan. This is significantly higher than the 0.4% national prevalence of all children (aged 0-18 years) subject to a child protection plan for abuse or neglect for the year 2018[37] ($p<0.001$). Further, across all local authorities the prevalence of child protection plans was higher amongst clients compared to the local general population of young people (Figure 24). Prevalence of child protection plans differed across local authorities with the highest prevalence amongst clients from Halton (12.5%; Warrington, 8.3%; Cheshire West and Chester, 7.1%; Cheshire East, 3.3%).
- There were significant associations between ever having had a child protection plan in place and gender (females, 42.1%; males, 15.3%; $p<0.05$).
- There were no significant associations between having ever had a child protection plan and health conditions, needs, or neurodiversity.

### *Child criminal and sexual exploitation*

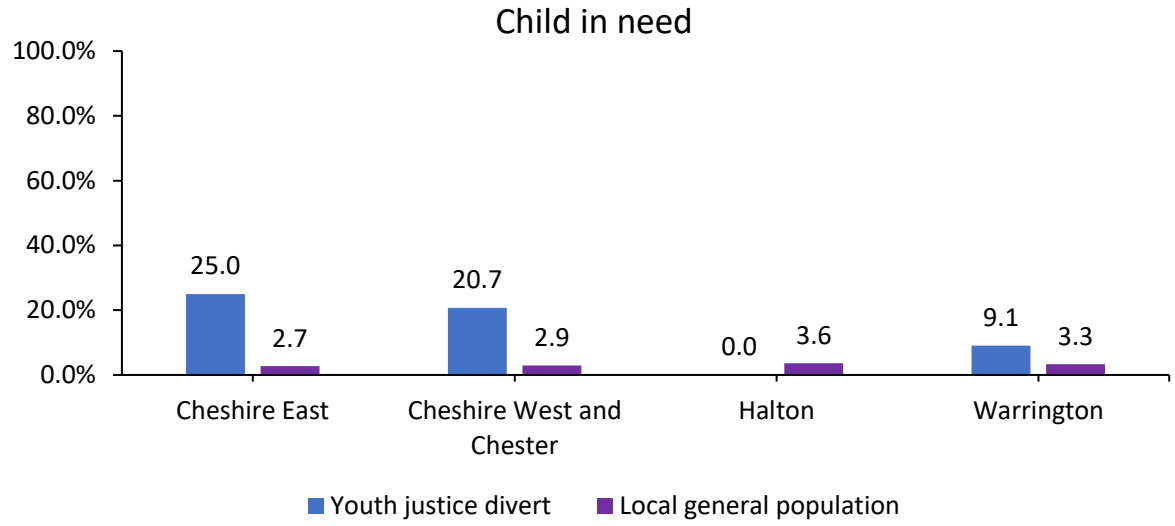
- A third (32.9%) of young people were considered vulnerable to criminal exploitation.
- Of those vulnerable to criminal exploitation, there were concerns for 66.7% that they were involved in county lines activities. In total, 6.3% had concerns that they were involved or at risk of being involved in county lines activities.
- There were significant associations between being vulnerable to criminal exploitation and: not living at home (70.0%; living at home, 27.1%; $p<0.01$); and not living with parents (62.5%; living with parents, 25.0%; $p<0.01$).
- There were no significant associations between being vulnerable to criminal exploitation and health conditions, needs, or neurodiversity.
- One in ten (12.0%) young people were considered vulnerable to sexual exploitation.
- There were significant associations between being vulnerable to sexual exploitation and: gender (females, 36.4%; males, 3.4%; $p<0.001$); not living at home (60.0%; living at home, 5.6%; $p<0.001$); and, not living with parents (37.5%; living with parents, 6.1%; $p<0.001$).
- There were no significant associations between sexual exploitation and any health conditions, needs, or neurodiversity.

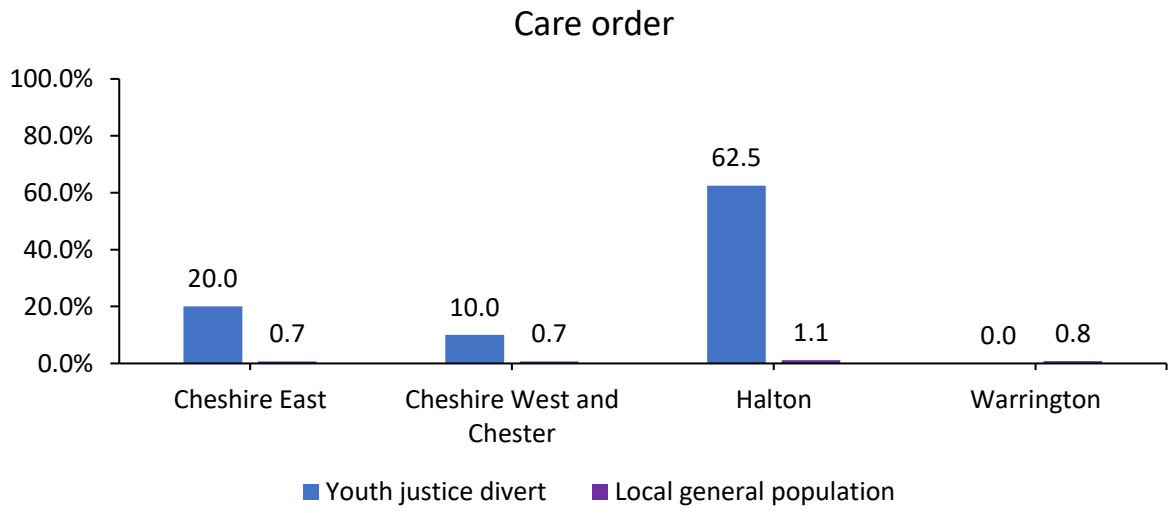
### *Missing children*

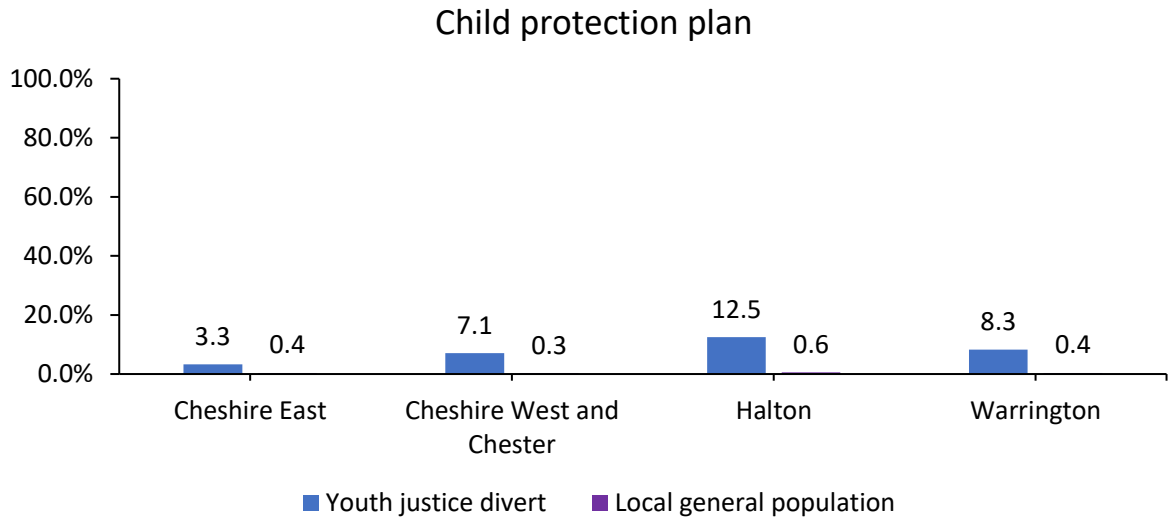
- Four in ten (41.5%) young people had at least one instance of being recorded missing.
- There were significant associations between ever being missing from home and: gender (females, 59.1%; males, 34.5%; $p<0.05$); ethnicity (White British, 49.3%; other ethnicities, 0.0%; $p<0.05$); not living at home (100.0%; living at home, 33.3%; $p<0.001$); and, not living with parents (75.0%; living with parents, 33.3%; $p<0.01$).
- A higher proportion of those with speech and language needs had ever been missing (52.0%) than those without (25.0%; $p<0.05$).

[37] Children subject to a child protection plan for abuse or neglect statistics. https://fingertips.phe.org.uk/profile/MH-JSNA/data#page/0/gid/1938132920/pat/6/par/E12000002/ati/102/are/E06000008/yrr/1/cid/4/tbm/1

**Figure 24: Social care needs by local authority amongst divert cases**



*Relationships*

- Nearly half (48.8%) of young people had caregivers who had underlying issues impacting the quality of care they provided for the young person. Of these young people, 50.0% had caregivers with multiple issues impacting their caregiving, 25.0% had mental health concerns only, 17.5% had substance misuse concerns only, while 7.5% had another type of concern only.
- A higher proportion of females had caregivers with underlying issues impacting the quality of care they provided (72.7%) than males (37.9%; $p<0.01$).
- A higher proportion of those with speech and language needs had caregivers with underlying issues impacting the quality of care they provided (56.0%) than those with no speech and language needs (29.2%; $p<0.05$).
- Nearly half (48.8%) of young people had incidents involving their current caregivers that risked the young person's safety and wellbeing.
- There were no significant associations between young people having had incidents involving their current caregivers risking the young person's safety and wellbeing and sociodemographics.
- A smaller proportion of those with educational needs had incidents involving their current caregivers that risked the young person's safety and wellbeing (36.6%) than those with no educational needs (62.5%; $p<0.05$).

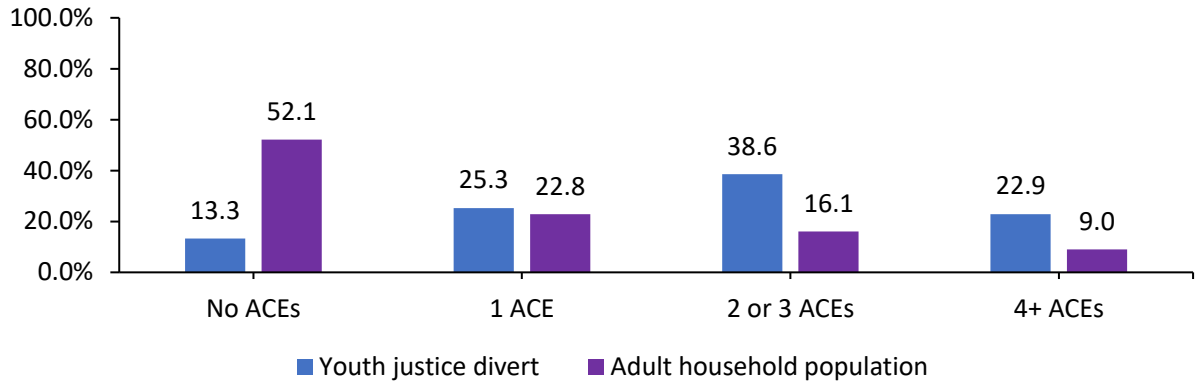
*Adverse childhood experiences*[38]

ACEs can have significant impacts on development and wellbeing during childhood and can be critical in shaping future health and social outcomes. Ten ACEs were recorded from the data which included: physical, verbal, and sexual abuse; physical and emotional neglect; parental separation; witnessing domestic violence; parental mental illness and substance misuse; and parental incarceration.

- The majority (86.7%) of young people had at least one ACE, compared to nationally whereby 47.9% of adults had experienced at least one ACE.
- Nearly a quarter (22.9%) had experienced 4+ ACEs. This is significantly higher than the estimated 9.0% prevalence of 4+ ACEs from a national retrospective study of adults in England ($p<0.001$).
- Whilst prevalence decreased as the number of ACEs increased for the nationally representative sample of adults, the reverse was true for the sample of young people on divert, with prevalence increasing as the number of ACEs increased, except for 4+ ACEs (Figure 25).
- The number of ACEs amongst young people ranged from 0 to 7. The mean number of ACEs was 2.4.
- There were significant associations between experiencing four or more ACEs and: not living at home (50.0%; living at home, 19.4%; $p<0.05$); and not living with parents (50.0%; living with parents, 16.7%; $p<0.01$).
- A higher proportion of those diagnosed with a mental health condition had 4 or more ACEs (62.5%), than those without a mental health condition (21.2%; $p<0.05$).

[38] National data and information for ACEs came from a representative household survey of people aged 18-69 years old (n=3885) undertaken in England in 2013 - https://bmcmedicine.biomedcentral.com/articles/10.1186/1741-7015-12-72

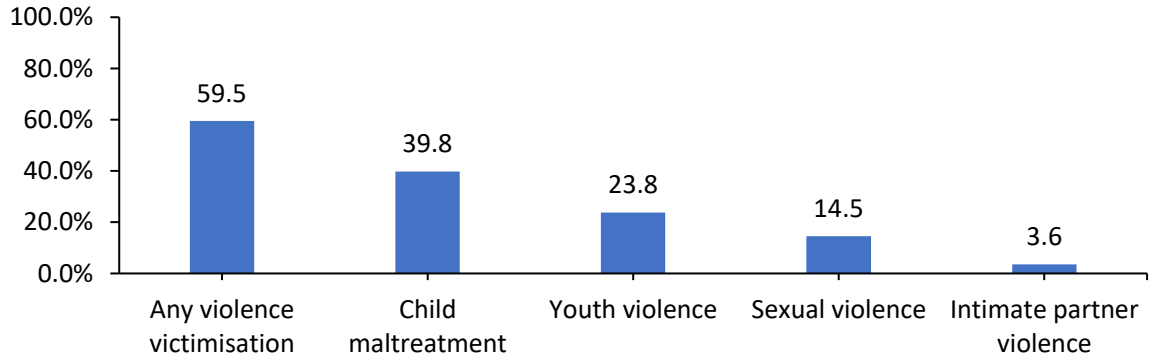
**Figure 25: Prevalence of ACEs amongst divert clients/nationally representative population of adults in England**




*Violence victimisation*

- Six in ten (59.5%) young people had experienced some form of violent victimisation (Figure 26).
- A higher proportion of females had ever experienced violent victimisation (77.3%), than males (51.7%; $p<0.05$).
- A higher proportion of those with speech and language needs had ever experienced violent victimisation (72.0%), than those without speech and language needs (41.7%; $p<0.05$).
- Four in ten (39.8%) experienced child maltreatment (Figure 26).
- Of those who experienced child maltreatment, 54.5% experienced multiple types of child maltreatment, 18.2% experienced neglect only, 18.2% experienced physical violence only, 6.1% experienced sexual violence only, and 3.0% experienced emotional child maltreatment only.
- A quarter (23.8%) experienced youth violence (Figure 26).
- Of those who experienced youth violence, 40.0% experienced bullying only, 40.0% experienced physical youth violence only, 10.0% experienced multiple types of violence, and 10% experienced emotional youth violence only.
- 14.5% experienced sexual violence (Figure 26).
- 3.6% experienced intimate partner violence (Figure 26).
- Of those who experienced intimate partner violence, 33.3% experienced physical violence only, 33.3% experienced emotional violence, and 33.3% experienced sexual intimate partner violence only.

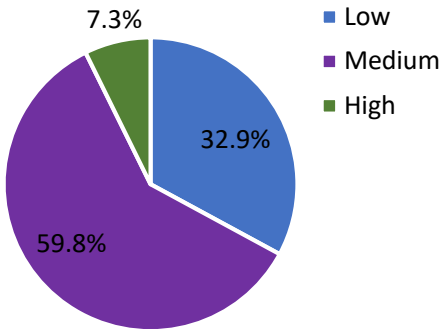
**Figure 26: Violence victimisation experiences of divert young people**



*Risk of future vulnerability and victimisation*

- 7.3% of young people were assessed as having high concerns for their safety and wellbeing (Figure 27).
- There were significant associations between safety and wellbeing ratings and: not living at home (40.0% high; living at home, 2.8% high; p<0.001); not living with parents (25.0% high; living with parents, 3.0% high; p<0.01).
- There were no significant associations between safety and wellbeing ratings and health conditions, needs, or neurodiversity.

