Public Health
England

Protecting and improving the nation's health

Collaborative approaches to preventing offending and re-offending in children (CAPRICORN)

A resource for local health & justice system leaders to support collaborative working for children and young people with complex needs

Withdrawn June 2024

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Public Health England
Wellington House
133-155 Waterloo Road
London SE1 8UG
Tel: 020 7654 8000
www.gov.uk/phe
Twitter: @PHE_uk
Facebook: www.facebook.com/PublicHealthEngland

Prepared by: Dr. Jo Peden, Sunita Stürup-Toft, Rachel Bath, Dr. Amrita Jesurasa.
Editor: Dr. Éamonn O'Moore
Acknowledgements to: Jane Leaman, Professor Huw Williams, Dr Prathiba Chitsabesan, Sue Sylvester, Dr Tanya Richardson, Superintendant Stan Gilmour TVP, Kirsty Blenkins, Nino Maddelena, Dr Anna Richards, Maria Saltrese and Claire Dhami
Infographics designed by Michael Heasman and Jo Peden

For queries relating to this document, please contact:
adminhealthandjustice@phe.gov.uk

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Glossary

CCGs	Clinical commisssioning groups
CPS	Crown Prosecution Service
CSP	Community safety partnerships
CYPSE	Children and young people's secure estate
CYP	Children and young people
DfE	Department for Education
HCWs	Healthcare workers
HMPPS	HM Prisons and Probation Service
HWB	Health and wellbeing boards
ICS	Integrated care systems
LAC	Looked-after children
L&D	Liaison and diversion services
LTP	NHS Long Term Plan
MoJ	Ministry of Justice
NEET	Not in education, employment or training
NICE	National Institute for Health and Care Excellence
PCC	Police and crime commissioners
PHE	Public Health England
PPO	Prison and Probation Ombudsman
PTSD	Post traumatic stress disorder
SCH	Secure children's home
SEN	Statement of educational need
SOP	Standard operating procedure
STC	Secure training centre
STIs	Sexually transmitted infections
STPs	Sustainability and transformation partnership
TBI	Traumatic brain injury
YCS	Youth Custody Service
YOI	Young offenders' institution
YOT	Youth offending teams

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Foreword

I am delighted to be asked to write a forward to this timely and practical report. Though we have seen significant reductions in the number of first time entrants to the justice system in the last 5 years and there are now fewer than 1,000 children in custody across England and Wales from a high of more than 3500 in 2005, there remain many challenges in preventing children from getting involved in crime and helping those who have convictions to move on from their offending and go on to become successful adults. In recent years, we have seen increases in knife crime and serious youth violence; this report sets out what we understand about the reasons why children offend and what can be done to prevent crime. It provides a useful description of the public health approach that has been so successful in reducing serious violence in Scotland, and in particular knife crime which has, against the trends in England and Wales, seen a sustained fall.

At the Summit on Serious Youth Violence in April 2019, the Prime Minister brought together ministers from across Government and other stakeholders to discuss the increases we have seen in violence in recent years. In her introductory remarks she set the tone that has been carried on through this report that "we can't just arrest our way out this problem". Most of the solutions to youth crime lie outside the justice system and this report sets out the way in which a multi-agency, localised approach can be successful, as the evidence has showed to work in Scotland.

Recent reviews by both David Lammy MP[1] and the Edward Timpson[2] have both alluded to the disproportionate number of children from BAME communities who are excluded from school and end up involved in the criminal justice system. Both reports talk about the need for health, education, local authority children's services, youth offending services, the police and other stakeholders to come together, and plan to support the most vulnerable children and their families in the knowledge that children who perpetrate crimes are often themselves victims. This report represents an important milestone in putting in place effective strategies to prevent crime and keep children safe.

Above all it sets out the need for leadership at every level, from central government, the police, local authorities, local health boards and the third sector in order to give the space and scope to develop solutions that are best suited to the local context. Rather

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[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/643001/lammy-review-final-report.pdf

[2] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/799979/Timpson_review_of_school_exclusion.pdf

than be prescriptive about processes, recognising that what works in one place, may not work in another, what is set out here are the principles of how an effective, public health approach to children involved with crime can work. It shows the way that with effective co-ordination, collaboration and determination we can protect communities, reduce the numbers of victims of crime, and, help children to go on to lead constructive lives.

Yours sincerely,

Charlie Taylor
Chair
Youth Justice Board for England and Wales

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Executive summary

Children and young people in contact with the justice system have been shown to have poorer health outcomes than children in the general population. Almost all of the causes of childhood offending lie outside of the direct influence of the youth justice system. Therefore, it is crucial that health, education, social care, law enforcement and other services form a collaborative approach to preventing offending and reoffending behaviour in children by addressing health and social determinants of offending and reoffending behaviour. Importantly, if there is to be a direct impact on practice and implementation then a local, place-based approach is essential for success.

The aim of this report is to provide a resource to help to join up action between organisations at a local level, to prevent offending and re-offending and to provide a framework for action.

This resource has been developed with a range of stakeholders across academia, national and local government, and the third sector. A steering group committee was set up with representation from policy, commissioning and provider organisations and qualitative interviews were undertaken with a range of key stakeholders.

This resource is intended to stimulate local action through engagement with a wide range of local health and justice system leaders including:

- police and crime commissioners
- senior police officers and police services
- local authorities: chief executives, director of public health, director of children's services, strategic lead for education, strategic lead for housing, health and wellbeing boards
- existing partnerships and collaborative bodies including community safety partnerships (CSPs) and youth offending teams (YOTs)
- local safeguarding children boards
- local academy head teachers and education networks
- other, non-mandated local multiagency partnerships, such as community multi-agency risk assessment conference (MARAC)
- clinical commissioning groups
- NHS England health and justice commissioners
- PHE centres
- third sector services, including service user and family representatives
- children and young people's secure estate
- youth offending institute governors
- secure training centre directors
- secure children's home managers

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- Jobcentre Plus
- Department for Work and Pensions employment support providers.

This resource highlights the health needs of those children in contact with the criminal justice system, but more importantly emphasises the overlap between the underlying contributing factors to offending and to poor health outcomes.

Consideration of risk and protective factors are suggested, using current evidence and case studies. We have developed the CAPRICORN framework for strategic action on primary (or upstream) factors and secondary (or downstream) factors to prevent offending or reoffending behaviour, including serious violence. Action is required at individual and family level (including supporting responsive relationships, strengthening core life skills, peer mentoring & family based interventions) as well as at community level (such as providing trauma informed services, supporting access to mental health and/or substance misuse services; supporting children stay in education including strengthening accountability around use of school exclusions, and addressing employment and housing needs).

The CAPRICORN framework will support health and justice system leaders in bringing together the best range of local actors to co-develop a place-based, needs-led strategy informed by the evidence and exemplars of good practice from around England. Action may occur through distributed leadership, taking into account assets in the community and a place-based approach.

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1. Introduction

There are many reasons for children to find themselves in contact with the justice system. However, offending should not mean that children forfeit their right to childhood and the opportunities to become law-abiding, productive members of society. The numbers of young people entering the youth custody have declined over time, however the number in contact with police and probation services has increased. Those in youth custody are more likely to have complex needs. The rates of reoffending behaviour among children and young people are concerning.

The Early Intervention Foundation (EIF) has estimated that the cost of late intervention in improving outcomes for children generally is £16.6 billion pounds a year (1). Considerable resources are being spent tackling issues that could have been prevented. However, little is understood on the costs associated with youth offending on future adult criminality, perpetuating the cycle of intergenerational crime and the wider impact on communities as safe, thriving localities to live and work in.

Almost all of the causes of childhood offending lie outside of the direct influence of the youth justice system. Therefore, it is crucial that health, education, social care and other services form a collaborative approach alongside law enforcement agencies to preventing offending and reoffending behaviour in children.

From a public health perspective preventing children offending and re-offending is a key consideration to avoid escalating levels of harm to both children and wider society. It is an essential part of addressing health inequalities and 'leaving no one behind', as articulated in the UN Sustainable Development Goals. Children in contact with the justice system have been shown to have poorer health outcomes, poor educational attainment. There is strong evidence that addressing the social determinants of health such as housing, education, and access to healthcare will result in better health outcomes, further enhanced by taking a life course approach by considering interventions from birth to old age (2). From conception onwards, there are multiple relevant points in an individual's life that can present an opportunity for appropriate interventions.

This resource takes a public health approach to prevent offending behaviour in children and young people. It describes the importance of understanding health and social care needs, identification of risk and protective factors to support individual and population level interventions and supports the development of a whole system approach to tackle complex problems.

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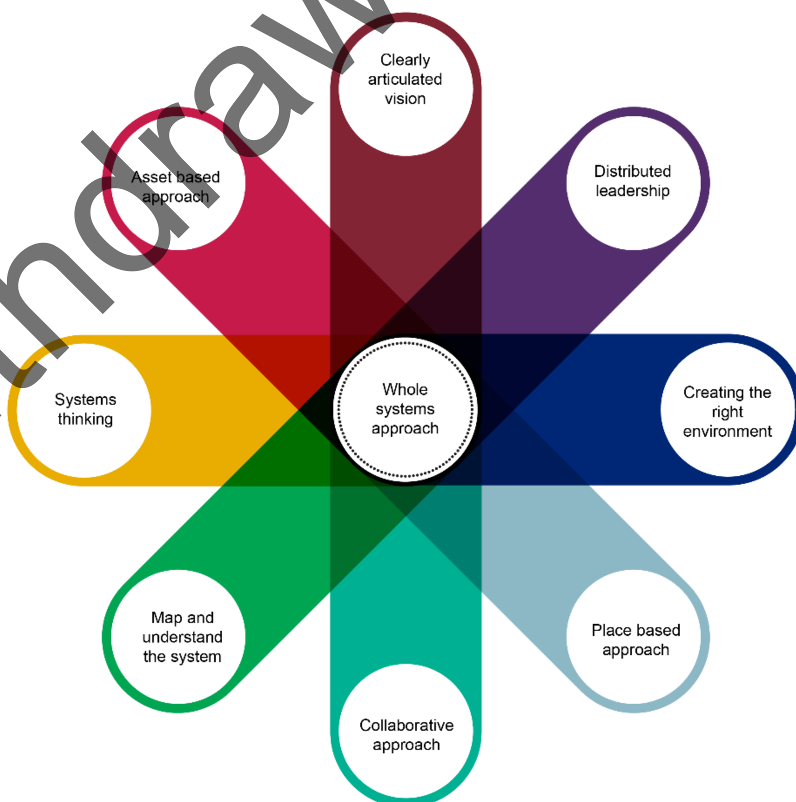
2. Collaborative approaches: a whole system approach

There is no single solution to preventing youth offending, reoffending and violence in children and young people. It is clear that in order to tackle this issue a broad range of actions are needed involving stakeholders from across the system. Preventing children coming into contact with the youth justice system is a complex and dynamic problem, where traditional approaches that focus on single interventions are unlikely to work. Academic research from other areas of public health, such as preventing obesity and interviews with system leaders has attempted to define what a whole system approach entails (3). This section of this resource draws on these ideas and helps to illustrate the key elements and steps needed for a whole system approach.

2.1 What is a whole system approach?

A systems approach to preventing offending, violence and reoffending moves away from silo working on isolated short-term interventions to working with stakeholders across the whole system to identify, align and review a range of actions to tackle offending in the short, medium and long term.

Figure 1: A whole system approach



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2.2 Clearly articulated vision

It is important that there is leadership across the system and that there is a defined vision for what is trying to be achieved, which is well articulated and communicated to all stakeholders. In a local area having the Police and Crime Commissioner, the Chief Executive of the Local Authority and the Chief Superintendent of Police, Acute Trust Chief Executive and support of elected members is vital to creating the right mind set and to for the success of this approach. It sends a clear signal that preventing offending and reoffending is a priority not just for public health but for the whole council and its wider stakeholders, thereby facilitating cooperation across departments and with local communities and partners

2.3 Distributed leadership

Successful approaches often adopt a distributed leadership approach at all levels of a range of organisations; working towards a common vision. Distributed leadership means that leadership responsibly is not necessarily linked to formal organisational roles but that anyone can act and influence people on this agenda at all levels of the organisation.

