



Young People in Contact with the Criminal Justice System in Lewisham

Joint Strategic Needs Assessment – June 2017

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Executive Summary

- This Joint Strategic Needs Assessment (JSNA) document has been produced in response to findings from a Full Joint Inspection of Youth Offending work in Lewisham by Her Majesty's Inspectorate of Probation (HMIP) in late 2016. The inspection noted areas of strength in mental health provision for Youth Offending Service users, but recommended improvements in assessment and management of their physical, and speech, language and communication needs.
- For the purposes of this report, physical health needs encompass acute and chronic health conditions such as asthma and diabetes, sexual health problems, and physical disabilities including hearing and visual impairments. Speech, Language and Communication Needs (SLCNs) encompass a range of receptive and expressive difficulties.
- There are well recognised links between physical ill-health and particularly SLCNs and offending among youth populations. The burden of SLCN among young offenders nationally may be as high as 60% based on survey results, compared with 10% in the general population. However, case recognition especially for SLCNs in youth offending populations is poor; SLCNs in particular are difficult to diagnose and may be effectively masked by young people themselves.
- An audit of 55 young offenders under the management of the Lewisham Youth Offending Service (YOS) from January-February 2017 carried out for this report revealed that 9% had diagnosed physical health conditions, and 13% SLCNs. There was no observed overlap in physical ill-health and SLCNs in this cohort, although one individual had overlapping SLCN and a diagnosed mental health problem. These figures likely significantly underestimate the true burden of need in this cohort. Rates of SLCN are some way below estimates from national surveys.
- There were significant challenges to data analysis and interpretation in the case audit. 18% of the young people did not have a current, completed Asset+ assessment, although in 70% of these cases this was because they had previously had an Asset assessment completed or their criminal justice outcome meant that no YOT intervention was required. Documentation of sexual health status was very limited. In five cases (9%), case workers documented significant concerns about undiagnosed SLCN or special educational needs (SEN) but no onward referral was documented or further clinical assessment was awaited.
- Lewisham YOT practitioners identified a range of challenges in assessment and management of physical health and SLCNs among young offenders. To help address these, they argued for improved data sharing between service partners (and especially with schools), and strengthened specialist input to support assessment and management of health needs by YOS staff.
- This report makes recommendations in two areas:
 - **Strengthening initial assessment and referral:** through dedicated YOT staff training in assessment and recognition of physical health needs and SLCN/SENs and increased expert support for physical health and SLCN/SEN assessment and interventions for YOS users. There are opportunities to strengthen expert input through work in partnership with the newly commissioned Young People's Health and Wellbeing Service in Lewisham.
 - **Improving data completion** through, for example, audit work to improve record completion in Asset+.

Section 1: Introduction

Purpose

1. The purpose of this Joint Strategic Needs Assessment (JSNA) is to examine rates of physical health, and speech, language and communication needs (SLCNs) among children and young people (CYP) who come into contact with Youth Justice Services (YJSs) in the London Borough of Lewisham, and to outline both current practice in Lewisham and best practice from elsewhere in assessment and management of these needs.
2. The report aims to support practitioners, managers, policy makers and commissioners in Lewisham in prioritising and targeting local resources effectively in future development of the service offer by Lewisham Youth Offending Team (YOT).

Definitions and methodology

3. The definitions of physical health and SLCN used in this report are as follows:
 - a. Physical health needs in young people encompass well-recognised chronic conditions such as asthma and type 1 diabetes (both of which are quite common in children and adolescents), episodes of acute illness, and long-term physical disabilities – which may include visual or hearing impairments, or mobility problems requiring support up to and including wheelchair use.
 - b. SLCN is a broad term that includes a range of receptive and expressive difficulties. Put simply, speech refers to saying sounds accurately and in the right places; language refers to understanding and making sense of what people say; communication refers to how we interact with others and to adapt this to suit different situations. SLCNs can exist in isolation, alongside other disabilities or indeed as a part of them. It is important to note that people diagnosed with Autism Spectrum Disorders (ASD) and learning difficulties will always have some form of SLCN and there is an increased risk of SLCN within young people with Attention Deficit Hyperactivity Disorder, Conduct Disorders, Social Emotional Behavioural Difficulties and dyslexia.
4. This document outlines findings from an evidence review of current physical health and speech, language and communication needs in the YOS cohort in Lewisham. Data were drawn from a number of different sources to support this, including:
 - a. A desk review of literature on youth offending nationally and in Lewisham. This included both peer-reviewed academic literature (drawn from academic journals) and non-peer reviewed grey literature reports from national bodies (such as the Ministry of Justice, Youth Justice Board, Centre for Mental Health and others), and local organisations (including Lewisham Council, and papers produced by the Lewisham YOT).
 - b. An in-depth review of case records held by the Lewisham YOT on 38 repeat offenders in contact with the service over January and February 2017. This group of young people has now been established as a “cohort”, and their records will be regularly reviewed over time to provide a clearer picture of risk factors for offending and repeat offending in the borough.
 - c. Focus group discussions with a selection of Lewisham YOT practitioners, to better understand the working pressures they operate under, and seek views on potential solutions to these.

Section 2: what is the policy context to this report?

National policy context

5. Youth offending teams (YOTs) are multi-agency partnerships that deliver youth justice services locally and require local partner cooperation to coordinate the provision of local youth justice services. YOTs are specifically tasked with reducing offending or re-offending among young people, and bring together stakeholders from the local authority, police, probation and health services.
6. YOTs were originally established under the terms of the Crime and Disorder Act 1998, with national oversight for both community and custodial sentences provided by the Youth Justice Board (YJB). In recent years there has been a shift towards reduced central oversight and reporting to the YJB in favour of greater local autonomy in youth justice provision, but this has coincided with broad-ranging cuts to funding, and healthcare delivery in this context has for some time been identified as an area for improvement across localities¹.
7. There is also broad recognition among policymakers of the need to redesign services around an early intervention, prevention and family-based model and an acknowledgement that to be effective, YOTs must bridge the criminal justice system and wider children and young people's services to bridge service gaps between the two. This approach has been a recurrent theme in national policy documents since the publication of the Government's *Healthy Children, Safer Communities* strategy in 2009².

Local context

8. In September 2016, Her Majesty's Inspectorate of Probation (HMIP) carried out a Full Joint Inspection of Youth Offending work in Lewisham³. The inspection report noted that while "the provision of mental health services was good...physical health and speech, language and communication needs were not being adequately met" in Lewisham.
9. The inspection team made a series of recommendations, primarily that the Youth Justice Management Board in the borough should redouble its efforts to improve outcomes for children and young people, aiming for a reduction in reoffending rates, better management of the risk of harms to others, and strengthened protection of vulnerable children and young people who have offended in the past. In relation to health specifically, they recommended that:
 - a. "The delivery of health services to YOS children and young people reflects the needs identified in The Joint Strategic Needs Assessment 2014...including physical health, and speech, language and communication needs" (Recommendation 8);
 - b. "Information sharing with health, substance misuse and social care partners is improved" (Recommendation 9).

¹ See the three Healthcare Commission/CQC and HMIP reports on this topic released between 2006 and 2011: Let's Talk About It: A review of healthcare in the community for young people who offend (Healthcare Commission, 2006); Actions Speak Louder : A second review of healthcare in the community for young people who offend (Healthcare Commission and Her Majesty's Inspectorate of Probation, 2009); Re: actions: A third review of healthcare in the community for young people who offend (Care Quality Commission, 2011)

² Department of Health, Department for Children, Schools and Families, Ministry of Justice, Home Office (2009). *Healthy children, safer communities - a strategy to promote the health and well-being of children and young people in contact with the youth justice system*. London: TSO.