**Figure 27: Safety and wellbeing risk level of divert young people**




### *3.3.14 Offending and violence perpetration (DIVERT cases)*

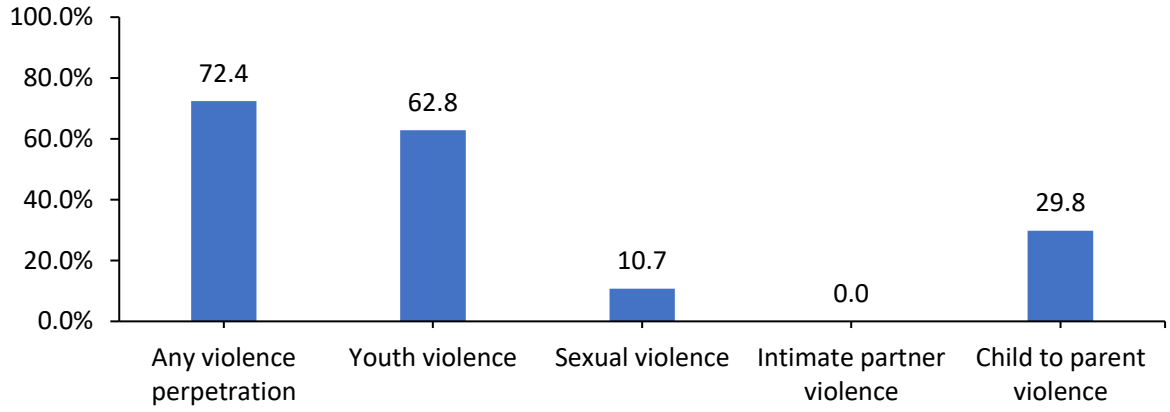
*Violence perpetration*[39]

- 72.4% of young people had perpetrated some form of violence (Figure 28).
- There were significant between violence perpetration and: gender (females, 91.7%; males, 63.9%; p<0.05); and living not at home (100.0%; living at home, 66.7%; p<0.05).
- There were no significant associations between violence perpetration and health conditions, needs, or neurodiversity.
- 62.8% perpetrated youth violence (Figure 28).
- Of those who perpetrated youth violence, 57.4% perpetrated physical youth violence only, 35.2% perpetrated multiple types of youth violence, and 7.4% perpetrated emotional youth violence only.
- One in ten (10.7%) perpetrated sexual violence (Figure 28).
- 0.0% perpetrated intimate partner violence (Figure 28).
- 29.8% perpetrated child to parent violence and abuse[40] (Figure 28).
- Of those who perpetrated child to parent violence and abuse 40.0% perpetrated emotional abuse only, 32.0% perpetrated physical abuse only, and 28.0% perpetrated multiple types of violence.

[39] WHO. World report on violence and health. https://apps.who.int/iris/bitstream/handle/10665/42495/9241545615_eng.pdf
Youth violence – physical, verbal, or sexual violence committed by the young person against an individual known or otherwise, outside of the family context. Examples include physical assaults – with or without weapons, gang-related violence, and bullying.
Sexual violence - any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work.
Intimate partner violence - any behaviour within an intimate relationship (including a dating relationship) that causes physical, psychological or sexual harm to those in the relationship. This may include acts of physical aggression, name calling, and controlling behaviours.

[40] Child to parent violence – any physical, psychological, or sexual acts perpetrated by the young person against their parent or primary caregiver (not including staff in care environments) causing harm. This may include acts of physical aggression, name calling, and controlling behaviours.

**Figure 28: Violence perpetration of divert young people**

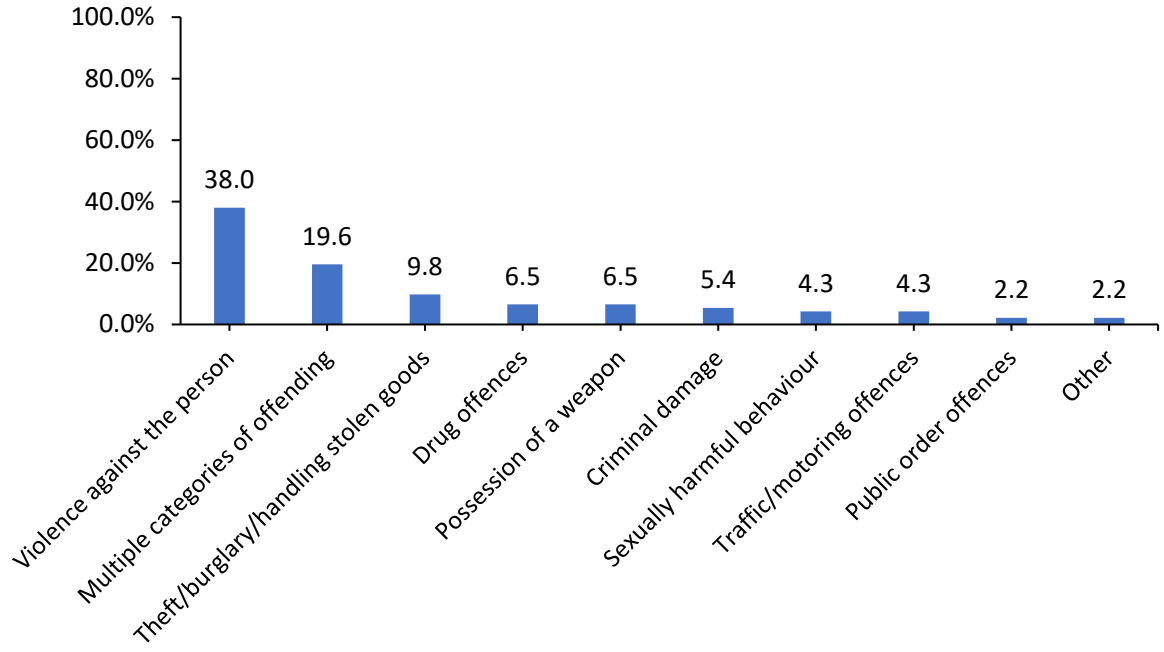



*Offending history*

- The most common category of most recent offence was violence against the person (38.0%), followed by multiple categories of offending (19.6%), and theft, burglary, or handling stolen goods offences (9.8%; Figure 29).
- Ages of the most recent offence ranged from 10.6 years to 17.6 years with a mean age of 14.9 years. Those with speech and language needs had a younger mean age of current offending (14.6 years) compared to those without speech and language needs (15.5 years; $p<0.05$).
- The seriousness of the most recent offence ranged from 1.0 to 6.0 with a mean seriousness of 2.9. Those who lived with their parents had a higher mean seriousness of the most recent offence (3.1) than those who lived not with their parents (2.7; $p<0.05$). There were no significant differences in the mean seriousness of the current offence by health conditions, needs, or neurodiversity.

- Ages of the first offence ranged from 10.6 years to 17.1 years with a mean age of 14.2 years. There were no significant associations between the mean age of the first offence and health conditions, needs, or neurodiversity.
- Seriousness of first offending ranged from 2.0 to 6.0 with a mean seriousness of the first offence of 2.8. There were no significant associations between the mean seriousness of the first offence and sociodemographics, or health conditions, needs, or neurodiversity.
- The total number of offences ranged from 1 to 9 with a mean of 2.4 offences committed. 91.2% committed five or fewer offences (one offence 45.1%; two offences 25.3%; three offences 13.2%; four offences 4.4%; five offences 3.3%).
- Those who lived not at home had a higher mean number of offences (3.9) than those who lived at home (2.1; $p<0.01$). Those who did not live with their parents had a higher mean number of offences (3.3) than those who lived with their parents (2.1; $p<0.05$).
- Those with speech and language needs had a higher mean number of offences (2.7 offences) than those without speech and language needs (1.7 offences; $p<0.01$).
- The number of separate incidents of offending ranged from 1 to 6 with a mean of 1.6 incidents of offending. The majority (97.8%) had five or fewer incidents of offending (one incident 68.5%; two incidents 15.2%; three incidents 8.7%; four incidents 2.2%; five incidents 3.3%).
- There were no significant associations between mean number of incidents of offending and sociodemographics.
- Those diagnosed with a mental health condition had a higher mean number of incidents of offending (2.5 incidents) than those with no mental health condition (1.6 incidents; $p<0.05$).

**Figure 29: Categories of most recent offence for divert young people**




*Risk of future offending*

- 6.1% of young people were judged as having a high likelihood of reoffending (Figure 30).
- 1.2% of young people were judged as posing a high risk of serious harm to others (Figure 31).

**Figure 30: Likelihood of reoffending for divert young people**

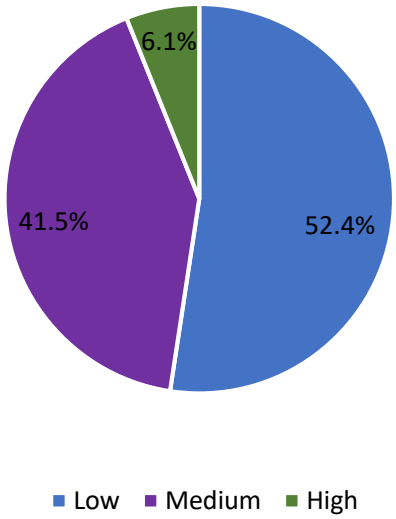
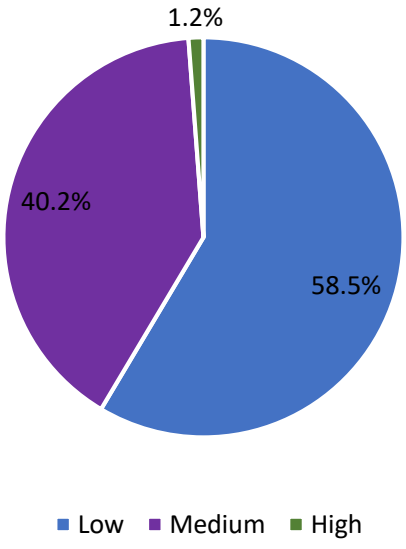



**Figure 31: Risk of serious harm to others for divert young people**



## 3.4 Understanding health priorities - engagement with stakeholders, parents, and young people[41]

### *3.4.1 Identifying the health and wellbeing needs of those involved in the Criminal Justice System*

Stakeholders involved in the delivery of services at Cheshire YJS and wider stakeholders across Cheshire identified a number of risk factors for young people becoming involved in crime. Many risk factors for crime were also related to health and wellbeing. Stakeholders reported a high proportion of children and young people presenting to the YJS with unidentified and unmet health needs. Several stakeholders discussed how these health and wellbeing needs have not previously been 'picked up' by other professionals. They acknowledged that it may not have escalated to the involvement of the YJS if some of these needs had been identified and supported sooner. Stakeholders agreed that it is important to look beyond presenting behaviours and explore the health and wellbeing needs of young people. Early identification of risk factors and health and wellbeing needs was seen as key to this.

*"The average age of a first-time entrant to the justice system in Cheshire, I think is 15-16. By that time, they've often developed patterns of behaviour because of a wide range of health issues that have gone undetected and undiagnosed" (S1, P1)*

*"What we see a lot of, is children where the health needs not necessarily being picked up. At school, paediatrics or health visitors, whenever it starts to present itself, it's after they've committed a crime and come to YJS. Then when we can see it quite clearly we've got the health team around that can go out and say, that's a quite an obvious health need" (S1, P2)*

*"I think it's pretty sad that children have to commit an offence to then get the support and the prevention side of it because it shouldn't come to that, it shouldn't be that that's what children have to do to get that support" (S10, P3)*

#### *Mental health and emotional wellbeing*

All stakeholders participating in the research agreed that poor mental health and emotional wellbeing for children and young people was a prominent risk factor for involvement in crime and a significant unmet wellbeing need for young people entering the CJS. This included anxiety, depression, low resilience, confidence, and self-esteem, which was seen as a much higher need compared to physical health needs. A number of stakeholders also reported an increase in low self-esteem amongst young females.

*"The biggest presenting need is emotional health and wellbeing or compromised emotional health and wellbeing" (SH1)*

*"I think mental health is becoming a lot more prevalent. So, I think that ranges from low self-esteem which can turn people towards their peers to get that kudos, and that relationship can maybe lead them down the road to crime. We see a lot of low self-esteem among our children" (S1, P2)*

*"Our children are just really good at masking it and finding coping strategies that work for them. Sometimes it's cannabis, sometimes it's crime, sometimes it's self-harm. Whatever works for them, they're going to go down that route, but actually it needs somebody to say this is what's happening for you, why you're feeling like that. That's why, just to explain it to*

[41] Quote key: wider stakeholder: SH; YJS staff member: S (for focus groups, P is member of that group, e.g., S4, P4 is staff focus group, participant 4); Parents: P; Young person: YP

*them. But that doesn't seem to be built into the system anywhere. It always feels to me very fragmented in health" (S2, P2)*

Stakeholders discussed that many young people are not taught how to problem solve and have a lack of resilience as well as poor emotional literacy. It was felt that young people do not have the resilience and coping mechanisms to help them to address these feelings, so they are left open to involvement in crime. Stakeholders spoke about the need to teach young people and provide them with an alternative, and a way out of being involved in crime. It was felt that young people feel under pressure because of the expectations that they place on themselves, but also that are placed on them by others.

*"There are usually things that have gone on in their lives that they've not known how to handle emotionally... A lot of them will then avoid whatever that is through drugs and that will then stick it all deep down under the surface and they end up kind of emotionally stunted" (SH10)*

*"The thing I always found with working with young men who are kind of aggressive or angry is that they're usually pretty sad" (SH14)*

Stakeholders explained that the COVID-19 pandemic had a negative impact on young people and their family's mental health and there had been a surge in demand for mental health support and increased complexity of needs. This included increased anxiety, low self-esteem and self-worth, drug use, and feelings of frustration due to elements of control being removed from young people's lives. It was highlighted that there is a 'domino effect' of behaviours around inward anger and damaging behaviours with increases seen in self-harm, suicidal ideology and eating disorders, and outwardly damaging behaviours of anger and violence. All of which were seen to be increasing and from a younger age. The pandemic had also increased isolation, which had further impacted on poor mental health, and also reduced social skills and support networks. These young people were also considered hard to reach and engage with. They explained more work was needed to help young people navigate these impacts. Poor mental health for parents was also seen to have created additional challenges for young people.

*"I think mental health is the biggest and because across the board, whether they're young people that we work with or whether they young people in society now. Mental health is a massive thing nowadays, not helped by COVID, obviously, because that had a drastic impact on everybody" (S10, P3)*

*"If they're living with a parent or two parents with poor mental health, surviving that is a huge challenge for young people. Coping with living like that and a part of that not having the needs met" (SH2)*

Stakeholders spoke about the importance of mental health (specialist and non-specialist) support for young people involved with the YJS or on the periphery of crime due to their chaotic lifestyles and risk-taking behaviours. Stakeholders believed that generally there is a lack of targeted health and wellbeing support to be able to get young people into services and this has far reaching implications.

Providing lower-level support linking families to secondary care mental health services was seen to be important. Stakeholders highlighted some of the current support available across Cheshire, including, Health Box (low-level intervention at individual, group and family level provided by a third sector provider as a wrap-around service) and Cheshire and Wirral Partnership (CWP) (CAMHS, NHS providers and specialist providers for bereavement etc.) Areas where lower-level social, emotional, and mental health support may be provided to young people included the mental health and school teams (e.g., Starting Well from the 0-19 service); the team around the family; and the Youth Service as well as reliance upon third sector organisations. Stakeholders spoke about investment being made

into mental health support teams, of which there are eight across Cheshire, but that these only address low to moderate depression and anxiety.

