Tamlyn Cairns Partnership

HMYOI PARC HEALTH AND SOCIAL CARE NEEDS ASSESSMENT

Commissioned by Cwm Taf Morgannwg Health Board

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Tamlyn Cairns is a trading name for a collaboration between Richard Tamlyn Ltd and Claire Cairns Associates Ltd.

List of Abbreviations and Acronyms

Acronym	Definition
A&E	Accident and Emergency
ABI	Acquired Brain Injury
ACE	Adverse Childhood Experience
ACCT	Assessment Care in Custody and Teamwork
ADHD	Attention Deficit Hyperactivity Disorder
AGP	Aerosol Generating Procedures
AIM	Assessment, Intervention, Moving-on (addressing sexually harmful behaviour)
ASD	Autism Spectrum Disorder
BBV	Blood Borne Virus
BMI	Body Mass Index
BAME	Black, Asian and Minority Ethnic
CAMHS	Child and Adolescent Mental Health Service
CBT	Cognitive Behavioural Therapy
CHAT	Comprehensive Health Assessment Tool
CHD	Coronary Heart Disease
ChiMat	Child and Maternal Health Observatory
COVID-19	Coronavirus Disease 2019
CSIP	Challenge Support and Intervention Plans
CuSP	Custody Support Plans
DTO	Detention and Treatment Order
EMDR	Eye Movement Desensitisation and Reprocessing
FACTS	Forensic Adolescent Consultation and Treatment Service
FASD	Foetal Alcohol Syndrome Disorder
F-CAMHS	Forensic Child & Adolescent Mental Health Service
FGM	Female Genital Mutilation
FTE	Full-Time Equivalent
GP	General Practitioner
HMIP	Her Majesty's Inspectorate of Prisons
HMYOI	Her Majesty's Young Offenders Institution
HNA	Health Needs Assessment
LAC	Looked After Children
LD	Learning Disability
LGBTQI	Lesbian, Gay, Bisexual, Transgender, Questioning and Intersex
LTC	Long Term Condition
MASH	Multi Agency Safeguarding Hub
MenACWY	Vaccination Protecting Against Four Strains of Meningitis
MDT	Multi-Disciplinary Team
MMPR	Minimising and Managing Physical Restraint
NEWT	Needs Engagement Wellbeing Team
NHS	National Health Service
NICE	National Institute of Clinical Excellence
NIMHE	National Institute for Mental Health in England
NRT	Nicotine Replacement Therapy
OHRN	Offender Health Research Network
ONS	Office for National Statistics
OOH	Out of Hours
PFI	Private Finance Initiative
PHE	Public Health England
PHW	Public Health Wales
PRT	Prison Reform Trust
PSHE	Personal, Social and Health Education (national curriculum)

PTSD	Post-Traumatic Stress Disorder
RCPCH	Royal College of Paediatrics and Child Health
RGN	Registered General Nurse
RMN	Registered Mental Health Nurse
RPS	Royal Pharmaceutical Society
SaLT	Speech and Language Therapist
SCH	Secure Children's Home
SLC	Speech, Language and Communication
SMS	Substance Misuse Service
SOP	Standard Operating Procedure
STI	Sexually Transmitted Infections
STOMP	Stopping Over Medication of People with a Learning Disability, Autism or both
SWCU	Secure Welfare Co-ordination Unit
TBI	Traumatic Brain Injury
WHO	World Health Organisation
YCS	Youth Custody Service
YJAF	Youth Justice Application Framework
YJB	Youth Justice Board
YJS	Youth Justice System
YOI	Young Offender Institution
YOS	Youth Offending Service
YOT	Youth Offending Team
YPU	Young Persons' Unit

Table of Contents

List of Abbreviations and Acronyms ..... **iii**

Table of Contents ..... **v**

Table of Figures ..... **viii**

Chapter One – Introduction **1**

1.1 Aims and Objectives 1
1.2 Purpose 2
1.3 Scope and Definitions 3
1.4 Methodology 3
1.4.1 Comparative *4*
1.5 Impact of Covid-19 5
1.5.1 Impact of Covid-19 – Interviews *5*
1.5.2 Impact of Covid-19 – Assessing and predicting need *6*
1.6 Key Policy Drivers 6
1.7 Report Overview 7

Chapter Two – Profile and Demographic Information **8**

2.1 Establishment Overview 8
2.2 General overview 8
2.2.1 Occupancy *9*
2.2.2 Status *9*
2.3 Age 10
2.4 Gender 10
2.5 Home Area 10
2.6 Length of Stay and Implications 11
2.7 Ethnicity 12
2.8 Disability 14
2.9 Parents and Carers 14
2.10 Care Experienced 14
2.11 Chapter Summary 16

Chapter Three – The Young Persons' Unit **17**

3.1 Purpose/Aim 17
3.2 The Building/Facilities 17
3.3 Operational Staffing and Case Management 17
3.3.1 Involving and consulting young people *18*
3.4 Risk Management 18
3.5 First Aid 19
3.6 Restraints and Violence 19
3.7 Interventions 20
3.8 Safeguarding 21
3.9 Chapter Summary 21

Chapter Four – Current Health Service Provision **22**

4.1 Health structure 22
4.1.1 Healthcare organisation *22*
4.1.2 Health staffing (physical health) *23*
4.2 Healthcare Provision 23
4.2.1 Arrival at HMYOI Parc *24*
4.2.2 Care During the Stay *25*

4.2.3 Continuity of care *25*
4.3 Pharmacy and Medicines Management 26
4.4 Out of Hours (OOH) and emergencies 28
4.5 Secondary Care 28
4.6 Data and Recording 29
4.7 Chapter Summary 29

Chapter Five – Physical Health Needs 30
5.1 Overview 30
5.2 Disability 30
5.3 Sight and Hearing 31
5.4 Oral Health 32
5.5 Immunisations and Vaccinations 33
5.6 Sexual Health 35
5.7 Long-Term and Chronic Conditions 36
5.7.1 Asthma and other respiratory difficulties *36*
5.7.2 Coronary Heart Disease (CHD) *37*
5.7.3 Diabetes *38*
5.7.4 Epilepsy *39*
5.7.5 Allergies and Eczema *39*
5.7.6 Sickle Cell *40*
5.8 Chapter Summary 40

Chapter Six – Substance Misuse 41
6.1 Overview of substance misuse needs in the CYP secure estate and at HMYOI Parc 41
6.2 Service Provision 41
6.3 Prevalence of Substance Misuse 44
6.4 Smoking 45
6.5 Alcohol 45
6.6 Drug Use in the YPU 46
6.7 Chapter Summary 46

Chapter Seven – Mental Health and Emotional Wellbeing 47
7.1 Prevalence of Mental Health Conditions in Secure Settings 47
7.2 Mental and Emotional Health and Wellbeing at HMYOI Parc 48
7.3 SECURE STAIRS 49
7.4 Mental Health Provision 51
7.4.1 Primary Mental Health *51*
7.4.2 In-reach (FACTS Team) *51*
7.4.3 Service Delivery *53*
7.5 Emotional Wellbeing 54
7.6 Trauma 55
7.7 Identified Mental Health Needs 57
7.7.1 Self-Harm *58*
7.7.2 Depression & Anxiety *60*
7.8 Conduct disorders 60
7.8.1 Emerging Personality Disorder *61*
7.8.2 Sexually harmful behaviour *61*
7.8.3 Eating disorders *61*
7.9 Chapter Summary 62

Chapter Eight – Neuro Disability 63
8.1 Neuro-Disabilities and other neurological conditions 63
8.1.1 Autism *64*
8.1.2 Attention Deficit Hyperactivity Disorder (ADHD) *65*

8.1.3 Learning Disability, Learning Difficulties and Educational Needs *65*
8.1.4 Speech, Language and Communication Difficulties *67*
8.1.5 Brain Injury *68*
8.1.6 Foetal Alcohol Syndrome Disorders (FASD) *68*
8.2 Chapter Summary 69

Chapter Nine – Physical Wellbeing and Health Promotion 70
9.1 Context 70
9.2 Education and Personal, Social and Health Education (PSHE) 71
9.3 Weight 71
9.4 Responding to Gender Identity 72
9.5 Chapter Summary 73

Chapter Ten – Overview of Findings and Recommendations 74
10.1 Summary and discussion 74
10.2 The Report 75
10.3 Findings and Recommendations 76

APPENDIX A – List of Interviewees 78

APPENDIX B – Policy References 79

Table of Figures

Figure 1 – Need, Demand and Supply Illustration 2
Figure 2 – Status (HMYOI Parc data) 9
Figure 3 – Age Profile of Young people Detained in HMYOI Parc and YCS average for 2020 10
Figure 4 – Home area (data supplied by HMYOI Parc) 10
Figure 5 – Ethnicity of young people Detained in HMYOI Parc 13
Figure 6 – Looked After Children (HMYOI Parc data) 15
Figure 7 – Core Staffing Ratio – Staff per young person 18
Figure 8 – Restraints and violent incidents 20
Figure 9 – Current Healthcare Provision in HMYOI Parc 22
Figure 10 – Physical Healthcare Resources 23
Figure 11 – Primary Care Clinic Data (SystmOne Appointment data) 25
Figure 12 – Residents Prescribed Medication (SystmOne data) 28
Figure 13 – Recorded Hearing Problems and Interventions (SystmOne data) 31
Figure 14 – Dentistry De-escalation Plan (Wales) 33
Figure 15 – Oral Health Records (SystmOne data) 33
Figure 16 – BBV Vaccination Records (SystmOne data) 34
Figure 17 – BBV Vaccination Records (SystmOne data) 34
Figure 18 – Sexual Health Records (SystmOne data) 35
Figure 19 – STI Screening Records (SystmOne data) 35
Figure 20 – BBV Screening Records (SystmOne data) 36
Figure 21 – Asthma and Breathing Problems (SystmOne data) 37
Figure 22 – Asthma Prevalence Comparison (QOF data) 37
Figure 23 – Hypertension (prevalence – males) 38
Figure 24 – Epilepsy (SystmOne data) 39
Figure 25 – Allergies (SystmOne data) 39
Figure 26 – Skin Conditions (SystmOne data) 40
Figure 27 – Substance Misuse Interventions for Young People 42
Figure 28 – History of Substance Use (SystmOne data) 44
Figure 29 – SystmOne Smoking data 45
Figure 30 – SECURE STAIRS 50
Figure 31 – The FACTS Team 52
Figure 32 – Comparison of mental health resourcing 52
Figure 33 – PTSD (SystmOne data) 56
Figure 34 – Traumatic Childhood Experiences (SystmOne data) 56
Figure 35 – Vulnerabilities (SystmOne data) 56
Figure 36 – Identified Mental Health Problems (SystmOne data) 57
Figure 37 – Self-harm incidents (data from HMYOI Parc) 59
Figure 38 – ACCTs opened per month (data from HMYOI Parc) 60
Figure 39 – Estimated Prevalence of Neuro-disability 63
Figure 40 – Identified Learning Needs (SystmOne data) 66
Figure 41 – Identified Speech and Language Needs (SystmOne data) 67

Chapter One – Introduction

1.1 Aims and Objectives

This Health and Social Care Needs Assessment and review complements the separate adult report, both were commissioned by Cwm Taf Morgannwg Health Board. The aim of this report is to inform understanding of the health and wellbeing needs of the young people at Her Majesty's Young Offenders Institution (HMYOI) Parc and to assess the extent to which the current demand for health and social care is being met. Undertaking this project meets the requirement, stipulated by the Royal College of Paediatrics and Child Health (RCPCH), that a health needs assessment is conducted every two years.[1]

RCPCH Standard 12.3.2

A health and wellbeing needs assessment for the secure setting (reviewing physical, mental, substance misuse and neuro-disability health including speech, language and communication needs facing the secure settings population) is completed and reviewed every two years, using a structured assessment tool, by the service planners/providers/commissioners with the secure setting.

The structured assessment tool used for this work is the Child and Maternal Health (ChiMat) Youth Justice Health and Wellbeing Needs Assessment Toolkit.[2] The standards at the core of the assessment are those from Healthcare of Children and Young People in Secure Settings[3] and the relevant standards are referred to throughout.

The methodology used for this HNA and review is from the National Institute of Health and Care Excellence (NICE):

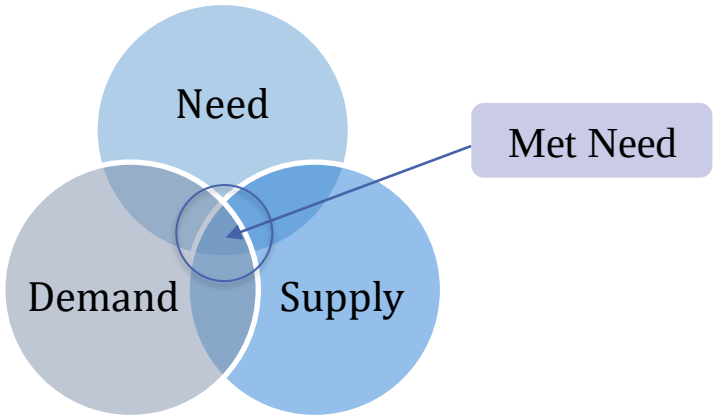
A health needs assessment is a systematic method for reviewing the health issues facing a population leading to agreed priorities and resource allocation that will improve health and reduce inequalities.[4]

Due to the small numbers involved it was clear that it would be more difficult than normal to ensure all conclusions drawn from the health data were robust, so this approach has been supplemented with consideration of associated relevant issues such as staffing models, pathways and available interventions. We discuss the impact of covid-19 on this HNA further below.

It should be noted that health needs may be *met* or *unmet*. It should also be noted that there is a difference between a *need* and a *demand* for a service.

[1] RCPCH (2019) Healthcare Standards for Children and Young People in Secure Settings. [Accessed 24/2/21]
[2] ChiMat (2012) Youth Justice Health and Wellbeing Needs Assessment Toolkit. [Accessed 24/2/21]
[3] RCPCH (2019) Healthcare Standards for Children and Young People in Secure Settings. [Accessed 24/2/21]
[4] Cavanagh S. & Chadwick K. (2005) 'Health Needs Assessment: A Practice Guide NICE'. [Accessed 24/2/21]

Figure 1 – Need, Demand and Supply Illustration



Establishing the extent to which expressed need may be being met is made more difficult by the fall-off between:

1. The existence of a mental or physical health concern
2. The establishment of this need e.g. assessment/diagnosis
3. The offer of an appropriate intervention
4. The take up of said intervention
5. The effectiveness and impact of the intervention

There is some data on the above in general population studies of young people but not all of this is fine-grained enough to be transferable or informative for the young people covered by this report. Key points to note though are that not all needs are apparent – including to the person concerned – and that potential service users may not take up available services. The former may be an issue about awareness and screening, the second is often about engagement.

1.2 Purpose

Cwm Taf Morgannwg Health Board commissioned this HNA and review of healthcare services in HMYOI Parc. It is intended to assist in considering whether the resources to deliver healthcare services in the YOI (Young Offender Institution) are consistent with identified needs and the likely future demand.

In the secure estate for children and young people, the wide range in age and developmental stages of the children and young people in its care creates challenges for those responsible for delivery of care. A key consideration is that the institution is also the child's home and their school. As such there is a strong emphasis on education and as healthy and normal a life as is possible under the circumstances.

Although this HNA relates mainly to HMYOI Parc, it looks beyond the care provided by the YOI alone. Delivering health and wellbeing services in secure settings needs to take account of the importance of providing continuity of care for a child or young person before, during and after their stay.

1.3 Scope and Definitions

This report covers the HMYOI Parc, situated in Bridgend. The YOI accommodates children from Wales and also from the southern half of England. Many children are accommodated a long way from home. This issue is explored below.

There is a fine line between a health needs assessment (HNA) and a service audit/review. This report focuses on describing the likely and actual health needs and the extent to which they appear to be being met rather than systematically assessing service efficacy. As well as the consideration of the relevant data this also involves consideration of various pathways, policies and procedures. As a reference, the review draws on the updated RCPCH standards[5] and many of the relevant standards are placed in the text. This report is not an audit so it is not a comprehensive review against all the standards, rather they are used where appropriate, to illustrate a point or offer a benchmark. (The original 2013 version of the standards specifically states that they apply to Wales. The 2019 refresh incorporates minor updates to the 2013 version; but is the more recent. This 2019 iteration does not specifically reference Wales but was undertaken by the College experts and the College covers the whole of the UK).

This review follows the ChiMat definitions: **health** refers to physical and mental health and also to the impact of substance misuse. On occasions, each of these aspects of health is considered separately.

This report reflects the approach in the YOI, in that there is a strong focus on **wellbeing**. For vulnerable young people, wellbeing is about strengthening the protective factors in their lives and improving their resilience to the risk factors and setbacks that are likely to have a continuing adverse impact on their long-term development. Wellbeing also encompasses how secure a young person feels about their personal identity and culture.[6]

This use of the term 'health and wellbeing' is consistent with the World Health Organisation (WHO) definition of health: *'a state of complete physical, mental and social well being and not merely the absence of disease or infirmity'*. It is consistent with the thinking underpinning *Healthy Children, Safer Communities* and with the approach of health and wellbeing boards and joint health and wellbeing strategies.[7] In addition, consideration is given to the duty upon agencies to cooperate to improve young people's wellbeing. Section 10 of the Children Act 2004 places a duty to cooperate with the local authority, the strategic health authority and primary care trusts (latterly clinical commissioning groups).

1.4 Methodology

The methodology is informed by a toolkit, ChiMat's 'Health and Wellbeing in Secure Settings' (2012). Whilst this report does not follow the same format as the toolkit, it is cross-checked to confirm that the key elements are incorporated.

[5] RCPCH (2019) Healthcare Standards for Children and Young People in Secure Settings. [Accessed 24/2/21]
[6] DH (2012) Health and Wellbeing Needs Assessment in The Youth Justice System Secure Settings Template. [Accessed 24/2/21]
[7] DH (2013) Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies. [Accessed 24/2/21]

We were able to access data on SystmOne for residents of HMYOI Parc over the last two years including the 27 current residents at the time of our data access (December 2020). At different points throughout the report, we have reported data from 2018/19 to present or from 2019/20 to present as appropriate. In places and where appropriate we have further separated data since the covid-19 pandemic began to impact.

Given the low numbers involved, this report is more descriptive than most HNAs. Note that it has not always been possible to draw firm conclusions on aspects of health need and provision in comparison to the national picture due to the low numbers of residents.

In order to avoid the possibility of identifying individuals, the convention is normally to supress numbers which are less than five. Because of the small population involved, following this convention would have risked creating a relatively meaningless report, so with the permission of the key stakeholders this convention has been ignored. This follows the approach taken in several other HNA reports, including our reports for Secure Children's Homes (SCH) and Secure Training Centres (STC).

1.4.1 Comparative

There is a relatively recent HNA for HMYOI Parc, published in June 2019,[8] this report references data from the previous HNA and explores changes. Where appropriate this report references data from HMYOI Cookham Wood Health and Social Care Needs Assessment (TamlynCairns 2019), HMYOI Wetherby(Offender HNA and Consultancy Projects 2019 which contains limited comparable data) also HMYOI Aylesbury (TamlynCairns 2019) which has a slightly older population. HMYOI Cookham Wood and HMYOI Wetherby have recently benefitted from significant additional funding under the SECURE STAIRS initiative. Not only has this resulted in many additional staff, but it has also under pinned a transformation in the ways of working. HMYOI Parc has not benefitted from such largesse, therefore whilst there is some validity in comparing identified need, there is less relevance in comparing many of the responses.

A recent report by the Children's Commissioner for England[9] laments the overall lack of data and the inconsistency and gaps in what is published, noting that this limits a true understanding of the needs of young people served by this sector.

Much of the data describing the needs of detained young people is published by the Youth Custody Service (YCS) which was previously the Youth Justice Board (YJB). Young people who are detained under YCS placements are a distinct and different demographic to those who are detained under welfare placements, specifically YCS placements tend to be older and welfare placements include more girls.

The Secure Welfare Coordination Unit (SWCU) is a recently formed body which co-ordinates all welfare placement applications in England and Wales and can provide useful data about this population. There is no such equivalent as yet for YCS placements but as the populations are quite similar, where there is no data specifically for YCS placements the report draws on data from the body of SWCU referrals as a comparator. There is also a recent Welsh study into children who are detained on welfare placements.[10]

[8] Public Health Wales (2019) Parc Prison Young Persons Unit Social, Health & Wellbeing Needs Assessment 2018-2019
[9] The Children's Commissioner (2019) Children locked Up Who are they? Where are they? [Accessed 24/2/21]
[10] Williams A et al (2019) The Experiences and outcomes of children and young people from Wales receiving Secure Accommodation Orders. [Accessed 24/2/21]

The Department for Education collates looked after children (LAC) data in England and the Welsh Government also produces less comprehensive data for LACs in Wales.[11] Whilst it is more relevant to the HMYOI Parc population than whole population data, it is of limited benefit, though is also referenced as a comparator when more specific data is not available.

A disproportionate number of looked after young people are from the lower socio-economic groups.[12] Health and wellbeing has been consistently and closely correlated to socio-economic status. For example, as an indicator of good physical health, someone born in the highest socio-economic group typically enjoys eight years longer life expectancy than someone born to the lowest socio-economic group.[13] In contrast to the wider population, a greater prevalence of mental health disorders is associated with LACs:

Currently half of all children in care meet the criteria for a possible mental health disorder, compared to one in ten children outside the care system.[14]

If there are no SCH or LAC specific reference sources for comparison, a broad approach for understanding the health needs of young people in SCHs is to assume that their health indicators will be most similar to those of the young people in the most deprived cohort in society.

YCS describe their decision making process to determine whether a placement is to a SCH, STC or YOI. In essence the 'more mature' and 'more resilient' young people will be placed in YOIs.[15] In recognition of less needs, the YOIs receive significantly less funding per place than SCHs or STCs.[16] Yet the same expectations are set out in the RCPCH standards and as evidenced in this report, the needs of the residents remain significant. All this combines to mean that by comparison any YOI is very poorly resourced in comparison to the other two elements of the young person's secure estate.

1.5 Impact of Covid-19

The pandemic has created less disruption in the YPU than in the adult prison. Residents are divided into two family cohorts Echo and Golf and do not mix. They are out of cell each day for education which has been running relatively normally, though with reduced class sizes.

Residents would normally eat all meals communally, they now take it in turns to eat one meal communally each day. Only one half can have association at any one time, so this is reduced.

1.5.1 Impact of Covid-19 – Interviews

Covid-19 has had a range of impacts on this HNA. Note that this HNA was written during national lock downs in both England and Wales. Consequently, it was not considered feasible to visit the establishment and interview people face to face.