2.4 Creating the right environment

It is important to spend time creating the right environment for change by articulating why this group of young people are vulnerable and that by improving their outcomes will have an impact on the whole system.

2.5 Place based approach

Health inequality has long been known as a 'wicked issue' i.e. one with complex causes which require complex solutions, including a whole systems approach, with strong systems leadership. A placed based approach provides an opportunity within which to do this. The definition of "place" is best defined by local leaders, taking into consideration populations of interest, geographies and boundaries of services and partner agencies.

Experiences from the Health Inequalities National Support Team identified the need for an 'organising hub' to provide a strategic focused approach to tackling these complex issues and achieve population level outcomes. Leadership and systemic engagement are needed to drive a strategic approach to ensure system, scale and sustainability.

The most promising examples have tended to feature the leadership of a partnership by one or more key partners. Whether this leadership sits within the health system, the youth justice system or elsewhere may be immaterial, but leadership – and ownership –

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appears to be a consistent factor for successful programmes with positive outcomes (4). The leadership challenge is to both understand the nature of the policy and organisational contexts within which addressing health inequalities and reducing offending and reoffending are being promoted, and to encourage and shape new ways of tackling the problems.

2.6 Collaborative approach

A collaborative approach brings stakeholders together from a broad range of functions to jointly develop and take ownership of the programme; sharing strategic plans and working towards joint outcomes. This may entail developing creative ways of joint working to overcome barriers. Research from developing whole system approaches to obesity highlight the importance of 'disrupting the system' which involves partners collectively identifying the most likely and productive areas of activity in the local system where a council and its partners can take action and building and aligning actions around key points. Stakeholders should meet regularly to discuss their progress towards the agreed goals and adjust activities where necessary.

2.7 Map and understand the system

The starting point to a whole systems approach is to have a thorough understanding of the system, to map the stakeholders and to identify potential leaders at all levels within the system. It is essential to understand local causes and linkages.

The first step is to identify key stakeholders from across the system. Developing programmes across health, justice and related services involve working across complex commissioning and funding lines. Key stakeholders who can contribute to a whole system approach might include:

- police and crime commissioners
- chief police officers and the police service: all police officers, and chief officers in particular, have the ability to provide valuable intelligence and data and also to drive change across their service
- local authorities including chief executive, director of public health, director of children's services, strategic lead for education, strategic lead for housing, health and wellbeing boards
- existing partnerships and collaborative bodies including community safety partnerships (CSPs) and youth offending teams (YOTs)
- local safeguarding children boards
- local academy head teachers and education networks
- other non-mandated local multiagency partnerships, such as community multi-agency risk assessment conference (MARAC) (which takes the multi-agency risk

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assessment conference pioneered in responding to domestic violence and extends it to vulnerable people) and MAPPA (multi-agency public protection arrangements).
- cinical commissioning groups, which have a statutory duty under the Crime and Disorder Act 1998 to work in partnership to reduce crime and disorder, substance misuse and re-offending locally, as well as duty to reduce health inequalities, including those experienced by offenders.
- NHS England health and justice commissioners who commission healthcare provision including liaison and diversion, and healthcare for those in secure and detained settings
- PHE centre health and justice public health specialists who provide leadership at PHE centre level to the Health and Justice agenda, supported by a national health and justice team in PHE
- third sector services, including user and family representatives. Many third sector (primarily community groups, charities and social enterprises) may already be connected through some of the partnerships outlined above. Where they are not, consideration should be given to if and how they should be engaged; third sector services and community groups often engage people who may be difficult for public services to retain contact with
- children's secure estate
- youth offending institute governors
- secure training centre directors
- secure children's home managers
- Jobcentre Plus
- Department for Work and Pensions (DWP) employment support providers (as well as delivering services itself through the Jobcentre Plus network, DWP commissions providers to provide support to people seeking work)

2.8 Use data from across the system to build a local picture

Health data has an essential role to play in preventing offending. When combined with or used alongside youth justice data it can:

- measure the levels and nature of violence in a local area
- identify the population groups and geographical areas most affected
- inform the development, targeting and evaluation of prevention activity

The establishment of successful, regular data sharing processes for anonymised health data between local health services and partners involved in addressing offending is crucial for supporting local prevention activity. The benefits of collecting and sharing anonymised health data for violence prevention have been demonstrated in Cardiff and London (5, 6).

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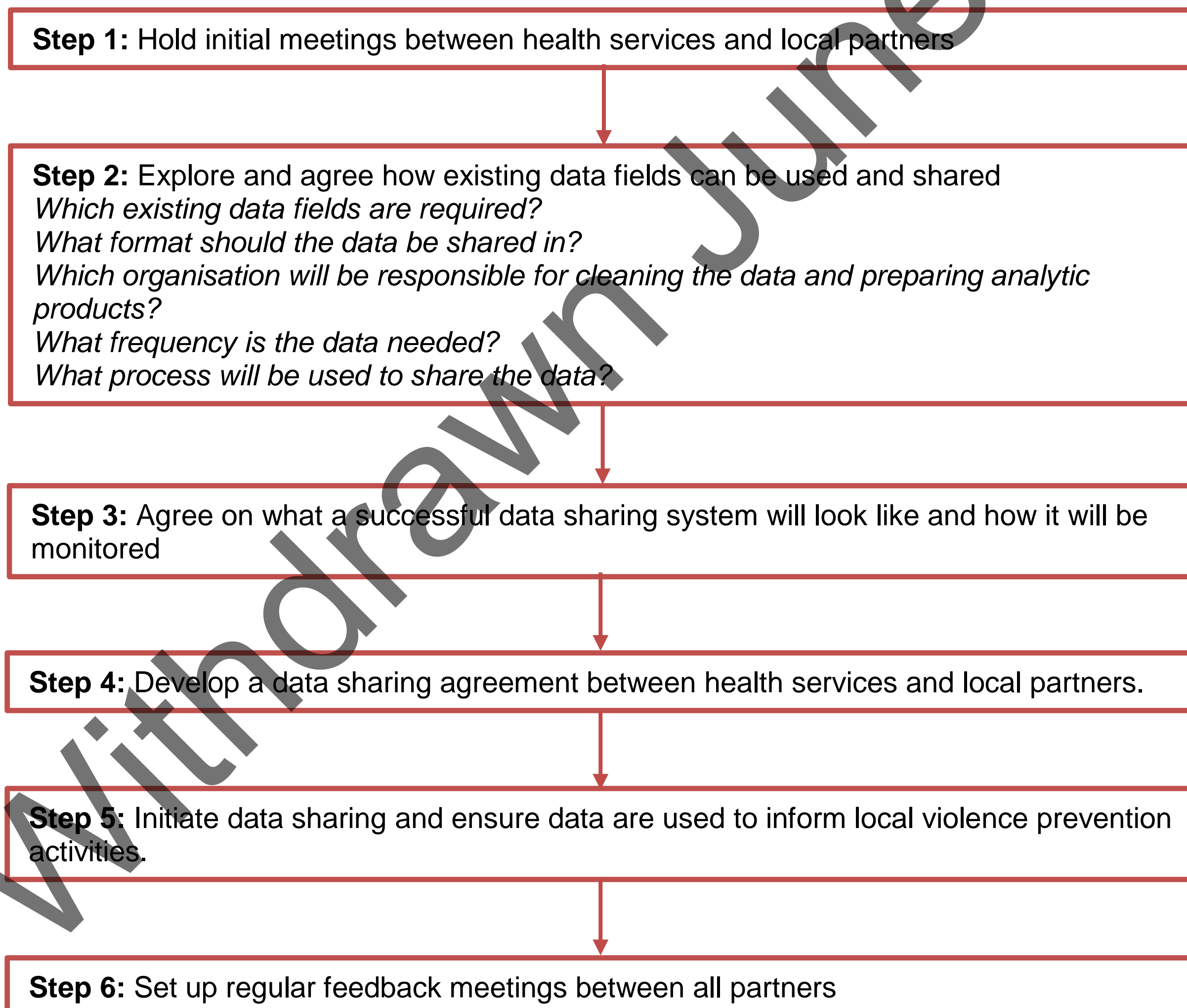
Fully anonymised health data are not regarded as personal data and therefore collection, use and storage of anonymised health data does not come under General Data Protection Regulation (7). Nonetheless the rules of the GDPR should be taken into consideration for all data that is collected, used and stored (8).

Sources of health data:

- local accident and emergency department (A&E) attendance data
- Hospital Episode Statistics (HES) experimental A&E data
- HES hospital admissions data
- ambulance service data
- Public Health Outcomes Framework indicators

Figure 2: Setting up data sharing systems (8)



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Research into how A&E data sharing processes are run in some local authority areas has identified a number of factors helpful in achieving success in this field (Giacomantonio et al. 2014; Wood et al. 2014) including:

- a dedicated post or staff member within the A&E to champion health data sharing, co-ordinate data collection and keep health data sharing on the agenda
- building strong relationships between the A&E and local partners
- the existence of a data sharing partner/agency, which can facilitate multi-agency communication and increase capacity for health data to be accessed by local partners easily and in a timely manner
- regular feedback to A&E staff about how local partners are using the data and the impact that data sharing has on the community
- fostering positive attitudes towards the collection and use of A&E data, both within the A&E and among local partners

2.9 Systems thinking

Systems thinking is needed to ensure that all areas are working towards the same goal and that a range of actions are incorporated into the plan. Research from Leeds Beckett University highlights the need to create a map of moving and interactive drivers and the need to recognise that tackling a single driver in isolation will not work. There is a need to examine the contributions of individual organisations but also how the whole system works together and can be 'more than the sum of its parts'.

One feature of system working is being able to have the flexibility to change and adapt plans when needed as the approach evolves. Actions should be aligned, monitored, reviewed and adjusted on a regular basis to: assess their effectiveness against agreed goals; incorporate any new learning; address changes in the needs of the local population or resource-base.

A flexible approach is needed with a willingness to try new methods and to be prepared to alter plans to circumvent obstacles or issues. A cross-sector range of actions – this involves identifying areas of activity where a local area can take action and creating a range of short, medium and long-term actions around these areas. Recognising the current financial and resource constraints, it is a good idea to local to focus on those areas of activity where they are likely to have the greatest impact.

The framework in Chapter 5 of this document provides a whole system approach to reducing youth offending, violence and reoffending. This can be the starting point for developing a joint strategy (identify risk and protective factors) which focuses on addressing the root causes and providing interventions for individuals and families and the wider community which prioritises upstream prevention and also aims to mitigate

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and work towards improving life opportunities for children already in contact with the youth justice system.

2.10 An asset-based approach

An asset-based approach means using your community to help you to reduce offending and reoffending. It entails involving children in the co-design of services and asking them what are the gaps in provision. It is about utilising all the assets in your community; skills; businesses, the voluntary sector to help to work together to achieving better outcomes for vulnerable children. Community life, social connections and having a voice in local decisions are all factors that have a vital contribution to make to health and wellbeing. These community determinants build control and resilience and can help buffer against disease and influence health-related behaviour.

Involving and empowering local communities, and particularly disadvantaged groups, is central to local and national strategies in England for both promoting health and wellbeing and reducing health inequalities. Participatory approaches can directly address marginalisation and powerlessness that underpin inequities and can therefore be more effective than professional-led services in reducing inequalities.

As well as having health needs, all communities have health assets that can contribute to the positive health and wellbeing of its members, including:

- the skills, knowledge, social competence and commitment of individual community members
- friendships, inter-generational solidarity, community cohesion and neighbourliness
- local groups and community and voluntary associations, ranging from formal organisations to informal, mutual aid networks such as babysitting circles
- physical, environmental and economic resources
- assets brought by external agencies including the public, private and third sector

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Figure 3: What are community health assets? (9)

Community-centered approaches are not just community-based, but about mobilising assets within communities, promoting equity, and increasing people's control over their health and lives.