*"Unless they're about to kill themselves. You don't get any support. It's like well, no, it's the young people are coming in with the start of an eating disorder or the start of an anxiety disorder. The start of something we need to get in there to prevent it escalating to the point" (S2, P4)*

*"We haven't invested in them as much as we should have done. That's through no fault of our own as commissioners. It's just most, most of the funding for children, young people's mental health services always gone towards CAMHS. I think parents and carers always think they need specialist intervention when in fact we want to be moving towards the low to moderate, to stop it in its tracks" (SH12)*

For specialist support, CAMHS was seen as specialist, with strict criteria and limited capacity. It was felt that an over-reliance could also be placed upon third sector organisations to 'mop up' those children and young people who were not able to access CAMHS. One stakeholder acknowledged that they did not feel they had invested in third sector organisations as much as they should have done. They spoke about trying to move to low/moderate interventions in order to take an upstream and preventative approach to mental health, rather than reactively when cases have become more severe. This was seen to be difficult to overcome due to the demand and long waiting lists for CAMHS. There were additional barriers reported for engaging with CAMHS, including parent's negative experiences of other statutory mainstream services and perceived stigma attached to engaging with the support.

*"It's like 'just a little bit of self-harming' and you've got a wait 6-12 weeks and things like that to get to get an appointment" (P2)*

*"If some of these kids need sort of emotional health support then CAMHS is brilliant and to be fair, if we do identify that and we get our CAMHS worker involved, the families are really appreciative because it kind of cuts down if they're on a big waiting list" (S3)*

### *Physical health*

Physical health needs were not discussed in great detail by any of the stakeholders, parents and young people participating in this research. However, it was discussed in relation to poverty and access to services, including families not being registered with a GP or dentist, or engaging with mainstream services. Ill-health linked to deprivation was also acknowledged, in terms of increasing costs of nutritious food and the implications for this on obesity and long-terms conditions including diabetes, bone health, and respiratory diseases. The links between poor physical health and poor mental health, were flagged, as well as parenting abilities and the access to healthcare for their children.

*"If they've been neglected by their parents, they probably have not good dental health" (SH14)*

In identifying and responding to health and wellbeing needs, one stakeholder spoke about questions being asked as part of their overall assessment about physical health. It was, however, noted that things can often be missed. Through the questions being asked, young people will also then be referred/signposted to relevant services. Support is also given to access services such as GPs and booking appointments. It was stated that the YOT are responsible for the provision of physical health services for those who are in contact with the YJS. Sexual health was not discussed in detail as an unmet health need compared to other health factors, however one stakeholder highlighted the benefit of co-location of services in Warrington meant young people had access to sexual health and wider health interventions at one central location.

*Neurodiversity and special educational needs and disability*

Neurodiversity was highlighted as a significant risk factor for young people becoming involved in crime, and stakeholders reported significantly high proportions of young people entering he CJS with unidentified special educational needs and disability (SEND) needs. This included ADHD and ASD. Stakeholders highlighted the risk factors associated with neurodiversity and SEND, including impulsive and thrill seeking behaviour, and 'acting out' at school. This was also seen as an increased risk factor for child criminal exploitation (CCE) and child sexual exploration (CSE) for young people who struggle to socialise and develop relationships and friendships, and want to impress adults, who may be at increased risk of exploitation when perpetrators show them interest. Difficulties with speech and language that may not previously have been identified was seen to lead to anger and frustration. Violent behaviour was also flagged as an expression of underlying speech and language and communication issues. Discussions also focused on the links between undiagnosed neurodiversity and poor mental health of adults in prison, with the question raised that if a diagnosis was made earlier could it have impacted on the trajectory for those who go onto receive a custodial sentence.

> *"(YP) has a diagnosis of ADHD, so he has always struggled with his emotional wellbeing and trying to express things" (P3)*

> *"I had a rough guess, about 70% have got speech language communication needs and if you're lucky, 3% of them have been previously identified… It is very commonly ADHD, everybody talks and this group being ASD, but ADHD is much more rife in youth justice… If I counted how many kids on case list have ADHD, it would be quicker to count the kids that don't, and that in itself, flags up some significant issues for me" (S4, P2)*

> *"I think a lot of services are generally quite medical model based as well… if you're looking at in person centred way, without language support those needs are going to persist throughout their lives" (S4, P1)*

Communication challenges associated with neurodiversity were also cited in terms of engaging with appointments and understanding processes. Stakeholders highlighted how professionals can misunderstand the needs of these young people, for example through teachers seeing them as 'naughty' or police seeing them as rude.

> *"For high-risk cohorts, we see a depressingly familiar kind of trajectory of kids where they may have a diagnosis of ADHD, ASD or may not but there's a typical behaviour. They've been kind of excluded really from the health offers because it's seen as behavioural. It's the kid that has grown up with multiple adverse childhood experiences, trauma and they've got that kind of almost permanent state of hyperarousal. The expression to flip your lid and that results often in violence. The violence, then, is the symptom. But flipping the lid that hyperarousal, that flooding of adrenaline in the system is the health issue, isn't it? And not easily treated when it's got to that point, it wouldn't necessarily have got to that point if there was a more inclusive educational health system earlier" (S1, P1)*

Stakeholders also gave examples of the long waiting lists for assessment and diagnosis. For young people with or without a diagnosis, there were examples of them self-medicating with drug use. It was felt that it is important to identify and acknowledge these risk-taking behaviours and potential pathways to criminality. It was commented that there are pathways in school that are present to look a risk-taking behaviour, but that they are not necessarily targeted around SEND, but more around managing young people effectively. The delay in diagnosis and long timeline for official diagnosis of up to three years once assessed meant that young people were missing out of an early and timely diagnosis and the support that comes with a diagnosis. This was seen to increase risk factors and

exacerbate the unmet health needs. Examples were provided for young people who had not had as assessment or diagnosis, where parents discussed long-term issues that had not been picked up by other services until engaging with YJS. Other examples were provided for parents who had reached out for support but not received any. Stakeholders also acknowledged that there is often a lack of support for these children as referrals to CAMHS are not accepted due to believing the child has behavioural issues, rather than neurodiversity and SEND.

*"We're often working with 15-16 year olds and a lot of speech language therapy services are not going to accept a referral at that age" (S4, P3)*

*"I didn't know where I was going with (YP) in the future, I've been telling social services about (YP needs) since he was six years of age, his attendance at school was 37% last year through no fault of my own. It's just that the school had him on a reduced timetable, I was saying how easily led he is, and no one was listening to me" (P1)*

Stakeholders at the multi-agency workshop reflected on the barriers for neurodiverse children and young people. Recognising that through unmet need, late diagnosis, and lack of education and awareness, that these young people are at risk of becoming marginalised and excluded from education and mainstream services and support, and ultimately excluded from society. The stakeholders felt that the current system is set up to fail these children and young people. School exclusion was highlighted as a significant barrier for families feeling punished and excluded rather than supported.

*"That early discrimination that society just give up and it almost feels that way for these kids, the ones that are excluded from our mainstream system. They're in a terrible place societally and psychologically. Then that plays out in their emotional behaviour, feelings and everything else" (WS)*

*"The systems that we have in terms of education support are specifically designed to exclude neurodiversity because they're not designed to address that fundamental need. So having somebody who cannot cope and engage with the highly structured day. The need for measurable outcomes in terms of academic achievement and attainment means that it actively excludes that group. It is felt as punishment and exclusion by those individuals and families when their child doesn't achieve, but could achieve massively with a different approach" (WS)*

One stakeholder explained that they did not feel that the SEND offer is easy for families to navigate. Stakeholders commented that there are gaps in support, and an appropriate coordinated approach is required. They noted multiagency work that is being undertaken around a new holistic neurodevelopmental pathway, accessed through early help, and involving third sector agencies. Stakeholders commented that there are gaps in support and an appropriate, coordinated approach is required. It was felt that picking up on these needs as early as possible was essential because of the potential for it to impact on the life course of young people and their life chances. Universal health services such as GP, school nurses, and Health Visitors are seen to support SEND. It was believed that there is a need to promote and raise awareness of the universal offer and that more outreach needs to take place bringing services to parents and families to proactively identify young people and families in need of support rather than waiting for parents to come to the services. It was felt that the current processes are archaic, for example, using a traditional medical setting with young people who would struggle to sit still and wait who may then cause a disturbance. One stakeholder stated that there needs to be a 'shake up' in the way in which services engage with young people to rethink how young people and their families can access services.

*"I think there's a bit of a gap, you know a child will touch certain professionals at certain ages, don't they? Then it's kind of stops. So health visitors stops at two, and then what? You know they're not yet at school. There's kind of a gap there. I wonder if screening for speech and language therapy, screening for mental health, screening maybe for physical health, maybe that needs to happen" (S2, P2)*

*"He's (YP) also got tics and I used to say to school sometimes his tics are swear words and it was like well he's swearing so they'd send him home, they'd say he can't use that language and I'd say well he can't help it. It was like they were trying to make out I had this naughty child, and I was making excuses, and I wasn't" (P1)*

*"The number of times you'll see referral and said, oh, they didn't seem to be very sorry about what it was that they'd done… he didn't take it seriously, he was with laughing, didn't have an empathy, didn't have remorse, and think they're cracking jokes when really they're not. If they got massive issues with autism or all sorts of things that will affect their ability to empathise or even fully recollect what they've done. So sometimes the referrals can come across as a little bit judgmental I think from the police. They just think kids taking the mick and they're not. It's a special educational need" (S2, P2&P4)*

*Substance use*

Drug and alcohol use were identified as another risk factor for young people engaging in crime and entering the CJS. Cannabis use was raised as a significant contributing factor and was often associated with dual diagnosis for young people struggling with their mental health, and for those using cannabis to self-medicate.

*"Because cannabis is the most prevalent used across the board of our young people with the THC levels getting higher. It's getting to the point where it's dangerous…So that leads to a lot of mental health, schizophrenia, addiction, behaviour cycles, the need to sustain your addictions so that creates criminality as in, you have to commit further offences, if you can't afford it" (S6)*

Early cannabis use was seen to act as a gateway into other forms of substance use, but also was linked to criminality in those instances, for example, where a debt is built that leads to a child or young person being exploited to commit crime in order to pay off their debts. Substance use was also recognised as a form of self-harm. The importance of acknowledging that children and young people from all backgrounds can become involved in early drug use such as cannabis and end up dealing drugs and drug running was highlighted. Discussion focussed on the physiological impact of cannabis use on brain function and how this can lead to young people not wanting to be involved with aspects such as school. Substance use within the family was also acknowledged as a risk factor with one stakeholder stating that a model of prevalence for families with drug and alcohol abuse and associated impacts is being developed. Lack of drug services for children and young people was seen as a barrier to young people accessing support. The voluntary nature of substance use services were also noted in terms of young people and their families not wanting to engage and having no statutory requirement to attend.

*"Often young people experimenting with cannabis when they're very young, they often move on to other drugs. The cannabis starts to have a significant impact on their mental health" (SH2)*

*"It depends how you define whether you define self-harm as there's self-injurious behaviours, cutting, or whether you expand it to drug use. These kind of reckless, less kind of obvious self-harm. Sad kids whose behaviour is a cry to say I am not happy. I'm struggling" (S1, P1)*

### *Education, training, and employment*

Disengagement from education was identified as a significant risk factor for young people becoming involved in the CJS. All four of the young people who participated in this research had been disengaged from school before their engagement with YJS. Stakeholders also described how high proportions of young people coming into contact with YJS were not in any EET, disengaged from school, had multiple missing episodes from school, or had been excluded from mainstream education. Particular risk factors relating to education and educational settings that were seen to increase the risk of children and young people becoming involved in criminality predominantly focussed on the impact of a poor journey through school. This included families not taking up early education provision i.e., nursery, so aspects that would have been identified prior to school entry at the age of 4/5 years of age are being missed. As well as the impact of the transition period from primary to secondary school, it was felt that there is a COVID-19 legacy and that this is having an emotional impact in terms of children not wanting to come to school.

*"We have young people who don't, who haven't been to school for quite a long time" (S7, P4)*

*"A lot of them [YP] are struggling, I think especially the ones who were in primary and missed the transition to high school, I think they're really finding it hard" (S2, P4)*

*"We had a lot of young people with special educational needs that have struggled to return after the pandemic. Calling people back in now because they've adjusted to being at home, which is a challenge. But also presents risks if they're not engaged in the education system, not just academically, but socially. It also makes them more vulnerable in lots of different ways. Risk losing some of these young people in the system" (WS)*

Stakeholders highlighted the relationship between 'behavioural issues' and school exclusions. they acknowledged that children and young people who are not in education, employment or training (NEET) are more likely to have had fixed term or permanent exclusions, absences from education, and attendance at alternative school provision such as PRU's. This stakeholder spoke about exclusions being bespoke to schools because of their levels of tolerance. They felt that as funding to deal with children who may need additional support has in many instances been removed, making schools less tolerant, i.e., one school may exclude, whereas another may not. Stakeholders also reported an increase in the number of permanent inclusions and young people attending PRUs and that this is seen to directly link to cases of CCE, and those at risk of grooming. Stakeholders described how those who are not in consistent education are more likely to become involved in crime and they can 'become bored' and begin adopting risky health behaviours such as smoking. Stakeholders felt that alternative education opportunities may be lacking for young people. It was recommended that further work is needed within the pre-16 statutory school environment to look at levels of risk to staff, the whole school and students before an exclusion is put in place and consistency around exclusions criteria.

Where young people are excluded as a result of criminal activity, stakeholders commented that the young person's life is irrevocably changed, and their life journey is significantly impacted. One stakeholder stated that it is 'game over' as they are moved away from their peers, they do not have access to statutory education, and their life chances decrease. It was felt that more work needs to be done in this area to mitigate against these outcomes. Stakeholders reported that education teachers attend subgroups looking at exclusions but noted that it is important to explore what is driving these, and that it is necessary to understand the behaviour from a systems approach. Stakeholders

highlighted that there is a provision of wrap-around social, emotional, and mental health support and safeguarding provided in schools as well as mental health support for staff in schools; with a new initiative launched so that schools have a direct pathway to CAMHS but also to third organisations for lower-level support.

*"I think that there is a real challenge with our schools in terms of what they're being driven to do by the regulators and what's happening to them from a financial situation. The lack of availability of staff, recruitment, reduction in their resources" (WS)*

School was described as a protective factor. Children were seen to be safer if they are in education because there are 'eyes on them' and it was felt that all children and young people have a right to access to education. However, stakeholders did question what happens to those children who do not access education. There was seen to be a reliance upon education settings to pick up issues. For children and young people who are not in education, it was considered that they do not have the access to people checking in and seeing if they are eating properly, getting enough sleep, having their childhood injections etc. It was discussed in these instances that young people need to have very articulate and vocal parents. One of the stakeholders provided an example around diagnosis of SEND and that there is a chronology which is important to follow and that it needs to be identified early so that aspects can be managed. This chronology can be disrupted, especially where you have a young person that has had frequent school changes (this can also impact on their mental health, willingness to engage, formation of friendships etc.).

The education system was seen as a conduit through which young people could be encouraged to access support and advocate for themselves. Having youth workers based within the school system was seen as a way in which young people may be given the time and attention they need. It was also identified that NEET children and young people would not have access to such support. Stakeholders also highlighted the need to build better relationships between the Police and young people. They commented that voluntary relationships with detached youth work could be key to breaking down barriers of distrust with professionals so that the young people spend time with people who 'they will allow to challenge their world views'. Employment was discussed in the context of those young people who may have already been involved in aspects of criminality. Employability and access to work was seen to be dependent upon the level of risk and crime committed.