[11] Welsh Government (2019) Experimental Statistics: Children looked after by local authorities 2018-19.[Accessed 24/2/21]
[12] Bywaters P (2016) Child protection and children 'looked after': The role of socio-economic inequalities. [Accessed 24/2/21]
[13] ONS (2015) Trend in life expectancy at birth and at age 65 by socio-economic position based on the National Statistics Socio-economic Classification, England and Wales. [Accessed 24/2/21]
[14] DH (2018) Website.[Accessed 8/10/20]
[15] YCS (2017) The Youth Custody Service Placement Team Overview of operational procedures. [Accessed 26/2/21]
[16] HM Government (2021) Children and Young People in Custody (part 2). Evidence presented to Parliament says a YOI funding per place is a quarter of that for a SCH place. [Accessed 26/2/21]

Interviewing people from a distance, whether over a visual medium or by phone is inevitably not as fruitful as face to face. It takes longer to establish the kind of rapport that supports open communication. It is potentially more difficult to communicate clearly as the non-verbal aspects of communication do not transmit as well if at all. It also reduces the potential to experience the interviewee's normal context. This can be particularly problematic with the young people themselves.

Interviewing from a distance also makes it more difficult to opportunistically talk to other people who happen to be available or who may be in a communicative mood at that point. This last point can be quite important where young people are concerned.

Lastly, it is more difficult to appreciate the environment. This can be on a literal level, such as the layout, size of rooms for example but also on a more subtle level such as the quality of décor, the cleanliness of facilities and even the feeling of the establishment and interactions between staff and residents.

Some people were not available to talk to due to illness or because they were isolating.

Where possible we have tried to compensate for these and other impacts and we believe that to a large extent we have managed to do this.

1.5.2 Impact of Covid-19 – Assessing and predicting need

Covid-19 has inevitably impacted on a range of variables from occupancy to outcomes of interventions and everything between.

In terms of assessing need and the meeting of that need, we have assumed that in the long run (post-covid-19) the situation will be roughly as it was pre-lockdown, although of course this is not certain.

Data during the covid-19 pandemic are in many cases different from that pre-lockdown, so in some places we outline and discuss both. Similarly, some pathways and processes have been obliged to change, where appropriate we discuss both with and without covid-19. Our aim is to highlight whatever is most useful for now and in the future, this can vary from one area of health to another.

One area of uncertainty is the impact on future health needs and outcomes of changes in provision during the covid-19 pandemic. This will vary considerably between one context and another but even then, is still very hard to predict. Where we think this may be an issue, we have raised this and hypothesised as to possible longer-term impacts.

1.6 Key Policy Drivers

Consideration has been given to a range of relevant documents (see Appendix B).

This report describes HMYOI Parc which is in Wales and subject to Welsh Government policies. However, at the time of writing in the region of 80% of residents originated from England and given that Parc is the only YOI in Wales comparators are in England. The

different policies informing practice and funding for services have presented significant challenges in our attempt to describe a fair picture of need and response in a context where we seek to view HMYOI Parc against a benchmark of comparable responses in the community or other secure settings. We have endeavoured to be both honest and fair. We are conscious that there are numerous references to England, we reviewed this approach. We considered a young person who is from London, the YCS could place him in (for example HMYOI Cookham Wood or HMYOI Parc) there is moral argument to say that if he presented similar needs in either setting these should be met with similar responses and he should have similar support.

In spite of assurance to the contrary, we have ascertained that SECURE STAIRS, which is a psychologically informed approach that has fundamentally changed care for young people in secure settings in England has not been adopted in Wales.[17] This is a clear example of where there is some rub, the YCS has a remit for England and Wales, yet core aspects of the services they commission are markedly different in the two countries.

Noting all of the above, it is well recognised nationally (across both Wales and England) that mental health services for children and young people are largely inadequate. There are several components including:

- Specialist child and adolescent mental health service for high risk young people with complex needs, (known as FACTS)
- A National Scoping Exercise of Secure Settings for Young People[18]
- Healthcare Standards for Children and Young People in Secure Settings[19]

1.7 Report Overview

This report describes the 'story' of the YPU, specifically looking at:

- Profile and Demographic Information
- Current Health Provision
- Physical Health Needs
- Substance Misuse Needs
- Mental Health and Emotional Wellbeing
- Physical Wellbeing and Health Promotion

There is a rationale and evidence base for the predictions we have used throughout the report.

[17] MOJ and NHS England (2019) (Reissued 2020) Estate. 'Relative sections of PSI 08/2012 Care and Management of Young People, which remain active in Wales but are hereby cancelled in England.'
[18] Warner, L. et al. (2018) Secure Settings for Young People: A National Scoping Exercise. [Accessed 26/2/21]
[19] RCPCH (2019) Healthcare Standards for Children and Young People in Secure Settings. [Accessed 26/2/21]

Chapter Two – Profile and Demographic Information

2.1 Establishment Overview

HMP & YOI Parc is a Category B prison located in Bridgend, Mid Glamorgan, Wales. Parc Prison is operated by G4S Care and Justice Services Limited. Healthcare is provided by G4S Health Services UK under a service level agreement with G4S Care and Justice Services, with appropriate access to community-based services. Education is provided on-site by G4S. It was one of the first private finance initiative (PFI) prisons and as such is approaching the end of a 25 year contract. This means that there will be an opportunity to review health provision and transfer responsibility to the NHS Local Health Board.

HMP & YOI Parc comprises of two facilities contained in one site. The YOI which accommodates up to 64 young people aged 15 to 18 years is separate from the adult prison which houses those over the age of 18 years. This report considers the needs of the children's population, a separate report focusses on the adults.

The most recent full HMIP Inspection report for the YOI side of the establishment was conducted jointly with Estyn Her Majesty's Inspectorate for Education and Training in Wales and describes HMYOI Parc as:

[E]asily the best performing YOI in England and Wales. .... I would suggest that there is much to learn from Parc, and that practitioners and others involved in the development of policy and delivery of operations in children's custody should pay close attention to this report.[20]

During the pandemic, HMIP have been conducting 'Short Scrutiny' visits to range of establishments, this included the YOI side, but not the adult of Parc.[21] The positive HMIP report describes a wide range of initiatives to increase time out of cell including retaining some purposeful activity, ensure provision of healthcare and maintain family links.

2.2 General overview

All places available at HMYOI Parc are commissioned on a contractual basis by the YCS.

There are four YOIs in England and one in Wales; all accept boys, from the age of 15 to up to their 18th birthday.[22] This report references these (YCS) placements and also occasionally data from the SWCU relating to welfare placements where a young person of similar age is detained in a secure children's home for their own safety.

YOIs have lower ratios of staff to young people than STCs and secure children's homes and accommodate larger numbers of young people. Consequently, they are less able to address the individual needs of young people and are generally considered to be less suitable accommodation for those who have been assessed as vulnerable.[23]

[20] HMIP (2020) Report of an unannounced inspection of HMYOI Parc by HM Chief Inspector of Prisons 11-22 November 2019 [Accessed 24/2/21]
[21] HMIP (2020) Report on short scrutiny visits to Young offender institutions holding children. [Accessed 26/2/21]
[22] Parliament (2021) Children and Young People in Custody (part 2). [Accessed 21/2/21]
[23] YJB (undated) Custody (part of a series of YJB Brochures). [Accessed 21/2/21]

In general, children and young people in contact with the youth justice system have more (and severe) unmet health and wellbeing needs than other young people of their age.[24] The legal frameworks and accountabilities involved also have implications, for example in the options available at key points in the young person's journey and how these decisions are made and who is involved.

2.2.1 Occupancy

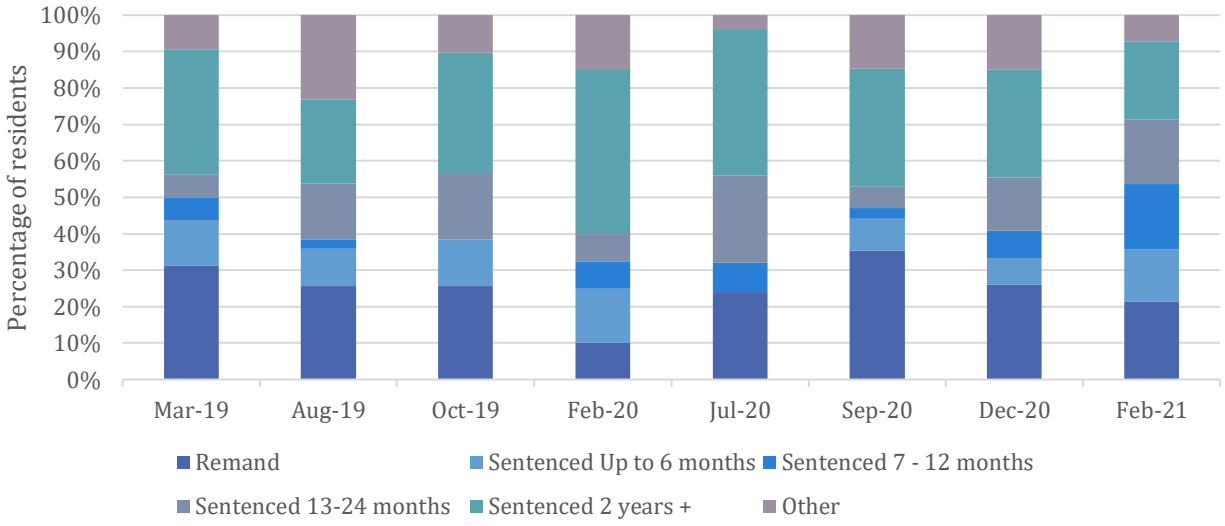
Across England and Wales, YCS use of YOIs has reduced dramatically in the last few years. In April 2015 there were 777 young people under 18 detained, April 2020 this average had fallen to 564 and by December 2020 this had fallen even further to 454.[25] Interviewees attributed the recent decrease to covid-19.

Whilst there are 64 beds, the numbers were generally around 40 residents. At the time of our data snapshot (December 2020), 27 beds were in use, around 30 residents had been common throughout the pandemic and interviewees attributed this to covid-19, therefore expect numbers to increase again in the future, but there is nothing to indicate that they could reach anything like capacity.

2.2.2 Status

The majority of residents are sentenced, their sentences range from short-term Detention and Treatment Orders (DTOs) to Indeterminate sentences.

Figure 2 – Status (HMYOI Parc data)



In interview it was noted that ten years ago the typical resident was serving a short DTO for the type of relatively minor offence which would now be dealt with via a community disposal. Now 25% of the residents are lifers at the beginning of sentences which typically have a tariff of over 16 years, it was noted that for a teenager who is facing say 16 or more years in prison and looking at release in their thirties, in many cases this will create a great deal of anxiety.

[24] See p5 of the CHIMAT toolkit – Health and Wellbeing Needs Assessment – SECURE SETTINGS. [Accessed 21/2/21]
[25] YJB (2020) Youth Custody Data December 2020. [Accessed 21/2/21]

There are a lot of high end offenders who exhibit risky behaviour. Around 95% have significant violence in the offence. (Head of Young Person's Unit (YPU)).

2.3 Age

HMYOI Parc accommodates young people aged between 15 and 17, those aged over 18 who remain in custody transfer to the adult prison estate. In the last two years an average of just over one resident per month transitioned to the adult estate.

In our December 2020 snapshot.

Figure 3 – Age Profile of Young people Detained in HMYOI Parc and YCS average for 2020[26]

Age	HMYOI Parc		National average for YOIs
	Number	Percent	Percent
15	1	4%	4%
16	3	11%	35%
17	23	85%	61%

A comment from an interviewee was that the average age of residents is getting older. The previous HNA did not include an age breakdown.

2.4 Gender

The unit only takes male residents.

2.5 Home Area

Nationally across the whole of the secure estate, YJB data suggest that 65% of detained young people are held within 50 miles of their homes;[27] this is not the case for HMYOI Parc.

The catchment area for HMYOI Parc includes Wales and the South West of England (from courts in Cornwall, Devon, Somerset, Bristol, Wiltshire). An increasing number of residents are placed in the YPU via transfer from other facilities across England. This now means that there are young people from: London, Manchester and other metropolitan areas. Interviewees noted that these tend to have more gang affiliations. The table below illustrates the proportion who originate from England and also from outside of the catchment area, note the change of time.

Figure 4 – Home area (data supplied by HMYOI Parc)

Month	% English	% Welsh	% Out of area
Feb 21	74%	26 %	41%
Dec 20	85%	15%	37%
Sept 20	82%	18%	38%

[26] HMPPS (2020) Youth custody data: August 2020. [Accessed 26/2/21]
[27] MOJ/YJB (2019) Youth Justice Statistics 2018/19 England and Wales. [Accessed 26/2/21]

Month	% English	% Welsh	% Out of area
July 20	88%	12%	32%
Feb 20	75%	25%	20%
Oct 19	62%	38%	21%
Aug 19	62%	38%	19%
March 19	47%	53%	9%

HMIP notes the negative impact of being held a long distance from home, citing that every 26 miles of additional distance results in one fewer professional visit to a young person.[28]

The two key variables for the home area are distance and the extent to which the home services (e.g. Youth Offending Team (YOTs)) have an established relationship with HMYOI Parc. Distance can impede contact and visits from family, as well as relevant professionals from the home area and thus can have an impact on longer-term health outcomes. Reduced contact with families can cause distress to young people and can make returning home more difficult. Larger distances also make it more difficult to facilitate joint work with young people and parents/carers together, or with the whole family. In normal times the YPU hosts bi-monthly family days.

However, this has changed since the onset of covid-19 as more of the interaction with family and professionals is taking place digitally, where distance is less relevant. This has opened up new options that will still be available post-covid-19, particularly where face to face is problematic for whatever reason.

A wide range of home areas means a wide range of agencies to liaise with to ensure effective continuity of treatment, care and resettlement. Where a home area is less common, this may mean needing to start from scratch each time to establish who the relevant personnel are and to build up the necessary working relationships. A key issue can be ensuring that medical records are gathered and passed on quickly so they can inform the assessment of the young person's needs and for having information sharing protocols in place, understood and followed. Each new or 'revived' area takes staff resources to establish these links and may make for less effective liaison and partnerships, all potentially impacting on health outcomes.

2.6 Length of Stay and Implications

Length of stay is critical when delivering healthcare interventions and support; the longer a young person is resident, the more that can be done for them. In addition, when planning care, the known or expected length of stay is important as certain interventions take time to complete safely.

YJB reports that for 2018 (the last complete year for which there are figures), the median number of nights YJB detention in a YOI was 81 nights.[29] (Note that as the median (as opposed to the mean).

[28] HMIP (2016) Thematic Report by HM Inspectorate of Prisons – The Impact of distance from home on children in custody. [Accessed 26/2/21]
[29] MOJ/YJB (2019) Youth Justice Statistics: 2017 to 2018 supplementary tables Chapter 7 Children in Youth Custody. Table 7.29. [Accessed 24/2/21]

Ten years ago the average stay was eight weeks, now the average stay is 18 months. (Head of YPU)

The implications of differing lengths of stay will vary, particularly with regard to the effective continuity of any treatment. Continuity is discussed further below. This can be difficult to ensure, particularly in the case of transfers back into the community. The comparatively short lengths of stay for some young people at HMYOI Parc can mean it is difficult for some longer interventions to have as sustained an impact as they otherwise might if they could be continued for longer. Longer-term interventions are also difficult to ensure whilst the young person is on secure remand, as it is not clear if or when they might leave and on occasions young people may leave immediately and unexpectedly if they are successful at a bail hearing.

There is a clear role for HMYOI Parc in doing what they can to increase the likelihood of an effective transition and continuance of treatment and care, e.g. establishing who would be responsible for any such interventions and that they are prepared to ensure they occur. This is not always easy to establish and can be considerably more difficult when there is little time in which to do so.

In theory at least, any ongoing physical healthcare concerns should be able to continue to be addressed whether a transfer is into another custodial setting or into the community, although in practice this will often depend on relevant professionals ensuring engagement and compliance. This can be more difficult with psychological and other mental health interventions owing to the scarcity of such resources for young people, particularly in the community. The transfer to poorly resourced adult services, whether in custody or the community, can also significantly derail psychological treatment and support and in many cases mean the end of any such interventions.

2.7 Ethnicity

YJB data reports that just over half of all children and young people in the youth custody system are from black, Asian and minority ethnic (BAME) backgrounds which is a significant over representation compared to 18% of the general population. NB nationally, the proportion of the detained population who are from BAME backgrounds has increased from 28% in 2010 to 51% in 2020).[30]

Because of the small numbers, the table below which is taken from HMIP data conflates some categories. Interviewees stated the population has become more diverse since 2019.

[30] YJB (2021) Assessing the needs of sentenced children in the Youth Justice System 2019/20. (Supplementary tables Ch7 Children in custody) [Accessed 21/2/21]

Figure 5 – Ethnicity of young people Detained in HMYOI Parc[31]

Ethnicity	Proportion of residents
White British	54%
White other	8%
Mixed	5%
Asian	5%
Black	27%
Other	3%

Whilst there is a direct correlation between ethnicity and some healthcare concerns, in most establishments the numbers are too small to impact the overall picture of health needs. There is an aspiration that staffing profiles should reflect the ethnic profile of residents, the population in Bridgend is only 3% BAME.[32]

One of the areas where this may be of relevance is in differences in the prevalence of some health problems across different ethnicities, e.g. a study of children and young people in secure settings noted that:

a significantly higher proportion of 'white' rather than of other ethnic background had mental health diagnoses/symptom clusters.[33]

There are also some conditions that are unique, or more common, to certain ethnicities. Sickle cell disease, for example, is most common amongst people of African heritage, with a prevalence of roughly one in 500. This means that there could be many years with no cases at HMYOI Parc and therefore, little need for universal screening. However, the chances of developing the disease increase radically if either parent has it, i.e. a simple question about parents could be a part of the secondary screen. This is just one example of where some fine tuning of healthcare screening could be carried out with minimal trouble but at the same time, recognising potential differences in needs amongst residents.

There are also ethnic variables in common conditions, e.g. long-term conditions (LTCs), although most of these manifest later in life and are less relevant to young people. One example is type 2 diabetes, where prevalence is up to six times more likely in people of South Asian descent and up to three times more likely in African and African-Caribbean people.[34]

Foreign nationals are rare at HMYOI Parc and the need for translation services for the young people is even rarer. At the time of the HMIP inspection there was one foreign national resident.[35]

Young people who are migrants may have incomplete health records and are unlikely to have received childhood immunisations as per the NHS schedule, although they may have benefitted from vaccination catch up programmes.

[31] HMIP (2019) Report on an unannounced inspection of HMYOI Parc 11-22 November 2019. [Accessed 24/2/21]
[32] Welsh Government Stats Wales [Accessed 12/3/21]
[33] Hales, H. et al. (2018) Census of young people in secure settings on 14 September 2016: characteristics, needs and pathways of care. [Accessed 24/2/21]
[34] Stratton et al (2000) Association of glycaemia with macrovascular and microvascular complications of type 2 diabetes (UKPDS 35): prospective observational study. BMJ 2000;321:405. [Accessed 24/2/21]
[35] H HMIP (2019) Report on an unannounced inspection of HMYOI Parc 11-22 November 2019. [Accessed 24/2/21]

2.8 Disability

Disability is discussed in more detail in Chapter Five. In this age group, most disabilities will be 'hidden', e.g. learning disability, autism, hearing or communication difficulties and so on.

In the HMIP survey (2019) 24% of respondents identified as having a disability, this mainly related to neuro disability.[36]

2.9 Parents and Carers

RCPCH Standards

6.6 Effective systems are in place to identify and support all children who are parents or expectant parents, including young men and women. This includes support for physical, mental and emotional wellbeing.

6.6.1 Education on childcare and child development is provided for all young parents and potential young parents, including young men and women.

The Office for National Statistics (ONS) reports that the rates in 2017 were 1.8 per 100 15-17 year olds; this continues a trend of year-on-year decrease.[37]

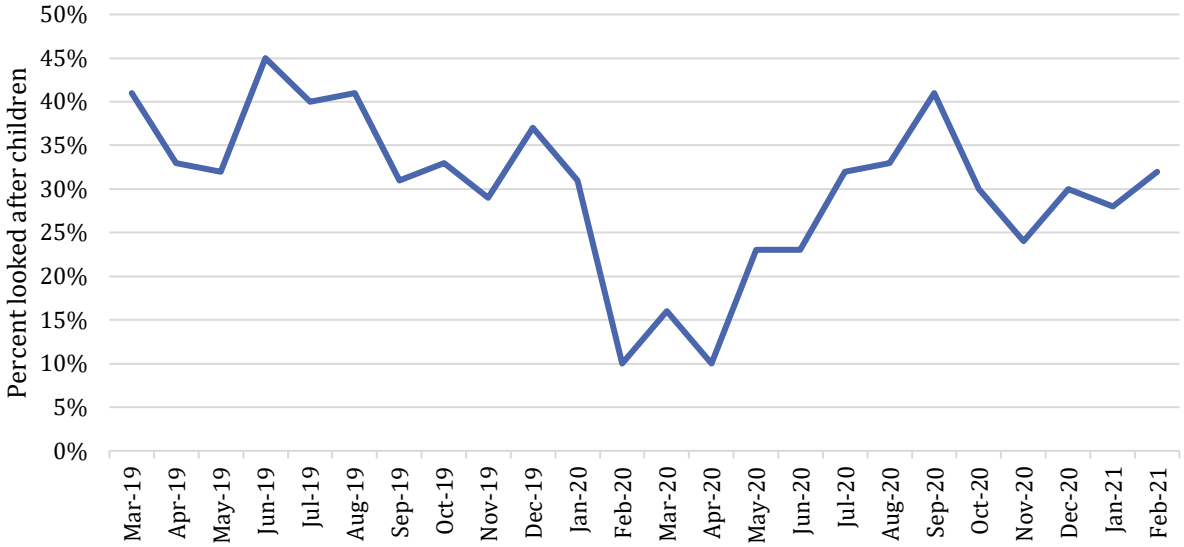
It is rare for any of the young people at HMYOI Parc to be parents themselves. Interviewees described trying to access services in the adult prison to visit and support one young person who is due to be a father.

2.10 Care Experienced

The proportion of residents who are deemed 'Looked After Children' fluctuates from month to month. The two relevant issues are the involvement and support of the relevant Looked After Children Social Worker and future community placements.

[36] HMIP (2019) Report on an unannounced inspection of HMYOI Parc 11-22 November 2019. [Accessed 24/2/21]
[37] ONS (2019) Conceptions in England and Wales 2017. [Accessed 24/2/21]

Figure 6 – Looked After Children (HMYOI Parc data)



The social workers from the home area in many cases overlap with some aspects of the parental role, e.g. they should be kept informed and consulted on any planned developments. They will liaise regularly (and formally) with HMYOI Parc (by phone or internet since the beginning of covid-19). They are also vital to what happens on release, particularly with regard to where the young person will live. This can be challenging when the young person is going to their family or back to a previous placement but can become very difficult if a new placement is needed. This issue is discussed further below.