³ HMIP (2016). *Full Joint Inspection of Youth Offending Work in Lewisham: an inspection led by HMI Probation*. December. London: HMIP.

10. Stakeholder observations and findings from the previous JSNA in this area⁴ support the view that there is scope for improving primary health provision for this cohort. This includes better management of physical health needs (including sexual health) and speech, language and communication needs.
11. In May 2017, a new Young Person's Health and Wellbeing Service was launched in Lewisham supporting CYP aged 10-19 years old (up to 25 years old for Learning Difficulties), addressing needs such as sexual health, substance misuse and mental health. The service is offered via a 'hub and spoke' model including in-reach to support the YOS cohort with their health needs. The service reflects an emergent move nationally towards outreach-based models of clinical services for young people to improve access. New models of care have been developed with a focus on greater accessibility, multi-agency working and integrated offer services in the community e.g. one-stop shops (hubs) and outreach clinics (spokes). Among other objectives, the Lewisham service aims specifically to:
 - a. Provide a universal and targeted early help, prevention and early intervention offer in accessible settings;
 - b. Provide a mobile holistic assessment and intervention service focused on the three main risk predictors of teenage ill-health (substance misuse, risky sexual behaviour and poor mental health);
 - c. Provide support to young people to develop healthy relationships, including managing their own sexual health needs for contraception and STI testing.
12. Alongside this, Lewisham YOS has embarked on a 'trauma-informed' approach, endorsed by the Mayor's Office for Policing and Crime, and coordinated by the London Resettlement Consortium. This approach emphasises awareness of possible trauma in the background of young people, and an understanding of the ways in which this can affect behaviour and service engagement.

Section 3: why do physical health and SLC needs among young people in contact with the criminal justice system matter?

13. Young offenders are often highly marginalised and there are significant challenges to healthcare provision for this group. The research evidence is clear that young offenders have higher rates of physical and mental ill-health, sexually transmitted disease, early pregnancy, injury and speech, language and communication problems than the general population⁵.
14. These health problems rarely exist in isolation. Health needs identified above often sit alongside high rates of tobacco use and alcohol dependency, as well as concurrent substance misuse and mental ill-health (sometimes referred to as "dual diagnosis" by service providers)⁶. And there are

⁴ London Borough of Lewisham (2014). Joint Strategic Needs Assessment (JSNA): Young people in contact with the criminal justice system. August.

⁵ Dolan, M., Holloway, J., Smith, C. & Bailey, S. (1999) Health status of juvenile offenders: a survey of young offenders appearing before the juvenile courts. *Journal of Adolescence* 22 137–144.

⁶ Dolan, M., Holloway, J., Smith, C. & Bailey, S. (1999) Health status of juvenile offenders: a survey of young offenders appearing before the juvenile courts. *Journal of Adolescence* 22 137–144; Ritakallio, M., Kaltiala-Heino, R., Kivivuori, J. & Rimpelä, M. (2005) Delinquent behaviour and depression in middle adolescence: A Finnish community sample. *Journal of Adolescence* 28 155–159; Galahad SMS Ltd. (2004) Substance Misuse and Juvenile Offenders. London: Youth Justice Board; Galahad SMS Ltd. (2009) Evaluation of the substance misuse project in the young person's secure estate. London: Youth Justice Board.

overlaps between these factors and educational underachievement, young parenthood and adolescent mental health problems. Risk factors cluster together in the lives of the most disadvantaged children and the chances of offending behaviour increases with the number of risk factors. YOT practitioners identify lifestyle, thinking and behaviour and statutory education as risk factors for offending; young offenders also cite lack of training and qualifications and neighbourhood.

Physical health problems

15. Links between physical ill-health and offending behaviour will usually be indirect, but they are often connected with issues of self-esteem and emotional well-being that may have a significant impact on behaviour. For example, poorly controlled type 1 diabetes may lead to alterations in cognitive function and even aggressive behaviour in extreme situations, resulting in disruptive behaviour. In a school setting this may ultimately result in exclusion.
16. The prevalence of sexually transmitted infection among young offenders is high, but detection in Youth Justice facilities and in the community for this group is generally poor despite positive attitudes towards testing among young people⁷, and the proven cost effectiveness of early intervention for these infections. This is problematic because many of the most common infections – chlamydia for example – are readily detectable using simple tests; failure to diagnose chlamydia promptly increases the risk of onward infections, and can result in long-term health problems including chronic pelvic pain and infertility in women, in addition to issues of self-esteem and emotional wellbeing.

Speech, language and communication needs

17. There is an extensive literature highlighting correlations between SLCNs, poor educational levels and literacy as risk factors for offending. We also know that the prevalence of SLCNs among youth offending populations nationally is very high. National surveys report rates of SLCNs among young people in contact with YJSs from around 40% to up to 60%, compared with 10% in the broader population. Around 30% of service users in the youth justice sector in a recent survey were thought to have SLCNs as their primary need⁸. Presence of SLCNs directly affect the ability of young people to engage in verbally-mediated interventions, putting them at risk of non-compliance, reduced engagement, and in turn, re-offending. Young people with SLCN are also more vulnerable to abuse than those without⁹, making them a deliberate target for some perpetrators of abuse.
18. However, SLCN diagnosis rates are poor. Reports show only 5% of young offenders had their SLCN identified prior to their entry to the YJS and identification in YJSs remains low despite high prevalence rates nationally¹⁰. This may be because:

⁷ Buston K, Wight D. Self-reported sexually transmitted infection testing behaviour amongst incarcerated young male offenders: findings from a qualitative study. *Journal of Family Planning and Reproductive Health Care*. 2010 Jan 1;36(1):7-11.

⁸ University of Sheffield, Birmingham City University and the Communication Trust (2015). *The Special Educational Needs and Disability Reforms and Speech, Language and communication Needs in the Youth Justice Sector: Findings from a Survey of Youth Justice Services in England*

⁹ Snow, P. (2009) Child maltreatment, mental health and oral language competence: inviting speech-language pathology to the prevention table, *International Journal of Speech-Language Pathology*, 11(2), pp. 95-103 (see p. 99); Stalker, K. and McArthur, K. (2010) Child abuse, child protection and disabled children: a review of recent research, *Child Abuse Review* (see p. 2 and p. 14).

¹⁰ Bryan K, Freer J and Furlong C. (2007) Language and communication difficulties in juvenile offenders. *International Journal of Language and Communication Disorders*, 42, 505-520.

- a. SLCNs can be difficult to identify: young people can become proficient in masking their problems by avoiding engagement or being disruptive so as to distract from their difficulties. Detection may be particularly difficult where social, emotional and behavioural difficulties co-exist¹¹.
- b. YOS staff do not feel adequately qualified either to identify SLCN with confidence, or to make the appropriate onward referrals for support where necessary: nearly half of those YOS practitioners surveyed in recent national research indicated that service users locally did not typically have a Statement of Special Educational Need (SEN) or an Education and Health Care Plan (EHP) put in place if a SCLN was identified¹².

Section 4: physical health, SLC needs and service provision among youth offenders in Lewisham

Characteristics of the population of children and people in Lewisham in general

19. The spectrum of need among children and young people in Lewisham is broad, with deteriorations in some important outcome measures in recent years. In 2014, 26.5% of the population of CYP under the age of 16 in Lewisham lived in poverty (a small increase compared with 2013), compared with a national average of 20.1%. The crude rate of looked after children (who are at greater risk of contact with YJSs than the general population) aged 16 and over in the borough increased from 192 per 10,000 in 2014/15 to 235 per 10,000 in 2016/17, both figures being well above both pan-London and national rates.
20. In physical health terms, the new STI diagnosis rate rose from 2,022 per 100,000 in 2012 to 2,131 per 100,000 in 2015 – again well above both pan-London and national rates¹³. There have also been increases in hospital admission rates due to substance misuse among young people aged 15-24, and hospital admission rates for some chronic diseases (e.g. asthma in those aged under 19).
21. Collectively, these figures suggest that the burden of health need among the population of young people in Lewisham who might potentially come into contact with the YOS is changing in ways that may place new demands on services in the borough.