*"I think time and time again we've been told teachers don't know where to access the support if they've got a child in school who's approached them and divulged something that they've done this. I think they do struggle in education and I think that that we need to strengthen that link between our education and health systems" (SH12)*

### *Home life and family*

Young people are seen to develop their values within the home environment and are heavily influenced by their parents. Neglect at home and lack of parental capacity was also flagged as a risk factor. Examples were provided for young people with no boundaries or parental control at home, due to neglect and/or a parent with their own complex needs. This was linked to ACEs. It was felt that young people can have a number of challenges around attachment and boundaries, including love, nurture, reassurance, and guidance.

*"A lack of support for parents, carers and guardians around understanding behaviours" (S6)*

*"What if they don't have parents around them. The mainstream service relies on all young people accessing the services to have parents, school staff and adults around them. That's how*

*they tend to sort of slip through the net in that sense because there is no one putting (support) in place" (S4, P1)*

Stakeholders acknowledged the impact of ACEs (e.g., absent parents, being a victim of abuse, domestic violence, substance use, parental mental health issues, parents involved with the CJS) upon the development and life course of children and young people, due to their experiences of parenting and attachment/bonding. In these instances, families are considered vulnerable, and it was seen to be likely that they will already be receiving support of some form e.g., if they are engaging in the safeguarding arena or they need intensive support. It was noted that there should be more family support for emotional health, substance misuse, and domestic abuse, with one stakeholder referring to this as the toxic triangle/trio. Another stakeholder highlighted the generations of trauma that have not been dealt with, which means that parents/carers cannot deal with the issues facing their own children.

*"Sometimes you have got generations of trauma that are just inherent in family backgrounds, some of the things that they can't do it because they don't know how to do it" (S8, P2)*

*"It's very complex families that we deal with. So, 9 times out of 10, the parents have got their own issues possibly not being addressed" (S7, P3)*

Failure to report their children missing during periods of missing episodes and parental disengagement with school, were also highlighted as risk factors and for barriers for engaging with support. Stakeholders explained that lack of parental capacity to protect within the home meant that young people were not protected from exploitation outside of the home. Stakeholders also highlighted the importance of understanding parental capacity when developing care plans for young people and being aware they may not be able to enforce rules or support their child. One staff member acknowledged that they are seeing generational involvement in crime, where parents have previously been involved in the CJS.

*"So they're living in a chaotic households where either mums in trouble, dad's in trouble, and that's that. That's how they perceive life. Those are the children, young people that don't get instrumental health services because they're living that chaotic life. It's a vicious circle, sort of generational" (SH12)*

Risks were also identified among young people brought up in single-parent families, or dealing with their parents own challenges, and parental relationship breakdown. It was, however, identified that those involved in criminality come from all different family backgrounds and included strict parents and parents who are emotionally unavailable. Children and young people in care or on the edge of care were felt to be more likely to become involved in criminality compared to others. Stakeholders also acknowledged that LAC are at an increased risk of criminal exploitation, especially for those who move out of areas for residential housing.

*"There's often quite a culmination of difficult family backgrounds. So sometimes they it's really hard to tease out which part of their health needs have been dealt with and which parts haven't which parts need further intervention" (S7, P4)*

*"We do a lot of work on healthy relationships, trying to establish them for moving forward to be able to manage relationships, whether that be intimate relationships, or family relationships" (S8, P1)*

### *Community and locality*

Looking at values and sense of community and belonging, and how these impact upon behaviour was seen to be vital in helping to reduce risk in children and young people. It was highlighted by many of the stakeholders that at the present time, many children and young people do not feel a sense of belonging to their local community or anywhere else.

*"I think that sense of belonging is a real strong one because sometimes that can be to do with your cultural identity, and you know how you fit in within the community" (SH2)*

When exploring geographical locality as a risk factor for criminality, stakeholders commented that it is not a simple approach as there are different factors present in different areas. For example, gang culture meant there was a lot of gang initiation resulting in young people being marginalised and being pressured to take part in criminal activity. It was also important to note that there is increased risk to those children and young people who live in more isolated pockets and areas because of lack of wrap-around care compared to bigger areas.

Partners described the lack of activities and opportunities for young people. They explained that young people are bored, frustrated, and have limited aspirations; this was intrinsically linked to the risk factors outlined above, including poverty. They reported that some areas have more resources and opportunities than others, which was seen as a protective factor, keeping young people 'in sight' and engaged. Funding cuts and impact of the Covid-19 pandemic were seen as contributing factors to lessening opportunities for young people. Limited availability of community projects and youth provision in the form of youth centres e that provide safe environments was highlighted. Stakeholders stressed the importance for grassroots support to help young people build basic skills and opportunities for them to engage in meaningful activities and engage with and become a valued member of their community. There was discussion around the need for positive male role models, acknowledging that this area is lacking for many young people involved in the YJS.

*"Some areas that you go to, they've got all singing and dancing activities for the kids, there's loads of things available for them, (other) deprived areas, you know they can't access and they don't have the same (offer)" (S8, P5)*

### *Poverty*

Poverty was raised as a significant risk factor for young people to become involved in crime, especially in terms of being vulnerable to exploitation. Stakeholders explained that in areas across Cheshire with low socio-economic status and high deprivation there are clear links between poverty, crime, trauma, and poor mental health. It was also highlighted that there can be pockets of deprivation within more affluent areas, such as in Frodsham.

*"A population of kids that have by definition really have fallen through the cracks. Because of educational exclusion, social exclusion, health exclusion. In terms of the wider determinants of health, we know the biggest link for crime is poverty We've got kids that have grown up largely in poverty" (S1, P1)*

Stakeholders participating in the research gave examples of low-income families struggling with food poverty, and the increased need for signposting to foodbanks. They also recognised digital poverty and the barriers for engaging in support throughout, and following, the COVID-19 pandemic. Those living in areas of deprivation were also considered at higher risk because they may be more vulnerable to exploitation and criminal behaviour where they may receive an immediate reward. Intergenerational aspirations were also cited as risk factors for involvement in criminality. It was

acknowledged that some young people feel a lack of entitlement that is passed down through the family dynamic and feelings of anger are associated with material gain and wealth.

Unemployment, low-income, debt, and the increased burden due to austerity and funding cuts were considered as risk factors, and were all seen to have been exacerbated by the COVID-19 pandemic and cost of living crisis. Stakeholders spoke about expecting to see a rise in need due to the fuel, food, and cost of living crisis, especially in Autumn and Winter. Stakeholders also expressed concerns around the potential increased risk of crime due to the increased poverty across Cheshire. Stakeholders reported seeing an increased presentation to services, and recognised the impacts for staff, both in terms of supporting the increased need, but also in terms of their own financial struggles. Poverty was linked to the pull factors for criminal activity and young people trying to financially provide for their families, and parents who were implicit to the criminal activity. A need for a route out for young people and their families to legitimately earn money was highlighted as critical.

*"One of the things that I immediately focus on is kind of food poverty and very, very low-income families. I mean, even more so now it's just getting magnified. I think this winter will be horrendous for most of the families that are service deal with" (S8, P3)*

*"We're really conscious it'll start to affect our practitioners. It's not just the children's families, it's our practice, our staff as well. It's the welfare of them" (SH1)*

Homelessness was also cited as both a risk factor and impact for involvement in crime for young people and their families. It was also seen to be important to look at housing situations and young people who may be experiencing homelessness as it was felt that this can be a generational trend which impacts upon access to health services, which in turn has a knock on effect for the development of young people.

### *Social networks and peer groups*

The stakeholders participating in the research considered the contextual safeguarding factors that increase the risk for some young people to engage in criminal activity, including the increased risk for criminal exploitation. The above risk factors and unmet health needs were linked to young people feeling isolated and lonely and may feel a sense of belonging from being involved in a gang or unhealthy behaviours with peers. This was also flagged for LAC and children unhappy at home looking for sanctuary from peer groups. These risk factors were a concern for CCE, CSE, and county lines involvement. One stakeholder noted the challenge of trying to support families whilst also competing against the push/pull factor that organised crime groups can have when grooming children and young people.

*"A lot of things they do, they do to survive or they do because they feel that's what they need to do it to survive within the groups and the environment that they're in" (SH10)*

*"Young people who find sanctuary within peers rather than at home because the family they got, they don't get any love and attention at home. They're out all the time with peers and unfortunately, peer pressure, obviously they're a vulnerable group" (S3)*

*"There are extrinsic factors though with organised crime groups. I think most things we deal with in public health, there's not an opposing force, actively working to unpick what's being done. Which is a bit different than most sort of like health needs assessments cause usually not fighting against something else trying to cause the problem" (WS)*

It was highlighted that peer pressure and the need for young people to try and fit in can be a strong risk factor. It was also reported that since COVID-19, there are more girls involved in extreme behaviours and who are more inclined towards violence and the use of alcohol. Those children and

young people who are part of gangs or are involved with groups who commit crime were also seen to be more likely to commit crime.

*"When you're going out every day, hanging out doing nothing you're going to want to get in trouble aren't you. Don't get me wrong, you make your own choices in life, it just hanging about with kids like that, it's not going to help is it?" (YP3)*

*"We've got certain elements of young people being peer influenced and peer pressure is one of the major sort of things really… they gravitate to those you know likeminded peers and friendship groups and in relationships as a whole really" (S8, P1)*

The majority of stakeholders reported the damaging role of social media and responsibility of these platforms in promoting unachievable lifestyles and as a platform for grooming and abuse of vulnerable young people. Parents of young people also acknowledged the damaging impact of social media to mental health. Online video gaming, television, and early access to pornographic content were also linked to increased violence at a younger age, with young people not always sure who to go to with their concerns related to graphic imagery.

*"They're always on the phones. I think that really messes with their mental health because they're looking at stuff and it's like this is what they're portraying reality to be and that's really not the case so there's like an expectation to be something that you're not and I think a lot of teenagers struggle with that" (P2)*

*"The impact of pornography on young people and it's been described as a massive health crisis for children because it's been linked to more and more harmful sexual behaviour, but also linked to mental health issues, anxiety, mood disorders because of the impacts of it… It's extremely violent" (S2, P4)*

### *Transition to adulthood*

Stakeholders identified a significant gap in provision for young people on the cusp of adulthood. This transition to adulthood was recognised as a critical point for young people. Stakeholders expressed concerns for young people turning 18 years of age, with those acknowledging that many vulnerable young people are not necessarily ready for adulthood. Examples were also given for the neurotoxic impacts of trauma on cognitive development. Stakeholders explained that many of these young people 'fall between the lines' once they no longer have access to child-focused services that provide more opportunities to engage with understanding professionals, more time spent on developing trusted relationships and increased chances to engage with services. Aftercare was also flagged for those young people who move up into adult services, and in general for all young people once they complete their DIVERT or statutory order. Stakeholders discussed the whole package offer that was in place under Cheshire YJS, and concerns were expressed for what happens once their order is complete, and they no longer have access to such wraparound support. Partners recognised the importance of exit strategies, and onward signposting and referral for wider and longer-term support.

*"Transitioning over… (CAMHS said) YP won't be getting spoon fed anymore, they would have to come to the appointments on her own, we can't do any appointments at home. That was the difference from a child on a Monday turning into an adult on a Tuesday… Just an example of where our mental health services provision is just woefully inadequate, isn't it?" (S2, P1)*

*"The young people are brought in through social care, pull their fingers out because they need to. The young person and the family get a huge amount of support for that period of time and*

*then they all pull out, it's temporary. Supposedly, we're putting a lot of things in place, but all of those things are going to be pulled away from that young person" (S4, P3)*

### *3.4.2 Responding to the health and wellbeing needs of those involved in the Criminal Justice System*

#### *Barriers to engaging with services*

The above risk factors and unmet health needs were all recognised as barriers to engaging in support. In addition to this, stakeholders acknowledged barriers around accessibility, past negative experiences of services, and difficulties navigating the system. Stakeholders commented that by the time a young person has become involved with the YJS, they and their families will more than likely have had a lot of involvement in early years work and have been through lots of different aspects of the system. The past experiences of young people and their families with services was identified as a risk factor, with young people feeling disenfranchised and therefore less likely to engage. This included generational fear and taboos about accessing support, particularly around accessing support from health services, previous negative experiences of services for family members, shame because of the offence, and stigma related to offending, and stigma or peer pressure of not wanting to admit they were seeking help.

*"One of the biggest barriers is that they're used to rejection and being failed by others" (S8, P2)*

*"It's difficult to engage them in the first place. You know, a lot of them can be coerced into that assessment process. Admitting speech and language difficulties is quite a difficult thing to present to a teenager who has potentially struggled all their life, tried to mask it and obviously we're talking potential emotional difficulties, including anger. Do they want to admit that they're struggling with something?" (S4, P3)*

The inability of some organisations to 'flex' around the young people needing support was seen to be a barrier as the needs of the young person were not necessarily being identified. For example, where a young person does not attend an appointment, they are removed from the list. This process might happen on a number of occasions with professionals seen to be missing opportunities to engage. Stakeholders felt that it was important to identify what the barriers are to these young people being able to engage; with many citing that more outreach is needed to go to young people where they are. Continuity of care was flagged as imperative. It was felt that timing of appointments can impact on young people engaging, for example, if a young person has been using drugs and alcohol the night before, then they are not likely to attend a 9am appointment. It was also discussed that there needs to be a consistency of approach across the services and that in other areas within Cheshire there are not equivalent roles, which makes it difficult to have a 'smooth handover' when handing over a young person to a new area.

*"I can't stand the kind of three strikes and you're out situation that that some services have. Your person's not turned up for three appointments. Therefore, that's it, you're not offering anything else. It just doesn't sit well that children are treated like that because they're not treated like that in any other aspect. Usually we don't give them that much responsibility for their own health until a certain age, don't we? But yet, when it comes to things like going to CAMHS appointments, we expect them to get there. That's not the ethos that we have at YJS, they'll go the extra mile" (S1, P2)*

*"A lot of them [YP] have got ADHD or OCD and they haven't got the patience to sit and wait. So that is a barrier right away. There's maybe a good, say 30 minutes/hour wait. You cant make a kid sit and wait that long and then sometimes they'll get off. You've got to go after them and you bring them back two and three times into the same place. But they're also causing a disturbance" (S8, P5)*

It was felt that some parents or carers do not know where to go to access support, with stakeholders commenting that this can lead to over reliance upon specific services, such as the police, when it is not necessarily their role. Parents and carers reportedly make assumptions that there is no support available, that it takes a long time to get support, they do not know what support is available, or they do not want to engage in support. It was recognised that sometimes it is not until a young people gets in trouble or seriously hurts themselves before support is offered to them, with no access to early intervention. Stakeholders reported that it was easier to engage with parents who are 'desperate to be helped', but that different approaches may need to be taken with those parents where this was not the case. Early help from services and articulating the potential benefits of support was seen as critical for engaging parents, as was collaboration with parents to facilitate support for young people.

*"I get the impression it's like they have to seriously hurt themselves, seriously hurt someone else or end up in hospital severely ill before there's any actual proper intervention. I mean, we're supposed to avoid children getting to that point that they feel like they want to kill themselves, or you know. I just feel that it's really wrong that they're just left without that early intervention" (P2)*

Engagement with parents was seen to be a challenge. Stakeholders felt that the health and wellbeing needs of children and young people are not necessarily being met as there is a lack of parental engagement with statutory services such as Health Visiting and targeted support through e.g., Children's Centres. Stakeholders also highlighted that young people need the support from parents to attend appointments for healthcare and wider support, acknowledging that young people might not turn up to appointments because their parent has not taken them to the appointment, and that families do not always have that 'scaffolding' and support networks in place to support them to engage with services.