2.11 Chapter Summary

- HMYOI Parc is the only YOI in Wales.
- The Young Person's Unit (YPU) comprises less than 2% of the population of a larger prison, mostly accommodating adults. The young people are kept completely separate from the adults.
- The YPU accommodates boys who are aged 15-18 years old, detained under YCS orders.
- The catchment area is Wales and an area of England stretching from Cornwall to Swindon. An increasing proportion are transferred from other establishments, so can be from further afield. Eighty percent of current residents are from England.
- The YPU has an operational capacity of 64 beds but in common with other youth custody facilities has been operating with vacancies due to reduced numbers of YCS placements. Compounding this long-term trend, there has been a further drop in occupancy since the beginning of covid-19, at the time of writing there are 27 residents.
- Interviewees noted that, as the numbers of YCS placements have dropped, those being placed are higher in tariff and seriousness of offence. A quarter are in the early stages of life sentences. A decade ago the average stay was eight weeks, it is now 18 months.
- Sixty two percent of residents are white (mostly white British). This is much higher than national data for the young people's secure estate (46%).

Chapter Three – The Young Persons' Unit

3.1 Purpose/Aim

HMYOI Parc is operated by G4S and was opened in 2002, it has been through various changes and expansions to its current form with capacity for 64 young people in two units, Echo One and Golf One.

The unit is within the walls of HMP Parc but separated from the adult side. Residents are escorted into the adult side to access services such as the dentist. When young people are being escorted through the adult prison, no other movements are allowed. This is an example of the measures that are in place to ensure the young people are kept completely separate from the adults.

3.2 The Building/Facilities

Echo One has an operational capacity of 24 with rooms over two levels, 16 single rooms and six doubles. Golf One has an operational capacity of 36 with 12 single rooms and 12 doubles, all on one level. Both units have on-site shower facilities and each cell has a television, toilet, desk, chair, sink and storage unit.[38]

Interviewees described a healthcare office and a separate treatment room. Talking therapies, which do not need a clinical space, can be delivered from a range of meeting rooms. One interviewee observed that in a small facility, other residents can see who meets with who, even if they do not hear the meeting. This is thought to inhibit some referrals, for example for sexually harmful behaviour interventions. As noted later in the report, there are wider concerns about the suitability of space in which to deliver talking therapies.

Residents have access to outside space and to a dedicated gym for the unit which has its own staffing and was described as high quality.

3.3 Operational Staffing and Case Management

There is a fixed operational team of prison officers who all volunteer to work on the unit and are selected according to merit. All receive training on joining the unit and some are working towards the Youth Justice Degree, it was reported that eight graduate each year.

The young people have far more contact with the core operational staff than with any of the health or education staff. Each young person has a keyworker who is a member of the operational team.

They also have a Needs Engagement Wellbeing Team (NEWT) Case worker who is part of the Interventions Team, these perform an essentially youth offending service (YOS) type function

[38] HMIP (2019) Report on an unannounced inspection of HMYOI Parc 11-22 November 2019. [Accessed 24/2/21]

within the unit, i.e. ensuring statutory functions are met and maintaining an overview. (See Section 3.7)

Interviewees described seven operational staff on each unit during the day and one on each unit at night. Daytime staffing rations are higher than those reported elsewhere and night-time are within the range reported elsewhere. If the units were to increase to full occupancy the night-time cover would be below the range seen elsewhere.

Figure 7 – Core Staffing Ratio – Staff per young person

	Number of core staff (day)	Ratio per child(day)	Number of core staff (night)	Ratio per child (night)
HMYOI Parc	14	0.47 based on 30 residents 0.22 based on op cap of 64	2	0.07 based on 30 residents 0.03 based on op cap of 64
Mixed average for a YOI[39]	N/A	0.13 (range 0.08- 0.21)	N/A	0.10 (range 0.05-0.14)

Interviewees stated that the YPU will be introducing Custody Support Plans (CuSP) later this year which will increase the support input from operational staffing with regular keywork sessions.

3.3.1 Involving and consulting young people

The Unit engages Barnardo's Advocates to help ensure young people's rights are observed and to act as an independent ear. These advocates were described as very visible and available to hear the voices of the young people, to manage complaints and concerns. Also to assist as advocates in a wider sense – the example given was assisting in securing accommodation for release.

3.4 Risk Management

Risk assessment and management is an important aspect of all activity within the unit and is referenced throughout the report. Daily MDTs address risk and also safeguarding issues.

All young people are initially risk assessed on arrival. There are several plans to help address potential and identified risk, including self-harm plans, safety plans, behaviour management plans and first night alert plans.

The YPU uses the prison service Assessment Care in Custody and Teamwork (ACCT)system to manage those at risk of self-harm.

[39] Warner, L. et al. (2018) Secure Settings for Young People: A National Scoping Exercise. [Accessed 24/2/21]

3.5 First Aid

RCPCH Standard 6.3.1

There is a member of staff trained in first aid and cardiopulmonary resuscitation present in the secure setting at all times.

All operational staff are trained in First Aid this is refreshed as required, typically every three years.

There is a nurse on duty in the YPU during core hours and out of hours a nurse is available to visit from the adult side of the prison.

3.6 Restraints and Violence

RCPCH Standard

6.7 Children receive support from a healthcare professional after restraint procedures. If support is refused, the reason why it is refused is recorded and repeated attempts are made. Note: healthcare staff do not restrain children but do have duties and responsibilities in regard to safety of a child during and following restraint.

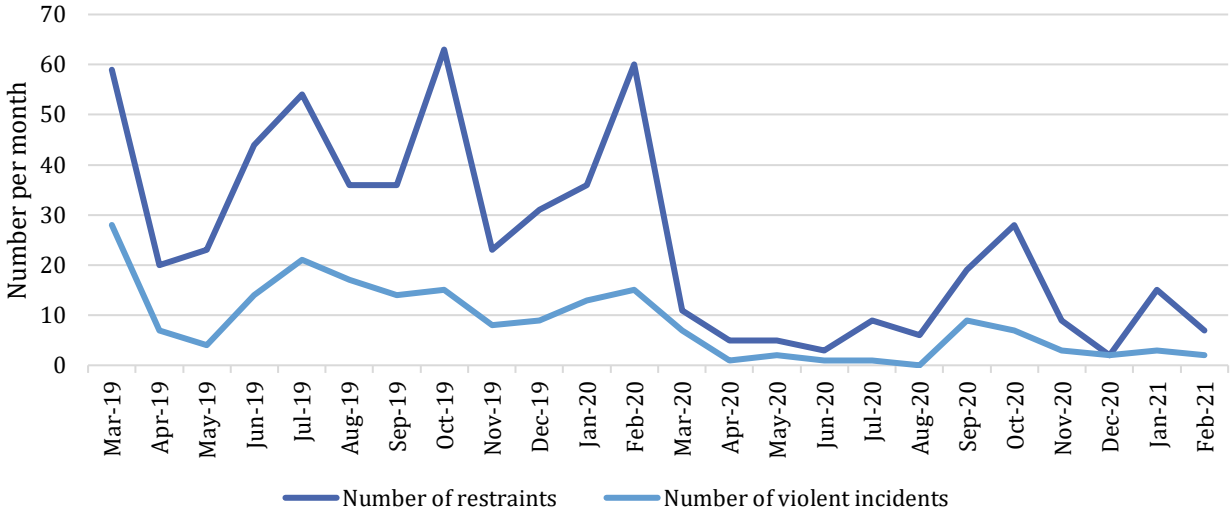
6.7.2 The advice of a healthcare professional is sought before all planned restraint procedures occurring within normal working hours and out of hours when healthcare staff are on-site.

6.7.3 Children subject to restraint procedures see a healthcare professional as soon as possible after restraint and any injuries sustained are fully documented, or as per policy.

Staffing make a handling plan for every new admission which is shared with all staff; this will include advice on how to communicate with the young person and their triggers.

SystmOne analysis informs us of the number (or percentage) of patients who are subject to restraints, not the number of incidents. From this we see that in the last two years under half of residents were ever subject to restraint (2019/20 41%, 2020/21 (to date) 33%). The establishment were able to provide month by month data on the number of incidents, these fluctuate though there is a general trend of decreasing numbers, but strong correlation between the two.

Figure 8 – Restraints and violent incidents



After every incident of restraint both the young person and staff involved are debriefed by a member of staff trained in managing and minimising physical restraint (MMPR). A nurse attends all planned restraints and sees a young person as part of the debrief, out of hours (OOH) a nurse from the adult side will attend the YPU. The General Practitioner (GP) reviews all incidents weekly and will review each young person after every restraint.

In order to pick up on any patterns, there are individual reviews for each young person after five and after 10 restraints.

Across the YOI estate there are an average 32.5 incidents of violence per 100 children per month.[40] It was stated that some 95% of young people have violence indicated in their offence(s). Anecdotally, it was said that violent incidents have reduced during the pandemic as young people spend less time together. Nurses will also be called upon where there has been a fight between residents, any serious injuries will be sent out to Accident and Emergency (A&E).

3.7 Interventions

Alongside any input from healthcare, all young people are offered help from the NEWTs who are the interventions team and focus on resettlement and reducing offending behaviour. There is inevitably some overlap with support from health, although there is close liaison to manage this via planning meetings.

NEWTS are not operational staff and are drawn from a range of backgrounds, whilst some may have been operational, others have backgrounds in counselling and psychology.

The work of interventions is really focussed on resettlement. Where a young person has over a decade to serve, the reality is that the community service is going to have little interest, so all the intervention work falls to the prison and this needs to be focussing on leading a positive life within custody not just focussing on the community, which for many will feel like

[40] HM Government (2021) Children and Young People in Custody (part 2). Evidence presented to Parliament says a YOI funding per place is a quarter of that for a SCH place [Accessed 26/2/21]

a lifetime away. The whole adverse childhood experience (ACE) agenda is strong in Wales and work is becoming far more trauma informed, staff need training to be able to adapt to the new and emerging needs of residents and also to apply contemporary learning. We heard a number of other anecdotal comments about unmet training needs.

Recommendation One: Ensure staff can receive professional development training opportunities to be able to adapt to meet the changing needs of residents (e.g. in trauma informed approaches).

3.8 Safeguarding

Safeguarding procedures were described by HMIP as 'sound'.

There was a social worker based in the unit who was the main link to the Bridgend Multi Agency Safeguarding Hub (MASH). When this postholder left, the opportunity was taken to tidy up the contractual basis for this position which has resulted in a gap in service. There has been a gap, though the post is said to be currently out to advert.

The normal process is for safeguarding concerns to be raised with MASH, then for a Strategy Meeting which will decide on a course of action. The Council previous relied on the Social Worker to air the young person's view, which was not really part of the Social Worker's role. From the interviews it appears that the council and the prison understand the context in which safeguarding referrals should be made and concerns are being managed appropriately.

The FACTS team explicitly acknowledged their role in ensuring safeguarding needs are met.

Risk management is comprehensive (see above). In addition to raising safeguarding issues at the daily MDT, the YPU has a separate monthly Safeguarding Meeting.

3.9 Chapter Summary

- HMYOI Parc run by G4S, the provider is approaching the end of a 25 year contract.
- The YPU has been subjected to a number of changes and currently comprises of two units (Echo One and Golf One).
- There are a mix of single and double rooms in each unit.
- The operational staff apply to work in the YPU and the team is formed of a regular and stable group, a number are working towards the Youth Justice Degree.
- Each young person has a case manager from the operational team and a Needs Engagement Wellbeing Team (NEWT) case worker who is part of the Interventions Team.
- There is a structured approach to safeguarding. As part of this the YPU undertakes a lot of risk management work to minimise the use of restraint.
- All operational staff are first aid trained.

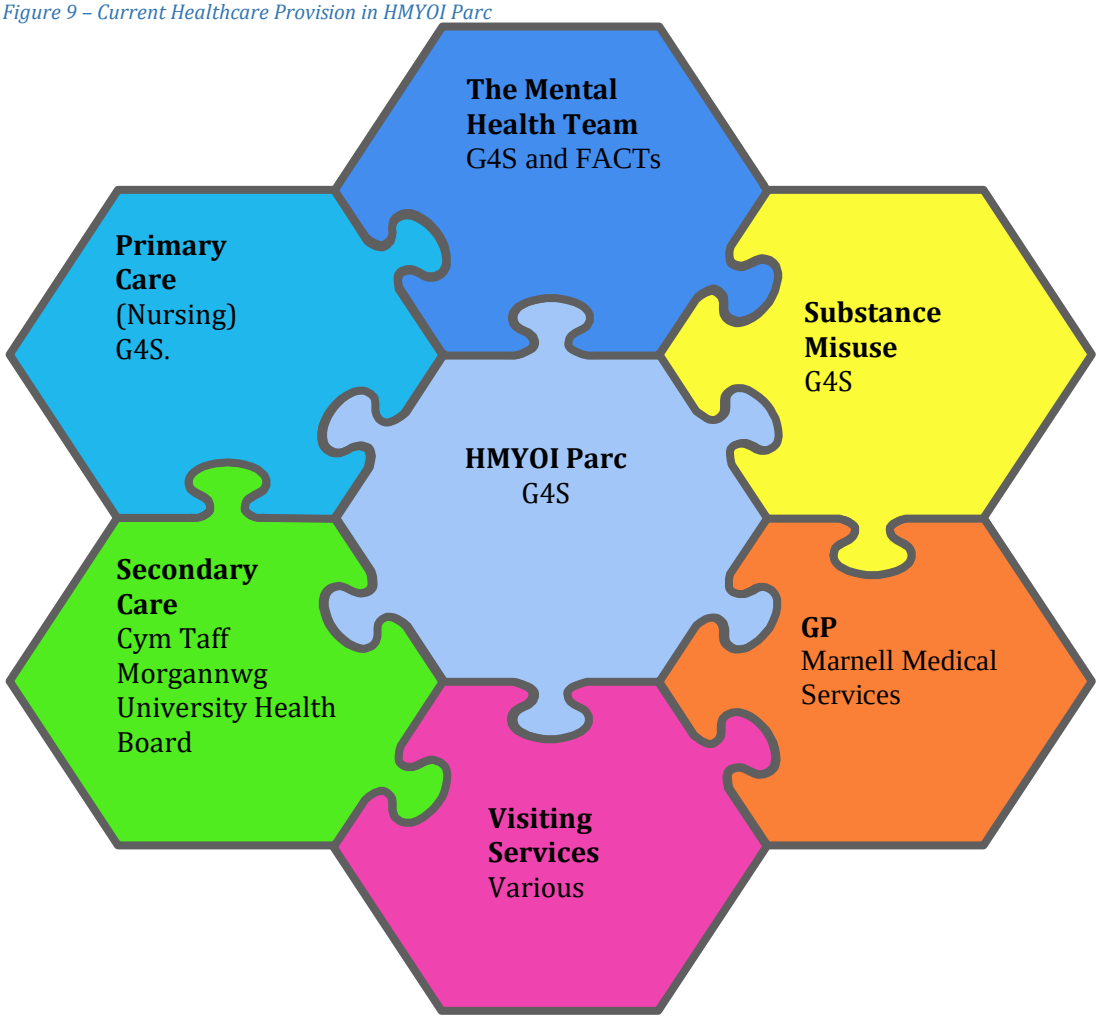
Chapter Four – Current Health Service Provision

RCPCH Standard
7.2 The secure setting has access to, and receives support from, a multi-disciplinary physical healthcare team appropriate to the needs of the children.

This chapter shows that overall, the young people's physical health needs whilst at HMYOI Parc are identified and where practicable are met.

4.1 Health structure

Figure 9 – Current Healthcare Provision in HMYOI Parc



4.1.1 Healthcare organisation

Most of the healthcare functions are delivered by G4S Health Services UK.

4.1.2 Health staffing (physical health)

Figure 10 – Physical Healthcare Resources

Role and banding	Provider	Hours/comments
Head of Healthcare	G4S	Small part of wider role across HMP and HMYOI Parc
GP	Marnell Medical Services	Three appointments per day were allocated to the YOs, now the routine is one session on a Wednesday morning. Urgent can be seen on the day
Primary Care Nurses	G4S	1 FTE, 1 RMN, 1RGN
Dentist	Time for Teeth	Nominally 1 session per week. In reality the first hour of the morning session on each weekday if needed
Optometry	F. Healthcare Ltd	As required

If we take two full-time equivalent (FTE) nurses and pro rata the Head of Healthcare time (0.05 FTE) based on the op cap the comparison of staffing rates per 100 residents is: HMYOI Parc 3.20, HMYOI Cookham Wood 6.38, HMYOI Aylesbury 3.56.

The structure for healthcare in HMP Parc is lead nurses managing different aspects of provision and accountable to the Head of Healthcare. For the YOI, no one identified a lead nurse, all our enquires were directed to either the Head of Healthcare or in the main to the two specialist (and experienced) nurses. There is a danger that the needs of some 30-40 YOs can easily be overshadowed by those of over 1600 adults, therefore it may be prudent to have a lead nurse in the line of accountability and to give voice to this area of work.

Recommendation Two: There should be a lead nurse with a special interest in the YPU.

Medical services are sub-contracted to Marnell Medical Services, a team of GPs who provide both in hours and OOH cover for the whole of HMP and YOI Parc. The contract includes one session per week for the YPU. This was previously a spread across the week (09.00 to 10.00 every weekday), now during the pandemic it was described as Wednesday morning supplemented by input 'as and when' needed.

4.2 Healthcare Provision

RCPCH Standards

7.1 Each secure setting has a comprehensive physical health strategy outlining the contributions of all staff to supporting and improving the physical health and wellbeing of children and acknowledging the close relationship between mental and physical health. This strategy should be reviewed annually.

7.1.1 The strategy incorporates a multi-disciplinary approach and is part of the secure settings health strategy.

We were unable to establish whether there was a comprehensive physical health strategy, although we believe that in terms of identifying and meeting the young people's needs most of

the elements of any such strategy were in place. However, a formal strategy is also useful as a framework for structuring and driving further development so we recommend that a strategy is developed/reviewed if there is not already an up to date one and if one already exists it is operationalised so staff on the ground are aware of it.

Note that such a strategy should reflect the population and would be quite different from a similar strategy for adults, e.g. it should say how health would ensure that young people in the YPU receive similar care to their peers in the community.

Recommendation Three: Develop and implement a comprehensive physical health strategy.

4.2.1 Arrival at HMYOI Parc

The first stage of the health pathway for the young person is their arrival at HMYOI Parc; although, as we discuss below there will ideally have been some health information arriving in advance.

Staff usually know a placement is expected.

RCPCH Standard 4.1.2

The CHAT reception health screen is completed for each child before their first night following admission and within two hours of their arrival. In settings where healthcare professionals are not available on-site 24 hours per day, standard operating procedures are developed to support other staff to identify any health concerns and decide what action to take.

Assessment of the young person uses the Comprehensive Health Assessment Tool (CHAT).

During the core working week the two nurses based in the YOI will conduct the CHAT. On the rare occasion that a young person arrives out of hours, then a duty nurse from the adult side will visit to complete the initial parts of the CHAT.

Nationally, 10% of all young people who have been continuously looked after for 12 months do not have an up to date LAC annual health check, 13% do not have up to date immunisations. Older young people were less likely to be up to date with immunisations – particularly older males.

After doing the initial reception CHAT, health staff try to secure further information from the relevant community services. The information that arrives before or with the young person can be variable in quality and what it covers, although health staff report that they can usually get what they need eventually.

RCPCH Standards

4.5 All children receive a timely full secure CHAT assessment, which includes an assessment of physical health (within three days of their arrival), mental health (within three days of their arrival), substance misuse (within five days of their arrival), and neuro-disability (within 10 days of their arrival).

4.5.1 The assessment is completed by a healthcare professional with, where appropriate, referral to a substance misuse specialist or other identified specialist trained to assess for health needs in children in a secure setting. Where there are concerns about speech, language and communication needs, support from a speech and language therapist should be sought.

4.5.4 The physical health assessment includes, as appropriate according to gender and developmental factors: social circumstances, ethnicity and culture, weight, height, body mass index, measurement of vital signs, immunisation status, sexual health, pregnancy and physical signs of self-harm or substance misuse needs, including nicotine withdrawal.

For those who are resident for a long period, the CHAT will be reviewed annually.

On occasions young people arrive without their medication, staff are able to call on the GP to help address this.

4.2.2 Care During the Stay

Care during the stay is a combination of addressing presenting problems as they arise and delivering planned courses of treatment and other interventions arising from the comprehensive assessments.

The two nurses are available throughout the core day. Clinic data from SystmOne only clearly identified two primary care clinics as specifically for the YPU population. for:

Figure 11 – Primary Care Clinic Data (SystmOne Appointment data)

May-20 to Oct-20	Average clinic sessions per month	Average appointments booked per clinic session	Average seen per clinic session	Percent DNA	Percent 'no access'	Clinic occupancy
Dental YP	1.5	1.3	1.1	8%	8%	83%
GP YP	0.3	1.5	1.5	0%	0%	100%

Key to RAG rating on above table:

	% patients seen < 70%		% patients seen between 70% & 80%		% patients seen > 80%

4.2.3 Continuity of care

Continuity is always a challenge, as the transition from custody to the community can be unsettling but this can be considerably worsened by uncertainties as to when this is happening or even where the young person might be going, never mind the practicalities of ensuring interventions can continue. Many of the young people will have already experienced

a disjointed and sometimes traumatic childhood with multiple carers in many locations. Having built strong bonds with staff in the unit, it is unfortunate (though inevitable) that these are broken when the young person leaves.

Young people receive a huge amount of care in the controlled environment of a YOI and returning to the community can be a real challenge. The Prison Reform Trust (PRT) notes the importance of continuity of care for young people leaving secure settings.[41]

Many of the young people have either a sentence end date after their 18th birthday, or an indeterminate sentence. So will be transferred to an adult prison.

On occasions the young person may leave with little or no notice, e.g. if they are granted bail at a court hearing. Note that uncertainty about length of stay may also act against commencing a course of interventions.

In some circumstances – particularly with looked after young people – it may not be clear until late in the day where the young person is going to go. Not all placements in the community may be suitable and it can be a significant challenge to find a suitable placement for some young people. This is made more difficult by the notable lack of step-down accommodation in England and Wales.

The young people should all have a YOT worker to support them on release. YOTs are central to the transition back into the community for young people in the criminal justice system. Many of the young people will also have a social worker, particularly those who were in care or who are returning to care.

4.3 Pharmacy and Medicines Management

Medicines management is an area of work informed by a good deal of policy and guidance. This is especially important considering that a range of medicines, including controlled drugs, may be stored and administered. Recent Royal Pharmaceutical Society (RPS) guidance covers secure environments.[42] The relevant RCPCH standard states:

RCPCH Standards

6.4 The secure setting has a comprehensive medicines management policy in place and is committed to stopping the over-medication of people with a learning disability, autism or both (STOMP).

6.4.1 Medicines are prescribed safely and in line with current evidence-based practice and local protocols including National Institute of Health and Care Excellence (NICE) guidance.