It involves:

- mapping out community assets and considering how you can build on these
- using non-clinical methods
- using participatory approaches, such as community members actively involved in design, delivery and evaluation
- reducing barriers to engagement
- utilising and building on the local community assets
- collaborating with those most at risk of poor health
- changing the conditions that drive poor health
- addressing community-level factors such as social networks, social capital and empowerment
- increasing people's control over their health

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3. Children and young people in contact with the youth justice system

Children and young people (CYP) in contact with the youth justice system those in custodial settings, those in contact with police services, and those under probation service supervision.[3]

In 2017-18, there were just over 65,800 arrests of children aged 10-17 from the Youth Justice Statistics 2017/18 based on data provided by the Home Office and in the same time period, 26,700 children aged 10-17 received either a caution or conviction (10, 11). In the year ending March 2018, there was an average of over 894 10-17 year olds or 986 including 18 year olds in the secure estate for children and young people(11).

However, rates of first time entrants of children entering the youth justice system have decreased significantly in the last decade, due to efforts to reduce the number of children in custody. In England and Wales (April 2017 to March 2018), there were around 14,400 first time entrants to the youth justice system, a fall of 86% since the year ending March 2008. For those entering the cohort between April 2016 and March 2017, 40.9% of children and young people reoffended within 12 months. Between April 2017 to March 2018 40.9% of children and young people reoffended. The reoffending rate decreased by 1.3 percentage points in the last year, though the reoffending rate is higher than 10 years ago (when it was 38.1%)(11).

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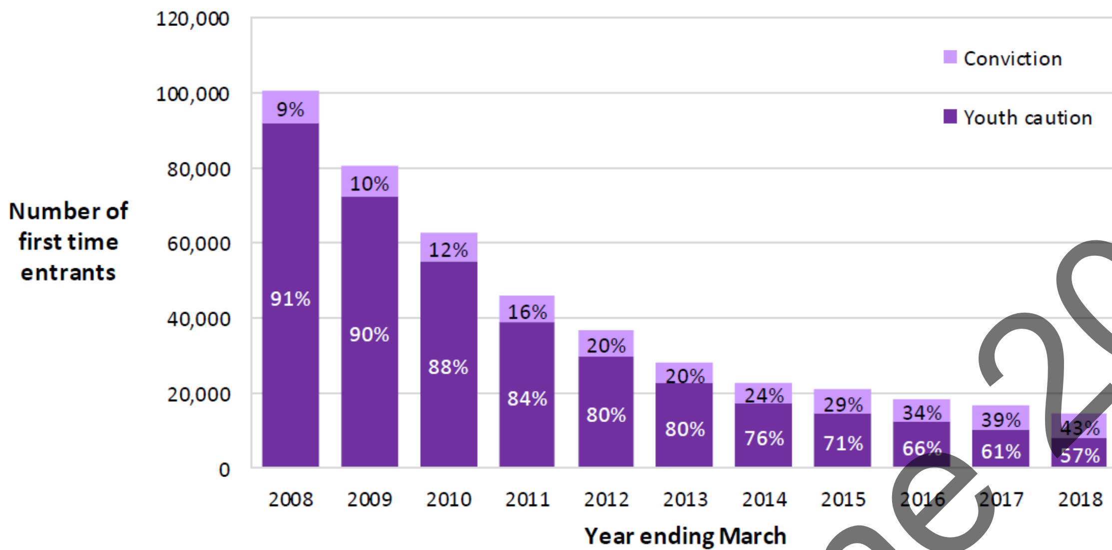
[3] Chidlren are referred to as under 18.

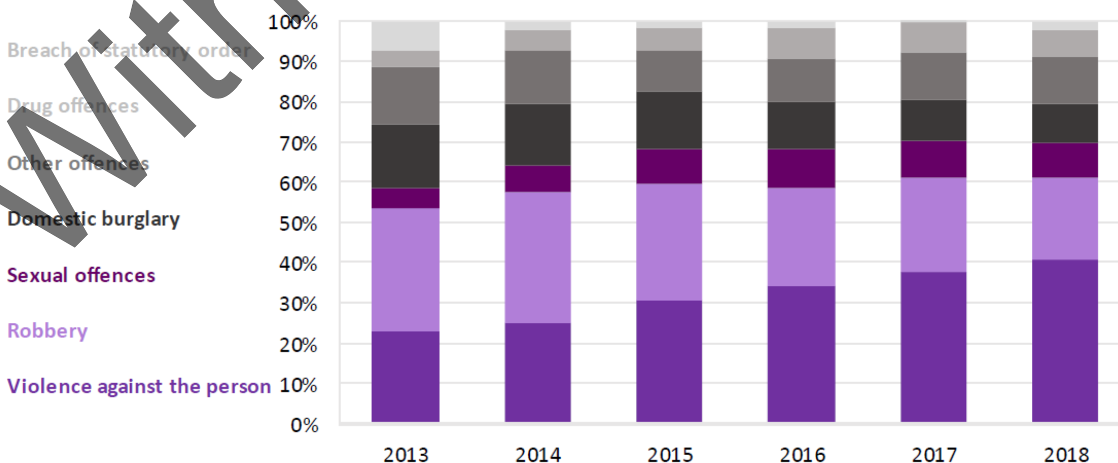
Figure 4: First time entrants to the youth justice system, England and Wales, years ending March 2008 to 2018 (11)



Custody should be a last resort in dealing with offending behaviour in young people. Data shows that 70% of children held in custody committed a violent offence(11).

The average length of stay that children spend in custody has increased and currently the average length of custodial sentence is 16.7 months (11). Across England, fewer custodial places at Young Offender Institutions are being commissioned, due to a decrease in demand, resulting in a smaller custodial population of a "much more concentrated mix of boys with both great vulnerability and challenging, sometimes very violent, behaviour who are a danger to themselves, other boys and staff" (12). Compared to other regions in England, London has the highest rates of children aged 10-17 in custody (4).

Figure 5: Proportion of children in custody by offence group, youth secure estate in England and Wales, years ending March 2013 to 2018 (11)



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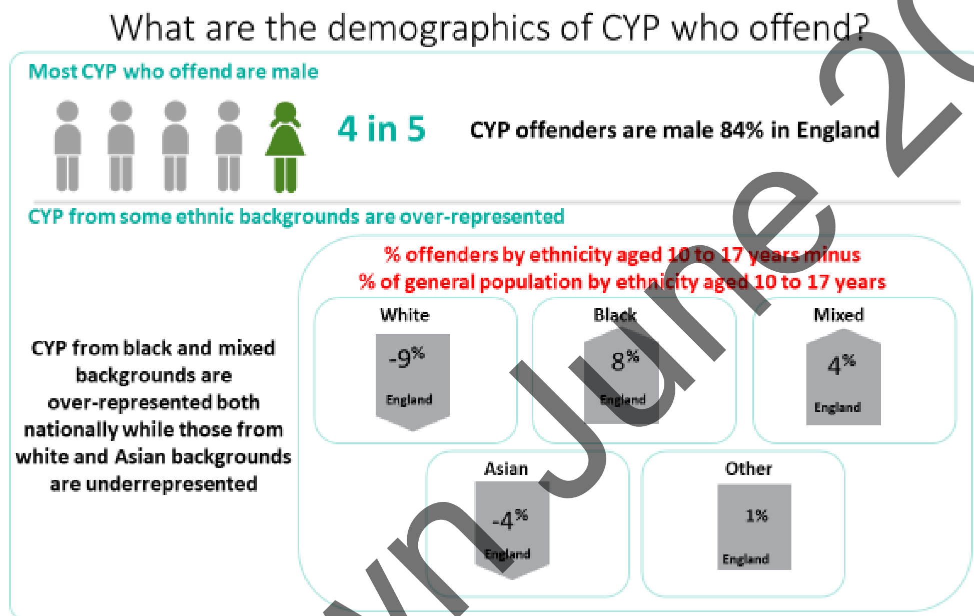
Several striking statistics highlight the overrepresentation of certain groups within the youth justice system. The vast majority of children who offend in England are male, with 84% of children cautioned or sentenced being male in 2017-18 (13). Children from black and mixed ethnicity are over-represented in the youth justice system while those from White and Asian backgrounds are under-represented (13). The Lammy review has highlighted these differences.[4]

Figure 6: Demographics of children and young people in the criminal justice system (13)



1. Ministry of Justice and Youth Justice Board, Youth Justice Annual Statistics: 2017 to 2018: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/774866/youth_justice_statistics_bulletin_2017_2018.pdf

Over half the children held in young offender institutions are, or have been previously, looked after children (LAC). In 2017-18, 4% of looked after children were convicted or were subject to youth cautions or youth conditional cautions. The figure was 5% in the previous two years.

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[4] https://www.gov.uk/government/organisations/lammy-review

4. Understanding the health and social care needs of children in contact with justice services

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Children and young people (CYP) in contact with the criminal justice system often experience adverse health, educational, environmental and socioeconomic factors that increase the risk of offending and reoffending behaviour (14). The health and wellbeing needs of children and young people tend to be particularly severe by the time they are at risk of receiving a community sentence, and even more so when they receive a custodial sentence(14). This presents particular challenges to those addressing their health and social care needs.

The Healthy Children, Safer Communities Strategy states that rates of smoking, drinking and use of illegal drugs before entering custody were substantially higher than among young people who do not offend (14).

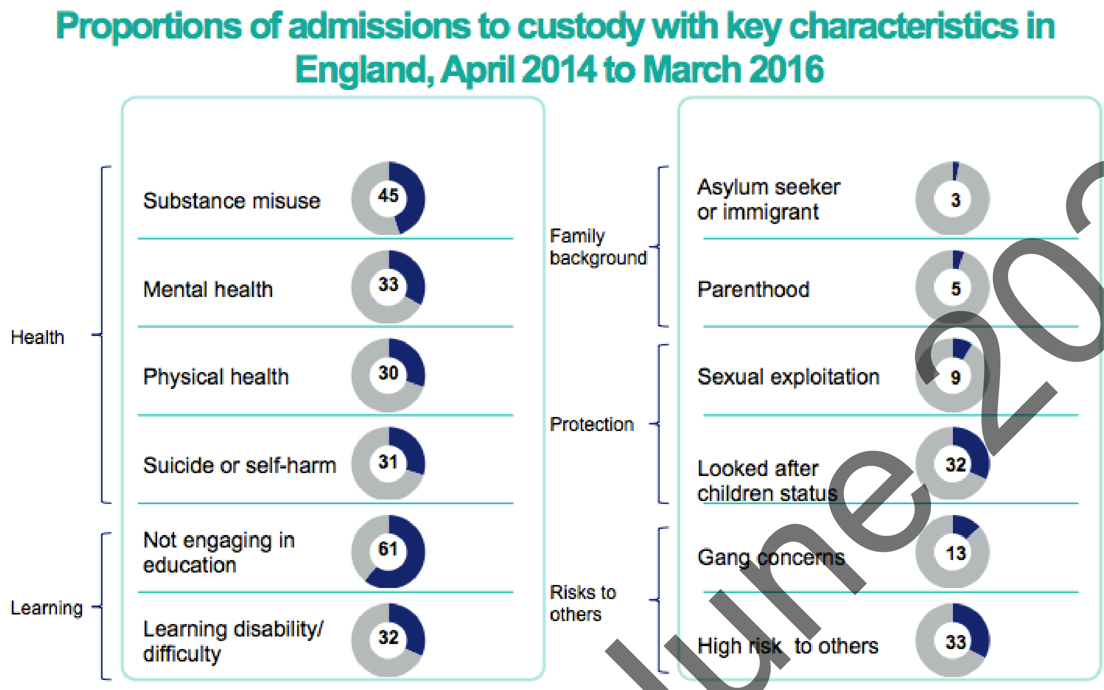
Half of 15-17 year olds entering YOIs have the literacy or numeracy levels expected of a 7-11 year old. Around 40% of children surveyed in under-18 YOIs reported that they had not been to school since they were aged 14, and nearly 9 out of 10 said they had been excluded from school at some point (15). Children with learning difficulties and neuro-disability are over represented in the youth justice system which can make it more difficult to cope with justice processes, such as police interviews, court proceedings or compliance with the requirements of a community sentence (16, 17). For those placed in custody, there is the added anxiety of being away from home, maintaining contact when placed at a distance, staying safe in unfamiliar surroundings and worrying about the welfare of family left behind. Once they have completed their sentence, CYP face the challenges of settling back into the community.