*"Those systems are geared up to work for families where there's a support system around them. You know the idea that if you if you get an appointment you stick to it, or if you can't make it, you're rearrange it. Families with financial poverty and relational poverty, that scaffolding around children just doesn't exist for some of the population, and it's from that population that we are getting the kids (at YJS) later in life" (S1, P1)*

It was identified that some parents do not see specific support as a helpful process, but it was acknowledged that this may in part be due to parents' ability to understand and engage with what is happening and advocate for their child due to their own diversities (including mental health and experiences of accessing services). Parents may have their own unaddressed issues, which makes it difficult for them to seek support for their children. Stakeholders also commented that those parents experiencing domestic violence would also be reluctant to access support for their child. There were also reports of parents wanting to have the situation 'fixed' and that once you dig below the surface, these high-functioning families come across issues that they do not want to address. It was commented that parents may be embarrassed and not want to engage (which was felt to make them appear defensive); but that it was also important to acknowledge that there are instances where parents may be complicit to criminal behaviour and do not want wider service involvement. There was

also the fear that engaging with services may result in police or social care involvement or changes to benefits.

*"The parents can be obstructive sometimes, if they're not able to engage themselves, domestic abuse at home or substance misuse and their lives are more chaotic than the children's lives. So they miss appointments" (S2, P4)*

Other barriers included literacy skills for both parents and young people, and also for families where English is their second language. There are different methods to engaging with young people to try and encourage them to engage, such as going out for a walk, going somewhere, doing something, or talking about things rather than sitting down with a pen, paper, and worksheets. Limited resources were noted as a barrier for some for adapting support to make it more accessible.

Stakeholders engaging in the research identified a number of protective factors that can reduce the risk of young people becoming involved in the CJS. These included a sense of belonging, consistency with education, strong sense of community, ambition, engagement in something that makes them feel good and feeling looked after, positive parenting, friendship groups, and experience of relationship building.

### *The YJS whole system model*

Stakeholders explained that professionals need confidence in how the system, as a whole, responds to children and young people's health and wellbeing needs. A whole system, whole family, holistic model of delivery and support was seen as the way in which to do this, so that it is possible to address the underlying issues of young people and 'get straight to the bottom of youth offending behaviour'. It was felt that a main driver of the work of organisations should be understanding why children and young people end up in the YJS and how to stop this happening. A whole system approach was seen to be important in both supporting and enabling links between partners. The YJS is considered to be forward thinking around its work with, for example, ACEs and mental health training and helping others to understand why children and young people and their parents/carers may behave in the ways they do. The health offer at Cheshire YJS was deemed essential in embedding specialist health practitioners who are better placed to work with the health needs of young people. Stakeholders at the multi-agency workshop recognised that the health offer had led to an increased recognition of unmet health needs as a risk factor for offending behaviour and the role healthcare plays in addressing needs and preventing offending. A multi-disciplinary approach to the YJS was seen to be beneficial, with one stakeholder commenting that when they had previously worked in Youth Justice, they had the 'luxury' of support from workers seconded into the team from different organisations/services, so there were people on hand to speak to. This multi-disciplinary approach was felt to have worked well and was seen as a 'big positive'. It was also felt, however, that it is important to strengthen relationships with education, and other health partners.

*"What you see in this data is very stark and very clear is the end point of a system that is not particularly inclusive… youth justice is catching the kids at the end of a system, that's enabled identify the needs and meet them in safeguarding way rather than a punitive way" (WS)*

*"As a system, the youth justice system nationally, not just in Cheshire, the system's been well ahead of the curve. There's been an awful lot of work going back years actually, where speech and language therapists have provided information to magistrates to explain (communication issues related to trauma or neurodiversity). I think youth justice have done it very well, trailblazers" (S1, P1)*

The YJS are seen to be constantly striving to improve the service and that there is now a focus that moves away from a culture of 'blame' towards one which looks to trying to develop relationships of trust with young people in order to understand their experiences, and the different ways in which they can be supported. One stakeholder commented that it is important for professionals working within the system to have an understanding and awareness of child development, championing co-production as a way of working within and across health. Wider stakeholders also provided examples of working alongside the DIVERT team and Cheshire YJS. Other examples were provided for cross team training and awareness.

*"There's something about services not being designed specifically for the target market. Whereas what YJS do in terms of the health offer, the persistence, the flexibility, and the adaptability of the offer, it is very much bespoke to the particular individual. That's not been working for the marginalised social, excluded educational kids, who arrive with all of those unmet, undiagnosed needs, that have deteriorated" (S1, P1)*

*"We try and make sure that any sort of social emotional regulation type work is joint working with them where applicable, making sure that we're sharing that information" (S4, P3)*

The importance of delivering support in whatever context it is needed, was highlighted. Engaging children and young people in support was seen to be imperative in showing them what their life could be like if they made different decisions (e.g., not taking drugs), with one stakeholder suggesting that this could be done through gentle encouragement rather than getting external services involved. It was acknowledged that while there will be some similarities across cases, every young person is different, and this will determine the support that they need; the challenge is understanding them and identifying the support that they need. Identifying and targeting the right people was seen to be essential, as was having a range of educational settings to meet everyone's needs and providing opportunities for YP to find something they are enjoy, uses their skills and helps them feel valued within the community.

*Complexity of DIVERT cases*

In terms of the YJS health offer, stakeholders also noted that as DIVERT is voluntary, it was important to make sure that support is as accessible as possible to avoid parents and young people opting out. The ability for the DIVERT team and wider YJS services to be delivered to families in the community and their homes, was seen as key to this, with stakeholders recognising the issues with other support systems that rely on families' abilities to go to them and attend their services. Some barriers were however noted for home visits, including finding a confidential space if other family members are present.

*"DIVERT is here to ensure children aren't 'punished' for their unmet needs" (WS)*

*"DIVERT comes with a very short time frame to work through. They come with exactly the same needs statutory ones… it's always a very quick turnaround, with the DIVERT, there's a lot to get through in a short space of time for such a complex young person and that is quite difficult" (S4, P3)*

Within the YJS operating model, a number of issues were reported in relation to mental health provision, specifically, young people engaging with the YJS through the DIVERT route. Whilst it was agreed that the partnership working allowed for a more efficient and streamlined pathway for support, staff were limited in what could be achieved for the young person within the 12-week period. For example, one stakeholder explained that CAMHS are only 'open' for a short period of time, after

the screening assessment has been completed and referral made, meaning that for identified needs, this could cross over into the community CAMHS period, outside of the DIVERT timeframes.

> *"Divert is for a period of up to three months. It's difficult because they're open for a short period of time. Because by the time you've done your assessment, made the referral to YJS CAMHS, workers have gone out and done their screening. Then if there's any identified things, there's always the sort of there's a cross over into sort of the community CAMHS period" (S3)*

> *"I think we fall back on the schools and the other adults around the young person because with DIVERT, the short period of time, we can spend 3 months trying to just build enough of a relationship to convince the young person to allow us to teach them a strategy. We like to spend a lot of time building that relationship, even if it's just an additional session before the assessment, convincing them to meet with us again" (S4, P3)*

In some instances, DIVERT cases were seen to be more complex than statutory cases, due to the levels of unmet need and missed opportunities for earlier intervention. Additionally, DIVERT cases often have a range of needs, such as communication issues, poor mental health, and neurodiversity (including undiagnosed neurodiversity), meaning that when they reach the DIVERT team, they are 'opening up a can of worms.' Time was limited within the 12-week DIVERT pathway, meaning it can be difficult for the children and young people to receive the support needed within this timeframe. Negative attitudes towards the police, and lack of parental engagement due to issues such as domestic abuse or substance misuse - were also seen to complicate DIVERT cases and cause reason for missed appointments.

> *"When we get these divert cases, they're more complex than some of our statutory cases sometimes because it's been either left that long where the families never had any involvement or the young person, as in or even if they are 10 and 11, all that stuff's gone on, they've ended up with us and it's kind of like they've not had any help or any of the other things. And it kind of opens a kind of worms sometimes… diverts are very short-term intervention and 12 weeks is never enough to kind of do what you need to do" (S10, P2)*

### *Partnership working*

It was felt that there is a lot of good work being implemented across Cheshire in terms of supporting children and young people that is provided by e.g., third sector services, early help offers with the local authority, grant commissioned services, Strong Start team who deal with paediatrics and commissioning etc. The ability of multi-disciplinary practice to provide bespoke provision so that professionals can address issues from a number of angles was seen to be a strength.

Multi-agency meetings take place where young people at high risk of exploitation or harm to themselves or others (including reoffending) are identified. In these cases, there may be the need to share information with other professionals. It was highlighted, however, that there is still work to be done around communication between partners and 'bringing it all together.' It was commented that any services/interventions that target young people need to be community-based. For example, one stakeholder from a mental health programme within the Cheshire and Merseyside Integrated Care Board, spoke about five colleagues across all of Cheshire East, Cheshire West and Chester moving to a place-based process covering Cheshire and Cheshire West. The Mental Health School Team was also seen to be very successful in providing support in schools. Stakeholders spoke about their roles in influencing commissioning and identifying gaps in service provision and where services are 'not

providing what they are supposed to be'. Specific examples of partnership working that were provided included The Team Around the Family (TAF), The Integrated Front Door, Community Safety Partnerships, Youth Offending Service health subgroup and Starting Well.

*"We work collaboratively, in terms of thinking about what the needs of those young people are, and then how we might meet those needs and then collectively, reviewing and delivering that and commissioning it. So it's all done in partnership. So it works quite well" (SH14)*

*"The flexibility and bespoke nature of what our workers can offer, because frankly they have the time and resources to do it. We know how overstretched services are. Given austerity too. I'm sure it will kind of demonstrate the effectiveness and value of the (YJS) offer. If we can at least retain what we've got because it it's invaluable, and it works" (S1, P1)*

*"We've got a whole team behind them trying to fulfil their need and put them to a level that they can make informed and positive decisions for themselves" (S6)*

Partner briefings and meetings were seen to be an important part of multi-disciplinary and partnership working so that services can understand what one another's support offers and any challenges they are experiencing. One stakeholder spoke about the ease of information sharing between their organisation and the YJS. A barrier was seen, however, with health organisations under the Children and Families umbrella and they spoke about poor communication and information sharing. Schools were also identified as being a barrier to information sharing. It was, however, acknowledged that alternative demands and overstretched workforces can prevent certain partners from attending meetings.

*Trauma-informed approach to practice*

Having a multi-agency approach in place was seen as important for that wider wrap-around support offer; however, stakeholders did highlight the barriers of having multiple organisations involved. They explained that families can struggle to differentiate between services and can feel re-traumatised if information is not effectively shared, and they need to re-tell their story to each professional. There was also the potential for them to fall between services if responsibility is not clear. It was highlighted by one of the stakeholders that fragmented relationships between services prevents wrap-around support due to a lack of communication between organisations. It was also highlighted that because of this, professionals do not necessarily have a full understanding of child development and unmet needs.

Stakeholders agreed that once a young person enters YJS, the wrap-around support is there, however, it is important to get to them before this point. Partners discussed that the key is preventing behaviours escalating before statutory services become involved. Also understanding the driver(s) to the behaviour of children and young people and providing them with alternatives to becoming involved in criminal activity. They agreed that there needs to be investment in early years support where some of the most important outcomes of children are experienced in terms of their health, their experiences of being parented, and whether they come from a safe, loving, nurturing environment where they can have positive experiences. It was felt that co-located services at the first point of entry to the YJS is important to provide a holistic approach to support. Working with young people, for example, where they are already using drugs, who have been out of education and are dealing with family breakdown etc., were considered more difficult to work with as their behaviours are already formed.

Early intervention is seen to allow the professionals to see the warning signs and successfully divert children and young people away from crime. However, it was highlighted that some children and

young people are 'not getting into the system early enough'. Within local areas those high-risk families and young people are known from both strategic and operational approaches, but there is a change in approach needed specifically around early intervention before further escalation of issues. The DIVERT offer within the YJS was highlighted as best practice in preventing first time entrants to the CJS becoming more involved, with stakeholders highlighting how this model with a health offer could be further developed to reach young people on the periphery of CJS to prevent offending.

*"Those early years can make a huge difference into the outcomes for children, those secure attachments and you know, having good health during your early years" (SH2)*

*"We should be trying to develop and put more emphasis on that preventative measure for our young people, because if we can get them before they come into the criminal justice system. Then surely if we're dealing with their health needs more in a better way prior to them coming in that that should be able to hopefully help divert them away from the criminal justice system" (S8, P1)*

Having a trauma-informed approach to practice was seen to be very important as it asks the important questions and explores the pathway that leads a young person to become involved in the CJS; thus, looking at 'the bigger picture'. One example of a service that used a trauma-informed approach is Our Ways of Working (West Cheshire Children's Trust) which is a multi-agency partnership that adopts a trauma-informed approach to understanding trauma on the whole family (from Children's into Adult Services). The use of techniques and models within this approach such as a motivational interviewing model and learning and problem solving, were seen to have positive effects. Upskilling professionals to embed a trauma-informed approach in practice was considered important. Cheshire YJS was seen to have adopted the child first, offender second approach, in their trauma-informed practice. Stakeholders did acknowledge that services are stretched meaning professionals have little capacity to think about alternative ways of working to maximise support for young people.

*"I think different areas that will come into contact with children work differently and are further along in that trauma-informed journey. I suppose some of it just comes down to time, money, timescales, background. The way people are trained, and what they trying to achieve" (S1, P2)*

*"The biggest problem everywhere is there is no capacity anywhere. There is no time to think about whether we can streamline something to make the capacity we have more effective and someone somewhere needs to stop, think and work that out again. That's not a youth justice issue. That's a whole NHS issue" (S4, P2)*

It was identified that staff need support and supervision to feel comfortable in what they are doing. They also need to be provided with the right advice and guidance so that young people can access universal as well as targeted services. Practitioners having the appropriate skill sets and accessible resources to hand was seen to be an overarching priority. Within this it was also important to know the local community and continue to build positive relationships with young people in a consistent way. This can be provided through more personalised services and targeted approaches. There was a belief that there is the capacity to do things if people want to, but that clinicians need to be on board. Staff spoke about having regular training in substance abuse and mental health. It was, however, highlighted that there needs to be more education around SEND and the YJS. The quality and value of the job of support workers and the YJS did not appear to be acknowledged, and it was highlighted that staff are leaving and not necessarily being replaced. Lack of consistency in some aspects of contracting

(e.g., fuel support, covid bonus) were also cited as an important aspect to be looked at, as it was felt to put staff and their families at a disadvantage.

*Tailored and bespoke support*

It was acknowledged that in order to have the greatest impact, services and interventions should be specifically tailored to the needs of that individual young person in terms of the offence they have committed, but also to take the young person 'on their own merits' and take into account their learning style, concentration levels, interests, skills, and strengths. It was also considered important to make any targets they may have achievable, as well as not overburdening them with many professionals that they need to engage with.

Stakeholders spoke about the importance and the need to be creative when trying to engage with young people. These aspects, as well as considering the risk level for the young person, should also impact on the intensity of the support given and how flexible and adaptable the support provided can be. In the instance of the YJS CAMHS support, it was felt that as long as it is possible to justify clinically why specific approaches to engaging with young people are being taken, then it is acceptable; this was seen to provide more flexibility than mainstream CAMHS. It was highlighted that to create more bespoke opportunities, regular and increased funding/resources were needed.