6.4.2 Professional standards on handling medicines in secure environments are used to deliver best practice.

[41] Prison Reform Trust (2016) In Care, Out of Trouble. [Accessed 24/2/21]
[42] Royal Pharmaceutical Society (2017) Professional Standards for optimising medicines for people in secure environments. [Accessed 24/2/21]

6.4.3 All medication for children (including non-prescription and over the counter) is recorded on their health record and administration or supply of medicines is also documented in an electronic or paper based medication administration record.

6.4.4 Children should usually receive their medicines under supervision (i.e. not in their possession). When a child is able to manage their medicines independently, an in-possession risk assessment is completed. Suitability for a child keeping their medicines is also reviewed on an ongoing basis as part of their care, to identify any risks to the child's safety or the safety of others. Medicines that can be managed independently could include, but are not limited to: inhalers for asthma, EpiPen's, externally applied medicines such as creams and ointments, or where those children are older adolescents. In cases where emergency medicines, such as EpiPen or asthma inhalers are not held by children, systems are in place so that these can be accessed quickly.

6.4.5 All supervised medicines are administered safely and in line with professional accountabilities appropriate to the secure setting. Where possible this should be overseen by a qualified nurse, pharmacist or pharmacy technician. All staff involved in the supervised administration of medicines should receive the necessary medicines management training and be assessed as competent to do so.

6.4.6 Mechanisms to access medicines, when needed, outside of healthcare team and pharmacy core hours are in place.

6.4.7 A medicines reconciliation is completed within 72 hours of admission to enable safe continuity of care.

6.4.8 Allergies to medicines are recorded and adverse effects and medicine interactions are identified and responded to promptly.

6.4.9 All medicines are stored, handled and disposed of safely and securely in line with legislation and best practice and with effective pharmaceutical stock management.

6.4.10 There is a documented risk assessment of the medication and the child before self-administration of medication is considered. Children are given information about the benefits and risks of self-administration of medication in a format they are able to understand. Self-administered medicines are dispensed appropriately and facilities are available for secure storage by children.

6.4.11 Governance systems are in place for the management of medicines and to ensure compliance with the medicines management policy, including: monitoring of prescribing trends, a pharmacist or qualified nurse undertakes and documents a monthly medicines audit, including psychoactive drugs and drugs for attention deficit hyperactivity disorder and the secure setting has access to specialist pharmacy support and advice.

All medication administrations are undertaken by nurses, either the two based on the unit, or OOH by nurses visiting from the adult side.

When a young person leaves, it was reported that they have at least seven days of medication.

SystmOne records indicated that of the 27 current residents, 19 (70%) were prescribed any medication (including prescription creams and shower gels). The percentage of patients recorded as receiving prescriptions was fairly consistent over the preceding two years.

Figure 12 – Residents Prescribed Medication (SystmOne data)

	2019/20	2020/21 April-January	Snapshot December 2020
Number receiving any prescription	50	38	19
Percentage prescribed	78%	83%	70%

4.4 Out of Hours (OOH) and emergencies

RCPCH Standards

6.3.2 Out of hours and emergency cover is well organised, responsive and effective. In settings where health professionals are not available on-site 24 hours per day, standard operating procedures (SOPs) or care pathways for accessing out of hours healthcare advice and treatment must be developed collaboratively between local health services and the secure setting.

6.3.3 The secure setting has a 24-hour, seven-day-a-week emergency medical and dental plan in place which is developed jointly and regularly updated with local emergency and urgent care services, out of hours GP services, out of hours mental health services and out of hours dental services. The plan includes security arrangements and stipulates what information is sent with the child when accessing emergency care and what information is sent back.

There are two nurses based in the YOI during weekday core hours and the prison had 24 hours per day seven day per week nursing cover who offer OOH cover for the unit.

The GP explained that because both the in and out of hours medic contracts sit with the same provider there is ready access to GPs who understand the population and have access to SystmOne 24 hours per day seven days per week. There is evidence that this resource is used when required.

In emergencies there is the facility for residents to be taken to outside hospitals under escort at any time.

4.5 Secondary Care

Planned secondary healthcare is rarely required but when needed, operational staff from the YPU facilitate the escort. Appointments include, planned secondary care, orthodontist and unplanned A&E visits. Interviewees reported that there are no issues with this arrangement.

4.6 Data and Recording

Health information regarding the young people at HMYOI Parc is recorded on SystmOne (secure setting version). This includes the CHAT forms completed on reception. As noted elsewhere the FACTS Team currently do not access SystmOne, nor does the substance misuse service (SMS) worker.

4.7 Chapter Summary

- The bulk of the physical health provision is covered by the registered general nurse (RGN) who is based in the YPU. The two nurses (RGN and registered mental health nurse (RMN)) are part of the healthcare team for the wider prison but appear separate. (See Recommendation).
- The GP provision is appropriate, this includes OOH cover.
- Health work during core hours Monday to Friday, with OOH cover at weekends provided by the nurses based in the adult prison.
- The initial screening process and subsequent comprehensive assessments (CHAT) meet required standards.
- Sometimes young people arrive without essential medication, when needed there is access to prescribing.
- Transition back to the community and continuity of care are big challenges.
- Secondary care needs are low but generally work well, even under covid-19 restrictions.

Chapter Five – Physical Health Needs

5.1 Overview

This chapter is focused on the physical health needs of the young people at HMYOI Parc and how these are addressed. Whilst there is limited evidence about the specific health problems of young people in secure settings, there is a clear message from the literature that young people in custody have significantly more severe physical health problems than the general population of young people. The YJB state that 56% of young people in custody have physical health needs.[43]

Over a quarter of young men and a third of young women in secure settings have a long-standing physical complaint including respiratory problems, musculoskeletal complaints, nervous system complaints, skin complaints, dental health problems, blood borne viruses, sexually transmitted infections and epilepsy.[44]

This is not surprising, given the evidence about the prevalence of smoking, drinking, use of illegal drugs and mental health problems among young people and young people in custody and about their histories of neglect, social exclusion and difficult family circumstances.

The health of the young people should be considered within a context of wellbeing. Wellbeing covers a wide range of domains including both physical and mental health. Many of the factors that are described as being fundamental to wellbeing will have been missing from the lives of young people in YOIs.

5.2 Disability

The World Health Organisation (WHO) defines disability in the following terms:

Disability is an umbrella term, covering impairments, activity limitations and participation restrictions. An impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action, while a participation restriction is a problem experienced by an individual in involvement in life situations. Thus, disability is a complex phenomenon, reflecting an interaction between features of a person's body and the society in which he or she lives.[45]

Disability is also a protected factor under the Equality Act 2010 and the Disability Discrimination Act 1995 and means YOIs must ensure that services are accessible for those with disabilities.

For the purposes of this baseline information, we have used the definition of disability in section 6(1) of the Equality Act 2010:

a person has a disability if s/he has a physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities.[46]

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[43] YJB (2021) Assessing the needs of sentenced children in the Youth Justice System 2019/20 (Supplementary tables)[Accessed 21/2/21]
[44] Ryan, M. et al. (2011) 'Evidence about the health and well-being needs of children and young people in contact with the youth justice system'.
[45] WHO (2015) Disabilities. [Accessed 24/2/21]
[46] Equality Act 2010. [Accessed 24/2/21]

A study found that the prevalence of physical disability was 4% for both welfare placements and for those detained through the YJS, this is about half the rate in the general population.[47]

RCPCH Standard

6.1.1 Children in secure settings have access to excellent primary care provision due to the multiple vulnerabilities of this group of children. This includes but is not limited to general medical services, general dental services and general optical services. Reasonable adjustments must be made to ensure access to these by those with a disability.

In this age group, most disabilities will be 'hidden', e.g. learning disability, autism, hearing or communication difficulties and so on, which are covered later in the report. There are few young people with physical disabilities.

Screening and assessment are such at HMYOI Parc that any disability should be identified and pathways are in place such that associated needs can be met.

5.3 Sight and Hearing

There is a lack of data on the prevalence of sensory disability among detained young people. Any failure to identify these issues can lead to learning and communication problems.

There is little published work describing the proportion of young people who need glasses. One American study states that around half of girls (51.9%) and 38.8% of boys aged 14-17 wear glasses or contact lenses.[48] The optician noted that historically boys had been anti-glasses but that there was now a more positive culture in this respect at HMYOI Parc, partly helped by the sourcing and provision of more fashionable frames, i.e. not just the NHS free options. This is a noteworthy example of where a judicious use of a small amount of money (for acceptable glasses) can make a great deal of difference to a young person's life.

HMIP noted that in normal circumstances all residents are offered an appointment with the Optician and praised this as good practice. Covid-19 restrictions have limited access to this service across the prison. Pre covid-19, nurses described how the young people would have appointments allocated at the beginning or end of every visit to the adult prison, now frequency has decreased to once a month.

It is apparent that assessment and provision are such that the young people's visual needs are largely being met.

Figure 13 – Recorded Hearing Problems and Interventions (SystmOne data)

SystmOne Record	2019/20	2020/21	Snapshot September 2020
Hearing problem	0%	11%	0%

[47] Hales, H. et al. (2018) Census of young people in secure settings on 14 September 2016: characteristics, needs and pathways of care. [Accessed 24/2/21]

[48] Black L. (2017) QuickStats: Percentage* of Children Aged 6–17 Years Who Wear Glasses or Contact Lenses,† by Sex and Age Group – National Health Interview Survey, 2016. [Accessed 24/2/21]

There is no routine access to audiology services and hearing tests, this gap was also noted in the 2019 HNA.

Recommendation Four: There should be access to audiology and hearing tests.

Visual needs are identified and met, hearing needs are not met.

5.4 Oral Health

RCPCH Standard

6.1.1 Children in secure settings have access to excellent primary care provision due to the multiple vulnerabilities of this group of children. This includes, but is not limited to general medical services, general dental service.

Whilst there is no national published data about young people in YOIs, there is a solid evidence base demonstrating that individuals in custody have poorer dental health than the general population.[49] One study showed that young offenders had greater numbers of decayed teeth, alongside fewer numbers of filled teeth, in comparison to women and older male prisoners.[50] Reasons for this include: chaotic lifestyles leading to oral neglect, poor nutrition and contaminants associated with substance misuse.

Nationally, 85% of young people who had been looked after continuously for 12 months had their teeth checked by a dentist; this dropped to 77% of those aged 16 years and over.[51]

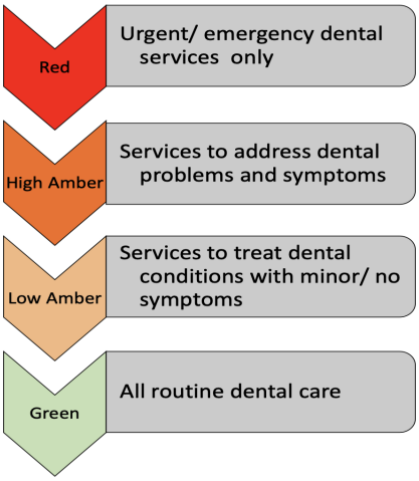
Some studies report that oral health is better in BAME communities:

Contrary to most health inequalities, oral health was better among non-White groups, in spite of lower use of dental services.[52]

In Wales, the chief dental officer, in response to the covid-19 pandemic, published the Wales De-escalation Pandemic Plan for Dentistry, which relates to community settings. The purpose of this is to ensure a risk-based approach to continuing dental care safely. Wales was in the 'red' phase initially and has now moved to amber (February 2021). The dentist is hoping that that a move to routine dental services (i.e. green) will happen in April.

[49] Jones, C.M. et al. Dental health of prisoners in the north west of England in 2000: Literature review and dental health survey results. Comm Dent Health 2005; 22: 113-117.
[50] British Dental Association (2012) Oral Health in Prisons and Secure Settings in England. [Accessed 24/2/21]
[51] DfE (2020) Children looked after in England (including adoption), 2018 to 2019. [Accessed 24/2/21]
[52] Arora, G. et al. (2017) Ethnic differences in oral health and use of dental services: cross-sectional study using the 2009 Adult Dental Health Survey. [Accessed 24/2/21]

Figure 14 – Dentistry De-escalation Plan (Wales)



Dental clinics normally allocate 9-10 am for the YOI population. The anecdotal reports were that prior to the pandemic waiting times for the YPU were very short. Following a virtual suspension of services, the service is now able to deliver a limited number of aerosol generating procedures (AGPs), thus the capacity per clinic is currently much lower than normal, the two factors have resulted in waiting lists building up.

SystmOne showed the following records for current and previous residents.

Figure 15 – Oral Health Records (SystmOne data)

SystmOne record	2019/20	2020/21	Snapshot December 2020
Seen by dentist	17%	22%	19%
Toothache	11%	7%	7%

The dental suite and its equipment was described as being a good facility and fit for purpose.

Orthodontist treatment episodes last a long time (generally not less than 12 months) and orthodontists can be reluctant to commence treatment they personally will not see through to completion. This can be a problem with the relatively short periods of stay of many residents in secure settings. For those in HMYOI Parc, the dentist described a robust pathway to a service in Cardiff. During covid-19, whilst they continue to make referrals, young people have not been able to access this service.

In summary, the dental needs are identified and met.

5.5 Immunisations and Vaccinations

RCPCH Standard

7.6.2 Children are offered vaccinations appropriate to their age and need as set out under national guidance for immunisations and vaccinations.

Nationally, 87% of young people who had been looked after continuously for 12 months were reported as being up to date with their immunisations; however, this fell to 78% of those aged 16 years.[53] All new arrivals are asked about vaccinations. Health staff report that it could take time to confirm the young person's history of immunisations and vaccinations, although when in doubt they generally erred on the side of caution and (in line with guidance) gave vaccinations.

Whilst many young people will have had their first round of immunisations, not all will have done. Many will not have a complete record of booster doses and later childhood vaccinations such as Human papillomavirus (HPV). The Public Health Wales (PHW) advice[54] is to follow the Public Health England (PHE) guidance which includes the following principles:

- *Unless there is a reliable vaccine history, individuals should be assumed to be unimmunised and a full course of immunisations planned*
- *If the primary course has been started but not completed, resume the course – no need to repeat doses or restart course*
- *Plan catch-up immunisation schedule with minimum number of visits and within a minimum possible timescale – aim to protect individual in shortest time possible*[55]

In addition to missing childhood vaccinations, for those aged 10-25 years, the following vaccinations should be offered

- Those aged from 14 years old who have never received a meningitis C-containing vaccine should be offered the MenACWY vaccination.
- Tetanus, diphtheria and polio – three-in-one teenage booster at 14 years of age

Figure 16 – BBV Vaccination Records (SystmOne data)

Vaccination type (HMYOI Parc)	2018/19	2019/20	Snapshot (December 2020)
No immunisation history record	0%	4%	7%

In addition, a small number of patients were recorded as having been given vaccinations against blood borne viruses (BBV):

Figure 17 – BBV Vaccination Records (SystmOne data)

Vaccination type (HMYOI Parc)	2018/19	2019/20	Snapshot (December 2020)
Hepatitis B 1	41% (26)	0%	15% (4)
Hepatitis B 2	36% (23)	0%	11% (3)
Hepatitis B 3	30% (19)	0%	11% (3)
Hepatitis B Booster	3% (2)	4% (2)	11% (3)

The uncertainty about the status of the young people where records are partial or absent makes it difficult for us to draw rigorous conclusions about the processes and pathways involved and the extent to which potential need is being identified and met. Health staff described effective pathways and approaches but the gaps in the data mean it is difficult to

[53] DfE (2020) Children looked after in England (including adoption), 2018 to 2019. [Accessed 24/2/21]
[54] Public Health Wales (2014) Child Health Immunisation Process Standards [Accessed 26/2/21]
[55] Public Health England (2019) Vaccination of individuals with uncertain or incomplete immunisation status. [Accessed 24/2/21]

confirm this. The levels of young people declining certain vaccinations may also be of concern, depending on why they have declined. All in all, we think that the pathways that exist are probably appropriate but the approach could perhaps be more assertive and secure higher rates of take-up. There should be increased clarity in the records, with confirmed histories recorded on SystmOne and more information on refusals and consideration of how to address these.

Note that the issue of consent for injections for some young people can delay them and even lead to them not happening at all, particularly if it is hard to establish where permission may need to be sought from, or where the responsible person (parent) has already made it clear that they do not agree but the young person wants the vaccination. In the latter case, primary care will usually go with the young person's wishes, as is national policy and good practice.

Data indicates that there could be greater engagement.

5.6 Sexual Health

RCPCH Standard

7.7 Young people have access to confidential advice and education about safer sexual practices and contraception within the context of relationships.

The available data from SystmOne indicated 78% of the current residents (n=21) as being sexually active. A fifth were recorded as having disclosed risky sexual behaviour (unprotected sexual intercourse). Note these codes are based on the CHAT assessment form but may also be recorded on an ad hoc basis during the young person's stay.

Figure 18 – Sexual Health Records (SystmOne data)

Risky sexual behaviour	2019/20	2020/21	Snapshot (December 2020)
Sexually active	84% (54)	83% (38)	78% (21)
Unprotected intercourse	42% (27)	35% (16)	19% (5)
Lifestyle advice regarding harm minimisation	30% (19)	43% (20)	37% (10)
Health education – safe sex	2% (1)	4% (2)	4% (1)

Testing for sexually transmitted infections (STI) is normally available on reception to HMYOI Parc.

Figure 19 – STI Screening Records (SystmOne data)

SystmOne record	2019/20	2020/21	Snapshot (December 2020)
Seen in GU medicine clinic	75%	72%	52%
Urine screen for chlamydia	63%	52%	44%
Chlamydia positive	2%	2%	0%
Urine screen for gonorrhoea	63%	50%	41%
Gonorrhoea positive	3%	0%	0%

There is also testing for BBVs which identify very few young people with a virus.

Figure 20 – BBV Screening Records (SystmOne data)

SystmOne Record	2019/20	2020/21	Snapshot (December 2020)
HIV test offered	66%	57%	44%
HIV screening test	45%	46%	33%
HIV positive	0%	0%	0%
Hepatitis c screening offered	66%	57%	44%
Hepatitis c screening	45%	46%	33%
Hepatitis C positive	0%	0%	0%
Hepatitis B screening offered	66%	57%	44%
Hepatitis B screening test	45%	46%	33%
Hepatitis B surface antigen positive	0%	0%	0%

Sexual health advice and interventions are mostly delivered by the primary care staff, although to some extent all staff will promote sexual health and positive relationships. Referrals for secondary care are infrequent. Sexual health and relationships are also covered in PSHE (personal, social and health education), with health input and it was reported that all residents receive sexual health education.

Section 9.4 describes sexual health in terms of healthy relationships.

The data indicate that there are some gaps.

5.7 Long-Term and Chronic Conditions

Incidence and prevalence of most serious long-term conditions (e.g. cancer) can be expected to be very low in a young population, particularly where there are such low numbers. Some conditions may never present at HMYOI Parc, or only very intermittently. Such conditions would invariably involve secondary care.

5.7.1 Asthma and other respiratory difficulties

Unlike most other chronic conditions, asthma is most prevalent in younger age groups; indeed, it is the most common chronic condition in young people.[56] Whilst there is little data on asthma specific to young people in secure accommodation, it is safe to assume that the need is at least at the same level as that of the general population. Some relevant data is that:

- One in 11 young people in the UK has asthma
- On average there are three young people with asthma in every (typical) classroom in the UK
- The UK has among the highest prevalence rates of asthma symptoms in young people worldwide
- In the UK a young person is admitted to hospital every 20 minutes because of an asthma attack and several die every year

[56] Asthma UK. [Accessed 15/10/20]

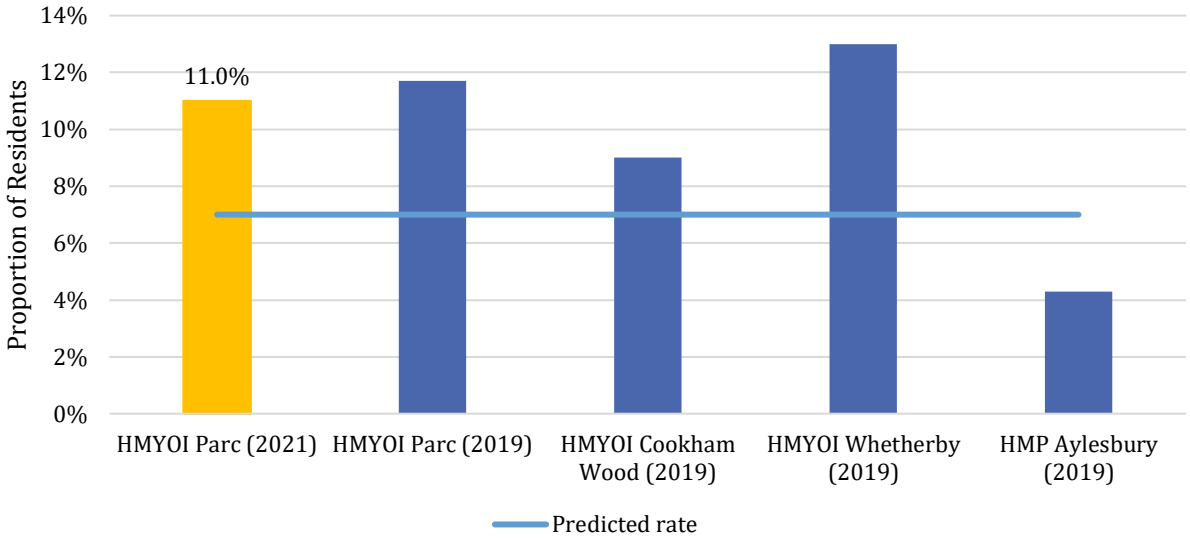
Community data describes 9.1% of young people with asthma and 8.3% of adults.[57] Research indicates that prevalence may be decreasing over time.[58]

Asthma was described as the one regular LTC.

Figure 21 – Asthma and Breathing Problems (SystmOne data)

SystmOne Record	2019/20	2020/21	Snapshot December 2020
Asthma diagnosis	20%	30%	30%
Asthma treated	n/a	n/a	11%

Figure 22 – Asthma Prevalence Comparison (QOF data)



The data and pathways suggest that most need with respect to asthma is identified and met.

5.7.2 Coronary Heart Disease (CHD)

The prevalence of CHD is highly age-correlated. The data does not report estimates for those under 16 years of age but for those aged 16-24 the rate is 0.1%.[59] The British Heart Foundation reports that CHD is 2.9 times more prevalent in men from the lowest socioeconomic group compared to the highest. SWCU states that 0.4% of referrals in 2018/19 had a heart condition. As such, whilst heart conditions should be more prevalent than in the general population, it is safe to assume that CHD would rarely present at HMYOI Parc. However, *'…heart disease is rare in young people, but many of the habits that lead to heart disease in later life are acquired in childhood'.*[60] (See chapter on health promotion).

Many patients with hypertension can manage their care themselves and good outcomes can depend on the patient attending to this. Lifestyle choices significantly impact on risk and steps that can be taken to reduce risk include healthier food choices and increasing aerobic exercise.