However, many children and young people's experience of a secure setting brings them into sustained and meaningful contact with health services for the first time. This can provide opportunities for the routine identification and subsequent treatment of health concerns and for those CYP with a disability, the appropriate provision of enhanced support and tailored responses.

4.1 Health-related drivers of offending behaviour for CYP

A host of risk factors contribute to a young person's likelihood to show offending behaviour, which can be rooted in populations with multiple and complex health and social care needs (Figure 7) .

Figure 7: Key characteristics among CYP taken into custody (15)



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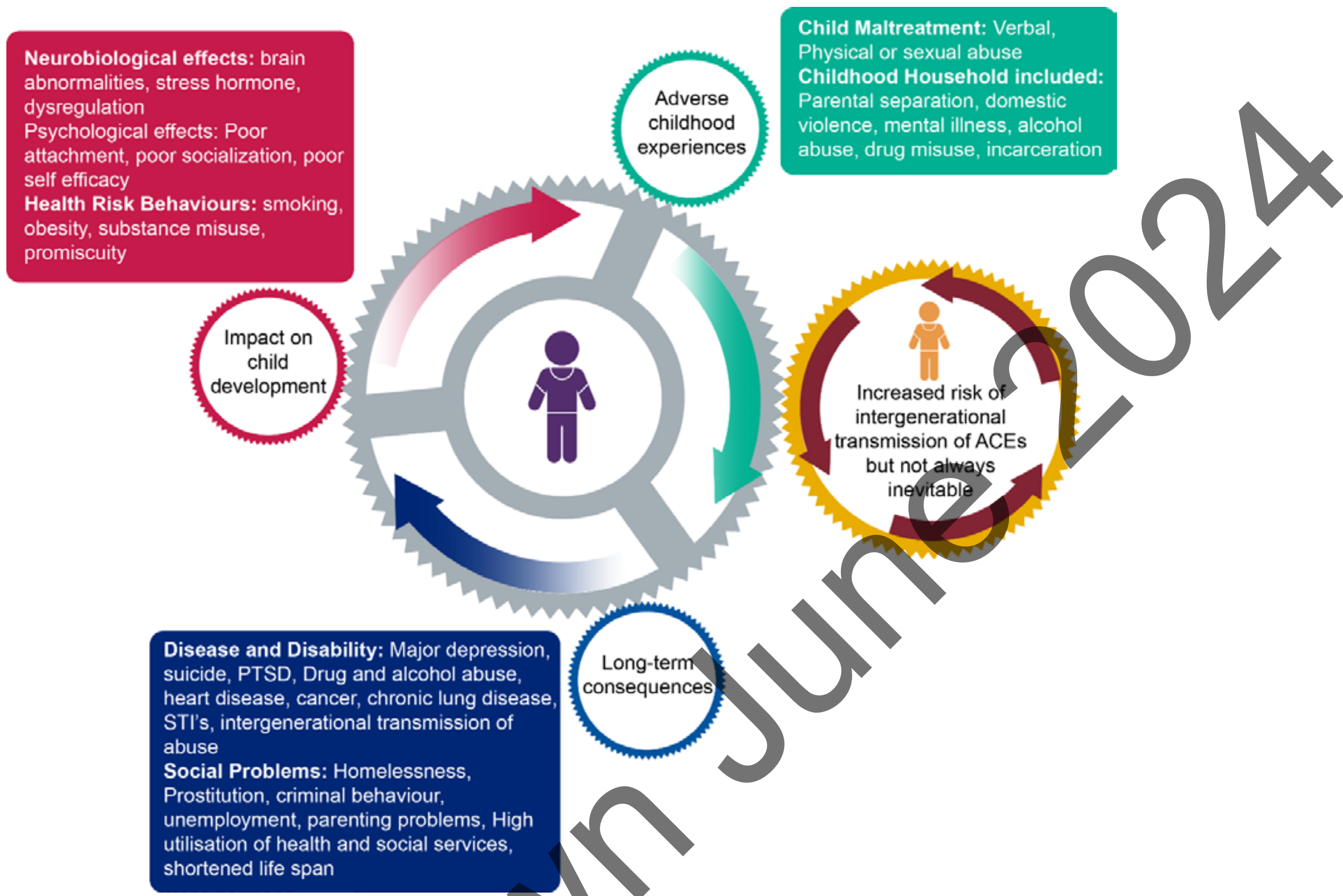
4.2 Adverse childhood experiences

A range of risk factors contribute to a young person's likelihood to show offending behaviour, including adverse childhood experiences (ACEs) and other vulnerabilities. The term ACEs is used to describe a wide range of stressful or traumatic experiences that children will be exposed to while growing up. ACEs range from experiences that directly harm a child (such as suffering physical, verbal or sexual abuse, and physical or emotional neglect) to those that affect the environment in which the child grows up (including parental separation, domestic violence, mental illness, alcohol abuse, drug use or incarceration and can include loss and bereavement). Not all children who experience adversity become victims or perpetrators of criminal offences, but statistically those experiencing multiple adversities are more likely to than people without these vulnerabilities.

Exposure to ACEs can impact in 3 ways on child development:

- a neurobiological effect altering brain development
- a psychological effect
- increase the likelihood of adopting health harming behaviours

Figure 8: Neurobiological, psychological and increased health harming behaviours are drivers of ACEs in children and consequences of ACEs in adults



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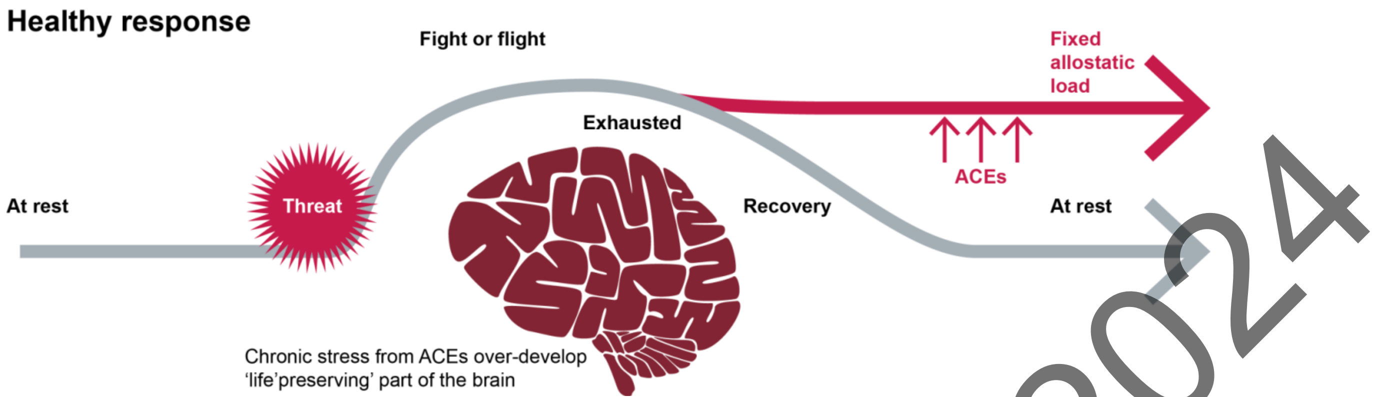
Learning how to cope with adversity is an important part of healthy child development. When there is a threat, the body responds by activating a variety of physiological responses, including increases in heart rate, blood pressure, and stress hormones such as cortisol producing what is called collectively as allostatic load. When a young child is protected by supportive relationships with adults and learns to cope with everyday challenges their stress response system returns to baseline after this increased allostatic load. Scientists call this positive stress. Tolerable stress occurs when more serious difficulties, such as the loss of a loved one, a natural disaster, or a frightening injury, are buffered by caring adults who help the child adapt, which mitigates the potentially damaging effects of abnormal levels of stress hormones. When strong, frequent, or prolonged adverse experiences such as extreme poverty or repeated abuse are experienced without adult support, stress becomes toxic, as excessive cortisol disrupts developing brain circuits and the allostatic load remains fixed at a higher level than baseline (19).

Figure 9: Biological impact of ACE-related stressors and trauma related response



The importance of preventing early adversity is clear, given the numerous studies demonstrating adverse associations with subsequent health and life opportunities that reverberate across generations (20, 21).

A key study from Wales reported that people with more than 4 adverse childhood experiences were 14 times more likely to be a victim of violence, 15 times more likely to be a perpetrator of violence in the last 12 months and 20 times more likely to have been incarcerated in their lives (22). Studies of ACEs in around 30 countries using similar methodologies and, although prevalence varies, most show around 10% prevalence of 4 or more ACEs which is the 'tipping point' for poorer health and social outcomes. Bellis et al concluded that although ACEs are more likely to occur in poorer communities, independent of deprivation ACE counts correlate with worse health, criminal justice, employment and educational outcomes over the life course. Evidence also highlights that it is common for children of incarcerated parents to also be exposed to other ACEs such as household member substance problems, household member mental illness, or parental divorce or separation and therefore this group of children are particularly vulnerable (23).

It is important to consider ACEs within the wider context of vulnerabilities and direct expertise and system leadership to focus on prevention. Children with multiple complex needs require a broad based coordinated approach across agencies to address those needs. ACEs are an important lens through which to view vulnerabilities, however it should not be used in isolation. It is important to consider ACEs alongside other evidence that helps us understand causes of poor health outcomes and inequalities.

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4.3 Wider socio-economic determinants of health and offending behaviour

Education

Poor educational attainment is a common factor in children who commit offences. Half of 15-17 year olds entering YOIs have the literacy or numeracy levels expected of a 7-11 year old (24). Almost 9 out of 10 boys aged 15-17 years old in custody had been excluded from school at some point (25). There is evidence to suggest that children who have a special educational need (SEN) may be over represented in custodial settings. In 2011-12 18% of sentenced children in custody had a SEN statement of, compared to 3 % of the general population (26).There was also a disproportionately high prevalence of learning disability among children in custodial institutions. Generalised learning disability is significantly more common in young people in custody, with research studies suggesting a prevalence of 23-32%, compared to 2-4% of the general population (17). Studies of speech and language skills in young offenders in the UK have demonstrated that many have impairment in both receptive and expressive language skills, with incidence rates reported to be as high as 60-90% (17). Rates of Traumatic Brain Injury (TBI) among 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% among populations in youth custody (17).

Homelessness

There is a recognised link between offending and homelessness. Many studies show that an involvement with the CJS can lead to difficulties in finding suitable accommodation for children and lack of suitable accommodation on leaving custody can contribute to the likelihood of the child going on to reoffend (27).

Poverty

One of the most important determinants of health and criminal behaviour is poverty and socioeconomic status. A number of studies have also found that poverty and low socio-economic status, during childhood is a risk factor for subsequent criminal and substance misuse behaviour. There is evidence that children who live in poverty can experience higher levels of stress, and negative life events, have limited educational opportunities, which can profoundly affect their social, cognitive, and neurological development (2, 28).

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5. Consideration of risk and protective factors

A public health approach to reducing offending, reoffending and youth violence in CYP focuses on identifying both risk and protective factors. A risk factor is anything that increases the probability that a person will suffer harm. A protective factor is something that decreases the potential harmful effect of a risk factor (29).

Risk factors can increase the likelihood that a person may offend, however they maybe a contributing factor and not necessarily a direct cause. Risk factors are not determinative and not everyone who is identified as at risk becomes a perpetrator of violence or offending (30).

Risk and protective factors can be found in every area of a child or adolescent's life, exerting different effects at different stages of development. The public health approach seeks to identify risk and protective factors, starting before birth and identifying points along the child's development were a child maybe more vulnerable and there maybe opportunities to intervene to reduce risk factors and enhance protective factors (29).