Characteristics of young people in contact with Lewisham YOS

General features of the population of young people in contact with the YOS

22. The YOS cohort includes all children aged 10 to 18 who have committed an offence and receive either a reprimand (warning) or are charged to appear in court. Rates of contact with youth offending services in Lewisham are high, in part because the borough is one of the most deprived in the country (48th most deprived Local Authority in England). To date in 2016/17, 270 young people have been on the Lewisham YOS caseload. Of these, 60 settled with out of court disposal,

¹¹ Gregory J, Bryan K. Speech and language therapy intervention with a group of persistent and prolific young offenders in a non-custodial setting with previously undiagnosed speech, language and communication difficulties. *International Journal of Language and Communication Disorders*. 2010;46(2):202-15.

¹² University of Sheffield, Birmingham City University and the Communication Trust (2015). *The Special Educational Needs and Disability Reforms and Speech, Language and communication Needs in the Youth Justice Sector: Findings from a Survey of Youth Justice Services in England*

¹³ These figures exclude new diagnoses of chlamydia in people under the age of 25.

20 were in custody (7.4%), 10 in remand, and 180 were given community orders. Of this total of 270 young people, 40 (15%) were looked after children.¹⁴

23. Importantly, there is evidence that the complexity of cases in contact with Lewisham YOS may be increasing over time. In 2016-17, there has been a 20% reduction in First Time Entrants (FTEs¹⁵) – the highest reduction in London over the same time period (the average reduction in FTEs across London over the same time period was 6.5%) – but this is partly offset by a 10.4% increase in frequency rate¹⁶, and an increase in the custody rate¹⁷ to 45 for the year. The increase in re-offences and the high number of custodial sentences suggest that a small number of young people locally are committing a high number of offences, often resulting in custody.
24. Ongoing monitoring of information in respect of YOS cohort entrants has until recently been challenging. However, a Youth Justice Board “Live Tracker” has now been set up, identifying 55 young people who received an Order between 1st January and 28th February 2017. These young people will now be tracked over the year, not only to extract and analyse outcomes but also to influence decisions when case managers assess that a risk of re-offending has increased.

Characteristics of the “Live Tracker” cohort

25. Of the 55 young people in the Live Tracker from January-February 2017, 17 (31%) were first time entrants (FTE) into the criminal justice system; the remaining 38 (69%) were repeat offenders. Data presented in the following sections relate to all young people in the live tracker (i.e. both FTEs and repeat offenders).
26. A large majority of young people in the repeat offending cohort were male (84%), and of Black African, Black British or Black Caribbean ethnicity (60% across all three of these ethnic groups). This is in contrast to overall figures on the ethnic makeup of the population of young people in Lewisham: in 2017, Black African, Black British and Black Caribbean young people account for around 27% of the population aged 10-18 in the borough¹⁸, meaning that these groups are disproportionately represented in the cohort. In age terms, the vast majority of young people (71%) were aged 16-18. It is not possible from this cross-sectional analysis to give a sense of how the age distribution of young people in contact with the YOS is changing over time.
27. The range in intensity of offending varied markedly within the repeat offending group. Most offending occurred at relatively low rates: 38 (69%) of the cohort had committed 3 or fewer offences. At the upper end, however, 2 cohort members had committed over 40 offences each since their first point of contact with the Lewisham YOS.

¹⁴ This percentage figure is likely a conservative estimate given that some of those in contact with the YOS will previously have been looked after children out of borough.

¹⁵ FTEs have no record of previous offences and no prior contacts with YJSs.

¹⁶ This is calculated by dividing the number of re-offences across the borough by the number of young people re-offending. It has historically been used as a standard measure of re-offending rates.

¹⁷ Defined as the proportion of young offenders given custodial – as opposed to community-based – sentences. Custodial sentences are usually reserved for more serious offences.

¹⁸ Estimate derived from Greater London Authority 2015 round ethnic group population projections, available here: <https://data.london.gov.uk/dataset/2015-round-ethnic-group-population-projections> (accessed 22/5/17)

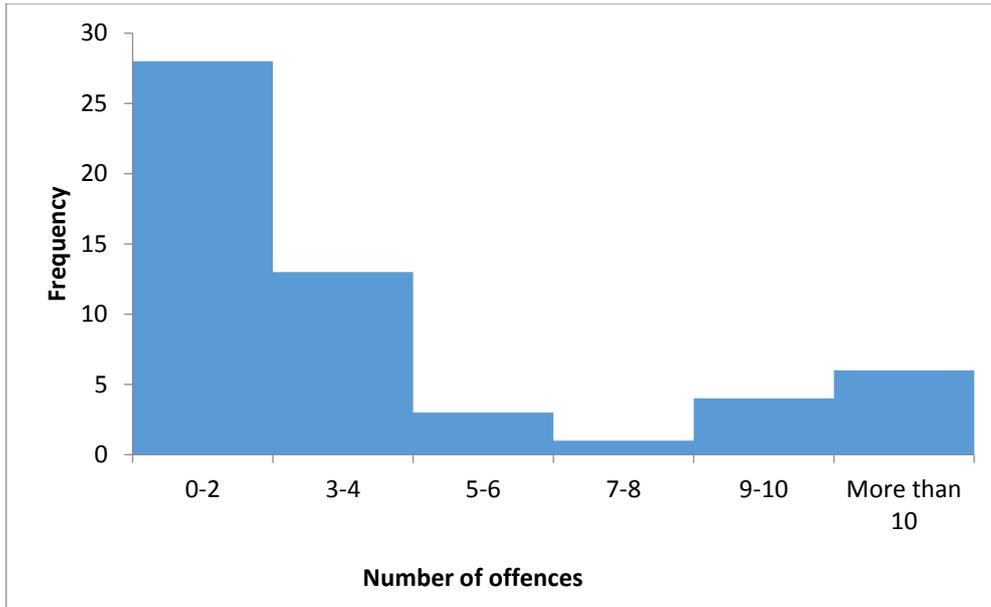


Figure 1. volume of offences by young offenders in the YOS cohort – showing that a majority of young people in this group have offended 4 times or less.

Health needs among the “Live Tracker” cohort

28. In physical health terms, 5 (9%) members of the cohort had a diagnosed physical health condition – including asthma, migraines, epilepsy and sickle cell anaemia. Three of these individuals were on regular medication at the time of their Asset+ assessment. It is difficult to benchmark these figures because data on physical health needs from other localities is not comprehensively gathered.