[57] Asthma UK. [Accessed 14/11/20]
[58] Simpson, C.R. and Sheikh, A. (2010) 'Trends in the epidemiology of asthma in England: a national study of 333,294 patients'. Journal of the Royal Society of Medicine. 103/3: 98-106; also Simpson and Sheikh (2014) 'Trends in the Prevalence of Asthma'. Chest. 145/2: 219-225. [Accessed 24/2/21]
[59] Aries, E. (2013) Cardiovascular risk factors among prisoners: an integrative review. Idem, Table 2.13. [Accessed 24/2/21]
[60] British Heart Foundation (2013) Children and Young People Statistics 2013. [Accessed 24/2/21]

Figure 23 – Hypertension (prevalence – males)[61]

	Treated	Untreated
16-24	0	5%
All ages	7%	15%

None of the current residents were identified with a diagnosed heart condition. The reception CHAT assessment asks about recent experiences of shortness of breath, chest pain and palpitations.

Screening and pathways suggest need would likely be noted and met.

5.7.3 Diabetes

Diabetes prevalence strongly correlates with age. Figures have been extrapolated from the age-specific prevalence of diabetes in community populations. Marshall *et al.* caution that diabetes could be between two and eight times as prevalent in prisons,[62] but there is no equivalent commentary for YOIs.

Self-care is important in the management of diabetes. For example, understanding the importance of adhering to a diabetic diet, the need to monitor blood sugar and (in the case of insulin dependent diabetes) adjustment of insulin doses and awareness of symptoms of hypoglycaemia are crucial.

Type 1 diabetes does affect young people and is sometimes called juvenile diabetes, or early-onset diabetes. It is the less common of the two main types and accounts for around 10% of all people with diabetes but 90% of young people who have diabetes. Type 1 diabetes is also referred to as insulin-dependent diabetes and is usually treated with injections of insulin.

In most cases, type 2 diabetes is linked with being overweight. Onset of this type of diabetes is generally in adulthood, although more young people are now being diagnosed with the condition, some as young as seven.

Overall, 0.99% of 10-19 year olds in England and Wales have diabetes. Of these, slightly more will be boys than girls. SWCU states that 1.25% of referrals in 2018/19 had diabetes.

Data confirmed that no residents in the past two years had a diagnosis of diabetes, though interviews indicated that there had previously been a case or cases. By contrast the prevalence in other establishments ranged from zero to 1.8% of the population.

Screening processes are such that we believe any need would likely be recognised and met, although there could be years between each case.

[61] British Heart Foundation (2012) Coronary Heart Disease Statistics 2012 Edition. Expected prevalence figures Table 5.3. [Accessed 24/2/21]

[62] From Marshall, T. et al. (2000) Health care in Prisons A health care needs assessment in prisons. University of Birmingham. Using data from Key Health Statistics from General Practice 1996. Prison population: Home Office statistics for 31 December 1998. [Accessed 24/2/21]

5.7.4 Epilepsy

Epilepsy is the most common significant long-term neurological condition of childhood and rates are 25% higher in the most deprived populations.[63] Although it is important to note that there is also a potential risk of young people being misdiagnosed with epilepsy.[64]

Given the above, this report takes the more recent estimate of 0.95% and adds 25% to give a revised figure of 1.19%. An unusually high rate of epilepsy may be explained by the condition being triggered by traumatic injuries. Anecdotal comments about previous injuries were reported in a French study which postulated a link between traumatic brain injury and the high rate of epilepsy amongst prisoners.[65] SWCU states that 0.6% of referrals in 2018/19 had epilepsy.

Whilst the data did not pick up any cases one current resident was mentioned in interview.

Figure 24 – Epilepsy (SystmOne data)

SystmOne Record	2019/20	2020/21	Snapshot December 2020
Epilepsy diagnosis	2%	2%	0%
Epilepsy treated	n/a	n/a	0%

This is similar to comparator establishments, with none identified at HMYOIs Cookham Wood, Werrington or Wetherby and 1.2% at Aylesbury.

As with other potential long-term conditions we feel that screening processes are such that any need would likely be recognised and met.

5.7.5 Allergies and Eczema

Whilst some allergies are common (NB hay fever above) SWCU states that only 1.25% of referrals in 2018/19 had eczema.

Skin conditions such as eczema and acne are common long-term conditions. Whilst these are rarely serious in health terms, they can be very troubling for the young people concerned. Health staff report that skin conditions are relatively common and there are several young people with low level acne, although few require a clinical treatment.

Figure 25 – Allergies (SystmOne data)

	2019/20	2020/21	Snapshot December 2020
Allergy	80%	67%	22%

[63] Joint Epilepsy Council (2011) Epilepsy Prevalence, Incidence and Other Statistics. [Accessed 24/2/21]
[64] NICE (2013) Epilepsy in children and young people. [Accessed 24/2/21]
[65] Waiter, L. et al. (2016) Prevalence of traumatic brain injury and epilepsy among prisoners in France: Results of the Fleury TBI Study. [Accessed 24/2/21]

Figure 26 – Skin Conditions (SystmOne data)

SystmOne Record	2019/20	2020/21	Snapshot December 2020
Skin complaint	14%	13%	11%

Prescribing data from SystmOne indicated that creams for various skin complaints made up a sizable proportion of the items issued on prescription. In interview the physical health nurse said skin complaints, especially acne were common.

Needs appeared to be being identified and addressed.

5.7.6 Sickle Cell

It is estimated that 14,000 people in the UK are living with the disease (one in 4600 people).[66] No current residents were reported to have the condition; however, two patients in 2019/20 were recorded on SystmOne as having a sickle cell diagnosis. Need should have already been identified in the community and the young person themselves would also be aware of it, so it is likely that all such need would be identified and met.

5.8 Chapter Summary

- The recorded prevalence for a range of physical health conditions is broadly as expected.
- The young people are routinely referred to the visiting optician. Hearing pathways are to secondary care.
- Young people have often had poor dental care. There is a fully equipped dental suite and most needs are identified and met.
- Mixed quality data makes it hard to assess take-up of immunisations and vaccinations but we believe that take-up and data can both be improved.
- Sexual health is primarily addressed by the nurse. Pathways for screening STIs appear appropriate but the engagement rate could be greater.
- Long-term conditions are as rare, as expected, (other than acne), although the screening and pathways are such that need would be met.

[66] Dormandy, E. et al. (2017) How many people have sickle cell disease in the UK? [Accessed 24/2/21]

Chapter Six – Substance Misuse

6.1 Overview of substance misuse needs in the CYP secure estate and at HMYOI Parc

The most prevalent substance misuse problems in the CYP secure estate are tobacco and alcohol.[67] Amongst the more commonly used illicit drugs, cannabis is by far the most commonly used. Other substance use tends to be experimental or recreational, although this use can potentially be risky or heavy in terms of quantity or toxicity. Dependency in this age group is not unknown but is rare, probably as it takes time and opportunity to become physically dependent.

Substance misuse amongst young people should largely be viewed in the context of 'normal' risk taking and adolescent behaviour. A large scale English study describes adolescents in the community where 65% experiment with illegal drugs, mostly cannabis, with only 4% moving on to regular misuse and long-term problems.[68] However, the risk factors for regular and more problematic substance misuse are considerably more pronounced in the HMYOI Parc population, including: ACEs, exclusion factors (truancy, offending behaviour, unemployment), social vulnerability factors (neglect, abuse, domestic conflict) and psychiatric, conduct or emotional disorders.

Interviewees explained that the current low levels of HMYOI Parc residents' substance use and the potential risk of future problematic use argues for an educational/preventative approach rather than the more common approach used with adults, of focusing on dependency and relapse. It also argues for substance use being considered within the context of other potentially risky behaviours. This is broadly the dominant approach used.

6.2 Service Provision

RCPCH Standard

9.2 The secure setting has access to, and receives support from, a substance misuse team appropriate to the needs of the children.

Children have access to substance misuse education, prevention activities and advice and information to reduce the risk of substance related harm.

A universal drugs education programme is in place covering legal and illegal drugs and substances (including alcohol, tobacco and solvents). (See section 6.5.)

For children requiring an individualised programme of support there is a targeted substance misuse programme that is up to date and has clear learning objectives and outcomes that are informed by children's needs and the current evidence base.

[67] Black C (2020) Review of Drugs - evidence relating to drug use, supply and effects, including current trends and future risks. [Accessed 16/3/21]
[68] DH (2017) Smoking, Drinking and Drug Use Among Young People in England – 2016. [Accessed 21/2/21]

A range of evidence-based substance misuse interventions are offered and delivered according to individual need.

In very general terms, substance misuse activity with young people, whether in the community or in the secure estate, falls into three categories as illustrated below. In the general community, the majority of young people's needs can be addressed by means of universal education; a smaller proportion will require targeted interventions and a very small proportion will require specialist interventions. All levels are addressed at HMYOI Parc and therefore the above standard is met.

Figure 27 – Substance Misuse Interventions for Young People

The above is underpinned in legislation, substance misuse and mental health should be part of a *'whole school approach'* taken by education in Wales.[69] In a national study, all YOIs indicated they had could offer substance misuse support.[70]

The drugs worker estimated that in terms of presenting need, nearly all warrant targeted support, very few need specialist. Irrespective of previous drug use patterns, risk factors that indicate that 90% need more than universal. Any universal work delivered by the drugs worker is separate to PHSE work undertaken by education and there is no structural link between the two.

The prevention, health promotion and harm-reduction aspects of substance misuse provision appear to be adequately addressed.

We received mixed reports about the need for clinical withdrawal, one interviewee said the need was very rare and described how when identified needs for clinical interventions were met by the GP who can prescribe, note the GP is experienced in prescribing for substance misuse as part of the role for the adult side of the prison. Clinical support can also be made available from the team working with adults. There has been a recent case where withdrawal from benzodiazepines had to be clinically managed. A different interviewee reported that a there had been a number of cases in withdrawal and a suggestion that more young people could have benefitted from clinical interventions.

In terms of specialist psychosocial substance misuse provision, there is a full-time post based in the unit Monday to Friday each week, though this post holder now has a number of roles including substance misuse. This experienced worker is stand-alone and not aligned to a

[69] Welsh Government (2019) Substance Misuse Delivery Plan 2019-2022. [Accessed 24/2/21]
[70] Warner, L. et al. (2018) Secure Settings for Young People: A National Scoping Exercise. [Accessed 24/2/21]

substance misuse service for professional supervision and support, also for updating of expertise and materials to respond to changing patterns of drug use.

The level of specialist provision is probably adequate to meet the likely need. Though level of current activity is low averaging six interventions per month (Dec '20 to Feb '21); it is not clear the extent to which restriction imposed by the pandemic are restricting activity.

There are a range of RCPCH standards relating to substance misuse assessment:

RCPCH Standards

4.5 All children receive a timely full secure CHAT assessment, which includes an assessment … substance misuse (within five days of their arrival).

4.5.1 The assessment is completed by a healthcare professional with, where appropriate, referral to a substance misuse specialist

4.5.6 The substance misuse assessment includes: drug and alcohol use history, resilience, risk and protective factors (which may include parental or sibling substance misuse), previous treatment and assessment of motivation to engage and affect change.

In many other young people's custodial settings the substance misuse workers describe completing the relevant sections of the CHAT, thus bringing a specialist focus to this area of the assessment. In the YPU the nurse completes all aspects of the CHAT, the SMS worker does not have access to SystmOne and receives a referral which leads to a specialist assessment.

Those whose CHAT flags a high level of need (including potentially dependency) will be seen 'straight away'. Those with moderate needs within 24 hours and all other arrivals, including those with no recorded history of drug or alcohol use will be seen with five days of arrival. In all cases the worker will complete a full assessment and action plan with in 10 days of arrival.

Those who are part of her caseload will meet once or twice a week. Some face to face work has continued though the covid-19 pandemic. This is supplemented by exercises including workbooks.

Some records are shared with interventions and YOTs via the Youth Justice Application Framework (YJAF) database, but case notes are on a standalone system.

The drugs worker liaises with YOTs and community drugs workers to support continuity of care upon release. It was noted that where young people are approaching or indeed turn 18 in custody this can be especially challenging.

RCPCH Standard

9.1 Each secure setting must have a comprehensive substance misuse strategy outlining the contributions of all staff to reducing the risk of substance related harm for children. This strategy should be reviewed annually.

We understand that whilst there are drug strategy meetings, there is no formal drug strategy for the YPU.

Recommendation Five: Ensure there is a substance misuse strategy.

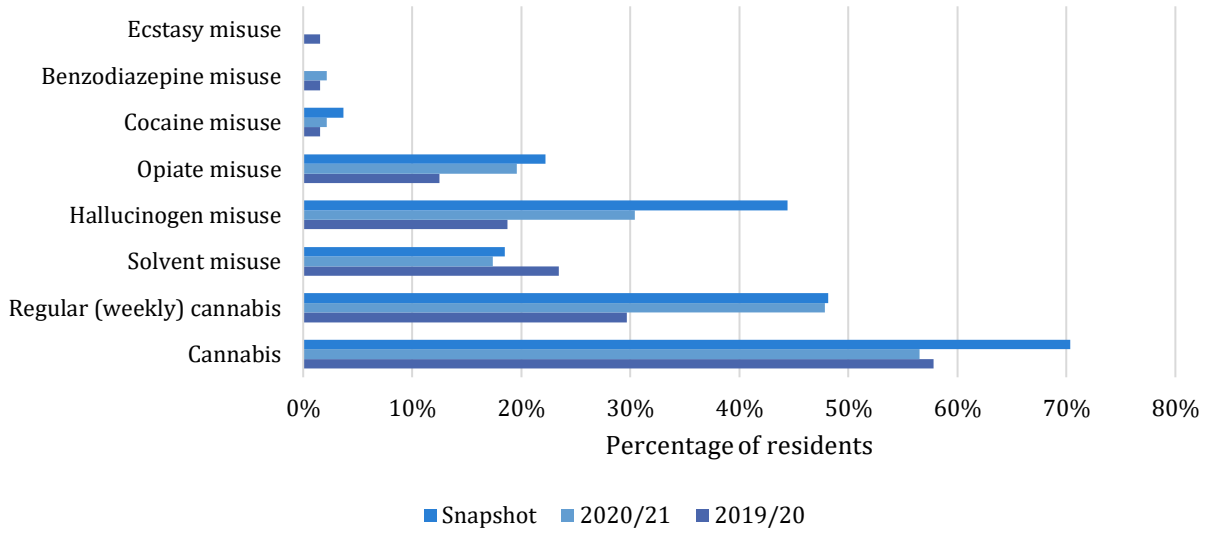
6.3 Prevalence of Substance Misuse

Data can conflate exposure and problems. Substance misuse amongst young people requires a nuanced approach to understanding prevalence and likely demand for services. Although high proportions of young people will experiment with illegal drugs, only a minority continue to use them harmfully and develop problems.

The YJB state 84% of sentenced young people have substance misuse concerns.[71] SWCU referrals for 2018/19 state that 86% of the young people had substance misuse issues; this is broken down into: alcohol 48%, illegal drugs 76% and tobacco 68%. In HMYOI Parc the proportion recorded on SystmOne was 59% (2019/20) and 74% (2020/21), both years' data is a little lower than predicted. Whilst there was anecdotal comment to suggest higher than UK average drug use in Wales and indeed amongst young people in Wales, the population in the YPU is predominately from England.

Whilst there are some reports of increasing rates of problematic alcohol use amongst young people, Office for National Statistics (ONS) data describe a decrease in the general population in both the frequency of consumption and the mean units consumed per episode over the last decade.[72] Surprisingly little is written about looked after young people and alcohol.

Figure 28 – History of Substance Use (SystmOne data)



Interviewees described a lot of cannabis use, some use of cocaine and also 'balloons' (nitrous oxide).

[71] YJB (2021) Assessing the needs of sentenced children in the Youth Justice System 2019/20 (Supplementary tables). [Accessed 21/2/21]
[72] ONS (2019) Smoking, Drinking and Drug Use Among Young People in England 2018. [Accessed 21/2/21]

6.4 Smoking

RCPCH Standard 7.9

Effective stop smoking interventions should be offered to children who smoke, with Nicotine Replacement Therapy (NRT) provided to children over 12 who are dependent on nicotine. Behavioural stop-smoking support should be provided to all children prescribed NRT and staff providing behavioural interventions should be trained to National Centre for Smoking Cessation and Training standards or its updates.

Smoking is the greatest cause of preventable illness and premature death in the UK. An estimated 7% of fifteen year olds are regular smokers.[73] Smoking is more prevalent in poorer groups, widening inequalities in health between social groups.[74]

Devitt cites a range of studies which all indicate that approximately 80% of young offenders smoke;[75] elsewhere, anecdotal comments suggest that this is a conservative estimate.

The SystmOne smoking data probably tells us more about data entry compliance than actual needs and activity. The rate of smokers is low (especially in 2020/21) but the referral rate seems more credible.

Figure 29 – SystmOne Smoking data

	2019/20	2020/21 (to date)	December 2020 snapshot
Smoker	53%	2%	19%
Ex-smoker	63%	57%	70%
Referred to smoking cessation	45%	33%	52%

NRT is licensed for young people over 12 years old, including those who smoke less than 20 cigarettes per day. HMYOI Parc is a smoke-free environment. Staff felt that while a number of arrivals identified as smokers, few had an established dependency, although they have on occasion offered NRT, i.e. lozenges, although this is usually time-limited and to support reduction and abstinence.

Primary care staff are the main deliverers of psychological smoking cessation interventions and health promotion in relation to smoking is covered in various settings including education.

6.5 Alcohol

In a large scale longitudinal English study of the general population,[76] [77] the proportion of 11 to 15 year olds who have ever had an alcoholic drink has been declining since 2003. In 2014, 43% of pupils had drunk alcohol, a considerable drop from when the survey began, when it

[73] ONS (2017) Smoking, Drinking and Drug Use among Young People in England 2016. [Accessed 21/2/21]
[74] Fuller, E. (2015) Smoking, drinking and drug use among young people in England 2014. [Accessed 21/2/21]
[75] Devitt, K. (2011) Young Adults Today. Substance Misuse and Young adults in the Criminal Justice System. Barrow Cadbury. [Accessed 21/2/21]
[76] DH (2017) Statistics on Alcohol England 2017. [Accessed 21/2/21]
[77] DH (2019) Smoking, Drinking and Drug Use among Young People in England 2018. [Accessed 21/2/21]

was 62%. Not surprisingly, the prevalence of drinking increased sharply with age, for boys from 16% at 11 years to 67% at 15.

Whilst drug dependency was described as very rare, in 2019/20 SystmOne recorded one young person with alcohol dependency, and in 2020/21 (to date) three.

It might be expected that young people with so many risk factors might be more likely to drink than their peers. Relevant in this regard might be anecdotal reporting from some young people we have interviewed in the secure estate who were wary of alcohol due to the need to be alert to avoid gang violence.

Whilst it is possible that a young person with the degree of alcohol dependency that required medical intervention might be otherwise considered appropriate for a secure placement, it is questionable whether this would be appropriate at HMYOI Parc. Whilst there is 24-hour nursing cover, regular close monitoring during patrol status would be difficult.

6.6 Drug Use in the YPU

A number of interviewees said use of any form of contraband (drugs or alcohol) is very rare in the YPU. The YPU used to do routine drug testing with the young people, but this is no longer undertaken. Whilst the previous HNA supported this and suggested the prison dogs should visit this was not supported by interviewees.

6.7 Chapter Summary

- HMYOI Parc has one substance misuse worker delivering psycho-social interventions.
- Physical dependence is rare, the GP is available to meet these needs.
- There is no substance misuse strategy. (See Recommendation.)
- A history of smoking is common. NRT is available.
- Cannabis is used by most young people (94%) placed at HMYOI Parc, there is a 'targeted' approach to meet needs.
- A small number of young people are presenting with alcohol dependency.
- Illicit drug/alcohol use within the YPU is rare.

Chapter Seven – Mental Health and Emotional Wellbeing

7.1 Prevalence of Mental Health Conditions in Secure Settings

Mental health problems in young people do not manifest themselves as clearly as they may do in adults. They can emerge in ways that are less easily defined or diagnosed – for example, through problems with conduct, attitude or behaviour, through other emotional difficulties, or through substance misuse, sexually problematic or risky behaviour, or through self-harm. This can lead to underestimates of the extent of mental health problems among groups of children and young people.[78]

The mental health needs of young people in secure settings are known to be considerable, severe and complex, with rates of psychosis, self-harm and suicide higher than in other groups of young people.[79] Looked after children in secure settings have histories of abuse, neglect and trauma and experiences of separation and loss.[80] There are complicating factors of substance misuse, neuro-disabilities and learning difficulties and of the young people's distress and anxiety at being locked up and away from home.[81] These issues are widely replicated in reports that focus on young offenders.[82]

The prevalence of mental health disorders is over three times greater in young people in secure settings compared with the general population. The most common disorders are conduct disorders, anxiety and depression. Prevalence rates of personality disorder, psychosis, attention disorders, post-traumatic stress disorder and self-harm are also high.[83]

In the community, it is estimated that 10% of young people have a clinically significant mental health problem;[84] this figure does not include all those with needs which fall outside of a diagnosable condition (as defined by WHO Internal Classification of Disease). YJB state that 78% of young people in custody have mental health concerns.[85]

The YJB reports on the identified needs of young people in SCH and YOI settings state:[86]

- 23% were classed as having a mental health issue[87]
- 7% had a formal diagnosis of mental illness[88]
- 47% had been referred to a mental health service[89]

[78] Mental Health Foundation (1999) Bright Futures: Promoting children and young people's mental health; Young Minds (2003) Mental Health Services for Adolescents and Young Adults.
[79] Ryan, M. et al. (2011) 'Evidence about the health and well-being needs of children and young people in contact with the youth justice system'.
[80] Furnivall, J. (2011) Attachment-informed practice with looked-after children and young people. The Institute for Research and Innovation in Social Services. [Accessed 21/2/21]
[81] DH 2007 Promoting mental health for children held in secure settings. [Accessed 21/2/21]
[82] Hagell, A. (2002) The mental health of young offenders. Bright futures: working with vulnerable young people. [Accessed 21/2/21]
[83] Ryan, M. et al. (2011) Op. cit.
[84] Meltzer et al. (2003). Persistence, Onset, Risk Factors and Outcomes of Childhood Mental Disorders. London: TSO.
[85] YJB (2021) Assessing the needs of sentenced children in the Youth Justice System 2019/20 (Supplementary tables). [Accessed 21/2/21]
[86] YJB (2013) Young People and the Secure Estate: Needs and Interventions. [Accessed 21/2/21]
[87] This is considered to be an underestimate as 44% of the total sample of 1,105 was missing within this post-court report variable. Researchers collating the administrative data recorded 21% of young people as having a mental health issue (n=210), with 86 unknowns. As researchers were not trained in mental health issues, this is not reported within the main body of the report.
[88] 12% of the total sample (1,105) was missing within this Asset variable.
[89] 13% of the total sample (1,105) was missing within this Asset variable.