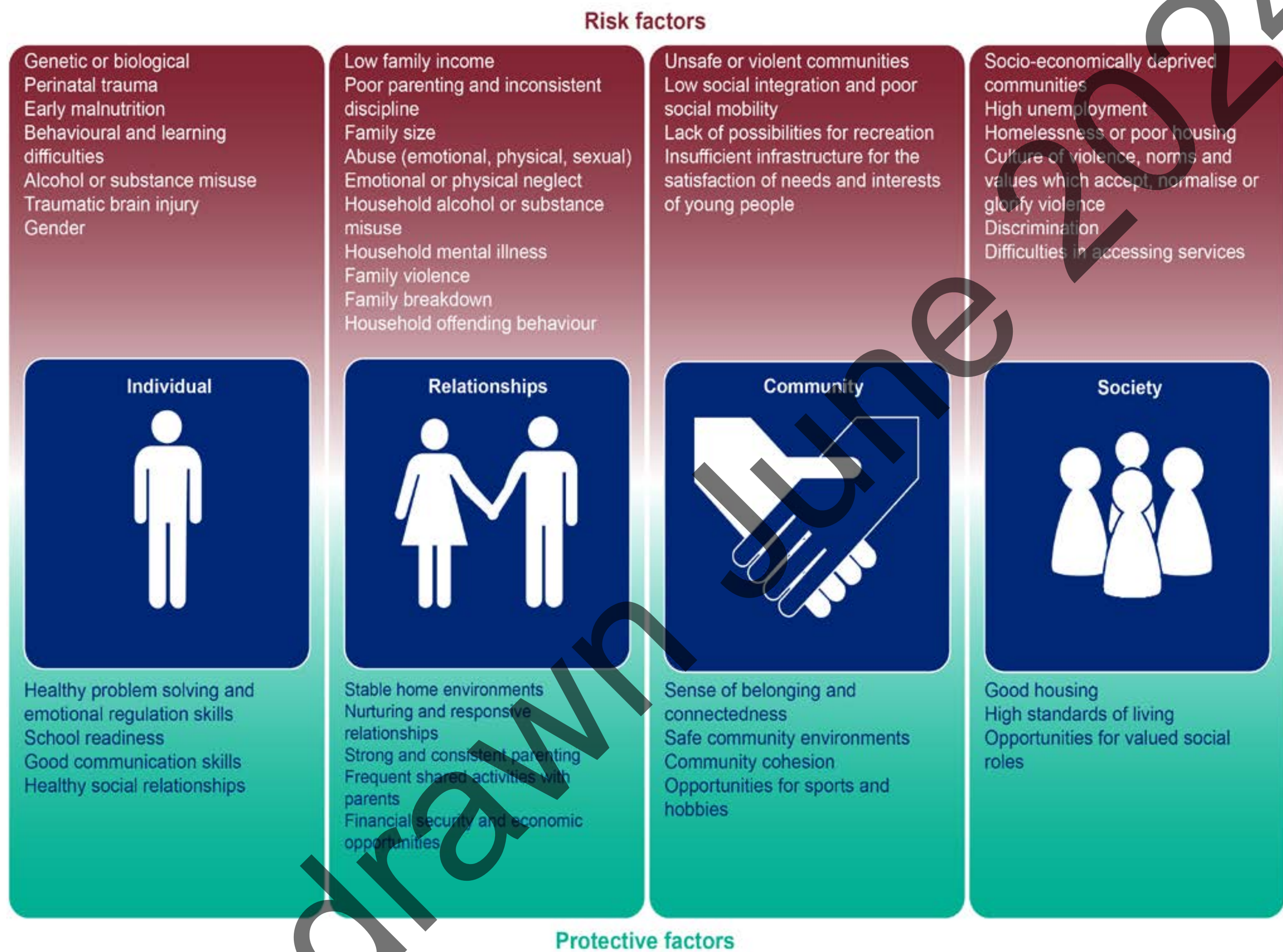
5.1 Risk factors

Risk factors maybe found at an individual level, family or environment level and can change over time depending on factors such as age. Research on violence prevention has categorised these risk factors into individual, relationship, community and society (Figure 10).

Risk factors usually exist in clusters, not in isolation. Children who are abused or neglected, for example, tend to be in poor families with single parents living in disadvantaged neighbourhoods beset with violence, drug use, and crime. Studies of multiple risk factors have found that they have independent, additive effects. The more risk factors a child is exposed to, the greater the likelihood that he or she will become violent (29). These risk factors can be cumulative in effect, and can interact in different ways to affect vulnerability to violence (31). For example, children who grow up in neighbourhoods where there are high levels of crime and socio-economic deprivation can be at increased risk of involvement in violence. There is also the risk of inter-generational transmission of risk factors such as parents with poor mental health, experience of trauma and abuse and neurodevelopment disorders. However, supportive parenting, strong social cohesion and individual factors such as high resilience can moderate this risk (31).

Research from the US has emphasised that the distinction between early and late risk factors is important. To be effective, prevention programs must address the risk factors that appear at a particular stage of development. The observed clustering of risk factors in childhood and in adolescence provides clear targets for intervention during these stages of the life course (29, 30).

Figure 10: A summary of risk factors for offending behaviour for CYP (29-33)



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5.2 Protective factors

Protective factors buffer against risk factors. They are conditions, characteristics and influences that may decrease the likelihood of children coming in contact with the youth justice system and encourage a positive, health promoting focus (Figure 10). They are at the core of asset based or strengths based prevention strategies (30).

Protective factors offer an explanation for why children and adolescents who face the same degree of risk may be affected differently. Multiple protective factors can even offset the potential harmful influence of risk factors that have accumulated over a child's development (30, 34-36).

Protective factors can also be categorised in a similar way to risk factors and grouped into individual, family, school, peer group, and community categories. Similar to risk factors protective factors can differ across the life course and can interact and produce aggregate effect (37-43).

Protective factors can increase a child's resilience and help to make them less susceptible to developing offending behaviour. Protective factors have been identified at an individual level as contributing to healthy problem-solving, emotional regulation skills, good school readiness and academic achievement (30, 34, 35, 44, 45).

Research has also highlighted that warm parent-youth relationships in which parents set consistent, developmentally appropriate limits and demonstrate interest in their children's education and social relationships are associated with healthy child and adolescent development and the prevention of violent behaviour (35, 45-51).

Schools can also be an important area for increasing resilience and protective factors and these have shown to be children feeling connected to their schools, experiencing academic success, having positive relationships with teachers and other caring adults, and interacting with prosocial and nonviolent peers (35).

In terms of the community, physical environments have been identified as playing a significant protective role in buffering violence. It is important that schools, parks, and business and residential areas are regularly repaired and maintained and designed to increase visibility, control access, and promote positive interactions and appropriate use of public spaces (35, 52, 53).

Additional community protective factors include household financial security, safe and stable housing, economic opportunities, increasing access to services and social support, residents willingness to assist each other, and collective views that violence is not acceptable (35). Strengthening protective factors at the different ecological levels of individual, relationship, community and society is an essential approach to helping to intervene to prevent children becoming in contact with the youth justice system.

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6. Developing a framework for action

In order to effectively address the causes of poor outcomes for children in contact with the youth justice system it is important to take a systematic approach addressing the two broad areas of intervention: **Upstream prevention** involves actions to prevent the occurrence of offending and **downstream prevention** involves actions to reduce the impact of offending and prevent re-offending. Both areas of prevention require actions at an individual/family level and at a communities and societal level.

There are 3 key principles underpinning the implementation of primary and secondary prevention actions.

Partnership and shared vision
A vital aspect is to ensure that work which reduces youth offending, re-offending and youth violence is coordinated across partnerships and there is a shared vision of what is trying to be achieved. In many local areas action in the framework is already happening but what is needed is a joined up collaborative approach to prevent silo working.

Employing a range of actions
There are a range of interventions which can improve health outcomes in children in contact with the youth justice system and these need to be unified and implemented systematically.

Identifying vulnerable children in all policies
A fundamental action which needs to be taken by all organisations is to ensure that vulnerable children are identified and included in all policies and considered in all decision making.

The CAPRICORN framework illustrated in Figure 11 provides a comprehensive overview for primary and secondary actions to prevent youth offending, re-offending and youth violence, using a public health approach, which integrates action at individual, family level and communities and societal level.

This has been developed from a review of the evidence, from academic and government experts, and practitioners working at a local level.

The outer ring of the framework is underpinned by evidence that addressing the wider determinants of health and structural barriers will help to improve outcomes for vulnerable children (2). The inner ring uses evidence from Harvard University Center for the Developing Child, which focuses on individuals and families (54). A dual approach is needed to address both structural and environmental determinants as well as

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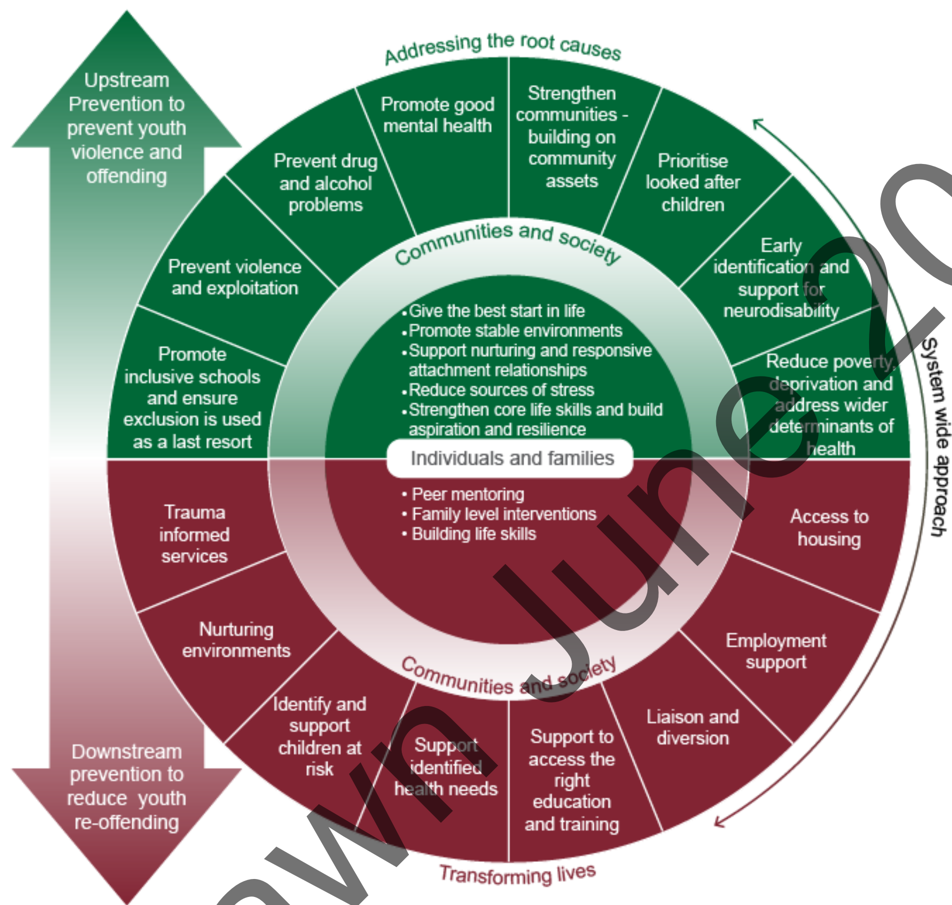
supporting individual children and families. The next two chapters describe some of the evidence base for each action area.