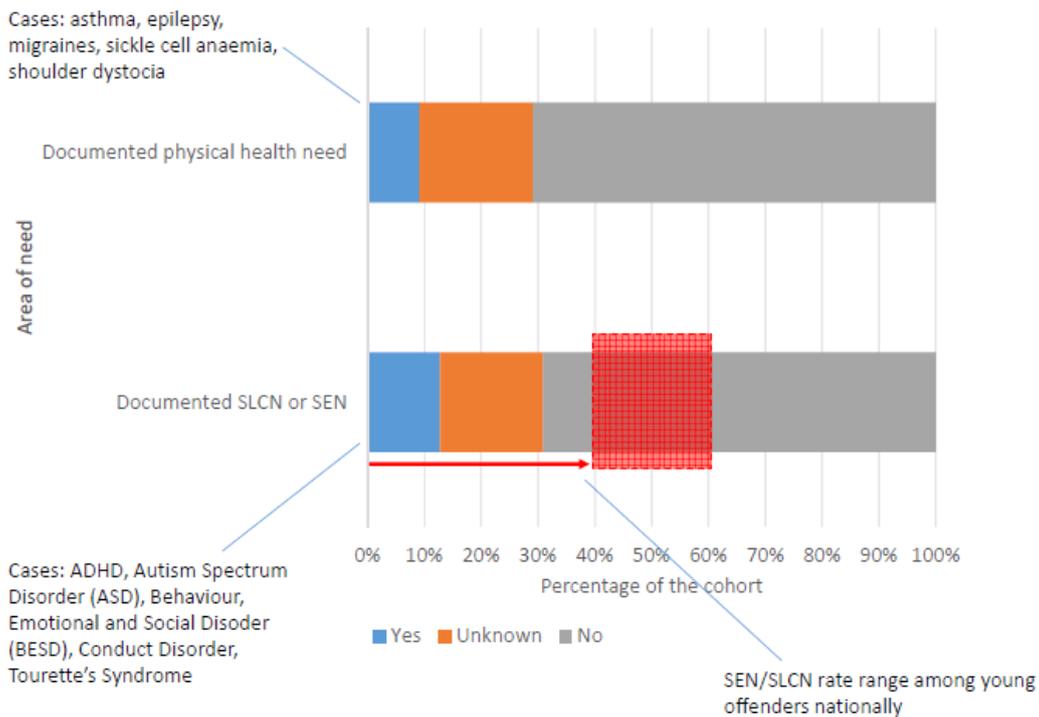


Figure 2. *Documented physical health and/or SLCN/SEN needs among the cohort of repeat offenders in the Live Tracker. These figures exclude those individuals for whom there was evidence of a physical health or SLCN need in the free text of the record, but who were not explicitly coded as having one of these needs.*

29. The extent to which physical health needs are being met under current arrangements within the YOS is uncertain. Of the 55 young people in the cohort, 16 (29%) were documented as registered with a General Practitioner. A further 10 young people were also in Looked After Care (LAC) for which specific physical health screening and management systems are in place. The registration status of the remaining 29 young people is unclear.
30. Turning to speech, language and communication, and special educational needs, 7 young people (13%) had recognised SENs (ADHD, Tourette's syndrome, conduct disorder and emotional or behavioural disorders across these cases) – a rate well below figures for the burden of SEN in this cohort nationally, which range from 40-60%. In a further 5 cases (9%), YOS workers identified significant concerns over SLCN and/or SEN needs but there was no formal diagnosis or the young person in question was awaiting clinical assessment at the time Asset+ assessment was completed.
31. Importantly, none of those young people with documented physical health needs in this cohort also had overlapping SLCN or SEN needs. One individual with documented SLCN or SEN needs also had an overlapping mental health condition for which they were receiving treatment.

Assessment processes and data completion

32. The case audit revealed some shortfalls in data completion in IYSS, and difficulties in case record interpretation are a significant problem for this cohort. 45 (81%) of case records had an accompanying Asset+ assessment recorded on IYSS, but 10 young people (18%) had no Asset+ assessment documented on the system. Of those young people without a completed Asset+ assessment, this was either because an assessment had previously been completed using the old Asset system (2 cases), the young person would not comply with the assessment (2 cases), or an assessment was not required because of the nature of the outcome of criminal justice proceedings (3 cases)¹⁹. In the remaining three cases, it was unclear why an Asset+ assessment had not been completed.
33. For physical health among repeat offenders, only 4 of the 5 individuals with known diagnoses were explicitly coded as such in Asset+ (details for the fourth were obtained from accompanying free text). Recording of sexual health issues was very limited across all case records. The case audit found no evidence that sexual health screening (in the form of targeting questioning) was performed during contacts with young people in the YOS, although information on child sexual exploitation was given, and contraceptive use among female young offenders was occasionally recorded in free text. Alcohol consumption was in general poorly recorded – 4 of the cohort (7%) were recorded as active consumers of alcohol (alongside cannabis in each case) but no data on volume of consumption was recorded and there is no evidence that assessments of alcohol-related harms are carried out for young people in contact with the service. Just 1 of the 55 young people in the cohort was coded as being a current or past user of opiates. For SLC needs, the case notes show that 4 of 7 young people with diagnosed SENs were not coded in the Asset+

¹⁹ Outcomes for which a YOT intervention (and therefore an Asset+ assessment) are not required include: a caution; a deferred sentence; absolute or conditional discharge; a bind over; a fine; or a compensation order. Further details are given in the Youth Justice Board's data recording guidance for 2016/17: <https://yjresourcehub.uk/yjb-effective-practice/youth-justice-kits/item/448-yot-data-recording-requirements-2017-18.html> [accessed 1st June 2017]

assessment – including ADHD and Conduct Disorders severe enough to interfere with daily activities.

34. For both documented physical health and SLCNs, a significant proportion of case records had no definitive coding (i.e. “unknown” status). Information on onward referrals was not available on IYSS so it was not possible to determine how assessment results had been acted upon.
35. Finally, there were discrepancies between documented SEN or SLCN status with the YOS and Lewisham Council’s Special Educational Need and Disabilities (SEND) services, which support children and young people in the borough with needs in this area. Of the 5 young people in the repeat offending cohort with document SENs, 2 were known to the Council’s SEND services. A further two young people were listed on the SEND caseload who were in contact with the YOT but did not have a formal SEN documented in their Asset+ assessments.

Practitioner perspectives on needs, assessment and service provision in Lewisham

36. A focus group was conducted with Lewisham YOS staff to explore practitioner perspectives on needs among young people in contact with service, methods of assessment and what an effective service to meet physical and SLCNs might look like.
37. Participants identified some overarching challenges relating both to the circumstances of CYP in the service, tools available to them to do assessments, and ways of working to better serve young people in contact with the YOT:
 - a. **The circumstances of some young people in contact with the service are particularly challenging, and assessments sometimes do not identify the extent of these needs.** Particular mention was made of CYP in the cohort who are themselves carer (e.g. for parents), and those with undiagnosed autism, ADHD or sexual health problems that are particularly vulnerable to exploitation.
 - b. Staff felt they were still **adapting to Asset+ as a tool for supporting assessments**. Some viewed the Common Assessment Framework for Children and Young People as a better tool for gathering information on physical health and family circumstances than Asset+.
 - c. All agreed that **sharing of information between services is essential** for effective assessment, and to facilitate a preventive rather than reactive way of working. Existing arrangements allowing YOS workers access to social care information on service users through the Integrated Children’s System (for children on the Child Protection Register) were highlighted as an example of how information sharing could make a very positive contribution to care.
 - d. In view of well-recognised **training needs in recognition of SCLNs and SENs in particular**, participants favoured having **a permanent, in-house health practitioner** to oversee assessment and initial management of health needs. A school pupil referral unit nurse was identified as potentially good candidate for this role in view of their knowledge of this cohort from the community.
 - e. Participants emphasised the central importance of **improved links with schools** especially as young people leave the care of the YOS. Better links are needed not just to enable information exchange, but also to ensure that long-term follow-up plans for young people are put in place and acted on once they leave the YOS’ care.