All of this suggests that there should be elevated levels of mental health need within the population in HMYOI Parc.

There is ample evidence of past inequality in mental healthcare between people of different ethnic origins.[90] Evidence on the impact of ethnicity upon emotional wellbeing and mental health problems of young people is inconclusive, although children and young people from some minority ethnic communities may be over represented within the Child and Adolescent Mental Health Service (CAMHS).[91] Contributory factors to this trend are the lack of appropriate early-intervention schemes for young people with mental health problems from BAME communities and the stigma within some communities that attaches to acknowledging mental health problems.[92]

7.2 Mental and Emotional Health and Wellbeing at HMYOI Parc

It is a reasonable starting point to presume that a proportion of young people in HMYOI Parc will have needs which have either not previously been recognised or for which they have not had support. Whilst the following quote is specifically referring to welfare placement in secure children's homes, the community services available to these children in Wales are similar to those available for young offenders.

[W]hile mental health problems, self-harm and suicide attempts were common among the children and young people before they were placed in secure accommodation, few received support from mental health services.[93]

RCPCH Standard

8.1 Each secure setting has a comprehensive mental health and neuro-disability (including speech, language and communication) strategy outlining the contributions of all staff to supporting and improving the mental health and wellbeing of children. This strategy should be reviewed annually.
There is a lead mental healthcare professional responsible for overseeing mental health provision within the secure setting.

We could not establish the existence of an overarching mental health strategy for the young people. We suggest that developing this will form part of the implementation plan for SECURE STAIRS recommended below.

[90] Sashidharan, S.P. for NIMHE (2003) Inside Outside: Improving mental health services for black and minority ethnic communities in England. Department of Health. [Accessed 21/2/21]
[91] See for example: Audit Commission (1999) Children in Mind – Child and Adolescent Mental Health Service. Audit Commission; O'Herlihy, A. et al. (2004) 'Characteristics of the residents of in-patient child and adolescent mental health services in England and Wales', Clinical Child Psychology and Psychiatry, 9(4): 579-588. Tolmac, J. and Hodes, M. (2004) 'Ethnic variation among adolescent psychiatric in-patients with psychotic disorders', British Journal of Psychiatry, 184(5): 428-431.
[92] ChiMat (2012) Youth Justice Health and Wellbeing Needs Assessment Toolkit. [Accessed 24/2/21]
[93] Williams A et al (2019) The Experiences and outcomes of children and young people from Wales receiving Secure Accommodation Orders [Accessed 24/2/21]

7.3 SECURE STAIRS

SECURE STAIRS is approach which is intended to inform practice in the young people's secure estate in England.[94] In England the initiative has attracted very significant additional funding, resulting in a large disparity between the two counties. This is relevant because young people in both countries are the responsibility of one YCS, also because most young people placed in the YPU originate from England and could have been placed in English or Welsh facilities., there is a clear discrepancy in terms of parity of care.

SECURE STAIRS has been mentioned by CAMHS but nothing has happened yet (RMN)

SECURE STAIRS is also relevant because the introduction to this report describes need and demand. Implementing SECURE STAIRS will change demand.

SECURE STAIRS is an overall framework and developmental driver for the model of care throughout most of the young people's secure estate, specifically where mental health and wellbeing is concerned but also as an overarching context for the care, support and management of residents and to some extent staff. The precise interventions used within the SECURE STAIRS framework vary between settings but one of the core principles of the framework is that the day-to-day staff are at the centre of the intervention, recognising that they have a pivotal role in developing the environmental and relational conditions that can manage risk, promote safety (relational security) and change for the young people. As such, the environment and the relationships within it (rather than specialist in-reach services) are proposed as the primary agents of change for young people within secure settings. The creation and maintenance of a trauma-informed therapeutic milieu is therefore a critical and essential task in its own right and SECURE is an acronym outlining key components of such a milieu. This is part of a wider shift in focus within the secure estate from interventions aimed at the young person to interventions aimed at the whole system.

The second dimension of the framework is supporting establishments to adopt a 'STAIRS' approach to creating change – STAIRS approaches are any approaches where clear 'destination-targets' are collaboratively identified, formulations collaboratively developed and whole-system interventions then planned, based on those formulations. 'STAIRS' approaches also clearly review impacts of interventions on targets and actively plan with future environments for sustainability. The development of the concept of STAIRS approaches is based on consideration of the key elements of effective practice in interventions that have a good evidence base with young people with conduct disorder type presentations. The figure below expands on some of the key principles involved:

[94] MOJ, HMPPS, YCS and NHS England (2020) Building Bridges: A Positive Behaviour Framework for the Children and Young People Secure Estate. [Accessed 26/2/21]

Figure 30 – SECURE STAIRS

S	**Staff** with the skill sets appropriate to the interventions that are needed.
E	**Emotionally** resilient staff who are able to remain child-centred in the face of challenging behaviour.
C	**Cared for staff,** through supervision and support.
U	**Understanding** across the establishment of child development, attachment, trauma and other relevant key theories.
R	**Reflective system,** staff who are able to consider the impact of trauma at all levels.
E	**'Every Interaction Matters',** a whole system approach.

S	**Scoping:** The presenting situation is assessed with clarity around the Children and Young People's pathway and life narrative.
T	**Targets:** Staff, CYP and the 'home' environment agrees on the goals for the CYP's time within the establishment.
A	**Activators:** All CYP have an agreed psycho-bio-social, developmentally informed, multi-factorial formulation (understanding not based on diagnosis) that clarifies what activates problems for the CYP.
I	**Interventions:** Specialist and core interventions, driven by the formulation and incorporating the risk assessment. Ensuring interventions are tailored to each CYP's risks and needs with content, intensity and timing of the intervention specified.
R	**Review and revise:** Clear 'real-life' outcome monitoring by the establishment and 'home', including the frequency and severity of high risk behaviours and of movement towards goals, regularly evaluated using a formulation-based approach at multidisciplinary reviews.
S	**Sustain:** Sustainability planning from the outset around maintaining goals upon release and the transition to 'home' or other services.

If SECURE STAIRS is fully implemented, we would expect to see the FACTS Team integrated on site rather than reaching in. Many of the current distinctions between the roles of different staff would be blurred and all staff would be further encouraged in joint working with the young people in their care. Where SECURE STAIRS has been implemented, staff describe how the model fundamentally changes their approach.

A core theme of SECURE STAIRS is ensuring that all teams (including residential, education, interventions, FACTS and primary healthcare) work together and in the same direction. With a large service working different shifts, communication is vital. Key to this is the formulation, which is developed from the start and continually reviewed throughout the young person's stay. Community services (e.g. YOT, LAC social worker) and family should all be involved from the start and depending on the formulation, most of the main departments in HMYOI Parc will be also, as well as the young person themselves.

The formulation should establish what direct interventions are planned and what everyone's roles and responsibilities are. Not having psychology input to create these individual formulations is a particular gap.

There will be significant training needs arising from the implementation of SECURE STAIRS. FACTS Team state they are in a position to offer some training to staff, indeed they did deliver training some three or four years ago, but the initiative did not take off.

Recommendation Six: Whether or not SECURE STAIRS is adopted in Wales. There should be additional psychology input to create and implement formulations for each young person.

7.4 Mental Health Provision

7.4.1 Primary Mental Health

There is one full-time RMN who works a core week (Monday to Friday) and shares primary care delivery with an RGN colleague.

The role of the RMN includes assessment, support for the young people in terms of a wide range of emotional wellbeing and common mental health presentations, also referral to the FACTS team.

The RMN described a range of talking therapy type support techniques, tailored to individual needs and abilities

- Distraction techniques
- Some talking therapy aimed at building self-confidence
- Relaxation, though it was observed that the environment is not conducive to relaxation techniques
- Fidget spinners
- CBT art therapy
- Stress reduction workbooks
- Sleep hygiene

The nurse said that there is not enough time to do much of the work that she would like to undertake. It may be useful to look to more use of evidence based time limited interventions such as Cognitive Behavioural Therapies (CBT) and Eye Movement Desensitisation and Reprocessing (EMDR) (specifically noting comments about high rates of trauma). (N.B. these may need to be delivered under the supervision of a clinical psychologist.)

Recommendation Seven: Explore alternative or additional primary mental health interventions to target identified needs, including trauma.

7.4.2 In-reach (FACTS Team)

The all Wales Forensic Adolescent Consultation and Treatment Service (FACTS) have been providing an in-reach service to HMYOI Parc since 2012.

The team's overarching philosophy is to provide a service which meets the specific needs of this population through a trauma informed service, addresses their complexity and does not exclude on the basis of diagnostic categories. The service seeks to take a whole systems approach to support the establishment in their provision of care for the young people.[95]

The specialist team input into HMYOI Parc comprises:

Figure 31 – The FACTS Team

Post (and banding)	FTE	Comment
Adolescent Forensic Consultant Psychiatrist	0.1	
Clinical Psychologist	0.5	
RMN	0.5	
Administrator	0.5	

Whilst the team is officially that described above, it was evident from our meeting that many members of the wider FACTS Team have an input.

There is no guidance on what an appropriate level of resourcing should be, from our recent work we are able to compile the following comparison, the numbers are based on capacity of the YPU (most, like Parc, had vacancies).

Figure 32 – Comparison of mental health resourcing

Facility	Year	Capacity	Rate per 10 residents	Comment
HMYOI Parc	2021	64	0.32	The core level of resourcing in the YOIs was broadly similar
HMYOI Cookham Wood (core)	2019	188	0.34	
HMYOI Cookham Wood (with SECURE STAIRS)	2019	188	0.92	The additional SECURE STAIRS funding tripled the input in to this YOI
Rainsbrook STC	2017	80	0.95	The support in a STC should (in theory) be greater than in a YOI
Oakhill STC	2017	76	0.99	

The table above illustrates that HMYOI Parc now has significantly less specialist mental health input that any of the other three establishments for which we have data.

The data for HMYOI Cookham Wood distinguishes between core funded services and SECURE STAIRS funded resources and illustrates how services in England have been allocated significant resources to implement the SECURE STAIRS initiative and all that this entails.

The description of resourcing for the STCs predates SECURE STAIRS, both were very similar, a STC should be able to offer more support than a YOI but the degree of difference is surprising.

THE FACTS team is large (we 'met' 13) there are a broad range of specialists within the team who could offer some limited input. Vetting and security issues inhibit ready access and restrict the service that can be offered.

In making the following recommendation, we note it is not new and is a repeat of that made in the previous HNA and in the HMIP report (both from 2019).

[95] FACTS Draft SLA

Recommendation Eight: The specialist mental health resource available for the young people is in need of urgent review.

7.4.3 Service Delivery

RCPCH Standards

8.2.1 The secure setting receives consultation, advice, supervision, support and training from the integrated CAMHS team.

8.2.2 All children will have a psychologically underpinned formulation, from a multidisciplinary team with a mental health practitioner embedded within the team. Dedicated and timely access to psychiatric and psychological input is available from the integrated CAMHS team, through which other professional services may be accessed. This may include occupational therapists, speech and language therapists, primary mental health workers, a clinician with neuro-disability expertise, and Community Forensic CAMHS.

8.4 A range of evidence-based mental health interventions is offered and delivered according to individual needs.

The FACTS team deliver clinics two mornings per week on an in-reach basis; these would normally be on site, but during the pandemic have been remote. Tuesday mornings are assessment clinics and Wednesday mornings are for individual casework The available resources are limited and focus on interventions for young people who are referred. In-reach means the team visits, rather than being part of the infrastructure, as noted above they are only involved in the care of a proportion of young people, a referral in rather than opt out arrangement; for example this means they are not in a position to assess and make formulations for all young people. Further they are not involved in on site meetings restricting their ability to contribute their expert input to developments in the unit. As described below records are held separately. The team do not have access to an on site office and the rooms used for their sessions are shared spaces which the previous HNA (2019) described as 'inadequate'.

Recommendation Nine: The FACTS Team need improved facilities from which to deliver sessions with the young people.

All parties: operational side, primary healthcare and FACTS portrayed an impression of some distance and disconnect. For example links between the FACTS service and substance misuse service/ GP/ physical health are not currently described as close.

Recommendation Ten: The FACTS Team should be integrated, this will include working from a base in the YPU, not operating on an in-reach basis.

The primary mental health nurse (as part of the core primary care team) uses SystmOne. The FACTS Team use a separate IT system (Myrddin) and do not enter records on SystmOne. The RMN reports that she has to scan or copy type entries from the FACTs notes on to SystmOne. SystmOne should be a universal tool holding a patient's records. This is important both for integrated care planning within in the establishment and also vital for continuity of care in

patients who are transferred within the secure estate, or as is the case for many transfer to the adult estate. Notes from FACTS state data recording is under review with an aim that in future they will enter records on to SystmOne.

Recommendation Eleven: G4S should give the FACTS Team access to SystmOne and the FACTS team should be responsible for entering their client records on the system. (NB With suitable connections, this can be done remotely.)

All young people receive an assessment from the primary RMN who completes the relevant sections of the CHAT form, a proportion are taken on by her and some are referred to the FACTS Team. In contrast to the adult in-reach service, the FACTS Team have a very broad acceptance criteria which in addition to those who fall under Part 2 of The Measure includes a range of psychological issues (trauma, attention deficit and hyperactivity disorder (ADHD), autism spectrum disorder (ASD) etc)and learning disability (LD). Whilst the only referral pathway in the YPU is via the primary care RMN, for example the NEWT workers cannot refer directly to FACTS. FACTS may also receive referrals direct from YOTs in the community, though it was noted that information on ASSET (Young Offender Assessment Profile) is not always complete. It was noted that the Every Child Matters agenda had promoted good interagency working which continues, though this is in a rather informal basis. The FACTS team working in HMYOI Parc is part of an all Wales team, so Welsh residents may already be known to the service in the community. The FACTS team say they would like to be able to accept referrals direct from other teams in the YPU, this may require investment in awareness raising and an understanding of appropriate pathways.

In summary the referral pathway to FACTS appears rather fragile. If there was a single point of access to mental health services for the YPU this could then feed into a MDT meeting. We observe that in some other settings all mental health referrals (and indeed sometimes also substance misuse referrals) are taken to a weekly referrals meeting for consideration and allocation. (If this model is adopted there would need to be a mechanism to prioritise urgent referrals and not delay interventions.)

Whilst there is not a lot of data, by way of illustration, on the day of the interview: there were 30 young residents, five (17%) were in the primary mental health caseload and three (10%) were under the FACTS caseload, a further one was due for release.

7.5 Emotional Wellbeing

Emotional wellbeing is subjective and therefore difficult to define.

Across the young people's secure estate, the perception is that:

There is a general lack of attention to promoting emotional wellbeing as opposed to responding to specific mental health problems.[96]

Good mental health is built on a foundation of emotional wellbeing. The staff we spoke to at HMYOI Parc saw the young person's wellbeing as central to their role.

[96] Children's Commissioner. (2011). I think I must have been born bad. Emotional wellbeing and mental health of children and young people in the youth justice system. [Accessed 21/2/21]

The RMN described using mood diaries with the young people.

HMIP praised the unit for having communal dining, even during the pandemic the staff have managed to allow young people to eat one meal per day in a communal setting.

7.6 Trauma

In recent years, there has been increasing recognition of the long-term impact of childhood trauma, including the concept of:

Adverse Childhood Experiences (ACEs), such as being a victim of violence or neglect, or living with a household member who abuses substances or is involved in criminal activity.[97]

The literature goes on to explain the impacts of these adverse childhood experiences:

A positive relationship was found between ACEs and certain lifestyle factors (smoking and unhealthy weight) and ACEs and long-term health conditions.

Patients with ≥2 ACEs were over two and a half times more likely to suffer from asthma and almost three times more likely to have complex health needs and be living with multiple long-term conditions, compared with those with 0-1 ACE(s).

Mental health had the strongest association with childhood adversity, with patients with ≥2 ACEs over three and a half times more likely to be experiencing current mental health problems, compared with those with 0-1 ACE(s). ACE count was also found to correlate with severity of depression and anxiety among those being treated for mental health problems.[98]

A previous study in Wales found that four or more ACE events are strongly correlated to health harming behaviours such as smoking, problem drinking, or drug use and consequently to poor physical and mental health outcomes.[99] This evidence is supported by a US study that drew data from several previous research papers.[100]

A more recent study focuses specifically on ACEs and looked after young people, noting the range of negative consequences described in the articles referenced above and also looking more broadly to include physical health impacts.[101]

Studies describe how young people who experience chronic stress from adverse events can become 'locked' into a state of hyper-arousal, wary of further trauma.[102]

[97] Hardcastle, K. and Bellis, M. (2018) Routine enquiry for history of adverse childhood experiences (ACEs) in the adult patient population in a general practice setting: A pathfinder study. [Accessed 21/2/21]
[98] Ibid.
[99] Bellis, M et al. (2015). Adverse childhood experiences and their impact on health-harming behaviours in the Welsh adult population. [Accessed 21/2/21]
[100] Monnat, S. (2015) Long Term Physical Health Consequences of Adverse Childhood Experiences. [Accessed 21/2/21]
[101] Simkiss, D. (2019) The needs of looked after children from an adverse childhood experience perspective. [Accessed 21/2/21]
[102] Anda, R.F. et al. (2006) The enduring effects of abuse and related adverse experiences in childhood. A convergence of evidence from neurobiology and epidemiology. [Accessed 21/2/21]

RCPCH Standard

4.5.2 All children should be assessed for experience and impact of current or past violence or abuse (to include, but not limited to: domestic and non-domestic violence and abuse; physical, emotional and sexual violence and abuse and female genital mutilation (FGM), child exploitation, grooming and trafficking).

4.5.3 Secure settings should create an environment for disclosing any form of previous abuse, by ensuring that healthcare staff are trained to ask children about their history, and that all staff are trained in complex trauma.

Noting the background histories of young people in YOIs, it is reasonable to assume that all will have experienced multiple adverse childhood experiences. The CHAT form has a section on post-traumatic stress disorder (PTSD), the record is informed by what the young person says in interview.

Figure 33 – PTSD (SystmOne data)

	2019/20	2020/21 (to December)	Snapshot December 2020
PTSD	0	2% (1)	4% (1)

At HMYOI Cookham Wood, under 4% of the population had a recorded PTSD diagnosis, as did 11% at HMYOI Aylesbury.

These factors and others potentially contributing to childhood trauma, were also common among residents in previous years, as shown in the tables below. Note that there may be under reporting, so the real figures are likely higher.

Figure 34 – Traumatic Childhood Experiences (SystmOne data)

	2019/20	2020/21 (to December)	Snapshot December 2020
Bereavement	2% (1)	2% (1)	None recorded
Victim of physical abuse	13% (8)	17% (8)	4% (1)
Victim of sexual abuse	6% (4)	7% (3)	None recorded
Child present during domestic abuse	19% (12)	20% (9)	19% (5)
Other traumatic experiences	25% (16)	28% (13)	22% (6)

Figure 35 – Vulnerabilities (SystmOne data)

	2019/20	2020/21 (to December)	Snapshot December 2020
'Open to exploitation' or 'victim of exploitation'	None recorded	4% (2)	4% (1)
Safeguarding child concern	17% (11)	20% (9)	30% (8)
Vulnerable personality	41% (26)	39% (18)	30% (8)
Homeless	None recorded	2% (1)	4% (1)
Young parent	None recorded	7% (3)	4% (1)
Child at risk			
Subject to child protection plan	6% (4)	4% (2)	11% (3)
On child protection register	22% (14)	13% (6)	15% (4)

The above data evidence the point made in interview, namely that many of the young people will have experienced multiple ACEs and there is a clear need for trauma informed therapy (as recommended above). Interviewees noted that the Blueprint for Youth Justice in Wales recognises a need for trauma informed approaches and facilities.

7.7 Identified Mental Health Needs

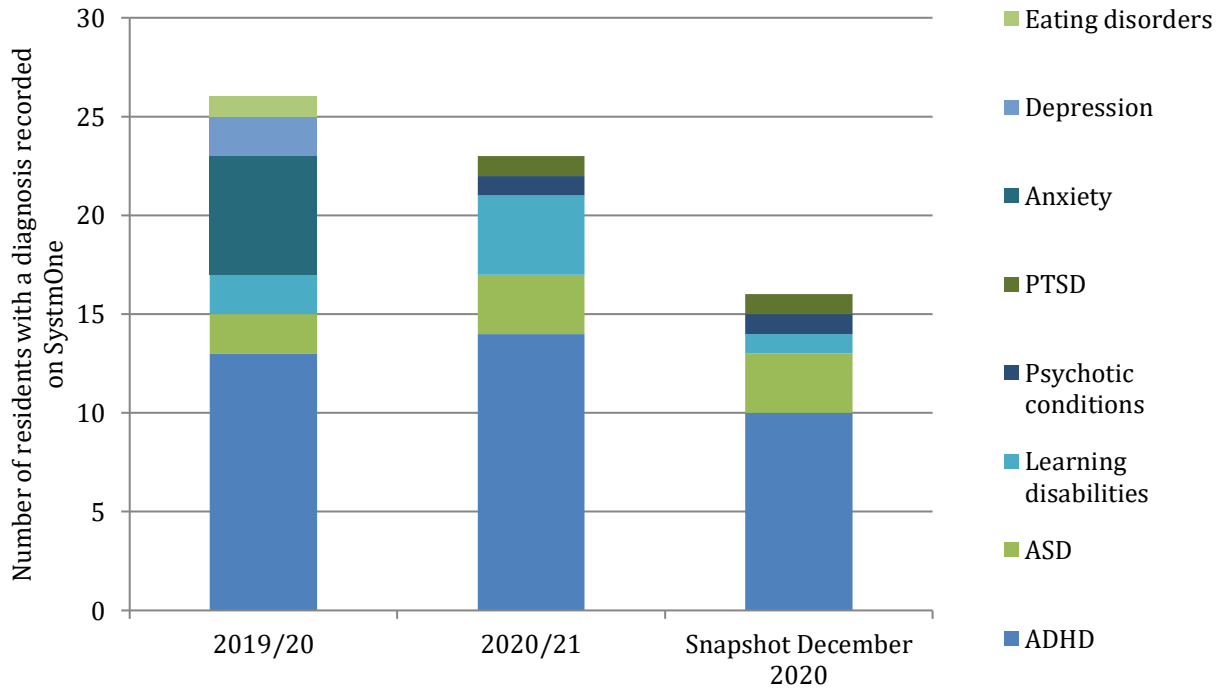
All young people are seen by a mental health nurse soon after they arrive. Assessment is often ongoing, not least as many of the young person's needs can be undiagnosed and what diagnoses there are, may well need reviewing.

SystmOne data for the current population suggests that many current residents (48%, as well as 46% of those in 2020/21 to date and 33% in 2019/20) were identified with a mental health problem.