> *"If the government recognised how imperative (agencies are) to change people's lives, they should give us more money, more resource to create these bespoke opportunities, because it's them reachable moments within. A young person engaging in something special which detaches them from their criminality, their dependency or the behaviours that is a reachable moment that gives them an understanding of how something can be very different for them" (S6)*

In terms of the type of support that works well, it was felt that children are '*very tuned in to whether you care or not, so whether that professional is where, whether it's from the health, from youth Justice service, from police, from social care and from education, even that young person's need to know that you genuinely care.'* This stakeholder commented that it is important for young people to know where they stand and what is expected from them as well as professionals being genuine with them. Young people explained that having this developed a relationship of trust and was key to their engagement. Stakeholders reported that young people can be suspicious of professionals resulting in a lack of trust. This was also seen to be true of some parents who are cautious of social services involvement for fear their child will be taken into care. Constant, regular support, social prescribing, good communications (being open and honest), pathways to external providers, and establishing a good connection with the young people were recognised as methods of support that work well. Having conversations with young people and learning about them, rather than 'firing questions' at them, was seen to develop relationships of trust and confidence between the professional and young person. Peer engagement and discussions with other young people was also seen as a facilitator to engaging young people with services.

> *"Without the connection from the young person you can't address or identify the needs, to be able to give them the opportunity or try and find opportunity or provider of a statutory or voluntary or a public sector agency" (S6)*

> *"A lot of it is just how you relate to these kids and families… being friendly, being approachable" (S3)*

> *"Being genuine with these young people, that makes a difference. You got to want them to want to work with you" (S6)*

### *3.4.3 Outcomes and impacts of the Cheshire Youth Justice Services health offer*

Stakeholders involved in the delivery of YJS interventions, and wider stakeholders involved in the commissioning and delivery of support for young people and their families across Cheshire, discussed the impact of effective support for young people to address their health needs. The young people and parents participating in this research also detailed the impact of engaging with the services and wider support.

#### *Individual and wider family impacts*

##### Early identification and access to support

The health offer at Cheshire YJS provided in-house mental health support with a specialist CAMHS worker and pathway into wider support at the CAMHS service. Engaging with YJS allowed for quicker and easier access to mental health support with CAMHS, with stakeholders reporting that families were appreciative of this pathway which reduced the time they would have waited if they had engaged with CAMHS via a different pathway. Having access to the SLT support as part of the YJS offer meant that for many young people, they had access to the right support for them, for the first time. Examples were given for a young person who was formally diagnosed with a hearing impairment.

> *"I've had the experience of CAMHS knocking us back all the time. There's no such thing as early intervention, which I think a lot of children actually need and to bridge the gap between the initial appointments and the referral and there isn't anything in there. Some of the support that's out there is really good. I think it's that struggle before you actually get there, and sometimes you just don't know where to turn to" (P2)*

> *"It's about the timing of it as well. We can say to the health worker, this young person's in court in four weeks' time. Can you come and do an assessment before then? She can get out next week and see them. CAMHS (external to YJS) are saying yes, we can offer that child an appointment, but it's going to be in about 6 weeks' time. We don't think in that kind of time frame and time scale, so having it in house is so much faster" (S1, P1)*

Stakeholders and parents spoke about becoming engaged with the YJS and the benefits this had in terms of being able to access the right support for the young person and their family. This included parents who had been trying to seek support for their children before they became under the care and support of the YJS. One parent spoke about asking for help and trying to get support for her child, but not succeeding until working with YJS. This parent felt very sad that it had got to the point of her child getting into trouble resulting in them hurting someone else before they received support, but since becoming involved with YJS, the right support for them had opened up. This included their case being re-opened with the social worker, so they have been able to get additional support through that route too. Engaging with the YJS also meant that they were able to engage with CAMHS, whom they had previously tried to access albeit unsuccessfully, as well as having other appropriate wider support in place, such as a suitable school moving forward.

> *"I always say to the families, while you're under our umbrella, let's see what we can get done, the likelihood is that we can get you support and we can get things moving quicker for you" (S3)*

> *"Even though it's been a really difficult year for us, something positive has come from it, the help that we've received and that we still are receiving. I just can't thank the health professionals enough, everybody that's been involved has been fantastic" (P3)*

*"You get a lot of parents that say, 'I'm not happy for them to be under these justice services, not happy what they did, but actually this is the best thing that has happened to them in terms of all the services coming together to support them'. I see the reliability of the service, to prevent that reoffending and to put all the things in place, theoretically it is to put all that support in place that they don't come back again" (S4, P1)*

*"We do see the impact of what we do, whether young people say thanks at the end… but actually I think little things do help them without them even realising" (S10, P2)*

It was highlighted by stakeholders that the level of support required was very much dependent upon the frequency and severity of the crimes that had been committed. Stakeholders, however, also reported encouraging families to access all the services they need whilst engaging with YJS to 'make the most of the umbrella service'. The importance of developing good relationships and connections with the young people and their families, and in turn, the impact that this has on uptake and engagement of support was also highlighted. This included maintaining regular contact with the young person and their family. This was further evidenced by parents and young people also reporting that it was important to be engaged and open to support.

*"I think that's the impact, listening, respecting them, 'oh my worker actually listens to what I say'. I know (name) has been thanked by loads of young people for actually being the one that listened, to give me the time of day and got me where I needed to be. That for me is an impact" (S10, P2)*

*"When they said I had to do it in court, I didn't want to do it, to be fair. It put me off it, I was just going to dodge it but when I met them, they're just sound people aren't they, like they're normal people, they're not anyone different" (YP3)*

*"The connection with the young person. That's a big one. That can help this young person further down the line. The youth justice services like to bridge to try and get them through or across the water of their poor decisions. You know, it's about giving that opportunity for support" (S6)*

*"I'd say with our experience and how things have gone, it has helped massively, it really has" (P3)*

The YJS were able to advocate for young people with SLT challenges through sharing SLT reports and through sharing information with colleagues to explain why someone may find it difficult to communicate, why they might not understand information, or why they may avoid eye contact or smirk when nervous. Being able to advocate for the young people in this way meant that other services were aware of their additional needs and barriers to engage.

*"We've had several cases where addendums to pre-sentence reports have been written by health workers that have in some cases even given a formal diagnosis. I can recall one case where a Crown Court judge explicitly said in their summing up that it was a difference between a child being sentenced to custody and sentenced to community. Similarly arguing against criminal behaviour orders for anti-social behaviour for previously undiagnosed kids… It has been really helpful and will potentially change the course of a child's life if it avoids them getting a criminal conviction that has an potentially has an impact for the rest of their life" (S1, P2)*

*"We had a child who was really struggling to sit through a session, would just get off and wander off. Didn't really seem to get it. Had major speech, language, communication needs, but also had no concept of time. So we actually put in something (in place), we could still only engage in for about 20 minutes at a time, but that was as much as he could do. But in that 20 minutes we got a proper focused session in. An example of how that the knowledge and experience that our profession can bring into a youth justice team can change the trajectory of a child's order" (S4, P2)*

*"Showing them to add an appointment and alert for reminders for appointments. Which sounds like a really simple step, but for a young person on a statutory order, getting them to attend an appointment that they might have missed and then therefore might have ended up breaching and going back to court. Purely because they had a poor understanding or poor memory. If we've just put that one small thing in place and they attend their appointments, you know it's a massive difference to them really is" (S4, P3)*

*"We've had Speech and Language Therapy involved with us. We've never had them involved before and they been able to do assessments and a report that I feel that has been needed throughout (YP) life. It's something else that's been positive that we've gone from it" (P3)*

It was, however, commented by stakeholders that young people and their families should be able to access this support prior to them coming into the YJS. It was felt to be vital that young people and their parents are educated about the services that are available (other than CAMHS), thus building their confidence to access support. One parent commented that on beginning engagement with the YJS they did not know what to expect but would 'highly recommend' that anyone in the same situation reaches out. This improved access to support and services was also felt to help young people and their families feel more in control of their situation. Stakeholders and parents spoke about the importance of being able to access peer support and the positive impact of this.

*"As soon as they come into the criminal justice system, the health workers can see you once a week for a few months or through your order, always here, available. That's great for them, but shouldn't we do that prior to them coming in?" (S8, P1)*

*"All new to us, so I wouldn't have known what to expect. But having had that support from people, if I know of somebody that was going through something not the same as us, but had to have them professionals involved, I would highly recommend that they reach out as much as they need to do, because that's what they're there for, to help you" (P3)*

### Improved knowledge and awareness

Stakeholders, parents and young people all commented that through engaging with the YJS, young people became more aware of their actions and the impact of these on their victims. One young person and their parent spoke about writing a letter to the victim of their crime. The young person also undertook work around the consequences of their actions, which helped them understand what they had done, but also so that they could move forward from it and not follow this behaviour (in this instance carrying a knife) again, this also included moving away from their peer group, which they did with the support from the YJS. Stakeholders commented that also providing coping

strategies and self-help to young people can change the way they behave in certain situations and improve their life course.

*"Usually, we just have a chat. We've done work on the consequences. I find it helpful, where I'm looked at being a bit naughty and that I'm looking thinking oh I can't do this because it's going to have this consequence" (YP2)*

*"The stuff I spoke to them about, made me think about what I'd done and that I don't want to do it again, I know that" (YP3)*

*"The stuff I spoke about with (caseworker) made me not want to carry a blade again" (YP3)*

### Improved communication and relationships

Stakeholders, parents and young people all reported significant improvements in communication and relationships. This in turn had improved the wellbeing of the whole family. Developing positive and trusting relationships between professionals and young people and their families was also evident. The young people engaged with the YJS were seen to feel supported in a non-judgemental and friendly environment and that they are 'worth something'. Stakeholders also commented about breaking down barriers between young people and the police.

*"They've helped me so much, it's a 12-month referral and I had the 3 month board meeting last night and they said I've done dead good and that's obviously because of the help they've give me "(YP3)*

*"Before this, I couldn't sit there on the phone to you, I wouldn't say I'm shy, but I just don't like being in situations like this, but they've helped with that as well" (YP3)*

One young person who has complex issues with ASD and ADHD which makes communication difficult, spoke about how the support they had received had allowed them to 'open up' and talk about how they were feeling to their YJS worker. Past experiences engaging with adults had not been positive as they felt as though they was being 'talked down to. The young person reported that the YJS worker was calm and felt that they understood and listened to them. This was supported by the young person's parent who said that working with the YJS worker had made a difference because of how the worker approached the situation and that it was clear she was very skilled in their role. It was felt that the young person also has increased self-confidence that has resulted in them being able to speak to someone on the telephone and improved relationships with their family.

*"They helped me, yeah. Just to open up really about how I how I felt about the offence" (YP4)*

*"It's nice that (YP) has built a good rapport up with (caseworkers). They're at a point where they're comfortable, because they have had a diagnosis of ADHD. They have always struggled with their emotional wellbeing and trying to express things. I do feel that having this service involved with us has helped quite a bit because they're a little bit more confident in coming and asking things, whereas they wouldn't normally do that before" (P3)*

*"I have a bit of a standing joke with (caseworker) saying, once it comes to an end, I'm just going to come and sit in with another child because I will miss it. It's been really, really positive, and it's nice that we've been able to build a good rapport with everyone that we've been involved with" (P3)*

### Improved health and wellbeing

When exploring the impact on health and wellbeing, it was identified that engaging with the YJS can result in increased confidence not only for the young person, but also for their family members. Furthermore, young people and their families experience improved wellbeing, for example, with one parent feeling that they felt supported and listened to and that they also had someone to advocate for them.

> *"I would sometimes rather struggle than ask for help. But I know that having everyone involved that we have, it has given me that confidence to reach out because that help is there" (P3)*

One parent spoke about the YJS worker arranging a gym pass for their child, which they were looking forward to using so they could engage in physical activity which is also beneficial for their mental wellbeing. This was part of a social prescribing pilot bringing the YJS and community organisations together to provide a more local and sustainable offer. Engaging with the YJS was also seen to reduce harm related behaviours (e.g., substance use, self-harm) in some young people as well as being abstinent and drug free and having coping mechanisms in place to be able to help with this.

> *"I think if you'd have asked that question a few years ago. We would have been sitting here with a completely different picture saying we've got a CAMHS gap, we've got an SLT gap there. We haven't got that now, it's a completely different picture. That's because (name) has managed to get all the services in place being provided, written into contracts. That's how we've got to where we are. So we would have had loads of mainstream gaps which we haven't, now it's the third sector and we want to branch into that" (S1, P2)*

### Engagement in diversionary activities to prevent reoffending

Increased involvement in diversionary activities for young people was considered a way in which to reduce offending. Stakeholders spoke about the young people they were supporting showing positive changes in their behaviour and improved decision-making. It was felt that these changes in behaviour were due to young people having increased awareness and understanding of the impact of their behaviours on others. It was also impacted by the introduction of routines and boundaries; with rewards being given for these positive changes in behaviour. Knowing who to go to for support was also seen to be important for young people to maintain these positive behaviour changes.

> *"YJS worker has been which working around the offence with me, teaching how to not do it again. So I don't reoffend" (YP4)*

> *"DIVERT… We delve into the reasons why, we delve into what the trauma that they've experienced and the help that they need therapeutic help not criminalisation. We've been able to get decent outcomes for them and avoid them getting on to the first rung of their criminal career" (S2, P2)*

> *"So rather than having them hanging around on the street with the certain groups, getting them interested in something that makes them feel good" (SH2)*

### Access to education, training, and employment

It was highlighted that through the support provided by the YJS, young people could experience increased engagement in education as well as being able to access an appropriate education setting, and to undertake training and gain meaningful employment.

> *"I've had a few girls that are victims of Child Exploitation and massively vulnerable, I managed to get them NFA'D [no further action] or Community*

*resolution and then I found out afterwards that ones now training to be a social worker another one is gone back home" (S2, P4)*

*"I've got a young person that wasn't engaged and he's coming up to his three month review now and he's doing so well, he's engaging in it. They used to be late whereas now, they are on time or text if he's late. It's small things where I think you can see the progress. We're working towards getting it back in education, which it's been out of it for three years, but actually he's thinking about it, which is a massive step" (S10, P1)*

*"I've seen a complete 360. So now he's got a job, he's gardening, he never misses his job. He gets up every day and he's there doing a half eight till 5 o'clock. But then I've seen that because he's brought himself away from his pro-criminal peers" (S10, P2)*

*"I reckon having the support behind him from the youth offending team has pushed him to get this wonderful place he's been offered at school. I don't think we would have got this far if (YJS) hadn't been involved" (P1)*

One of the parents spoke about their child returning to education and now having a place in a school to support their additional needs where they will be in a smaller class with extra teachers. This parent was firm in their belief that this would not have happened without the YJS. Another parent spoke about feeling happy that their child will gain qualifications through re-engaging with school which will give them more choices and opportunities when they reach 16, for example, going to college or university. Another young person spoke about completing a construction course and gaining a qualification and that they now have a full-time job, which had brought them structure. This young person spoke about feeling proud of their achievements. They also explained that YJS were flexible with appointments so they could attend outside of work hours and it did not impact on their new job. Moving forward, this young person had been seeing their case worker regularly, but these had now been reduced to once a fortnight.

*"We've got YP back into an education… they've given them a programme that they can work on and they have only has to go to school once or twice a week for an hour a time. They doesn't have to go into class and They doesn't have to wear uniform, which I think if they was in a class setting, I think that would be setting them up to fail. So they've agreed that YP can go and do their maths and English one to one and get a laptop so they can work at home as well… Then as soon as they turn 16, they've got the opportunity to go to college or a work placement and things like that. So really, they've got a lot to look forward to" (P2)*

*"I make myself proud to be fair, seeing them tell me I'm doing alright in life" (YP3)*

### *Impacts for the community*

It was felt that the support provided by the YJS to young people and their families can have wider impacts for the community in terms of increased feelings of safety. Young people and their families are also noted to have improved social networks. It was felt that within this, however, there needs to be an increased community awareness and understanding around anti-social behaviour. One stakeholder spoke about seeing an impact with regards to this through a community summer project that involved residents and families which was seen to 'help break the fear factor' as they viewed the young people differently '*I never saw them as children', 'they were just playing, you know they are just being kids.'* Other impacts for the community included reduced levels of anti-social behaviour,

reductions in young people bringing or buying drugs in the area, reduced levels of confrontation, and overall a reduction in levels of criminality.