38. Participants also identified some practice issues and solutions specific to each of the main health domains of interest in this report – as outlined below:

Domain	Issues	Potential solutions
Physical health	<ul style="list-style-type: none"> • Young people cannot be forced to register a GP if they do not see value in it • There is a perception among service users that they are seeing the YOT mainly about their offence – not about health needs • Parent’s lack of understanding of importance of health disclosure is a factor in low recognition of physical health needs 	<ul style="list-style-type: none"> • Some localities (e.g. Enfield) have a nurse present at triage for new entrants into the YOT to ensure that physical health needs are recognised at this early stage • In-house capacity would better support identification of health needs
Sexual health	<ul style="list-style-type: none"> • Asset+ assessments offer opportunities to open this topic, but how far it is pursued depends on each case worker’s experience and comfort 	<ul style="list-style-type: none"> • Specialist, in-house support would assist with identification of sexual health needs
Speech, language and communication needs	<ul style="list-style-type: none"> • CYP often compensate for SLCNs – making identification more difficult • SENs are under-diagnosed and often interpreted simply as “bad behaviour” • There are particular concerns about assessment and management of dyslexia and dyspraxia. Case workers reported low levels of confidence in assessing needs for these young people • Referrals from the YOT for SLCN interventions are not yet happening 	<ul style="list-style-type: none"> • Regular training for case workers would improve confidence in needs assessment • Letters to families need to be pictorial with less technical jargon – this area is unfamiliar to many people • A commissioned service is likely to be needed to ensure appropriate management of SLCNs identified by the service.

Table 1. Issues identified and potential solutions from participants in the Lewisham YOT practitioner focus group discussion.

Section 5: healthcare and SLCN provision for young offenders– what works?

Literature evidence on alternative models of healthcare provision

39. Various models for health care provision for YOS users have been developed, distinguished by the extent of health worker integration into the YOT (table 2). Most of these have been developed to support mental health care provision, but they illustrate some of the ways in which wider health provision – including physical health and SLCNs – could support the YOT’s work, ranging from fully integrated health teams, to teams operating completely independently of the YOT but inputting directly into its work.

Case studies of good practice from other localities

40. Case studies in this section have been chosen on the basis of discussions with practitioners in the Lewisham YOS and with input from the Youth Justice Board.

Lambeth

41. In Lambeth²⁰, a YOS Health Co-ordination Group and YOS Health Action Plan was initiated in 2013, providing for a General Practitioner role to be commissioned to offer cover for one afternoon every two weeks in the YOS, alongside a youth worker to perform general physical health screening (using Asset+, as in Lewisham), sexual health screening (including discussions regarding sexually transmitted infections and condom use). The purpose of commissioning two linked roles was to improve referral rates into health services. This basic service has since been upgraded into

²⁰ Information in this case study is derived from an interview with the YOS Head of Service in Lambeth.

a full, co-located YOS Health Team comprising: the Child and Adolescent Mental Health Service (CAMHS), Assessment, Intervention and Moving on (AIM), SLT, Substance Misuse and GP service (all provided in partnership with the Well Centre, a youth centre in the borough).

42. This service offers (through the youth worker): group work programmes on various topics including healthy relationships, identifying and managing negative emotions, alcohol, cannabis, Multi Systemic Therapy (MST) in partnership with Troubled Families, Come Correct condom distribution service and single-person Intervention and Brief Advice (IBA) for alcohol use.

Greenwich

43. In Greenwich²¹, a service has been developed that combines assessment and referral support by a nurse with speech and language therapy input. A Band 7 practice nurse is commissioned 3 days a week to provide support on health matters. The nurse is integrated within the YOT and their post sits under children's services. They have access to the Safeguarding records for CYP at risk or looked after. The nurse recruited to this post developed their own assessment tools based around Asset+ and CHAT, findings from which they discuss with the allocated caseworker for each service use. They will action all the points or allocate any needs picked up to the caseworker – such as a need to address incomplete vaccination schedules.
44. A Speech and Language Therapist is employed in-house in the YOS, partly in response to concerns among caseworkers about missing SLCNs for which they felt they had little training to complete meaningful assessments. The therapist now does the screening, and works with the caseworkers and help develop assessment skills within the team, and improve knowledge on appropriate follow-up. If high level needs are picked up then the service user is referred to specialist services.

Durham

45. County Durham YOS have developed an innovative approach based around a comprehensive strategy to address SLCNs among young people in contact with them, and their approach is evolving over time²². The strategy, originally launched in 2014, combines staff training across the service with integrated SLCN expertise in the form of a Speech and Language Therapist (SLT) sitting within the service. This post is full-time and is funded jointly by the YOS and North Tees and Hartlepool NHS Foundation Trust. The service is now expanding to incorporate specialist SLT assessments and interventions, and has also developed a range of communication-friendly tools to support young people who offend (ClearCut Communication).

²¹ Information in this case study is derived from an interview with the YOS Head of Service.

²² Durham County Council (2017). County Durham Youth Offending Service Speech, Language and Communication Needs Strategy. Report to the Health and Wellbeing Board, 31st January 2017. Online at: <https://democracy.durham.gov.uk/documents/s71294/Item%206%20-%20CDYOS%20SLCN.pdf> (accessed 22/5/17).

Model	Description	Advantages	Disadvantages
Health team within the YOT Example: Lewisham Adolescent Resource and Therapy Service (ARTS)	<ul style="list-style-type: none"> The Lewisham ARTS team is located in the YOT itself and includes a clinical psychologist, team manager, two mental health substance misuse nurses, a consultant psychiatrist, an administrator, a mental health liaison and diversion worker for young people – all funded through the South London and Maudsley NHS Foundation Trust (SLAM). Cases are generally managed in-house by the ARTS forensic team, although some referrals are made to other services. A speech and language worker based elsewhere provides consultation and training for YOT caseworkers, schools, parents and magistrates. 	<ul style="list-style-type: none"> Better joint working with YOT caseworkers because of co-location No waiting lists for assessments Good opportunities for shared clinical learning and professional development Availability of a broad range of skills onsite. 	<ul style="list-style-type: none"> Risk of the young people remaining in YOT 'silos' and not making use of the full range of mainstream community services Risk of staff becoming isolated from developments in mainstream services.
Lone health practitioner within the YOT Example: Enfield	<ul style="list-style-type: none"> Some YOTs operate a service model involving a single health practitioner working full-time within the service and operating alongside a multi-disciplinary team Most services operating in this way integrate workers with a mental health background (usually from CAMHS). 	<ul style="list-style-type: none"> Ability to attract energetic and enthusiastic workers Caseworkers value having expertise on-site to see advice informally 	<ul style="list-style-type: none"> Risk of professional isolation and weakened links into "mainstream" services Ability to identify needs limited by the individual practitioner's training and experience
Foot in, foot out Example: Lambeth, Newcastle	<ul style="list-style-type: none"> Health practitioner has a presence in the YOT and good clinical and operational links with a specific local health team 	<ul style="list-style-type: none"> Ability to maintain connections with both the YOT and other teams Improved opportunities for health worker professional development 	<ul style="list-style-type: none"> Few identified by practitioners elsewhere
Virtual locality health team model Example: Sheffield, Bradford	<ul style="list-style-type: none"> Extends the foot in, foot out model – health workers see themselves as having shared responsibility for all CYP across the local area, in partnership with colleagues outside the YOT Health workers are located in the YOT, but have strong clinical and operational links outside it 	<ul style="list-style-type: none"> Sense of shared ownership improves strategic coordination of services Access to good quality clinical supervision and peer support for the health worker Good continuity of care for YPs when they exist the YOS 	<ul style="list-style-type: none"> Some gaps in provision reported in areas operating this model
Outreach consultative model	<ul style="list-style-type: none"> Clinical teams located outside the YOT provide direct services to very high risk or vulnerable YPs, but also provide supervision and/or telephone support to workers in the YOT and in custodial settings 	<ul style="list-style-type: none"> The main advantage of this approach is easy access to expertise and support for young people in YOTs (often via telephone contact) 	<ul style="list-style-type: none"> Uncertain sustainability in funding terms because of the cost of contracting specialists in this way