Figure 11: The CAPRICORN framework



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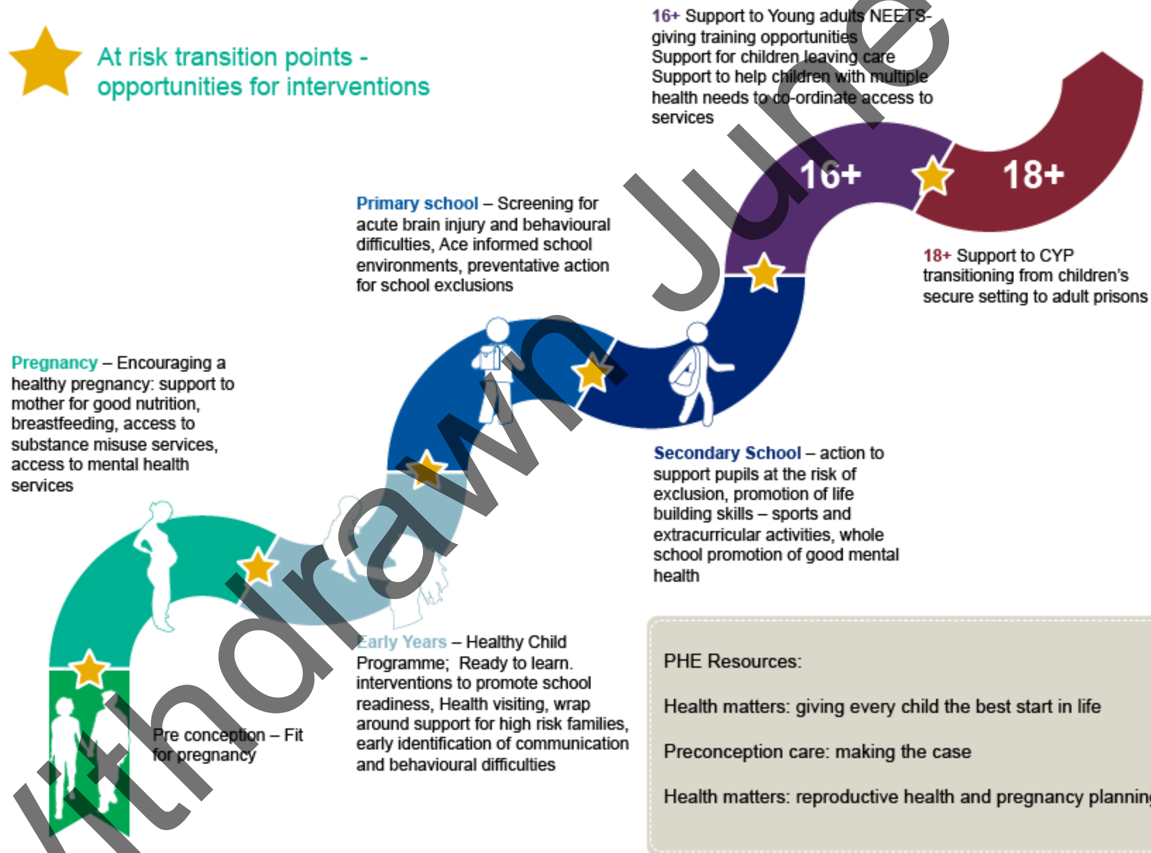
7. Upstream prevention: reducing offending

7.1 Action at individual and family level

The foundations for virtually every aspect of human development - physical, intellectual and emotional - are laid in early childhood. What happens during these early years (including pregnancy) has lifelong effects on many aspects of health and wellbeing, from obesity, heart disease and mental health, to educational achievement and economic status (2). It is essential to focus on giving every child the best start in life.

Figure 12: Identifying opportunities for intervention for children and young people



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7.2 Giving the best start in life

There is strong evidence on the effectiveness of home visiting programmes in preventing child maltreatment and other negative child outcomes (55, 56). Early years interventions can focus on the development of parenting skills or by offering support to families. Parenting programmes such as Triple P, Incredible Years and home visiting programmes such as the Family Nurse Partnership and the Early Start Programme, have had positive results.

Professor Marmot and the Chief Medical Officer both recognise the importance of building on the support in the early years and sustaining this across the life course for school-aged children and young people to improve outcomes and reduce inequalities through universal provision and targeted support (2). There will be challenges within a child's or a young person's life and times when they need additional support. Universal and targeted public health services provided by health visiting and school nursing teams are crucial to improving the health and wellbeing of all children and young people. The Healthy Child Programme is a universal programme available to all children and aims to ensure that every child gets the good start they need to lay the foundations of a healthy life.

Good health, wellbeing and resilience are vital for all our children now and for the future of society. There is firm evidence about what is important to achieve this through robust children and young people's public health. This is brought together in the national Healthy Child Programme 0-19, which includes:

Healthy Child Programme: Pregnancy and the first five years of life (57)

Healthy Child Programme rapid review to update evidence (58)

Healthy Child Programme: From 5-19 years old (59)

PHE have published a rapid review of the evidence in relation to safeguarding guidance in the Healthy Child Programme for 5 -19 year olds. The review focuses on the areas of child abuse and neglect, child sexual abuse and exploitation, intimate partner violence (IPV), female genital mutilation (FGM) and gang violence.

The 0-5 element of the Healthy Child Programme is led by health visiting services and the 5-19 element is led by school nursing services, providing place-based services and working in partnership with education and other providers. These professional teams provide the vast majority of Healthy Child Programme services. The universal reach of the Healthy Child Programme provides an invaluable opportunity from early in a child's life to identify families that are in need of additional support and children who are at risk of poor outcomes.

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Research shows that a large number of children face instability in their lives. To develop to their full potential children need safe and stable housing, secure relationships with adult care givers, nurturing and responsive parenting and high quality learning opportunities at home, in child care settings and at school (60, 61). Stable environments and supportive relationships with adults can act as a buffer against any negative effects of instability, and children can learn to cope with adversity (54).

Guidelines based on 3 core principles to improve outcomes in children and families include supporting responsive relationships, reducing sources of stress, and strengthening core skills and resilience at individual and familial level (54). These are further detailed below:

Support responsive relationships
Evidence shows that starting at birth and continuing throughout life, our ability to thrive is affected by our ongoing relationships and experiences and the degree to which they are healthy, supportive, and responsive or not (54).

There is a significant body of evidence that demonstrates the importance of sensitive attuned parenting on the development of the baby's brain and in promoting secure attachment and bonding. Preventing and intervening early to address attachment and parenting issues will have an impact on the resilience and physical, mental and socio-economic outcomes of an individual in later life (62). Research has also demonstrated a clear link between later parenting practices (e.g. characterised by harsh, inconsistent discipline, little positive parental involvement with the child, and poor monitoring and supervision) and child antisocial behaviour (63). Positive, proactive parenting (e.g. involving praise, encouragement and affection) is strongly associated with high child self-esteem and social and academic competence and is protective against later disruptive behaviour and substance misuse (64, 65).

There is strong evidence that conflict between parents, whether together or separated, can have a significant negative impact on children's mental health and long-term life-chances (60). Not all conflict is damaging, but where this is frequent, intense and poorly resolved it can harm children's outcomes.

Reduce sources of stress in the lives of children and families
Severe stress that is a defining feature of life for millions of children and families experiencing deep poverty, community violence, substance abuse, and/or mental illness can cause long-lasting problems for children and the adults who care for them. Reducing the pile-up of potential sources of stress will protect children directly (i.e., their stress response is triggered less frequently and powerfully) and indirectly (i.e., the adults they depend upon are better able to protect and support them, thereby preventing lasting harm). Stable and responsive relationships in the earliest years of life

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help protect children from the potential harm that excessive stress can cause, and in adulthood they provide the buffering and hope that are necessary for resilience (54).

Strengthen core life skills and build resilience
Children facing significant adversity can develop core life skills and adults can strengthen them when policies, programmes, and skilled caregivers or caseworkers create environments that provide "scaffolding" for efforts to use these skills. Scaffolding is simply developmentally appropriate support that gets people started and steps in as needed, allowing them to practice the skills before they must perform them alone.

Life and social skills are defined as "the abilities for adaptive and positive behaviour that enable individuals to deal effectively with the demands and challenges of everyday life" (66). Life and social skills development programmes help young people increase their self-awareness and more accurately read and regulate their emotions. They also help young people establish and maintain positive relationships and take the perspective of – and empathize with – others. Programmes to develop such skills aim to enable young people to deal constructively with daily life demands and with stressors and interpersonal conflicts (67).

Figure 13: Ten core life skills (67)

problem solving	interpersonal relationship skills
critical thinking	self-awareness building
effective communication	empathy
decision-making	coping with stress
creative thinking	coping with emotions

Resilience is the capacity to bounce back from adversity. Protective factors increase resilience, whereas risk factors increase vulnerability. Resilient individuals, families and communities are more able to deal with difficulties and adversities than those with less resilience (68). It is important that resilience is strengthened at both an individual and a societal level. Those who are resilient do well despite adversity, although it does not imply that those who are resilient are unharmed – they often have poorer outcomes than those who have low-risk background but less resilience. This applies to health outcomes and effects success in a range of areas of life across the life course. Evidence shows that resilience could contribute to healthy behaviours, higher qualifications and skills, better employment, better mental wellbeing, and a quicker or more successful recovery from illness.

A public health approach to resilience does not just seek to improve young people's personal coping skills, but also ensures that conditions are relationships in the family and local community, and that services are available and appropriate for when they are needed. Those who face the most adversity are least likely to have the resources

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necessary to build resilience. This ‘double burden’ means that inequalities in resilience are likely to contribute to health inequalities and is therefore an important upstream protective factor to address.

7.3 Action at community level

Ensure school exclusion is a last resort

School exclusion is linked to subsequent negative outcomes, including failure within the academic curriculum, aggreavated anti-social behaviour, and an increaded likelihood of contact with the criminal justice system (69).

The Edinburgh Study of Youth Transitions and Crime highlighted it can be difficult for children who are labelled troublemakers and experience a repeated cycle of exclusionary practices to shrug off this label (70). Multiple and long-term exclusion should act as a warning signal that young people are at risk and need help (71). Research in this area has consistently shown that exclusion disproportionally effects the most vulnerable in school; looked after children, ethnic minorities, those who come from disadvantaged economic backgrounds, and those presenting special educational needs (69). Black Caribbean pupils are educated in pupil referral units at just over 3 times (3.1) the rate we would expect, given the ethnicity of the overall national pupil population (72).

Evidence from the 2019 Timpson Review of School Exclusion suggests that excluded children have worse trajectories in the long term (73). The report says:

“Over one third of children who completed Key Stage 4 in AP [alternative provision] go on to be NEET (not in education, employment or training). Exclusion is a marker for being at higher risk of becoming a victim or perpetrator of crime – 23% of young offenders sentenced to less than 12 months in custody, in 2014, had been permanently excluded from school prior to their sentence date. However, it would be wrong to suggest that we have evidence that exclusion of any kind causes crime or that preventing the use of exclusion would, in itself, prevent crime. There are many factors that may lead a child to becoming involved in criminal activity, and for some children these factors may well have been the cause for them to have been excluded from school. However, it is right to recognise exclusion as one indicator, among others, of a higher risk of exposure to and involvement in crime, and we should therefore fully consider the form and content of the education a child receives following exclusion, in efforts to prevent and tackle serious violence” (73).

The 30 recommendations put forward in the Timpson Review, and agreed in principle by the Department for Education, provide a course of action for the whole system to reduce the variation in the use of exclusion and to work together to try and ensure children remain in the education that best suits their needs for as long as possible (73).

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School can act as a protective factor to vulnerable children by encouraging educational achievement, creating strong mentoring relationships, developing social skills and self-esteem and schools have been shown to reduce the incidence of antisocial behaviour (74, 75). The Early Intervention Foundation (EIF) advocates that:

"reducing behavioural problems in childhood will result in children being less disruptive at school and requiring less additional support from teaching staff. This has the potential to lead to improvements in school attainment and lifetime earnings, both for the child who receives the early intervention support, and for their peers, who are less badly disrupted at school. It may reduce the likelihood of children being excluded from school and referred to high-cost pupil referral units, and the likelihood that they will engage in criminal activity, thereby reducing the burden on the police and youth justice system. It may also lead to children engaging less in other risky behaviour, such as alcohol or drug abuse, which can have knock-on consequences in terms of the cost of health provision and improvements in their lifetime wellbeing" (76).

The green paper, Transforming Children and Young People's Mental Health Provision, 2017 provides an opportunity to develop prevention and early intervention programmes within school (77). By identifying a designated senior mental health lead within schools and investment in new mental health support teams working across primary and secondary schools there is an opportunity to develop whole school approaches to mental health and well-being as well as early identification and support for CYP presenting with initial emotional and behavioural difficulties.

Further research is needed in this area focussing on the causal effects of exclusion, addressing the racial gap, effective school interventions which ensure exclusion is used as a last resort, and more systematic collection and analysis of data which examines the link between school exclusion and subsequent criminal behaviour.