> *"If you can get someone to reduce their drug use and become more personal responsible for their actions. The impact for the community is massive, they're not out causing ASB, they're not bringing, buying or selling drugs in that area… There is less confrontation. There is less criminality, there's less coming and going, there's more safety and people feel safer. If you can help a young person to address their needs themselves, with support, the family relationships get better" (S6)*

#### *Wider impacts across the system*

There were a number of wider system impacts identified by stakeholders. It was felt that through the YJS there was improved/increased multi-agency working and that this joined-up, holistic approach to working with young people and their families reduced the number of young people re-entering the system due to decreased involvement of young people in criminal activity (including reoffending). Some stakeholders commented that the work of the YJS resulted in reduced demand on services e.g., policing, people presenting at A&E, and secondary care (e.g., reducing the number of people with mental health issues not escalating from primary to secondary care). Stakeholders acknowledged that through the work of the YJS and associated partners that there may be an increase in the diagnoses of health and wellbeing needs, but this was deemed positive as it meant that young people and their families are receiving the support (including onward referral) that they need. It was also noted that through education, training, and employability, young people will be in a position to contribute to the economy in the longer-term.

#### *Measurement of outputs, outcomes, and impact*

##### Standardised data collection and sharing of data

When looking at how outcomes and impact may be measured, the organisation in which the stakeholders worked determined the measurement tools that were in place to explore outcomes experienced by service users and wider beneficiaries. Stakeholders spoke about it being difficult to analyse and measure impact, and also to explicitly sattribute that the difference in behaviour came from specific support. One stakeholder spoke about having an analyst who collates data forms on a monthly report to evidence cost savings and other impacts, and how they are starting to look at evidencing the pre and post health and wellbeing. Stakeholders also spoke about there being a number of different tools that they could use, but that it was dependent upon the young person and also that using too many questionnaires etc. could be very off putting for the young person so should only do so if they feel appropriate.

> *"A lot of our young people, if we pulled out a little questionnaire would panic and run for the hills. So it's doing it very carefully if it's appropriate" (S7, P1)*

In terms of the types of outcomes data that was collected, there were a number of examples provided by stakeholders. One of the stakeholders spoke about using the 'three houses' (which looks at what is going well, what is not going so well, and what needs to be improved). A second stakeholder spoke about the routine outcomes measures that they collect in CAMHS which includes: health of the nation's outcome scales for children and adolescents; anxiety questionnaires; and goal-setting. A third spoke about using the Youth Star, which focusses on relationships; My Mind Star to measure mental health and wellbeing; the Stirling Scale; and feedback about what they enjoyed or did not enjoy. Others spoke about having more general feedback that does not necessarily focus on health and wellbeing outcomes. It was felt that those services where pre and post measures are recorded were more likely to be commissioned organisations. Stakeholders spoke about how this lack of a

standardised method for collecting data and limited data sharing made it difficult to bring data together from across different organisations. It was felt that this prevented the development of a 'triangulated picture of what's going on' and whether their specific programme of intervention was working. It also did not allow for individuals to be tracked between services or followed up longitudinally beyond their exit from the YJS, making the measurement of long-term outcomes impossible.

*"To get the voice… so what's going well, what's not going well and what needs to happen" (SH2)*

*"The data does not talk to one another. That's my biggest bug bear. It needs to, if we want to move into finding out what's going on, on the ground and stop letting these children and young people down" (SH12)*

*"I bet the panel members sometimes look and think what has this young person actually done in them three months, but actually they've got gone to work on time. They took up a new activity. They've actually engaged and they're attending, whereas back then they might not have been… Think of all the other good things that they've done. I think it's not always measured right" (S10, P2)*

Service user voice was an aspect that all stakeholders felt to be important when looking to monitor and evaluate the experiences of young people (and families) engaged with the YJS such as a focus upon 'softer outcomes' so that services can follow the young person's journey across the system in terms of support they have received. The importance of having a more consistent approach to collecting data from young people and that it needs to be outcomes-based reporting identifying aspects such as start and finish dates for engagements but also looking at what that engagement has meant to the young person was also highlighted. It was considered imperative to ensure that any data collection tools are relevant and should include goals for young people and their families that are achievable and realistic. Specific ways in which service user voice can be heard through the YJS (statutory and diversionary) included questionnaires with young people at the end of their YJS engagement that explore how successfully a young person completes their criminal justice order. Other ways in which service user voice could be captured were identified, such as patient experience teams and complaints teams but also, patient and parent feedback forums such as Parent Care and Health Watch, children in care council, the youth council, and the leaving care/supporting independence forum. It was also felt that positive feedback can be measured in other ways, for example through returning to appointments *('actions speak louder than words')*.

### *Moving forward*

At the multi-agency workshop, stakeholders discussed the impact of the HNA key findings and agreed that intelligence produced through the HNA should be used to raise awareness, promote action, and influence practice across partnerships. Stakeholders were appreciative that the HNA had enabled discussions and potential opportunities moving forward to promote change in practice and across the wider system.

*"Take this back into our local partnerships and boards for them to understand how discriminated against some of these young people are and how society gives up on them" (WS)*

*"The real challenge is how we 'tie in' other services… youth justice issues are everybody's business!" (WS)*

*"We don't have to accept the criminalisation of kids in the way that it's happening, and that there are interventions that we can apply. Through our communities, support for families, local authorities, healthcare, education and policing and the justice system itself" (WS)*

Considerations for dissemination of findings included:

- Share throughout Cheshire YJS and more widely across North-West and national YJSs, including publishing the HNA on the YJS Resource Hub and other YJS resources including Basecamp.
- Inform the forthcoming annual youth justice plan.
- Inform Joint Strategic Needs Assessment (JSNA) which will be carried out as part of the new Serious Youth Violence strategy requirements, including informing a public health approach to tackling serious violence.
- Sharing with the Cheshire Early Help Boards, Children's Trust, and Starting Well Programme Boards.
- Data should be fed into the new pan-Cheshire extra familiar harms strategy which is being developed with Cheshire Constabulary.
- The health sub-group will support dissemination and sharing of findings across partners.

# 4. Planning for change - learning from the Health Needs Assessment

## 4.1 Identifying need

Data analysis of Cheshire YJS case note data provided a wealth of data on the health needs for young people engaging with the YJS. This was supported and complimented by extensive engagement with key stakeholders across the YJS and wider services across Cheshire, and a small representation from young people and their parents who were engaged with the YJS. The data included 92 (82 with assessments) young people from DIVERT and 122 (119 with assessments) young people from the statutory YJS route. This data also informed the HNA to provide a clear overview of the characteristics and needs of young people entering the CJS and working with the YJS. Violence was the major contributing factor that had brought them into contact with the YJS, with 85.6% of statutory and 72.4% of DIVERT cases having perpetrated some form of violence (eight in ten statutory, and six in ten DIVERT had perpetrated youth violence). As expected, the mean number of offences (7.7 vs 2.4) was higher, and incidents (4.1 vs 1.6) were higher for statutory than DIVERT cases. Data also shows that violent related crime has increased since the first HNA, which was completed in 2015, highlighting increased complexity (The Centre for Public Innovation, 2015).

Young people entering the YJS were predominantly males (90.2% statutory and 70.7% DIVERT), aged between 15-17 years (67.2% statutory and 59.8% DIVERT [although DIVERT were generally younger than statutory cases]) and high proportions were currently or had previously been identified as a child in need (75.4% statutory and 39.0% DIVERT). Compared to the national prevalence (3.2%), proportions of young people (15.3% statutory and 19.5% DIVERT) were significantly higher for those currently identified as a child in need. Whilst females were less represented within the YJS (and the CJS nationally), the data did show that they had higher risk factors for some areas, including exploitation, victimisation, and perpetration of child to parent violence. There were also more females engaged with the DIVERT route and some stakeholders reported seeing increased violence amongst this cohort.

Through engagement with stakeholders and service users, multiple and complex issues were identified for the young people involved in the CJS. These issues were seen as both risk factors (and unmet health needs) for them becoming involved in crime, and as impacts of being involved in crime and the CJS. They also created additional barriers for young people and their families for engaging with services. The COVID-19 pandemic and cost of living crisis were both seen to have exacerbated health needs and negative impacts for young people and their families. Dahlgren and Whitehead (1991) termed the model of health determinants over thirty years ago to understand the factors that increase health inequalities, which included central factors, individual lifestyle factors, social and community networks, and socio-economic, cultural, and environmental conditions. The Marmot review (Marmot, 2010), and subsequent 10 year review (Marmot, 2020) of health equity across England calls for action on the social determinants of health with the aim of reducing inequalities.

Understanding the findings of the Cheshire YJS HNA, using the model of health determinants, we can see a number of factors that are increasing inequality and health and wellbeing needs for young people involved with the CJS. Stakeholders engaging in the research acknowledged that by the time a young person becomes involved with the YJS, they have usually had involvement with a number of other services. However, findings from the HNA suggest that young people enter the YJS with a number of unmet and unidentified health needs that may have contributed to the reason for needing YJS input, suggesting early intervention is critical.

Additional data collected by the YJS, at assessment and during the time the young people were engaged, also provided wider context. This flagged risk factors that may have contributed to the crime

and may also contribute to further offending behaviour. This data enables the YJS to work together to develop a tailored strategy and pathway of care for individual young people to help meet their needs and reduce health and re-offending risks (29.4% of statutory cases and 6.1% of DIVERT cases were assessed as having a high likelihood of reoffending [27.1% and 1.2% posing a risk of serious harm to others]). Findings from the HNA add to the increasing evidence-base for risks associated with young people becoming involved in criminal behaviour, including risk of criminal exploitation. Over half (59.5%) of statutory cases and nearly one third (32.9%) of DIVERT cases were considered vulnerable to criminal exploitation, with high proportions of young people experiencing violent victimisation (72.9% statutory and 59.5% DIVERT). Whilst offences were predominantly perpetrated against other young people, violence experienced by young people was primarily perpetrated by adults, with smaller proportions recorded as victims of youth violence (34.7% statutory and 23.8% DIVERT). Proportions of young people were also deemed at high risk (26.1% statutory and 7.3% DIVERT) and very high (1.7% statutory) of future risks to safety and wellbeing.

This HNA evidences significant unmet health needs in terms of three main areas; mental health, neurodiversity and SEND, and substance use. All of these are linked to additional needs related to the health, social care, criminal justice, and education sector. Stakeholders, parents, and young people provided examples of these health factors, suggesting young people are in need of support in these areas for some time before the criminal activity that had led to their work with the YJS. The quantitative data analysis further confirmed this, by demonstrating that high numbers of young people engaged with YJS had poor mental health, SEND requirements, and were using drugs and alcohol. These three key areas all form part of the health offer provided by Cheshire YJS meaning that these needs could be identified, and support put in place to start to address them.

For mental health, overall, 17.7% of young people had a formally diagnosed mental health condition (22.0% of statutory and 10.8% of DIVERT cases). Overall, 47.9% of young people were accessing mental health services (57.3% of statutory cases and 32.9% of DIVERT cases), suggesting more were engaging in support than had an official diagnosis, bringing into question the unidentified needs of those young people not engaging with any support (these were highlighted in the qualitative work). Of those with a diagnosed mental health condition, 97.1% were accessing mental health services (100.0% for statutory cases and 87.5% for DIVERT). Mental health needs were higher than presenting physical health needs, with one in ten for both statutory and DIVERT having needs in this area. Stakeholders gave examples of the increasing mental and emotional health needs for the young people they work with, as well as the increasing need for their parents and families in this area. The parents and young people participating in the research reported poor mental health, anxiety, low self-esteem and confidence, self-harm, and difficulty in accessing support, including long waiting lists and not meeting risk thresholds for CAMHS. The COVID-19 pandemic and cost of living crisis were seen to have exacerbated these mental health needs, with poverty being flagged as intrinsically linked to poor mental health and increased risk of offending.

For neurodiversity and SEND, 63.4% of young people had some form of SEND (67.8% for statutory cases and 56.2% for DIVERT), with 45.7% having a SEN that was identified (56.0% of statutory cases and 28.6% of DIVERT). Overall, 63.7% had some type of speech and language needs (61.3% of statutory cases and 67.6% of DIVERT) and 12.5% of young people had a traumatic brain injury (13.2% of statutory cases and 11.4% of divert). High proportions of young people had social skills difficulties (58.5% statutory and 66.2% DIVERT). Overall, 42.2% of young people had a formal diagnosis of a neurodivergent condition (46.2% statutory, 36.3% DIVERT), while a further 15.6% were awaiting diagnosis or referral (13.4% statutory, 18.8% DIVERT). Prevalence of neurodiversity and other needs amongst young people differed across local authorities, with Warrington in general having higher

levels of need. Across all qualitative data collection, SEND and neurodiversity were the most common theme discussed for risks associated with offending (including exploitation) and unmet health needs for this cohort of young people.

Stakeholders discussed the difficulty and long waiting times for diagnosis and the impacts of this for young people for their behaviour (both inside and outside of school), and the impact of this in terms of their mental health, relationships, and ability to cope. Issues were also raised about wider professional awareness of conditions (especially where there is no diagnosis), and the negative impact this can have on a child throughout the CJS, healthcare, and wider sector settings. Young people and parents discussed the struggles at school (and how they had disengaged from school), and the challenges with communication, difficulties in getting help (and a diagnosis), and the negative impacts this had on the young person's life.

For substance use, higher proportions of young people had ever or were currently using drugs, alcohol, or smoked, when compared to the national averages for these health behaviours. Prevalence rates were higher for all three for young people on statutory orders compared to DIVERT cases. For statutory cases 79.0% (and 48.2% of DIVERT cases) had ever used drugs, and 58.0% (statutory), 32.5% (DIVERT) were currently using drugs (mixed drug use and cannabis were the highest reported). For alcohol 45.4% (statutory), 33.3% (DIVERT) had ever drunk alcohol, with less young people currently drinking alcohol compared to drug use (30.3% statutory, 28.6% DIVERT). Smoking prevalence was also high, with 31.1% (statutory), 12.0% (DIVERT) ever smoking, and of those, many young people were currently smoking tobacco (26.1% statutory, 9.6% DIVERT). The qualitative findings further evidence this with concerns raised about the increased prevalence of cannabis use among young people entering the CJS and the negative impact of this on their physical and mental health, communication, and relationships, and also the increased risks for criminal exploitation (including risks of county lines involvement).

Risks for CJS involvement also included living in poverty, experience of trauma and ACEs, family and home life issues, and broader contextual safeguarding issues including risks within peer groups and the community (which were both linked to social media use). The majority of statutory (91.5%) and DIVERT (86.7%) cases had at least one ACE (55.1% and 22.9% respectively had 4+ ACEs), which is significantly higher than the national average (based on a national retrospective study of adults in England; 47.9% one ACE and 9.0% 4+ ACEs) (Bellis et al., 2014)

Half of all young people had caregivers who had underlying issues impacting the quality of care they provided for them and had experienced incidents involving their current caregivers that risked the young person's safety and wellbeing. There was also high proportions of young people who had perpetrated child to parent violence and abuse (39.0% statutory cases and 29.8% DIVERT). Transition to adulthood and adult service provision was highlighted as a critical point for young people, with gaps in services identified that put this age group at increased risk, both in terms of their health needs and risk of offending.