Example: Northumberland, Islington	<ul style="list-style-type: none"> • After screening young people for general health and mental health needs, the health practitioner checks that young people are registered with GPs, before dealing with general health and sexual health needs and delivering lower threshold mental health support (such as anger management sessions or brief interventions) 		
External YOT health one-stop shop Example: Head 2 Head Nottinghamshire	<ul style="list-style-type: none"> • A team of health practitioners assembled to support the YOT, with a health manager located within the YOT to provide coordination • Contacts with service users are outreach-based and available (in this case) 7 days a week 	<ul style="list-style-type: none"> • Ability to offer broad ranging expertise and intensive support, with often quicker responses to referrals • Some of those areas in which the model operates are able to provide 7-day cover • Strong links to other services 	<ul style="list-style-type: none"> • High cost of providing broad-ranging support of this nature • Perceived constraints on access to health support and advice because workers are not co-located.

Table 2. Six potential service models for physical health and SLCN support provision in or working with the YOT²³. Some of these describe service models for mental health needs rather than physical health or SLCN/SEN, but broad principles regarding the degree of integration with YOTs remain relevant.

²³ Details of these models are derived mainly from: Khan and Wilson (2010). You just get on and do it: healthcare provision in Youth Offending Teams. London: Centre for Mental Health. Online at: <http://www.ohrn.nhs.uk/resource/policy/Justgetonanddoit.pdf> (accessed on 22/5/17)

Conclusions and recommendations

Summary of main findings

46. The HMIP inspection identified important areas of strength in the YOS offer in Lewisham, not least the comprehensive nature of mental health support. However, both the inspection report and this needs assessment have identified important areas for further development, including:

- a. **Issues around the collection of data on the physical health and SLCNs of young people using the service remain**, as evidenced by the data audit, and there are some areas in which it appears that almost no information is gathered (e.g. sexual health) – although trade-offs between the need to build a rapport with young people at initial consultations, and the need for detailed information gathering is acknowledged. Overall, this means that it is difficult to be certain whether the reported burden of physical health and SLCN/SEN needs given earlier in this report truthfully describes needs among the young people in contact with Lewisham YOS, or reflects under-recognition and under-reporting.
- b. **There is some uncertainty as to how information on physical health and speech, language and communication needs gathered through Asset+ is acted on.** The data audit found little information on onward referrals where needs are suspected, and management of those with documented needs is also uncertain. The Lewisham YOT is currently developing an algorithm to support case workers in identifying the most appropriate lines of action when physical, mental health or SEN/SCLN needs are identified.
- c. There was broad agreement on the value of **sharing information on young people in the YJS across other services**. Concerns were raised that services work in isolation and because of confidentiality were often unable to share information on individual children. Findings from the data audit show that availability of accessory information on Asset+ around physical health is limited. Case workers typically will not have access to health information unless the young person or their family agrees to share clinical letters with them; access was generally better for young people in LAC – for whom information could be verified against social care data systems. In addition, it appears that some young people in the YOS known to have SEN/SCLN needs are not then accessing the Council's SEND service, and vice versa.
- d. **Training around speech and language for YOS staff** was seen as a priority by workshop participants. Practitioners felt lack of confidence contributed to low levels of SLCN/SEN recognition among staff, and low reporting in case records.
- e. However, there was also **agreement that increasing specialist speech and language input to the service would be an advantage**. This could be in the form of a SLT based at the YOS – either part or full time – by re-purposing existing specialist input to provide the necessary support, or by linking in with the new Young People's Health and Wellbeing Service. The potential for support in recognition and management of learning disability from clinical psychologists working for CAMHS in the YOT was identified as one means of bringing in necessary expertise without significant cost implications.
- f. **Various models of good practice elsewhere** have been identified in this report which could form the basis of a service model to support physical health and SLC needs locally. The particular shape of the service ultimately developed will depend on availability of resources locally.

Recommendations

47. In light of the findings outlined above, the following recommendations are made:

Recognition and initial assessment of needs

- a. Greater attention to **information gathering around potential sexual health needs among young people** presenting to the YOS should be considered, possibly through the addition of screening questions to the existing Asset+ assessment. There are a number of short screening questionnaires or proformas in use in General Practice in the UK on which these questions could be modelled.
- b. **Dedicated YOT staff training in assessment and recognition of physical health needs and SEN/SLCN should be supported** to improve knowledge and awareness. There are a number of providers who could fulfil this function, locally and nationally and discussions are already underway in the YOS in this area.
- c. **Existing expertise within the service could be involved in assessment and management of need in new ways** – particularly for SEN/SLCN through, for example, involvement of clinical psychologists (with CAMHS) in assessment and initial management of young people with learning disabilities.

Management of physical health and SEN/SLCNs

- d. **Existing pathways for referral of young people with identified needs to specialists should be strengthened.** Some of this work is already underway. An algorithm to guide case workers in appropriate course of action when particular needs are identified by Asset+ assessments is currently in development in the YOS. Implementation of this approach should be supported, to ensure referrals are completed.
- e. **Strengthening expert support for physical health and SLCN/SEN assessment and interventions for YOS users should be a priority.** There are now opportunities to achieve this through work in partnership with the newly commissioned Young People's Health and Wellbeing Service in Lewisham, a holistic service with a strong preventive focus that includes capacity for assessment and brief intervention for substance misuse, sexual health problems and mental ill-health including self-harm. The specification for this new service includes conditions requiring the provider to co-locate services with key partners in the borough – including the YOS. The service model was being finalised at the time of this JSNA and included developing the in-reach offer to the YOS. However, further discussion will be needed with key local partners including primary care to ensure young people can access the full range of physical health services (including immunisations for example)

Data completion, audit and information sharing between partners

- f. **Mechanisms for strengthening information collection and analysis through Asset+ should be put in place to ensure accuracy and completeness** – by, for example, conducting regular case audits to ensure high levels of completion, and by ensuring that accessory documents are regularly uploaded by case workers.
- g. **Opportunities for sharing information between key stakeholders working with the YOS should be maximised**, through regular meetings and if necessary reciprocal agreements or memoranda of understanding to ensure that service user confidentiality is maintained.

Appendix 1: exploring risk factors for first contact with the Youth Justice System in Lewisham

- Alongside the JSNA refresh outlined above, a broader needs analysis that focuses upstream on young people who are not in contact with the criminal justice system but who are at risk of being so due to their challenging behaviour is also underway. This work includes an assessment of LBL's wider children and youth services, and ways in which these can be further developed to support prevention. This falls outside the scope of the recommendations from HMIP's inspection in Lewisham. It aims to complement and build upon three Safer Lewisham Partnership reports:
 - Local area profile on serious youth violence
 - JSNA on domestic violence affecting under 25 year olds
 - Report on CSE and radicalisation
- Results presented in this appendix are preliminary. Work is ongoing to understand the range and nature of risks for first time entry into the YJS in Lewisham.

Conceptualising young people's involvement with the criminal justice system: what are the key risk factors?

48. Key risk factors for youth offending are well recognised in the research literature²⁴. Broadly speaking they fall into four categories: those associated with the family, with school, with the community, and finally those which are individual and related to peer-group experiences.