The more common conditions, such as depression, are generally less prevalent than attachment and trauma-related disorders.

The chart below shows the annual number of residents identified with various mental health conditions (note that some residents will have been identified with multiple problems). The most commonly identified condition over the past few years has been ADHD. The column for 2019/20 describes a whole year; 20/21 describes nine months and the snapshot is for current residents.

Figure 36 – Identified Mental Health Problems (SystmOne data)



Several of these conditions are discussed in more detail in the rest of this chapter.

7.7.1 Self-Harm

Globally, suicide is the second leading cause of death among 15–29 year olds, and self-harm is one of the strongest known predictors of death by suicide.[103]

Self-harm covers a wide range of behaviours and may be defined as an intentional act of self-poisoning or self-injury, irrespective of the type of motivation or degree of suicidal intent. Some elements of substance misuse may be considered as self-harm. Self-injury is more specific, usually referring to cutting, burning, hitting or mutilating body parts and attempted hanging or strangulation.

Rates of self-harm have increased in the UK and are much higher among adolescents and young adults. They are particularly high for adolescents with mental health problems such as anxiety and depression. Self-harm is more common among young women than young men but studies have noted that young men may engage in different forms of self-harm that might be easier to conceal.[104]

Between 2007 and 2009 there was a cluster of suicides amongst 13-to-17-year-olds in Bridgend, all except one was by hanging. ONS report that recent rates of suicide amongst 10-19 years olds in Wales are below those for England (ONS 2019 data: 5.7 per 100,000 in England and 3.5 in Wales).[105]

Slightly dated YJB data in 2015/16 show that the rate of self-harm for young people throughout the secure estate was roughly twice as high for the greatly smaller number of females as for the males but was broadly comparable for white and BAME young people.[106]

Although the suicide rate among teenagers is falling nationally (now roughly one in 20,000[107]), it is recognised that the risk of suicide among children and young people is much higher if they are in contact with the youth justice system (and are separated from their family) and if they have mental health or substance misuse problems and/or have experienced abuse or neglect. Typical risk factors, include:

- family factors such as mental illness
- abuse and neglect
- bereavement and experience of suicide
- bullying
- social isolation or withdrawal
- physical health conditions that may have social impact
- alcohol and illicit drugs
- mental ill health, self-harm and suicidal ideas

[103] Suicide and Self Harm: advancing from science to preventing deaths. Journal of Child Psychology and Psychiatry 60:10 (2019), pp 1043–1045. [Accessed 4/3/21]
[104] NCSS (2011) Self harm in children and young people handbook. [Accessed 4/3/21]
[105] ONS (2020) Suicides in England and Wales. Tables 6&7. [Accessed 4/3/21]
[106] ONS (2017) Youth Justice statistics 2015/16. [Accessed 4/3/21]
[107] ONS (2017) Suicides in the UK: 2016 registrations. [Accessed 4/3/21]

RCPCH Standards

8.6 Children at risk of self-harm or suicide are provided with individual care and support.

8.6.1 Personal factors or significant events which may trigger self-harm, are identified in the child's healthcare plan and discussed with all staff.

8.6.2 A range of evidence-based interventions is offered and delivered to address the underlying causes of self-harming behaviour.

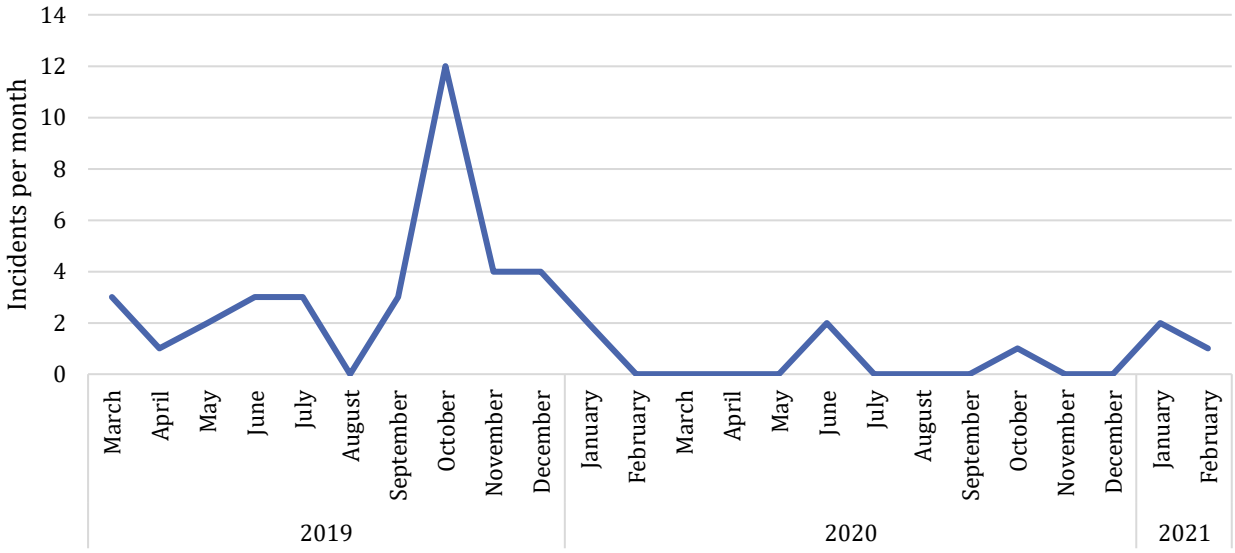
8.6.3 All incidents of self-harm or attempts to self-harm are recorded and referred to the named safeguarding lead.

Rates of self-harm amongst young people in the secure estate nationally, are high:

8% of young people held at SCHs were known to have self-harmed while in custody…. However, these figures are likely underestimates.[108]

Whilst rates are reported to be higher amongst girls than boys, boys may conceal their self-harm.[109]

Figure 37 – Self-harm incidents (data from HMYOI Parc)



The table average rate for HMYOI Parc for 2019 was 14.3 per 100 residents per month (assuming an average of 40 residents). In 2020 this fell to an average of six per 100 residents per month (assuming and average of 30 residents). By contrast, the most recent national data (2019/20) describes 24.2 incidents per 100 young people in custody per month which is a 35% increase over the previous year and the highest rate in five years.[110]

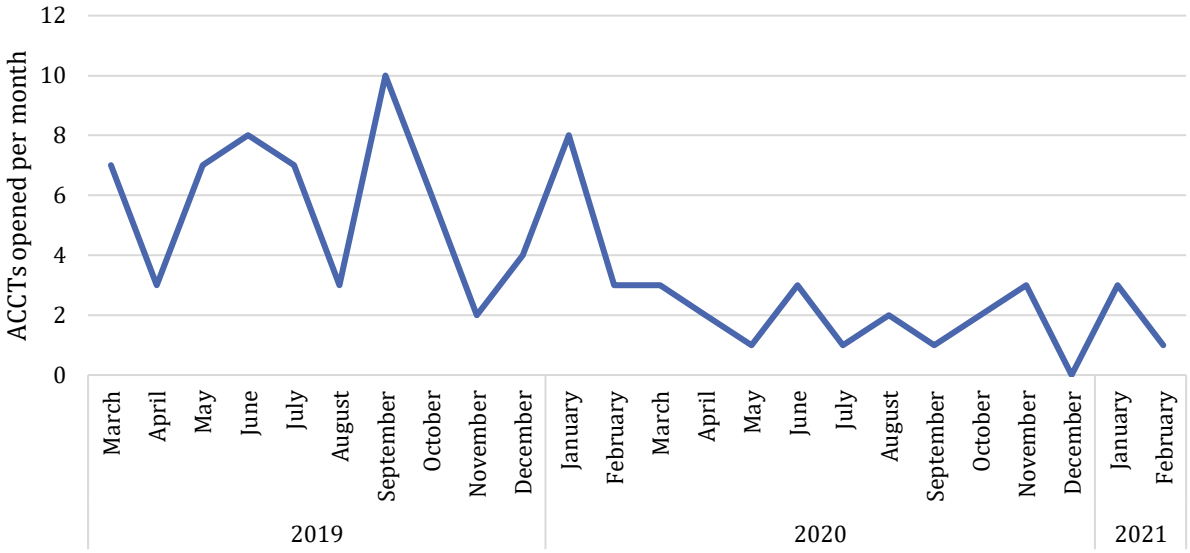
Self-harm is managed using the prison service ACCT process and young people who arrive with a 'red flag' for self-harm are automatically placed straight on to an ACCT and booked for a mental health assessment. In addition to individual ACCT reviews and the daily MDT

[108] Youth Justice Board (2013) Young People and the Secure Estate: Needs and Interventions. [Accessed 24/2/21]
[109] National CAMHS Support Service (2011). Self-Harm in children and young people handbook. [Accessed 4/3/21]
[110] MOJ and YJB (2021) Youth Justice Statistics 2019/20. [Accessed 16/3/21]

meeting, the unit participates in the monthly prison wide safeguarding meeting where ACCT data is reviewed.

Sitting beneath the ACCT process is the Challenge Support and Intervention Plans (CSIP) which are a multi-disciplinary approach to the care and support of each resident.

Figure 38 – ACCTs opened per month (data from HMYOI Parc)



The RMN referred to working through materials such as The Truth About Self Harm.[111]

7.7.2 Depression & Anxiety

The prevalence of depression among young people in custody is twice as high for boys than in the community. Studies show that 11% of boys and 29% of girls in custody have a major depressive disorder.[112] [113]

Only two residents (both in 2019/20 have a READ code for depression. Also in 2019/20 two residents (we cannot tell if it the same two) had READ codes for anxiety. However, the CHAT assessment asks about symptoms that could be indicative of mental health issues including depression, such as feelings of hopelessness, sleep disturbances and anhedonia.

The primary care RMN made specific reference to using the BECK Anxiety Inventory with young people.

7.8 Conduct disorders

Studies show that the prevalence of conduct disorder among children and young people in custody is three times greater than in the general population.[114] Early onset of conduct disorder (under age 10) is particularly likely to result in persistent difficulties and poor

[111] MHF (undated) The Truth About Self Harm [Accessed 4/3/21]
[112] MHF (2002) Mental Health Needs Of Young Offenders Update. [Accessed 4/3/21]
[113] Lennox & Khan (2012) Youth justice. [Accessed 4/3/21]
[114] Ryan and Tunnard (2012) Evidence about the health and well-being needs of children and young people in contact with the youth justice system. Quoted in RCPCH (2013) Healthcare Standards for Children and Young People in Secure Settings. [Accessed 4/3/21]

outcomes, including offending.[115] This also applies to those whose conduct problems are below the threshold for a clinical diagnosis. One study estimated that around 80% of all criminal activity is attributable to people who had conduct problems in childhood and adolescence, including about 30% specifically associated with conduct disorder.[116]

7.8.1 Emerging Personality Disorder

There is a lack of data on the overall prevalence of emerging personality disorder among young people in contact with the YJS or otherwise in the secure estate. The prevalence of conduct disorders may give some indication, as a sizeable number of young people with conduct disorder go on to develop personality disorder.

7.8.2 Sexually harmful behaviour

RCPCH Standard

8.4.6 There is specific evidence based screening, assessment and treatment available for managing harmful sexual behaviour.

A review[117] of research into sexually harmful behaviour carried out for the YJB noted that young people who commit sexual offences have frequently experienced sexual, physical or emotional abuse. A sizeable proportion show poor social competence and high impulsivity, have learning difficulties or disabilities and are coping with the impact of a disrupted and neglectful family background.

There is no specific programme to address sexually harmful behaviour.

We were going to do something 2-3 years ago (RMN)

Recommendation Twelve: There should be specific targeted programme addressing harmful sexual behaviour.

We suggest that to meet the recommendation above staff should be AIM3 trained (Assessment, Intervention, Moving-on[118]).

7.8.3 Eating disorders

Teenage years are the most likely for an eating disorder to present but this is still only about one in 5,000 for boys. What little research there has been on eating disorders in custody has been on adult women, where the incidence is high, though little of this research was in the UK. As such, there are no figures on eating disorders amongst young people in the UK criminal justice system or in custody, although it is likely that incidence will be higher than in the general population.

Eating disorders are very rare and more likely to involve overeating, particularly of snacks.

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[115] Richards, Abbotts et al, (2009) Childhood Mental Health and Life Chances in Post-war Britain. [Accessed 4/3/21]
[116] Richards, Abbotts et al, (2009) Childhood Mental Health and Life Chances in Post-war Britain. [Accessed 4/3/21]
[117] Grimshaw, R (2008) Young people who sexually abuse. [Accessed 4/3/21]
[118] AIM Project's website. [Accessed 26/2/21]

7.9 Chapter Summary

- There is a long-established body of evidence describing a high prevalence of mental health conditions amongst looked after and detained young people.
- This is largely attributed to childhood trauma. Adverse Childhood Experiences (ACEs) are common amongst HMYOI Parc residents.
- Most interventions are psychosocial rather than medical.
- Mental health services, especially the in-reach services are poorly resourced. (See Recommendation.)
- The in-reach team should be integrated. (See Recommendations.)
- There is a strong emphasis on the young people's health and wellbeing and all staff see this as central to their role. A wide and varied range of interventions and activities support wellbeing.
- Emotional wellbeing is very much part of every team's role.
- The almost ubiquitous presence of Adverse Childhood Experiences (ACEs) is recognised but there is a paucity of trauma-focused interventions and approaches.
- A range of mental health conditions and symptoms have been identified at HMYOI Parc, though the emphasis seems to be on trauma-related conditions.
- Rates of self-harm fluctuate but appear to be well below the national average. Self-harm is managed via the ACCT processes.
- Rates of depression and anxiety are lower than might be expected.
- Eating disorders are rare.
- SECURE STAIRS has not been funded or implemented in Wales. This has generated a significant gap between the services offered in England and in Wales. Noting placements fall under one YCS and that most young people originate from England, this raises questions of equity.

Chapter Eight – Neuro Disability

8.1 Neuro-Disabilities and other neurological conditions

Neuro-disability is a term used to encompass a range of disorders which are largely chronic and developmental. They include disorders such as autism.

There is a now rather dated report on the needs of young offenders with special educational needs in Wales.[119] The focus was on young people in contact with YOT services in the community but does make a wider point about the importance of transitional arrangements for release.

RCPCH Standard

8.5 A range of evidence-based neuro-disability interventions is offered and delivered according to individual needs.

8.5.1 This includes, but is not limited to, interventions for the following:
Traumatic brain injury;
Speech, language and communication difficulties;
Attention deficit hyperactivity disorder;
Learning disabilities and educational needs;
Autistic spectrum disorder.

Figure 39 – Estimated Prevalence of Neuro-disability

	Community	Secure setting
Acquired brain injury	0.7%[120]	-
ADHD	5%[121]	10-20%
Learning disability[122]	2-4%	23-32%
Autism spectrum disorder (ASD)[123]	0.6-1.2%	15%
Epilepsy[124]	0.45-1%	0.7-0.8%
Foetal alcohol syndrome[125]	0.1-5%	10.9-11.7%

HMIP (2019) observed that:

'positive learning support was in place tailored to the needs of individual children'.[126]

Mental health staff screen for neuro-disabilities as part of their assessment and then refer on where necessary. In contrast to the adult side of the prison where there is an exceptionally

[119] Evans J (2009) Analysis of support for young people with special educational needs (SEN) in the youth justice sector in Wales. [Accessed 25/2/21]
[120] Thurman, D. (2016) The Epidemiology of Traumatic Brain Injury in Children and Youths: A Review of Research Since 1990. [Accessed 4/3/21]
[121] ADISS (undated) ADHD: Paying enough attention?. [Accessed 4/3/21]
[122] Children's Commissioner (2012) Nobody made the connection. [Accessed 4/3/21]
[123] Idem. NB based on only one study in custody.
[124] Children's Commissioner (2012) Nobody made the connection. [Accessed 4/3/21]
[125] Ibid.
[126] HMIP (2019) Report on an unannounced inspection of HMYOI Parc 11-22 November 2019. [Accessed 24/2/21]

well developed LD pathway, in the YOI environment descriptions were rather vague. We understand that an LD nurse from the adult side can be called upon if needed.

8.1.1 Autism

Research data indicates relatively high prevalence of autism spectrum disorder (ASD) in secure settings when compared to the general population. Prevalence among young people in general is now thought to be one in 100 and higher amongst males. Some studies suggest a relatively low involvement with offending whilst others suggest an overrepresentation relative to the number of those with autism spectrum conditions in the general population (although prevalence in the general population is itself unclear). Nevertheless, there is agreement that children and young people on the autism spectrum who encounter the YJS as perpetrators of offences are likely to experience additional distress and difficulty because of their condition.[127]

Whilst often bundled alongside learning disabilities,[128] ASD is quite distinct, although recent research from the Learning Disabilities Observatory indicates that around 20%-30% of people with a learning disability also have an autism spectrum condition.[129]

The 2014 Adult Psychiatric Morbidity Survey estimated a UK prevalence rate of 0.8% among adults in the general population.[130] A number of studies have indicated a similar rate (around 1% nationally) of ASD among young people.[131] Because ASD is becoming more widely recognised and much of the UK wide data are quite old, it is useful to note some recent focused work in Northern Ireland. Here they found the recorded prevalence rate in young people rose from 1.2% in 2008/9 to 3.3% a decade later in 2018/19.

In contrast to any of these community figures, there is an estimate that 15% of young people living in secure settings have ASD.[132]

A more recent study into the prevalence of ASD found 5% of those detained through the YJS had the condition; this compared to 1% in the general population.[133]

Of current residents at HMYOI Parc, 11% (n=3) had a record of ASD. The proportion of residents identified has increased from 3% (n=5) in 2019/20 to 5% (n=6) during the first nine months of 2020/21. This rate is higher than HMYOI Cookham Wood (2019) which was 4.8% and HMYOI Aylesbury (2019) – 3.2%.

Autism is clearly being recognised though it is less clear what is being offered to help those with the condition.

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[127] See NICE (2014) NICE guidance for medical staff. [Accessed 4/3/21]
[128] See for example HM Inspectorates of Prisons and Probation (2015) A joint inspection of the treatment of offenders with learning disabilities within the criminal justice system. [Accessed 4/3/21]
[129] DH (2015) Equal Access, Equal Care: Guidance for Prison Healthcare Staff treating Patients with Learning Disabilities. [Accessed 4/3/21]
[130] McManus, S. et al. (2016) Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014. [Accessed 4/3/21]
[131] Baird, G. et al. Prevalence of disorders of the autism spectrum in a population cohort of children in South Thames: the Special Needs and Autism Project (SNAP). Lancet, 2006; 368(9531): 210–215; Green, H. et al. (2005) Mental Health of Children and Young People in Great Britain, 2004. Hampshire: Palgrave McMillan.
[132] Children's Commissioner (2012) Nobody made the connection. [Accessed 4/3/21]
[133] Hales, H. et al. (2018) Census of young people in secure settings on 14 September 2016: characteristics, needs and pathways of care. [Accessed 4/3/21]

8.1.2 Attention Deficit Hyperactivity Disorder (ADHD)

ADHD is a relatively common disorder amongst young people, NICE quotes estimates suggesting a prevalence of 3.62% in boys between five and 15 years.[134] Prevalence rates in young offenders vary depending on the methodology of the study, although in comparison to the general population, rates of ADHD are significantly greater amongst young offenders. The prevalence of ADHD is two to four times higher among young people in custody than in the community.[135] An international systematic review, including UK studies, found that 10% of boys in custody were diagnosed with ADHD.[136] ADHD was the most important predictor of violent offending.[137]

A more recent study found that the prevalence of ADHD in different placements was fairly similar; 25% on welfare placements and 17% of those detained through the YJS.[138]

As noted previously, a third (37%) of the current residents had a recorded diagnosis of ADHD on SystmOne, while 20% to 30% of residents in previous years had a record of the disorder. This compares to HMYOI Cookham Wood where 25% were identified, and 19% at HMYOI Aylesbury.

Whilst ADHD is clearly being recognised, prescribing data indicated no current residents prescribed medications for ADHD and the GP drew attention to the fact that certain medications cannot be initiated by a GP.

Recommendation Thirteen: There needs to be some psychiatrist input into primary care mental health, for example to oversee and initiate prescribing for ADHD.

8.1.3 Learning Disability, Learning Difficulties and Educational Needs

Most people with learning difficulties should receive any assistance they require from education, though all staff need to be aware of these difficulties. Education staff are experienced and skilled in assessing and working with learning difficulties, though at times seek specialist input.

Learning disability is a more restricted definition and may involve input from healthcare staff as well. A learning disability involves a significantly reduced ability to understand complex information or learn new skills (impaired intelligence), a reduced ability to cope independently (impaired social functioning) and is a condition which started before adulthood (18 years of age) and has a lasting effect.[139]

A learning disability is defined by three criteria: an IQ score of less than 70; significant difficulties with everyday tasks; and onset prior to adulthood.[140]

[134] NICE (2018) Attention Deficit and Hyperactivity Disorder. [Accessed 4/3/21]
[135] Connor et al (2012) Adolescent Attention Deficit Hyperactivity Disorder in the Secure Treatment Setting. [Accessed 4/3/21]
[136] Ryan, M. et al. (2011) 'Evidence about the health and well-being needs of children and young people in contact with the youth justice system'.
[137] Young et al (2011) The identification and management of ADHD offenders within the criminal justice system: a consensus statement from the UK Adult ADHD Network and criminal justice agencies. [Accessed 4/3/21]
[138] Hales, H. et al. (2018) Census of young people in secure settings on 14 September 2016: characteristics, needs and pathways of care. [Accessed 4/3/21]
[139] DH (2001) Valuing people: a new strategy for learning disability for the 21st century. [Accessed 4/3/21]
[140] Children's Commissioner (2012) Nobody made the connection. [Accessed 4/3/21]

As is apparent, there is not a sharp and clear line between learning difficulties and disabilities and good practice should be to focus on the young person and their needs rather than on any diagnosis. For example, they might not have developed age-appropriate functional abilities such as self-care skills or age appropriate relationships. Identification of need is the key starting point, considering the deficits in daily life and activities such as struggling socially and emotionally, having poor organisational and planning skills and struggling in education.[141] [142] [143]

It can be difficult to identify mild or moderate learning disabilities and there is a lack of exact figures on young people with learning disabilities or difficulties in custody or as looked after children. IQ is a possible measure when assessing learning disabilities, although not the only one. Research involving boys in four secure children's homes assessed 27% of them as having an IQ of less than 70 and 43% as having an IQ of between 70 and 85. A study of nearly 3,000 prisoners found 7% of those screened had learning disabilities. In addition, a significant percentage of the prison population have a borderline learning disability, defined as an IQ between 70 and 80.[144] HMIP recognised that figures may be as high as 30%.[145]

The estimated prevalence of learning disabilities amongst young people is 2-4% but for young people in custody the prevalence is nearly ten-fold at 23-32%.[146] Another study found that the prevalence of learning disability varied: 12% on welfare placements and 5% of those detained through the YJS.[147]

Specific reading difficulties, such as dyslexia, appear significantly more common in young people who offend, with research studies suggesting a prevalence of between 43 and 57%, compared to around 10% of the general population.[148]

The SWCU data for learning difficulties only covers a one month period (March 2019) so is a limited sample but indicates 29% had *'an SEN statement'*.