Disengagement from education was also evidenced within the quantitative and qualitative data analysis. Data showed that statutory cases were more likely to be disengaged from school compared to DIVERT cases. However, the other education related data was similar, with 35.6% of statutory cases (8.5% DIVERT) not in any form of education, employment, or training (NEET), and 21.2% of statutory cases (29.3% DIVERT) in alternative education provision (such as a PRU). Around half of the young people had participation or attendance issues, and half had experienced some form of school exclusion (for both statutory and DIVERT). This is significantly higher than the 4.3% national prevalence of school exclusions (ONS, 2022). This was further evidenced through the representation of the voice

of four young people within the HNA, all of whom had been disengaged from school before they came into contact with the YJS. Stakeholders at the multi-agency workshop reflected on the barriers for neurodiverse children and young people. Recognising that through unmet need, late diagnosis and lack of education and awareness, that these young people are at risk of becoming marginalised and excluded from education and mainstream services and support, and ultimately excluded from society.

Information provided by parents, young people and stakeholders suggested that high proportions of young people had co-morbidities, meaning that young people had multiple, complex needs and many of these health needs were interlinked and co-existing for many of them. This included, for example, young people who were neurodiverse, who were struggling with their social skills, experiencing poor mental health, and had disengaged from school. Other examples were provided for young people using cannabis to self-medicate (for both mental health and neurodiversity) or as a form of self-harm, and examples for LAC and children in need, experiencing multiple risk factors and unmet health needs compared to their peers. The quantitative data confirmed this, showing that higher (and significantly higher) proportions of young people (compared to their peers and those in YJS without these needs), were more likely to have additional needs. A higher proportion of those with educational needs had been diagnosed with a mental health condition, were vulnerable to criminal exploitation, had a concern noted about their significant relationships, and had a higher mean number of incidents of offending and risk of re-offending. A higher proportion of those diagnosed with a mental health condition had also used drugs, had four or more ACEs, and a higher mean number of incidents of offending and risk of reoffending. A higher proportion of those with speech and language needs had experienced violent victimisation and also had perpetrated violence, had caregivers with underlying issues impacting the quality of care, had been excluded from school, and had a higher mean number of offences and a higher risk of re-offending. A higher proportion of those who had difficulties with social skills had self-harmed and were more likely to have experienced violent victimisation. There were also significant associations between ever being a child in need and educational needs, neurodiverse diagnosis, and mental health condition.

The unmet health needs and risk factors experienced by young people and their families created barriers for them engaging in mainstream sectors such as education and barriers to engaging with support from services. Additional barriers also included knowing where and how to access support, long waiting times, and difficulty with diagnosis. Previous negative experiences or negative perceptions of services (for both young people and parents) also make it more difficult to engage, due to stigma and fear. Parents own health needs, capacity, and barriers played a significant part of how well young people were able to engage with services. Families involved with multiple agencies also had increased challenges of navigating support if services were not well connected.

## 4.2 Identifying assets

Findings from the HNA and the wider evidence-base demonstrate that there are a number of protective factors that can reduce the risk of young people becoming involved in the CJS. These protective factors were seen to provide young people with better chances in life, have more positive experiences, and help them make more positive choices. This in turn is thought to prevent and reduce offending behaviour and prevent re-offending.

Stakeholders and families participating in this HNA highlighted what young people and their families need from the YJS to meet their health needs and overcome some of the challenges that may have contributed to them entering the CJS, and the barriers they face in engaging with services. This included a trauma-informed system that understands the impacts of ACEs and trauma and looks beyond the presenting behaviour or crime, and also involves skilled and experienced staff who could

build trusted relationships with them, with knowledge of wider support pathways for appropriate referral and signposting. This requires a system that puts the child first and provides a bespoke and tailored care for their individual needs, using a flexible and adaptable approach to develop a trusted relationship. Understanding complex health needs is important for preventing young people entering the CJS, and supporting those who do, through the system. This means working in a way to understand the context, help young people feel understood through listening to them, exploring their frustrations, and building trust with them. Providing a safe and non-judgemental space was key, as well as utilising innovative and accessible communication methods and activities. Understanding of the wider context and barriers for parents was also seen as essential in supporting them to support their children, as was understanding the challenges some people may have in attending appointments (and not closing these people off from support). Using this approach was seen as a way to not miss opportunities to engage families in timely and effective support best placed to meet their needs.

Supporting vulnerable children and young people through the CJS is a key priority, with the Health and Justice Specialised Commissioning Workstream, and other key initiatives in place across the CJS to meet the mental health and wider health needs of young people. Stakeholders involved in this research suggested that nationally, the Youth Justice Board is ahead of the curve with their child first approach. Cheshire YJS adopting the health offer was seen as a way to begin to address these unmet heath needs, and to better support young people to minimise further inequality for young people involved in the CJS and reduce the likelihood of them staying or returning to the CJS.

This pathway was seen as critical given the risk factors and unmet need associated with neurodiversity, coupled with findings from other research, evidencing that neurodiverse young people are disproportionately represented within the YJS. Studies also suggest that aspects of the system including custody can be more traumatic and damaging for those who are neurodiverse. This highlights that system-wider change is needed to understand and treat this population with dignity and care; as well as support and understanding around their communication barriers, especially when it comes to sharing how they are feeling and being able to advocate for themselves in the CJS and other settings.

The health model at Cheshire YJS provides a good opportunity to bring specialist providers together to deliver a cohesive offer. This takes on board key findings and recommendations from the previous HNA (Centre for Public Innovation, 2015), which highlighted the unequitable access to healthcare for young people engaged in the CJS across Cheshire. The offer now provides that key link into mental health, substance use, and SLT support, through an equitable healthcare assessment available to all young people entering the YJS. This provided a key opportunity to assess and identify any unmet health needs in these three areas (and wider health and safeguarding needs), which may not have otherwise been identified, and for many was the first time they had access to such healthcare screening. This multi-agency approach not only allowed for quicker identification during the healthcare screening, but it also meant more timely specialist support for families who would have otherwise had long waiting lists to see specialists from CAMHS and SLT. This was identified as an effective way to open the door to this pathway of wider support, recognising that these health needs were associated to the offending behaviour and need to be addressed to prevent further re-offending.

The Cheshire YJS model also provides an opportunity for multi-agency working, not only to provide that overarching multi-disciplinary offer for children and young people, but also in terms of how services work together across Cheshire. This was identified as a good opportunity to create awareness across the area around the different pathways of support available with clear communication around signposting and referral, highlighting the impact across the system (which also included potential reduction in demand and increased awareness and training opportunities). Considering the health

offer and the wider support beyond this, across Cheshire, findings suggest that there is good coverage of service provision to meet the healthcare needs for young people and their families. However, the high levels of risk and unmet need identified does highlight that more support is needed around early intervention within the system, and more capacity across the system for specialist services such as CAMHS and SLT. Parents also believed that not enough support was in place at earlier points for their child and family.

For the healthcare model itself, there were a few challenges reported. Staff were able to identify where there are gaps in support, which was a positive, but it meant that services may use them as a 'fixing service' and often they would end up 'filling' these gaps which added additional pressures to their workload. It was also agreed that a clearer pathway aid/resource would be useful in relation to the health aspect so that for someone looking in on the service from the outside (including quality assessors etc.) would be able to understand how it works. There were also complexities for staff working as part of the YJS services, but based within other areas of work across Cheshire, meaning that working policies and procedures are not consistent or equitable for key members with similar roles.

Concerns were also raised about the complexity of the DIVERT caseload. Whilst the DIVERT route provided a good opportunity to provide early intervention to prevent further offending and the young person receiving a criminal record. Stakeholders reported that there used to be a clear distinction between the differences in complexity (and resource required) for a DIVERT case compared to a statutory case which were deemed often more complex and resource intensive, but that DIVERT were now just as complex. The quantitative data does show high risks for both statutory and DIVERT cases. Stakeholders were unsure whether young people's needs were increasing and whether this was related to the pandemic and cost of living rise, but it does pose a question around the use of the DIVERT pathway (and resources available for this). Given the unmet need for these young people, findings suggest that this would be the appropriate pathway, although further longitudinal work would be needed around the outcomes for young people following DIVERT work.

Feedback from providers and engagement with young people and their parents (from both statutory and DIVERT cases) allowed the HNA to capture the outcomes and impact for some of the young people engaged with Cheshire YJS and what this involvement meant to them. Parents described the upset which had got to the point of offending, both in terms of the negative impact for any victims involved in the criminal behaviour, and the negative impact for the young person themselves and their family. It was, however, seen that this had led them to the YJS and the opportunity for much needed support. Engaging with the healthcare assessment had provided direct support around mental health and neurodiversity, the family had increased awareness around these issues and how they could impact on behaviour, and the staff had advocated for the young person in a number of settings. The young people had been supported to re-engage with education, training and employment, with a place at a new school designed to support SEND, a training qualification, and employment, meaning that these young people felt they had future options they did not have beforehand. There were reports of increased confidence and self-esteem and reduced anxiety. Significant improvements in communication and improved relationships were also reported, with parents and young people feeling that the trusted relationship with YJS staff had helped them to open up, which had then impacted positively on wider relationships. The work carried out at YJS had also improved knowledge for young people around the impact of their crime and for any victims of this. Wider potential impacts for the community included increased feelings of safety and community cohesion, improved awareness (of the challenges faced by young people), and reduced anti-social behaviour, violence, and crime.

Sustainable support for those completing their statutory and DIVERT order was also highlighted, and especially for those on the DIVERT pathway when support closes with YJS following completion of the 12 week scheme. Stakeholders reported more complex needs for DIVERT than previously, which is further evidenced by the high levels of risk and need within the quantitative analysis. This made it difficult to identify and address these issues (especially taking time into account to break down barriers and build trust) during the 12-week timeframe, meaning often more work was needed beyond this time. Whilst parents praised the wraparound support that the YJS offer provided, stakeholders reported concerns on having an influx of support available (often to families who do not have any other support) for it then to be removed at the end of the order, and the associated impacts of this.

Community based support was seen as key, not only in taking that support out to the young people (YJS using home visits was seen as key in breaking down attendance barriers), but also for linking in community organisations as ways to provide local support and support families to feel more connected to their community. Involving grassroots organisations and the voluntary sector was identified as a gap in service provision linked to supporting young people with more community based diversionary activities. The YJS are piloting social prescribing based initiatives to try to bridge this gap and provide a more sustainable offer beyond the young person's time with the YJS. Linking young people into the appropriate healthcare pathways in a timely way, and having opportunities for ongoing statutory and mainstream support, as well as community-based support was identified as essential. A transparent exit plan and aftercare provision were seen as important for those completing their order or transitioning into adult services.

## 4.3 Determining priorities

The HNA provided an opportunity to engage with stakeholder and young people (and their parents) who were working with Cheshire YJS, to capture their voice and understand their experiences of support and any unmet health needs. Stakeholders who recognised the challenges of engaging young people in more formal feedback processes saw this as particularly important in understanding their needs, experiences and view of the support provided via the YJS, and more widely across Cheshire.

The HNA engaged with a wide range of professional stakeholders and brought partners together to share views and experiences, providing a forum for shared learning. This allowed stakeholders to help identify needs and assets and determine priorities together. The multiagency stakeholder workshop built on this, through shaping the recommendations for effective action. The HNA involved a multi-agency team of cross sector stakeholders who are able to undertake actions and take recommendations forward to improve delivery for the health and wellbeing of young people involved in the CJS. This highlights the importance of partnership working and strategic and operational buy in from partners to take these actions forward.

## 4.4 Recommendations

- The high levels of unmet need when entering the YJS is demonstrated throughout the HNA, and further work is needed externally to the YJS to ensure early intervention is prioritised. Cheshire YJS have highlighted a priority of further understanding unmet need in terms of diagnosis so they can work with partners to identify needs earlier, provide more timely support, and potentially prevent offending occurring in the first place. The data items within the case management system at the YJS provide good key indicators around this area, however, additional detail could be provided for a distinction between unmet and undiagnosed health needs prior to the young person coming into YJS. Measures and guidance

need to be put in place to ensure consistency of reporting. This would firmly evidence the unmet need to lever changes within the wider system.

- The data set derived from the case management system provides a wealth of data and has allowed exploration of data around ACEs and contextual safeguarding that is not always possible to report on and therefore provides key insight. However, the majority of this data is not readily available to routinely monitor and much of this data was derived from individual case notes, which would be resource and time intensive outside of the HNA. Further exploration of how these data items could be more easily and routinely captured and monitored would be useful.
- Further data analysis is needed to explore changes in complexity of DIVERT caseloads cross time. Additional longitudinal research could be implemented to investigate the outcomes of these cases in relation to that wider healthcare need being met and the impact on re-offending. Exploration of the changing complexity would also be required. This would strengthen the evidence for the DIVERT pathway and argue the case for additional resource and funding to support the changing complexity.
- Findings demonstrate the high demand for SLT and CAMHS provision, linking into the wider CAMHS and SLT provision within the community beyond the YJS involvement. Additional capacity is required for cases that cannot be fully supported during the YJS timeframe (especially DIVERT cases). This is especially important given the high levels of co-morbidity in this cohort.
- Having SLT support to advocate for young people and explain their communication difficulties was seen as key in helping the young people navigate the system and understand their own feelings and behaviour. This would be beneficial in other settings of the CJS (and often before it reaches YJS), in settings such as arrest interviews, custody and court, as this may change the outcome of that process for some young people. Additional resource would be required for this.
- The YJS health offer has increased equity for healthcare screening in the CJS for young people across the four areas in Cheshire. However, there are still travel and accessibility issues for some young people from the more rural parts of Cheshire. YJS takes support directly to the young people with home visits, although this option is not always possible for diversionary activities that take place in other parts of Cheshire. To increase the equity of this offer additional support in terms of funding and buy in from other providers across the area (including grassroots organisations) could help facilitate more local access.
- Whilst incorporating key staff from each of the four areas ensures equitable access for young people, the working policies, and procedures within the four areas are not consistent or equitable for staff members with similar roles. The YJS should link in with each area to explore whether this can be streamlined, taking different working practices into account.
- The social prescribing pilot interventions offer a good opportunity to link in with community and grassroots services, to provide local aftercare and a more sustainable offer. This also enables the commissioning of services that are shaped by and for children and families to support engagement. YJS could look to extend the health offer to develop a structured key role for community services within this model. This is especially important for alternative holistic options and for aftercare and exit strategies as young people move on from YJS.
- The YJS healthcare specialists have been able to provide training within YJS and externally to wider services across Cheshire to upskill staff on key areas around young people's healthcare needs, in particular for SLT. This could be developed into a more formal offer, with pre and post evaluation to explore changes in knowledge, attitude and working practices.

- The HNA highlights the key work from YJS and wider services across Cheshire in supporting families to reduce inequalities, improve wellbeing and reduce offending. This required skilled, experienced staff working in a trauma-informed way, using a child focused approach. Support for these staff should be recognised with further opportunity for training and supervision.
- HNA key findings and intelligence should be shared with relevant partnerships and boards across Cheshire. Information should also be shared with partners as part of key safeguarding training for colleagues including education, healthcare including A&E and police (including neighbourhood policing teams) to support earlier identification of risk factors and neurodiverse condition. This would also enable other partners to advocate for children and young people, which in turn would reduce reliance on YJS for this support.
- Further exploration is needed around impacts of school exclusions and work alongside education to support teachers to recognise and support children and young people (and their families) with additional needs. Utilising the Thrive model for building mental health resilience across education and wider services would support a systemic approach to supporting families and reducing exclusion.
- The HNA highlights a significant level of trauma experienced by children and young people engaging with the YJS. Supervision and support for staff, alongside ongoing training is essential.
- Partnership buy-in across Cheshire is required to mobilise change in practice and provide a multi-agency response in supporting families moving forward.

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