- a. **Family-related risk factors** include poor parental supervision and discipline, a history of criminal activity within the family, and parental attitudes that condone anti-social behaviour and criminality. More broadly, the associations between poor housing, low family income and criminal behaviour among young people are recognised.
- b. **School-related risk factors** include a disorganised school environment, but mainly provide early indicators of a move towards offending behaviour. For example, low academic achievement, aggressive behaviour (including bullying) and lack of commitment to school work and activities (up to and including truancy) can all be indicators of a move towards offending.
- c. At **community-level**, risk of youth offending is increased in disadvantaged neighbourhoods, those with high population turnover and low levels of social attachment, and those where drugs are widely available.
- d. The literature on **individual-level risk factors** has tended in the past to focus on personal characteristics (e.g. hyperactivity, impulsivity, low intelligence and/or cognitive impairment), attitudes (principally those condoning antisocial behaviour or criminality), early involvement in crime and disorder, and peer relationships – in particular those with individuals who are already actively involved in crime and/or drug misuse.

49. In the analysis that follows, we have tried to identify and quantify proxies for the family-, school-, community- and individual-level risk factors identified above where possible.

²⁴ Among many research papers and summary reports on this topic, see for example: Youth Justice Board (2005). Risk and Protective Factors. London: Youth Justice Board; Farrington, Ttofi and Piquero (2016). Risk, promotive, and protective factors in youth offending: Results from the Cambridge study in delinquent development. Journal of Criminal Justice 45 (2016) 63–70.

Characterising the cohort of first-time entrants in Lewisham

50. Of the 55 young people in the Live Tracker from January-February 2017, 17 (31%) were first time entrants (FTE) into the criminal justice system; the remaining 38 (69%) were repeat offenders. Data presented in the sections that follow explore risk factor patterns among the FTE and repeat offending groups. Direct comparisons between these groups should be treated with caution, for two reasons. First, the number of young people in the Live Tracker cohort is small, and simple statistical testing showed that only a minority of the observed differences between FTE and offender groups were significant²⁵. Second, this audit presents a cross-sectional analysis of risk factors (i.e. at a fixed point in time) – so it is not possible to say whether the risks identified *explain* contact with the youth justice system or are simply associated with it.

- From a demographic perspective, FTEs were (perhaps surprisingly) in general of a similar age to repeat offenders in the Live Tracker cohort. The vast majority (15 – or 88%) were male. The distribution of ethnicities in this group was more diverse than among repeat offenders in the cohort, but Black African, Black British and Black Caribbean young people were again disproportionately represented by comparison with the population of Lewisham as a whole (47% of all records reviewed).
- Examination of risk factors for contact with the criminal justice system revealed a mixed pattern. At community level, the proportion of both FTEs and repeat offenders living in areas of high deprivation was predictably high. It was not possible from the data available to gather information systematically on other community-level risk factors.

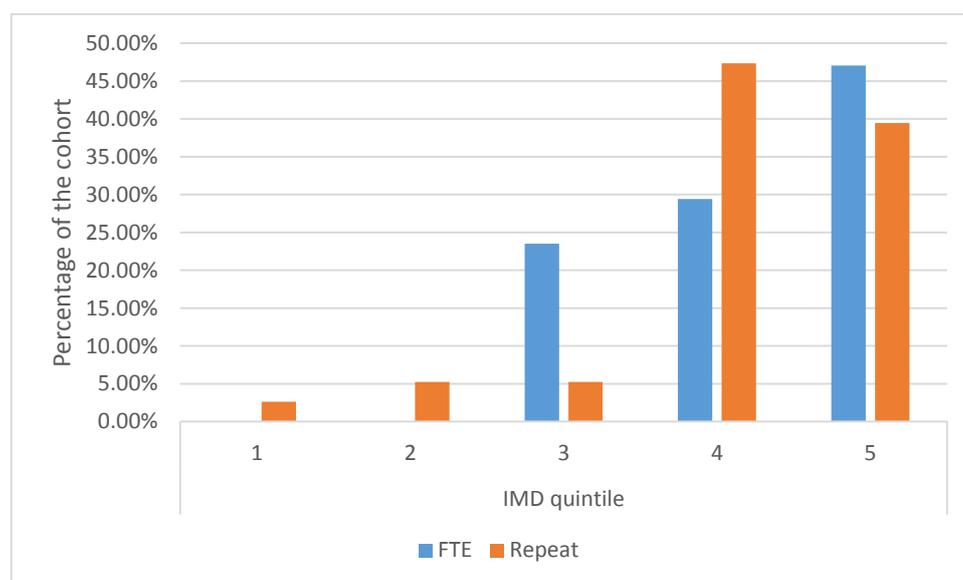


Figure 3. Distribution of young people in the cohort by index of multiple deprivation quintile. If a young person is in quintile 5, they live in one of the most deprived areas of the borough; if they are in quintile 1, one of the least deprived areas.

- The prevalence of key family risk factors was generally lower among the FTE group. For example, the proportion of young people who were looked after or in foster care was lower than the repeat offending group (12% among FTEs compared with 32% among repeat offenders). Similarly, documented domestic violence (either current or historical) prevalence in families of FTEs was

²⁵ Crude univariate analyses were carried out by calculating 95% confidence intervals for the difference in the proportion of young people in each group documented to have each risk factor.

12% compared with 26% among repeat offenders. Neither of these differences was statistically significant, however.

- There were important differences in prevalence of school-related risk factors between the two groups. The proportion of repeat offenders with poor school attendance was 39%, and 26% with evidence of aggressive behaviour in school, compared with 6% for both groups among FTEs. Both of these differences were statistically significant.
- On an individual level, documented gang affiliation was more common among repeat than FTEs (26% and 12% respectively), as were previous episodes in which the young person had themselves been a victim of crime (18% and 12% respectively – most commonly assault). Perceived negative peer group influences were common in both groups (55% among repeats, 47% among FTEs). None of these differences were significant however.
- In health terms, the prevalence of diagnosed physical conditions was comparable with the repeat offenders group (12% compared to 11% in the repeat offending group). One of the FTE group was identified as having SLCN or SEN needs, and one with a mental health diagnosis. There was a marked discrepancy in the prevalence of current or past substance misuse between the two groups however; the prevalence of substance misuse in the repeat offending group was 63% compared with 12% among the FTE group. This was statistically significant.