The above data suggests that learning disabilities can be expected at HMYOI Parc and learning difficulties should be quite common. Only one current resident at HMYOI Parc was recorded on SystmOne as having learning difficulties. The table below shows the percentage of residents in recent years recorded with various learning related needs (this is based on the CHAT assessment on SystmOne). The current figure is lower than we would expect.

Figure 40 – Identified Learning Needs (SystmOne data)

SystmOne Record	2019/20	2020/21 (to December)	Snapshot December 2020
Learning difficulties	3%	9%	4%
Statement of special educational needs	16%	37%	26%

[141] Children's Commissioner (2012) Nobody made the connection. [Accessed 4/3/21]
[142] ARC (2016) People with Learning Disabilities in the Criminal Justice System. [Accessed 4/3/21]
[143] Lennox & Khan (2012) Youth justice. [Accessed 4/3/21]
[144] DH (2015) Equal Access, Equal Care: Guidance for Prison Healthcare Staff treating Patients with Learning Disabilities. [Accessed 4/3/21]
[145] HM Inspectorates of Prisons and Probation (2015) A joint inspection of the treatment of offenders with learning disabilities within the criminal justice system. [Accessed 4/3/21]
[146] Ibid.
[147] Hales, H. et al. (2018) Census of young people in secure settings on 14 September 2016: characteristics, needs and pathways of care. [Accessed 4/3/21]
[148] Children's Commissioner (2012) Nobody made the connection. [Accessed 4/3/21]

The QOF data described no current residents with learning disabilities, the data did not allow for a search of historic records.

Special educational need is an issue for education rather than healthcare. Direct involvement from health staff would normally only be towards the disabilities end of the difficulties/disabilities spectrum.

8.1.4 Speech, Language and Communication Difficulties

The Royal College of Speech and Language Therapists produced a dossier of evidence in 2017 that suggests a high prevalence of speech, language and communication disorders amongst young offenders, with figures ranging from 60-90%.[149] This can cause a range of difficulties, including with education, interpersonal interactions, therapeutic interventions and programmes and with compliance with a structured regime. Most institutions are language-based environments and problems with speech and language can make it difficult to understand and follow the regime and can undermine healthy and productive relationships between residents and staff. Assessments are verbal, information tends to be presented in written form, consent to treatment needs to be recorded and lessons, programmes and interventions generally rely on a capacity to use language. In addition, the risks of misunderstanding instructions and other communication can lead to frustration, escalation and conflict.

There are various estimates of the prevalence of speech, language and communication (SLC) difficulties; the YJB state that 78% of sentenced children have speech, language and communication difficulties.[150] One frequently quoted study of looked after children in North Yorkshire found that whilst 62% had communication needs, very few (two) had received specialist support.[151]

Figure 41 – Identified Speech and Language Needs (SystmOne data)

SystmOne record	2019/20	2020/21	Snapshot September 2020
Speech and language disorder	2%	4%	4%

There is no speech and language therapist (SaLT) provision in the YPU. A major focus of a SaLT's work would be with staff (residential and education), helping them to understand young people's communication difficulties and to communicate more effectively with them, both verbally and in written text. Ideally this would involve staff reflecting on what might work best with that young person at any one point and in that respect the SaLT would be able to advise on individual young people.

Recommendation Fourteen: There should be some (probably part-time) SaLT input in the YPU.

[149] Royal College of Speech and Language Therapists (201) Justice Evidence Base Consolidation 2017. [Accessed 21/2/21]
[150] YJB (2021) Assessing the needs of sentenced children in the Youth Justice System 2019/20 (Supplementary tables). [Accessed 21/2/21]
[151] RCSLT (undated) Giving Voice: Supporting looked after children. [Accessed 21/2/21]

8.1.5 Brain Injury

There are two terms commonly used:

- ABI – acquired brain injury is an umbrella term for describing an injury to the brain that happens after birth, after a period of normal development
- TBI – traumatic brain injury is a brain injury acquired by a blow to the head. It is also sometimes referred to as head injury[152]

There are around 900,000 hospital admissions for head injuries each year; of these 10% are categorised as severe. Head injuries are proportionately higher among young adults and those over 75 years. Estimates state that some 60% of offenders have a history of traumatic brain injury.[153] Traumatic brain injury is especially associated with offending patterns in young offenders. This was suggested to be linked to increasingly violent lifestyles[154] and is picked up by the Children's Commissioner:

Rates of TBI amongst the general population have been identified as being between 5% and 24%, with self-report measures of TBI often finding higher prevalence rates. This compares with rates of 65% to 76% amongst populations in youth custody.[155]

Brain injury is covered in the neuro-disability part of the CHAT. One resident in 2019/20 (2%) was reported to have a history of head injury. This is a lower number than expected.

The symptoms associated with brain injury can include coordination problems, sensory problems, epilepsy, learning and memory problems. These are all issues that the establishment can manage.

8.1.6 Foetal Alcohol Syndrome Disorders (FASD)

FASD can be easily confused with other neuro-developmental disorders. Although, as a diagnosis, it helps throw light on causality, it may be less crucial to highlighting appropriate interventions for presenting conditions. There is no specific treatment for FASD, though various psychosocial interventions may help with aspects of the disorder, e.g. those for ADHD or Autism.

FASD is an umbrella term encompassing several different diagnostic categories related to permanent birth defects resulting from prenatal alcohol exposure due to maternal consumption of alcohol during pregnancy. Traits include: characteristic facial features; reduced height, weight, and/or head circumference; and damage to the central nervous system. A few international studies exploring the prevalence of FASD in young offenders suggest a higher rate in comparison to the general population, with rates of 10.9-11.7% compared to 0.1-5%.[156]

It should be noted that a more recent UK based prevalence study described far higher rates of up to 17% of young people screening positive for some symptoms; the study did caution that

[152] Wilkinson, L. (2018) Childhood Acquired Brain Injury: The hidden disability. [Accessed 4/3/21]
[153] Parsonage, M. (2016) Traumatic Brain injury and offending. [Accessed 4/3/21]
[154] Williams, H. et al. Self-reported traumatic brain injury in male young offenders: A risk factor for re-offending, poor mental health and violence? Neuropsychological Rehabilitation: An International Journal Volume 20, Issue 6, 2010.
[155] Children's Commissioner (2012) Nobody made the connection. [Accessed 4/3/21]
[156] Children's Commissioner (2012) Nobody made the connection. [Accessed 4/3/21]

screening does not imply diagnosis.[157] SWCU states that 0.6% of referrals in 2018/19 had FASD.

Health issues may include below average height and weight, problems with a range of internal organs, sensory issues, lack of co-ordination, learning difficulties including hyperactivity, lack of focus and poor concentration. All of these can be managed within the YPU. Currently health staff do not routinely screen for FASD.

Recommendation Fifteen: Neuro-disability screens should also consider Foetal Alcohol Syndrome Disorders.

8.2 Chapter Summary

- Rates of identified ASD are as expected, but it is not clear what services are offered for those with the condition.
- ADHD is recognised, though there is little prescribing of medication that cannot be initiated by the GP. (See Recommendation.)
- LD appears under recognised.
- There is no SaLT provision. (See Recommendation.)
- ABI appears under recognised.
- Health should screen for FASD. (See Recommendation.)

[157] McQuire, C. et al.(2019) Screening prevalence of foetal alcohol spectrum disorders in a region of the United Kingdom: A population-based birth-cohort study. [Accessed 4/3/21]

Chapter Nine – Physical Wellbeing and Health Promotion

9.1 Context

RCPCH Standards

6.5 There is a comprehensive whole system approach to improving health and wellbeing across the secure setting which includes a health improvement strategy.

6.5.1 The strategy should:
Be linked to the secure setting's overall health and wellbeing strategy.

Use evidence-based approaches to encourage behavioural change.

Include strategies and access to services to:
(a) improve mental health and wellbeing
(b) encourage smoking cessation/reduction
(c) encourage healthy eating and good nutrition
(d) promote healthy lifestyles including sexual health and relationships, and sleep hygiene
(e) reduce drug and alcohol issues
(f) increase physical activity and time outside of the child's room
(g) improve oral health
(h) improve coping with being in a secure setting
(i) improve communication skills for building and maintaining relationships

Build on protective factors, focusing on improving resilience, encouraging a commitment to learning, improving self-esteem and creating a sense of purpose.

Be led by a cross organisational group with representation from, but not limited to, health, care, education, facilities, catering, physical education, children, parents/carers and senior management.

Be an integral part of the secure setting's overall health strategy.

Reflect current practice and includes a mechanism for review, evaluation and feedback.

6.5.2 Health promotion materials are up to date and developmentally and age appropriate.

A placement at HMYOI Parc can provide a valuable window for health education and promotion, an opportunity to improve lifestyle choices and help young people learn how to interact with healthcare professionals.

Various aspects of the above are covered elsewhere in the report:

a) mental health and wellbeing are explored in Chapter Seven
b) encouraging smoking cessation/reduction in section 6.4
c) reducing drug and alcohol issues in Chapter Six
d) improving oral health described in section 5.4

HMIP commented on:

a positive and integrated health promotion culture in the children's unit which included monthly health promotion themes, adequate time out of cell, time in the fresh air and access to the gym.[158]

HMIP went on to observe '*good links between healthcare and the gym'*. The necessary response to covid-19 has restricted this for nearly a year.

Nurses described how, every month, there is a different health promotion theme, where possible the gym staff will link this to a qualification.

Interviewees described how staff from a range of disciplines were involved in delivering health promotion.

9.2 Education and Personal, Social and Health Education (PSHE)

After the residential staff, the education staff are the professionals who spend the most time with the young people and therefore have considerable potential to impact on their health and wellbeing. As well as PSHE, there are several other ways education staff enhance and promote health and wellbeing. These range from covering related subjects in structured teaching activities to discussions during class and the day-to-day interaction with the young person.

Nurses described how health education is a multidisciplinary effort , involving education, health and the gym staff.

In addition to the above the equalities team run awareness raising events, a recent example being Chinese New Year.

9.3 Weight

Health and wellbeing in both the short and long term is heavily influenced by the interaction between weight, diet and exercise. Relevant statistics aren't available for young people in the Youth Justice System or for looked after children and it cannot be assumed (as with other conditions) that weight problems will necessarily be greater amongst this population, not least as neglect and/or lifestyle may mean some are underweight.

Nearly a third of young people between 11-15 are thought to be overweight or obese.[159] Public Health Wales data illustrate a strong correlation between obesity and deprivation.[160] Obesity is associated with poor psychological and emotional health, poor sleep and many young people experience bullying linked to their weight. Obese young people are more likely to become obese adults and have a higher risk of morbidity, disability and premature mortality in adulthood. Rising levels of obesity in both adults and young people in the UK is a major public health problem. Poor diet and low levels of physical activity are the primary causal

[158] HMIP (2019) Report on an unannounced inspection of HMYOI Parc 11-22 November 2019. [Accessed 24/2/21]
[159] Baker, C (2019) Obesity Statistics 2019. [Accessed 24/2/21]
[160] PHW (2020) National Survey for Wales 19-20. [Accessed 24/2/21]

factors to excess weight. Low levels of physical activity and increased sedentary behaviours of children and young people exacerbate the problems of poor diet and nutrition and the amount of sugar that young people consume daily is a major contributing factor to gaining weight.

Body mass index (BMI) measuring gives an indication of the levels of obesity, though how applicable it is for young people is debated. We were not confident of previous data, the current snapshot described 11% (n=3) as overweight. Being underweight is also an issue and one young person was previously recorded as being under weight. This compares to 17% of the population at HMYOI Cookham Wood recorded as having a BMI indicating obesity or being overweight.

Education includes classes on diet and cooking.

9.4 Responding to Gender Identity

A growing body of research confirms the significant health inequalities amongst people from gender minority groups, this is summarised in a recent meta-analysis:

Health inequalities were experienced differently between LGBTI groups and spanned both physical and mental health. LGB people reported significantly worse physical health compared to the general population with gay men showing an increased incidence of long-term conditions that restricted their activities of daily living…In relation to mental health, significant inequalities exist with LGBT people being twice to three times more likely to report enduring psychological or emotional problems compared to the general population. Suicide attempts, suicidal ideation, depression and anxiety disorders were 1.5 times higher for LGB people compared to heterosexual peers with alcohol related substance dependence over the previous 12 months being 1.5 times more common in LGB people. Disparities related to mental distress were most pronounced for LGB people under the age of 35, and people over the age of 55. Intersex people also showed a raised incidence of suicide attempts at 19%, with 60% having considered suicide compared to 3% in mainstream populations…Whilst accessing treatment and care, LGBTI people were more likely to report unfavourable experiences. General concerns were around communication with health professionals and overall dissatisfaction with treatment and care provided. Trans people frequently experienced negative interactions with health professionals….[161]

Thinking on gender and gender identity is changing rapidly. HMYOI Parc report having not previously had a young person who identified as other than male, although they recognise that this is inevitable at some point. The adult side of the prison regularly accommodates transgender residents and has developed a comprehensive transgender policy which can be applied in the YPU when needed and will help them be prepared for accommodating young people with a range of non-binary gender identities.

[161] Zeeman, L. et al. (2019) A review of lesbian, gay, bisexual, trans and intersex (LGBTI) health and healthcare inequalities. [Accessed 24/2/21]

9.5 Chapter Summary

- There is a proactive approach to health promotion.
- Promotion of physical health and wellbeing is evidenced in links between healthcare and the gym.
- The YPU has not accommodates a transgender resident. There is a lot of experience from the adult side that is available to assist the YPU when needed.

Chapter Ten – Overview of Findings and Recommendations

10.1 Summary and discussion

A conventional HNA would be largely informed by data but with small numbers, the data can be subjected to variations so is less reliable. Whilst we include and discuss data in the report, it has had to be supported by some examination of pathways and practices cross-referenced to a selection of the RCPCH quality standards and compared to our experience of other relevant settings.

HMYOI Parc is currently operating below capacity, there are generally around 30 residents out of the capacity of 64. The reduction in YCS placements is part of a general trend where there has been a year on year reduction in custodial placements, interviewees said this is currently exacerbated by covid-19.

The onset of covid-19 has inevitably impacted in a range of ways but the staff have been creative in maintaining a regime. Interviewees commented that covid has had less impact on the YPU than in the main prison and young people are still able to spend time out of cell each day. For example, they would normally all eat every meal communally, at present the two cohorts eat communicably in turn, so both eat out of cell once a day.

Writing this report has been unusually challenging. Reasonable expectations of what can be delivered are dictated by the resources that are available. The formula used by YCS, grants around four times the funding per placement to a Secure Children's Home than to a YOI, Secure Training Centres sit between the two. The YCS say that their placements team only place those with high levels of maturity and resilience in YOIs. Yet we observe that the numbers of young people in custody have more than halved since 2001. Interviewees noted that this means only those who commit more serious offences and are the tip of the iceberg are now detained; therefore there will no longer be a pool of mature and resilient offenders in the way there was twenty years ago and only the more complex young people are detained. For example the type of sentences has changed and now a quarter of residents are in the early stages of life sentences.

This report notes that in comparison to other YOIs and STCs who are well on with their journey of implementing SECURE STAIRS, this initiative and the funding attached does not extend to HMYOI Parc.

There are other examples in the report. Countered against this, sharing the site with a large adult population facilitates a range of services which would be far less accessible if the YPU was standalone, (GP, dentist, optician etc).

We feel health resourcing is sufficient to meet physical health needs both now and in likely future scenarios. We heard about a proactive range of wellbeing initiatives. However, in common with the conclusions in at least two previous reports, we found that mental health resources are inadequate and that there are significant gaps in the provision available.

10.2 The Report

This chapter summary outlines the key findings in each area with specific recommendations below.

Chapter One sets the context for secure healthcare and the rationale for the health and social care needs assessment. It also details the methodology used to combine qualitative and quantitative methods to achieve a balanced analysis of need.

Chapter Two outlines the demographic information from HMYOI Parc, with a focus on those demographics that are known to affect the demand for aspects of healthcare. The YPU is for young people placed there by the youth custody service including those sentenced and on secure remand. Over time the population has become more complex and higher tariff as numbers have declined. The YPU accepts young males from 15-18. Whilst the YPU is the only such resource in Wales, most residents originate from England. The average length of stay is increasing and is currently 18 months, this increase presents more opportunities for a range of interventions.

Chapter Three covers the YPU, the non-health staff and their impact on the young people's health and wellbeing. HMYOI Parc is run by G4S. The YPU consists of two units and has been remodelled and adapted to needs over the years. It is purpose built to a high standard and well resourced, with excellent facilities. An intervention team (NEWTs) focuses on offending behaviour. Risk is managed well.

Chapter Four describes the healthcare provision, the bulk of the physical health provision is delivered by an RGN nurse who is based on the unit. The GP provision is appropriate. Primary care is well regarded and operates normal office hours with on-call cover at weekends.

Chapter Five describes the physical health need and responses. The young people are generally very healthy and the prevalence for most conditions is as expected. Young people have often had poor dental care. There is a fully equipped dental suite and needs are identified and met. Take up (and recording) of immunisations and vaccinations could be improved. Sexual health needs are primarily addressed by the nurse.

Chapter Six looks at substance misuse. There is a psychosocial drugs worker. Physical dependence on drugs is rare, most interventions are psychosocial.

A history of smoking is common. Cannabis is used by almost all the young people and cocaine use is common. Contraband is rare, in response security measures have been scaled back.

Chapter Seven explores mental health need and provision. As expected, there are high levels of mental health conditions, largely attributed to childhood trauma. Most interventions are psychosocial rather than medical. The primary care nursing does not include a trauma informed approach. The in-reach team is under resourced and there are many gaps in provision.

Chapter Eight covers neurological disabilities. Many of these are currently under recognised and provision is limited as described above.

Chapter Nine describes wellbeing and health promotion. There appears to be a sold approach to health promotion and a range of interventions designed to promote wellbeing. The YPU has both outside space and good gym facilities for fitness and exercise.

10.3 Findings and Recommendations

There is a substantial overlap between our findings and recommendations and those made in a similar needs assessment which was written in 2019 and also overlap with the 2019 HMIP recommendations. Unless there have been substantial changes which fundamentally impact on needs, it is unusual to repeat writing needs assessments in such a short measure of time. Our observation is that only one interviewee referenced the previous needs assessment report, it was published prior to an HMIP inspection which stated there was no needs assessment. Unless a needs assessment is a live document resulting in an action plan where recommendations are regularly reviewed (for example during review meetings with the Local Health Board) the document will gather dust on a shelf. We urge stakeholders to generate an action plan for these recommendations noting that this will be at least the third independent review in recent years to have reached a similar conclusion and set of recommendations.

The righthand column below notes where our recommendation broadly repeats one in either previous HNA or by HMIP (both 2019).

Finding	Recommendation	Repeat?
The needs of the residents are changing, they are now serving much longer sentences, there is a growing awareness of the importance of trauma informed interventions.	1. Ensure staff can receive professional development training opportunities to be able to adapt to meet the changing needs of residents (e.g. in trauma informed approaches).	
There is a danger of the small YPU being lost in the shadow of the needs presenting in the far larger adult prison.	2. There should be a lead nurse with a special interest in the YPU.	
We did not find evidence of a physical health strategy.	3. Develop and implement a comprehensive physical health strategy.	
There is no access to onsite hearing tests.	4. There should be access to audiology and hearing tests.	HNA
We did not find evidence of a drug misuse strategy.	5. Ensure there is a substance misuse strategy.	
There is a lack of psychology capacity to create formulations to inform the care of the young people.	6. Whether or not SECURE STAIRS is adopted in Wales. There should be additional psychology input to create and implement formulations for each young person.	

Finding	Recommendation	Repeat?
The primary mental health capacity is stretched and in particular does not include trauma informed evidence based interventions.	7. Explore alternative or additional primary mental health interventions to target identified needs, including trauma.	HNA
There is simply far too little specialist mental health input, this includes psychology and access to trauma informed approaches.	8. The specialist mental health resource available for the young people is in need of urgent review.	HMIP
The FACTs Team do not have office space or adequate facilities in which to work with young people.	9. The FACTS Team need improved facilities from which to deliver sessions with the young people.	HNA
The FACTs team operate on an 'in-reach' model. Example of this distance include: separate IT recording systems, they do not participate in strategic meetings.	10. The FACTS Team should be integrated, this will include working from a base in the YPU, not operating on an inreach basis.	HNA
	11. G4S should give the FACTS Team access to SystmOne and the FACTS Team should be responsible for entering their client records on the system. (NB With suitable connections, this can be done remotely.)	HNA HMIP
There are no specific interventions to address sexually harmful behaviour.	12. There should be specific targeted programme addressing harmful sexual behaviour.	HNA
Whilst young people with ADHD are identified there is little prescribing.	13. There needs to be some psychiatrist input into primary care mental health, for example to oversee and initiate prescribing for ADHD.	HNA
There is no SaLT input.	14. There should be some (probably part-time) SaLT input in the YPU.	HNA
There were no recorded cases of FASD which is unlikely to reflect true need.	15. Neuro-disability screens should also consider Foetal Alcohol Syndrome Disorders.	

APPENDIX A – List of Interviewees

Name	Role	Organization
Janet Walsgrove	Director	G4S
Clare Frost	Head of Healthcare	G4S Medical
Dr Rose Marnell	GP	Marnell Medical Services
Kirsten Mallins	Pharmacy Manager	G4S Medical
Nicola Horn	Practice Manager	G4S Medical
Kelvin Hughes	Chair	IMB
Daniel Srivastava	Lead Dentist	Time for Teeth
Sophie Thomas	RGN YPU	G4S
Sylvia Jones	RMN YPU	G4S
Scott Threadgood	Head of Residence	G4S
Anna-Marie Jackson	Senior Operational Manager	G4S
Catherine Nicholas-Jones	Senior Resettlement Manager	G4S
Jason Evans	Head of YPU	G4S
Jacky Brown	SMS Worker	G4S

We joined a Team Meeting attended by 13 members of the FACTS Team

As part of this project, nine residents completed a questionnaire.

APPENDIX B – Policy References

Relevant policy documents include the following but are not limited to:

- Communication Trust (2014); Doing Justice to Speech, Language and Communication Needs: Proceedings of a Round Table on Speech Language and Communication Needs in the Youth Justice Sector
- OHRN (2013) Manual for the Comprehensive Health Assessment Tool (CHAT): Young People in the Secure Estate
- Various NICE Guidelines
- RPS (2017) Professional Standards for optimising medicines for people in secure environments
- MOJ and Welsh Government (2019) Blue Print for Youth Justice in Wales.
- MOJ and Welsh Government (2019) Blue Print for Youth Justice in Wales implementation plan