Prevent violence

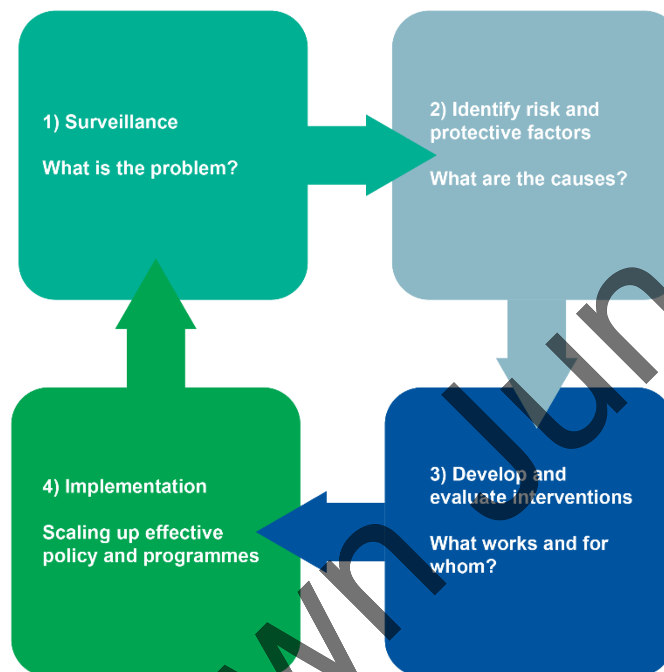
The WHO public health approach to violence prevention seeks to improve health and safety for all individuals in a population by addressing underlying risk factors that increase the likelihood that an individual will become a victim or a perpetrator of violence (Figure 14) (78).

The approach consists of 4 steps.

1. Defining the problem through the systematic collection of information about the magnitude, scope, characteristics and consequences of violence.
2. Establishing why violence occurs using research to determine the causes and correlates of violence, the factors that increase or decrease the risk for violence, and the factors that could be modified through interventions.

3. Finding out what works to prevent violence by designing, implementing and evaluating interventions.
4. Implement effective and promising interventions in a wide range of settings. The effects of these interventions on risk factors and the target outcome should be monitored, and their impact and cost-effectiveness should be evaluated.

Figure 14: WHO public health four-step approach to violence prevention (78)



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Violence prevention is an essential part of improving outcomes for vulnerable children and a range of different interventions throughout the life course can reduce individuals' propensity for violence, lower the chances of those involved in violence being involved again and ensure that those affected by violence get the support they require (31). Programmes that support parents and families, develop life skills in children, work with high-risk youth and reduce the availability and misuse of alcohol have proven effective at reducing violence (60). It is important that there are measures in place to ensure appropriate identification, care and support mechanisms to minimising the harms caused by violence and reduce its recurrence (31). In many cases health economic analyses are already available that demonstrates significant cost savings where violence prevention programmes have been established (31).

Violence of all types is strongly associated with social determinants such as weak governance, poor rule of law, cultural, social and gender norms, unemployment, income and gender inequality, rapid social change and limited educational opportunities (78). Together these factors create a social climate that is conducive to violence, and in the

absence of efforts to address them, sustained violence prevention gains are difficult to achieve. A comprehensive violence prevention strategy must identify ways to mitigate or provide a buffer against these risks, including through policy and other measures. As part of a multi-sectoral approach to violence prevention, involvement is needed in a co-ordinated way by a range of institutions such as the criminal justice sector (police, courts and prisons) as well as health, education, local authorities and the voluntary sector, to ensure that prevention strategies are effective in addressing these social determinants (67).

If it is not possible to prevent violence, early intervention should be undertaken to mitigate against the escalation of violence. Secondary prevention involves early warning and early intervention, de-escalation and conflict handling (81).

The EIF has reviewed the evidence into what works to prevent gang involvement, youth violence and crime. Interventions with strong evidence behind them include skills based and family focussed programmes. The key features of successful interventions are programmes that:

- seek to create positive changes in the lives of youth and or their families, as well as prevent negative outcomes
- use a trained facilitator, experienced in working with children and families
- work with youth in their natural environments and include skills practice, parent training and or therapy depending on the level of risk

For more information, see https://www.eif.org.uk/report/preventing-gang-and-youth-violence-a-review-of-risk-and-protective-factors.

A recent review Public Health Approaches to Reducing Violence by the Local Government Association outlines the WHO public health approach to violence prevention and the current evidence base for interventions. PHE has recently worked with the College of Policing to produce a resource called Public Health Approaches to Policing which outlines what is meant to a ‘public health approach’ in the context of policing.

Case study: Scotland’s Violence Reduction Unit

The Scottish Violence Reduction Unit (VRU) is a national centre of expertise on violence and sits within Police Scotland. The unit was originally founded in 2005 by Strathclyde Police; after Scotland was branded the most violent country in the developed world, they wanted to try a different approach to tackling violence (82).

In 2006 the unit expanded from its Glasgow focus to become a national Scottish VRU directly funded by the Scottish Government with an annual budget of around one million pounds (82).

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Scotland's public health approach has 3 broad strands incorporating enforcement, attitudinal change and prevention and include multi-agency working to deliver collaborative projects and programmes (83, 84). Since 2005 an extensive variety of violence prevention initiatives have been pursued through different organisations and partnerships in different localities across Scotland. Prevention projects currently being delivered specifically under the banner of Scotland's VRU include the following (82).

Mentors in Violence Prevention: a schools-based programme that focuses on teaching bystander intervention strategies to confront specific forms of violence and abusive behaviour such as rape, dating violence, sexual harassment and bullying.

Street and Arrow: a project that provides mentoring and career support to prior offenders or those deemed at risk of committing crime.

Ask Support Care: a programme training a range of professionals so that they can reach out and offer to support to those they encounter who may be victims of domestic abuse.

Navigator: a hospital and community-based programme that engages with victims of violence and attempts to steer them away from a potential cycle of violence.

Since the establishment of the VRU Scotland has seen a 54% decrease in non-sexual violence recorded by the police (85) and consistent decline in emergency hospital admissions due to assault (86). Identifying the role and impact of the public health approach and the VRU specifically in this decline is not possible due to the lack of evaluations that have been carried out.

Case study: West Midlands Violence Prevention Alliance

The West Midlands Violence Prevention Alliance is made up of stakeholders from a range of organisations including PHE, the police, the Association of Directors of Public Health, NHS trusts and partners from the voluntary, community and social enterprise sector.

The Alliance has promoted increased awareness of protective and risk factors for experience of violence including adverse childhood experiences and other vulnerabilities. Other Alliance work programmes include:

- Mentors in Violence Prevention: a schools-based peer mentoring programme for students based on the Scotland programme
- Identification and Referral to Improve Safety: initiative to train GP practice staff to identify patients affected by domestic abuse
- Redthreads: providing youth workers in A&E departments to work with patients affected by violence and referring them to local youth services

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PHE and Warwickshire County Council published a review into understanding child sexual exploitation (CSE) in the West Midlands. The review identified the current position of local CSE awareness and work across the 14 local authorities. The review concluded that CSE is a public health issue and that public health could play a crucial role in the prevention of CSE through community engagement, partnership working and providing intelligence to help identify those at risk. The National Working Group on tackling CSE continues to endorse the approach in the West Midlands as a model of best practice.

PHE has worked with West Midlands Strategic Migration Partner and the local health and care system to more effectively protect and meet the needs of unaccompanied asylum-seeking children.

Prevent domestic violence

Preventing domestic violence is an important component of preventing offending. Evidence shows that children who have experienced domestic violence and abuse in the home display increased fear, inhibition, depression, as well as high levels of aggression and antisocial behaviour, which can persist into adolescence and adulthood (87-91).

Research shows there is a strong link between exposure of domestic violence and child maltreatment and youth and adult offending (87). Domestic violence also has inter-generational consequences in terms of the repetition of abusive and violent behaviours (87). In 2014 NICE published its guidance on domestic violence which advocates effective strategies for commissioning and the development of integrated care pathways; how to create environments which support safe and appropriate disclosure; improving access to services which improves a comprehensive referral pathway; the provision of tailored services which take account of the needs of different population groups including those with existing mental problems (92).

The Early Intervention Foundation has also developed guidance on domestic abuse which highlighted that there are 3 key forms of preventive public service activity that respond to the specific challenges of domestic violence and abuse:

- the work of universal services in embedding an understanding of good relationships in childhood and adolescence (tends to be called primary prevention in health context)
- early intervention and activity to support social and emotional skills and provide other support to groups such as young mothers who are particularly at risk (secondary prevention)
- work to support victims, safeguard children and reduce the recidivism of perpetrators (a mixture of acute services and tertiary prevention)

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EIF also showcased innovative approaches that offer promise for preventing domestic violence and abuse. These include approaches in schools to develop a zero tolerance approach to domestic violence and abuse, prevention through augmentations to parenting programmes and through support to the quality of parenting relationships. These require further development and testing using rigorous evaluation methods (87).

Incorporating preventing domestic violence into health and well-being plans and incorporating it into a whole system approach will help to address the underlying risk factors for youth offending.

Prevent child exploitation

Child Criminal Exploitation occurs where an individual or group takes advantage of an imbalance of power to coerce, control, manipulate or deceive a child or young person under the age of 18. The victim may have been criminally exploited even if the activity appears consensual. Child Criminal Exploitation does not always involve physical contact; it can also occur through the use of technology (93).

The Home Office (2018) has highlighted that risk factors for involvement in child criminal exploitation are (93):

- having prior experience of neglect, physical and/or sexual abuse
- lack of a safe/stable home environment, now or in the past (domestic violence or parental substance misuse, mental health issues or criminality, for example)
- social isolation or social difficulties
- economic vulnerability
- homelessness or insecure accommodation status
- connections with other people involved in gangs
- having a physical or learning disability
- having mental health or substance misuse issues;
- being in care (particularly those in residential care and those with interrupted care histories)
- being excluded from mainstream education, in particular attending a pupil referral unit

Tackling child criminal exploitation needs to be a core part of the whole system approach to preventing youth offending, violence and re-offending.

Prevent sexual exploitation

A public health approach could enhance both individual and population-wide resilience to child sexual exploitation (CSE) and associated vulnerabilities. It should protect and improve children and young people's health and wellbeing through both preventative and responsive initiatives (94). In doing so it could address the inequalities,

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vulnerabilities and broader social detriments that can impact on health and wellbeing in children and young people which create the context for CSE. It should also address the consequent vulnerabilities and inequalities that can result from it (94-96).

Action is needed to increase the ability of children and young people to realise they are being exploited and seek help. Local services need to identify those children at risk and get them to the help they need. Girls involved with gangs can be particularly vulnerable to mental health problems resulting from sexual and intimate partner violence (97).

Prevention also includes making full use of licensing powers on those premises posing a risk to children, to education work in schools and local communities which not only gives children an awareness of sexual exploitation, but also the confidence to seek help for themselves and their friends.

Services such as those for drugs, alcohol and sexual health, all have contact with children and young people who may be at an increased risk of sexual exploitation. By providing support and encouraging disclosure, these services can help those affected by exploitation at the earliest possibly opportunity. NHS England, working in partnership with PHE and MoJ, have outlined a strategic direction for sexual assault and abuse services which includes actions to strengthen prevention (98). The Strategic Direction is underpinned by the following 6 core priorities:

- strengthening the approach to prevention
- promoting safeguarding and the safety, protection and welfare of victims and survivors
- involving victims and survivors in the development and improvement of services
- introducing consistent quality standards
- driving collaboration and reducing fragmentation
- ensuring an appropriately trained workforce

Prevent drug and alcohol problems

There are many factors associated with an increased risk of alcohol and drug problems among young people. Some young people are particularly vulnerable to misusing drugs and alcohol including young offenders, those with poor mental and emotional health and those experiencing child sexual exploitation and abuse (99).

The latest estimates from NHS Digital's Smoking, Drinking and Drug Use Among Young People in England survey shows that 44% of 11 to 15-year-old pupils have ever had an alcoholic drink, 19% have ever smoked cigarettes and 24% have ever taken drugs (100). The latest crime survey for England and Wales shows that younger people are more likely to take drugs than older people.

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The most recent treatment data tells us that cannabis and alcohol are the most common substances that young people are seeking help (101). However young people also come to treatment services using a range of substances including ecstasy (MDMA), cocaine and solvents. A very small minority will present using heroin (101) .

Data from young people's specialist substance misuse services indicates that the young people who go to these services with a need for drug and alcohol treatment have a range of vulnerabilities and that the majority present with poly-drug use.