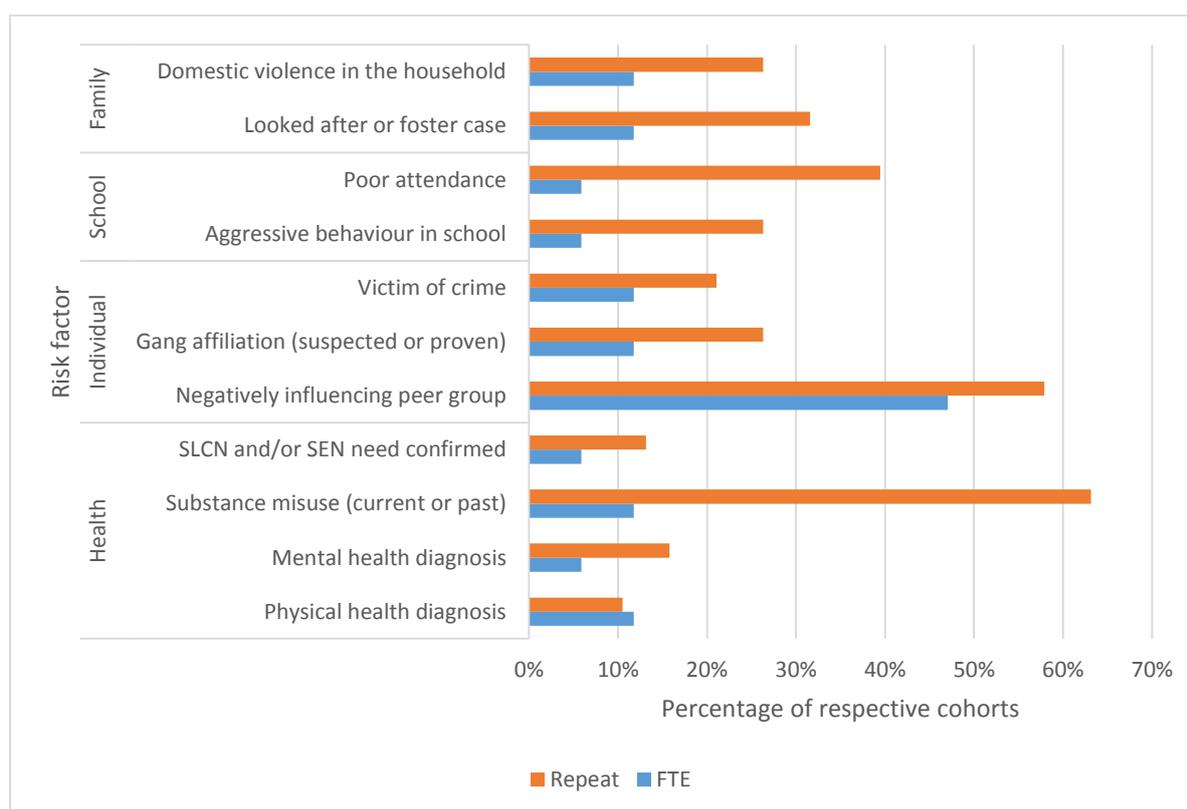


Figure 4. Proportion of the cohort with documented evidence of a series of family, school, individual and personal health risk factors, across first time entrants, and repeat offenders.

- **On the basis of these figures, the clearest risk factor for FTE contact with the youth justice system appears to be exposure to a negatively influencing peer group.** The documented prevalence of other risk factors for youth offending was generally low in this group (no more than 12%). Work is ongoing to further characterise needs among this group and to understand differences in risk factor profile between FTEs and young people who repeatedly offend.

Appendix 2: Asset+ assessment proformas for physical and mental health, and SLCN needs

Physical health

Physical Health and Development Screening Tool		
Young Person _____		
Please indicate whether the following apply to the young person:		
Q1	Has a diagnosed physical health condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yet to clarify
Q2	Experiencing current physical health symptoms? e.g. breathing problems, chest pains, seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yet to clarify
Q3	Currently taking prescribed medication for a physical illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yet to clarify
Q4	Has any current contact with GP or hospitals in relation to a major physical illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yet to clarify
Q5	Is pregnant or could be pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yet to clarify
Q6	Health is being put at risk through his/her own behaviour?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yet to clarify
Further exploration: Please provide as much detail as possible here:		
<div style="border: 1px solid black; height: 80px;"></div>		
Note any positives, and/or any other concerns that require further investigation, referral or action. <i>(including registration with GP, lack of access to appropriate services, concerns expressed by the young person and parents/carers etc).</i>		
<div style="border: 1px solid black; height: 80px;"></div>		

Mental health

Mental Health and Emotional Development Screening Tool

Young Person _____

Please indicate whether the following apply to the young person:

Q1	Any formal diagnosed mental health condition? (current/previous)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yet to clarify
Q2	Any contact with mental health services?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yet to clarify
Q3	Any prescribed medication for mental health problems? (current/previous)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yet to clarify
Q4	Has current feelings of sadness, anxiety/stress or irritability?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yet to clarify
Q5	Feels constantly in low mood?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yet to clarify
Q6	Feels hopeless about the future?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yet to clarify
Q7	Has flashbacks of past traumatic events?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yet to clarify
Q8	Experiencing unusual thoughts?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yet to clarify
Q9	Sees or hears things that other people cannot?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yet to clarify
Q10	Has longstanding symptoms of overactivity, inattention and impulsivity in multiple settings? (e.g. home, school etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yet to clarify
Q11	Has history of deliberate self-harm?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yet to clarify
Q12	Has previously attempted suicide?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yet to clarify
Q13	Has current thoughts to self-harm or wish to commit suicide?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yet to clarify
Q14	Looks depressed or is behaving unusually?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yet to clarify
Q15	Risks/ concerns from others (family/professionals) about young person's mental health?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yet to clarify

Further exploration:

Please provide as much detail as possible here including: the events/circumstances; nature of emotions arising (anger, grief, fear etc); impact on young person's life etc.

SEN/SLCN

Speech, Language, Communication and Neuro-disability Screening Tool		
Young Person _____		
Please indicate whether the following apply to the young person:		
<i>Speaking</i>		
Q1	Have difficulty thinking of the words he/she wants to say?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
Q2	Only use very simple vocabulary?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
Q3	Have difficulties explaining things? Eg do they leave out important details or give information out of sequence?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
Q4	Is their speech difficult to understand? Eg do they stammer/stutter or find it hard to say long words; do they mispronounce words frequently?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
<i>Understanding spoken language</i>		
Q5	Have difficulty remembering things people say?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
Q6	Have difficulty following spoken instructions or only follow part of them?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
Q7	Have difficulty understanding the meaning of words?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
<i>Non-verbal</i>		
Q8	Have difficulty using non-verbal communication? Eg too little or unusual eye contact, body language, facial expression	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
Q9	Have difficulties showing emotions? Eg do they smile or laugh at the right times?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes

Social skills difficulties (inc Autistic Spectrum Disorders)

Q10	Have difficulties initiating and/or maintaining friendships?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
Q11	Is socially awkward and inappropriate?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
Q12	Appear frustrated or anxious when there is no obvious cause?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
Q13	Have difficulty thinking about the thoughts/feelings of others?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
Q14	Has been diagnosed with social communication difficulties? (e.g. Autistic Spectrum Disorder)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yet to Clarify
Q15	Has a professional/ family member expressed concerns about social communication skills?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yet to Clarify

Education needs & Learning Disability

Q16	Have problems with reading or writing?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
Q17	Have difficulties with time concepts? Eg telling the time, using a calendar, understanding date and time concepts such as 'day after tomorrow'?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
Q18	Needs support in daily living skills? e.g. washing, getting ready for school, cooking etc.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
Q19	Have any Special Educational Needs been identified?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yet to Clarify

Further exploration:

Please provide details of special educational needs here:

Identified SEN	Responses to identified SEN
<input type="checkbox"/> Specific Learning Difficulty (SpLD) <input type="checkbox"/> Moderate Learning Difficulty (MLD) <input type="checkbox"/> Severe Learning Difficulty (SLD) <input type="checkbox"/> Profound and Multiple Learning Difficulty (PMLD) <input type="checkbox"/> Behaviour, Emotional and Social Difficulty (BESD) <input type="checkbox"/> Speech, Language and Communication Needs (SLCN) <input type="checkbox"/> Autistic Spectrum Disorder (ASD) <input type="checkbox"/> Visual Impairment (VI) <input type="checkbox"/> Hearing Impairment (HI) <input type="checkbox"/> Multi-Sensory Impairment (MSI) <input type="checkbox"/> Physical Disability (PD) <input type="checkbox"/> Other (please specify)	

Q20 Has a professional/ family member expressed concerns about learning needs?

- Yes
- No
- Yet to Clarify

Traumatic Brain Injury

Q20 Head injury that caused him/her to be knocked out or dazed or confused?

- Yes
- No
- Yet to Clarify

Further exploration:

Please provide as much detail as possible here: e.g. is there something unusual about the way the individual communicates? Please give examples such as 'difficult to have a conversation with them/fixed smile/reluctant to talk'.