Alcohol and drug prevention tackles the risk factors which increase the likelihood of someone suffering harm. It can help build resilience to developing alcohol and drug problems. It can also help people avoid problems by providing opportunities for alternative, healthier life choices and developing better skills and decision making.

Interventions can range from targeted programmes to universal environmental or fiscal policies. It's vital that people have access to accurate, relevant information about health harm. Young people at increased risk of harm from alcohol and drug use need to have targeted approaches aimed at them such as young people in contact with the youth justice system. It is important to take a systematic approach addressing both preventative approaches, targeted provision to those identified as being at risk and offering specialist substance misuse provision to those who need it.

A number of factors and types of intervention are linked to positive outcomes (102):

- early interventions, particularly generic pre-school programmes, improving literacy and numeracy, have a long-term effect personal and social skills education
- links to school interventions including school environment improvement programmes: positive ethos; disaffection; truancy; participation; academic and social-emotional learning
- a focus on 'risk and resilience' factors
- multi-component programmes involving parenting interventions and support for individuals and families, which may require joined up commissioning and planning
- staff who are qualified and competent to deliver the interventions they provide

Promote good mental health

Around half of all mental health problems start before the age of 14 and we know that Child and Adolescent Mental Health Services are currently facing an increase in demand (77). Prevention is therefore key and makes sense from the point of view of children and their families. The recent green paper Transforming children and young people's mental health provision: a green paper sets out actions that will be put in place across the education sector to strengthen the focus on children and young people's mental health (77).

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The designated lead for mental health in a school or college will have oversight of a 'whole school/college approach'. This provides schools with an opportunity to develop trauma informed practices and to provide supportive, inclusive and flexible school environments. The diagram below illustrates a whole school approach to promoting emotional health and wellbeing in schools (Figure 15).

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Figure 15: A whole school approach to promoting positive mental wellbeing

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Strengthen communities

An asset-based approach understands health as a positive dimension and focuses on the factors and solutions that lead to good health. These often lie within the resources of people and communities and the connections between them (2).

Positive health outcomes are underpinned by addressing the factors that protect and create health and wellbeing and many of these are at a community level.

Community life, social connections and having a voice in local decisions are all factors that have a vital contribution to make to health and wellbeing. These community determinants build control and resilience and can help buffer against disease and influence health-related behaviour.

As well as having health needs, all communities have health assets that can contribute to the positive health and wellbeing of its members, including (9):

- the skills, knowledge, social competence and commitment of individual community members
- friendships, inter-generational solidarity, community cohesion and neighbourliness
- local groups and community and voluntary associations, ranging from formal organisations to informal, mutual aid networks such as babysitting circles
- physical, environmental and economic resources
- assets brought by external agencies including the public, private and third sector

At a community level, encouraging communities to be more self-managing and to take control of factors affecting their health and wellbeing is beneficial. It is useful to build capacity by involving people as community champions, peer support or similar. This can develop strong collaborative/partnership relationships that in turn support good health (103).

Prioritise looked after children

While the vast majority of looked-after children do not have any involvement in the youth justice system, they remain significantly over-represented when compared to their non looked-after peers. Looked after children (LAC) (who have been looked after for at least 12 months) are five times more likely to offend than all children with 4% of looked after children convicted or subject to youth cautions or youth conditional cautions in 2017-18 (104).

LAC in the youth justice system need to have extra assistance to ensure on release they have the support from community services. LAC in the youth justice system were less likely than their peers to say that they knew where they would be living when they left. (52% compared with 89%). This is a time when children are particularly vulnerable and need extra support. It is especially important in terms of preventing re-offending (105).

The majority of children and young people enter care due to abuse or neglect (63% as a primary need in 2017-18) and we must recognise the impact of trauma and abuse, or additional vulnerabilities, on theiremotional and behavioural development. This can result in behaviour perceived as challenging and should inform responses to such behaviours. Secondly, we must ensure our response to incidents does not initiate or exacerbate negative behaviour and contribute to unnecessary police involvement or criminalisation.

The cross-government National Protocol on Unnecessary Criminalisation of Looked after Children and care leavers provides a recommended framework to help keep looked-after children out of the criminal justice system (106). The protocol was developed in partnership with, and is endorsed by, leaders in the statutory and voluntary sectors and from across children's social care, justice, police and health. It advocates a

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multi-agency, whole system approach recognising that the care system is not just about keeping children safe, but also promoting recovery, resilliance and wellbeing (106). The framework promotes:

- an understanding of trauma and attachment and their impact on neurodevelopment and behaviour amongst all key professionals
- an understanding of where children (UK as well as foreign nationals) may have been coerced and subsequently criminally exploited (for example, through running county lines or in cannabis cultivation)
- the use of positive parenting whilst in care
- learning from incidents
- listening to children and young people's voice/views and using this to inform practice
- the development of strong understanding of local data and circumstances;
- use of restorative approaches
- an attitude where all professionals ask themselves 'would such behaviour lead to an arrest if the child had been living with their family?'

The protocol is aimed at at local authority children's services, local care providers (fostering services, children's homes and other arrangements), police forces, Youth Offending Teams (YOTs), the Crown Prosecution Service (CPS) and HM Courts and Tribunal Service (HMCTS), local Youth Panel (Magistrates), and local health services including mental health. It is essential that these agencies work together to co-produce and implement the protocol at a local/regional level.

Early identification and support for neurodisability

Evidence from a range of international contexts has demonstrated a consistently high incidence of neurodevelopmental impairment, (including TBI) among young people in contact with the youth justice system (17). Neurodevelopmental impairments are expressed through a wide range of symptoms, including deficits in reasoning, thinking and perception and the expression of emotion and formation of relationships. Despite the high prevalence of learning disability (23%-32%) among young offenders their learning needs may be missed, and often overshadowed by their challenging behaviour.

A greater severity of TBI (as measured by loss of consciousness) is associated with higher likelihood of impairments in cognition (to plan, pay attention, remember, and to control impulses). TBI leads to earlier onset, more violent, and repeated offending, and to greater mental health problems, substance misuse and suicidality. Key time points for injury are around 3 years for both genders, and particularly in adolescence for boys. Socio-economic deprivation increases risk of injury fivefold in the most deprived children under 5 years of age (17).

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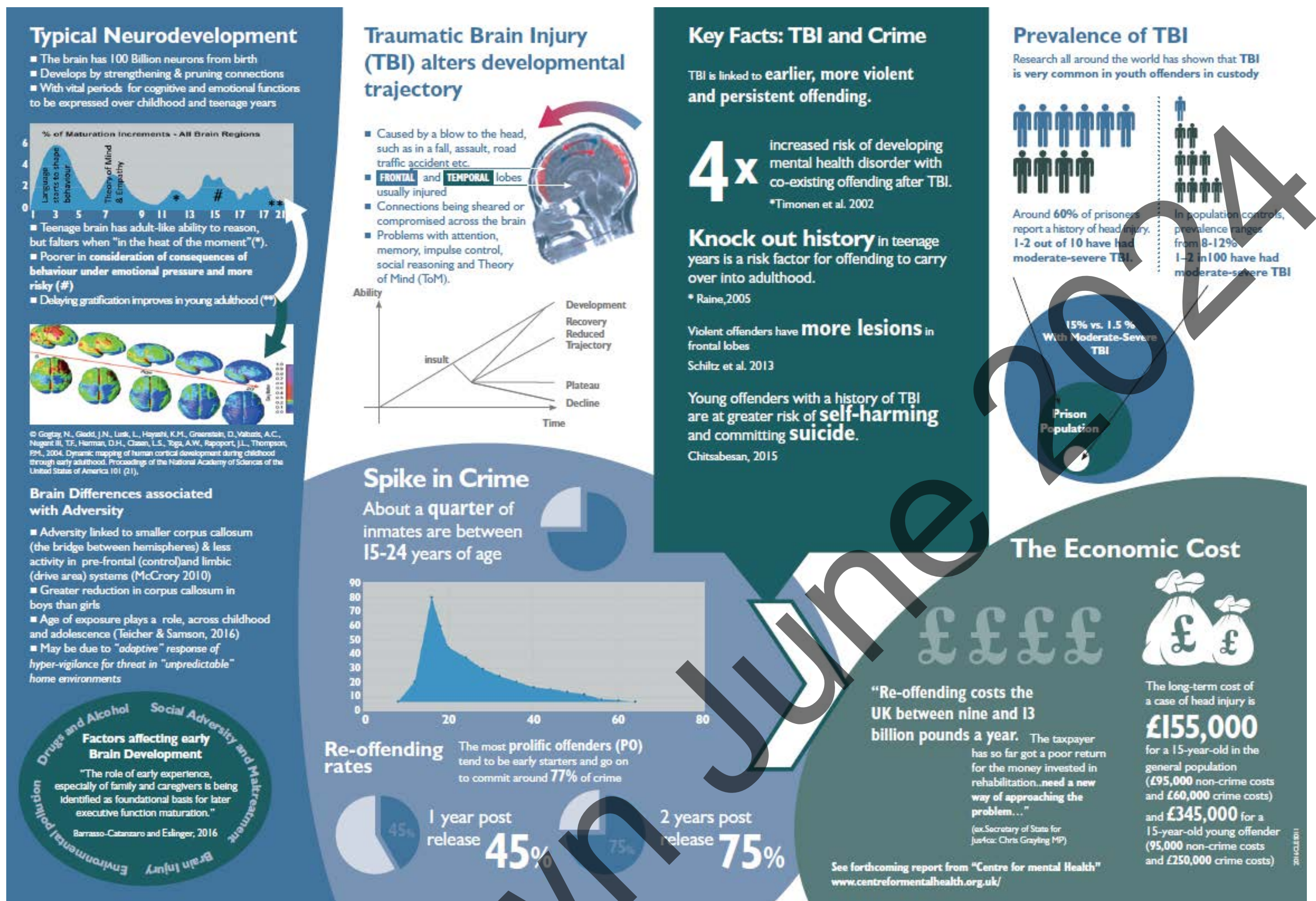
Figure 16: Neurodevelopment, maturity and crime[5]



Studies to date suggest that one of the most common reasons for unmet need is lack of appropriate and timely assessment. An awareness of the developmental pathways of young people with neurodevelopmental impairments who offend necessitates earlier intervention through family and educational support, so as to prevent the development of secondary risk such as problematic family functioning, detachment from education, or negative peer group influence.

Young people at risk of later antisocial behaviour can often be identified early within the education system by their challenging behaviour or problems with academic engagement or attainment. Indeed, young people exhibiting early signs of difficulty should be routinely assessed for underlying cognitive and emotional needs so as to support appropriate attempts to maintain educational engagement, with the aim of not only reducing offending but also promoting better educational outcomes. For example, identification of neurodevelopmental difficulties with early signs of language difficulties

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[5] http://psychology.exeter.ac.uk/documents/INFOGRAPHIC_WILLIAMS_Brain_Injury_CRIME.pdf

can promote support during changes to classroom teaching at age 8, while awareness of need at primary school can allow young people to be appropriately supported on transition to secondary school.

This suggests a significant set of training needs across a range of services in order to ensure appropriate assessment and response. Staff in education services, family intervention projects, social services and primary health care settings, as well as in the youth justice system, require support to recognise and understand issues relating to neurodevelopmental impairment. Awareness raising across a range of practitioners and professionals will also support more appropriate referral to relevant specialist services for further assessment and intervention.

In recent years there has been a growing body of evidence on early language development. This evidence makes a powerful case for language as a primary indicator of child wellbeing due to its influence on social, emotional and learning outcomes (107). Delay in early language development can be recognised by the time children are 2 years old and may have a more visible impact by the time children enter school. The risks of delayed development can have a profound impact on children's learning and social development and has also been shown to influence outcomes in adult life.

At least 60% of young people in the UK who are accessing youth justice services present with speech, language and communication difficulties which are largely unrecognized (108). When populations of young offenders are examined, despite high levels of difficulties demonstrated, none or almost none is known to local SLT services or is flagged as having communication difficulties (108). Research in Milton Keynes showed that 2% of a sample of young offenders in the community in the UK were known to SLT services (109). This suggests that the current young offender population in the UK has not reached SLT services. Also, the agencies involved with those young people have either not recognised their language difficulties or have not deemed these in need of intervention.

Reduce poverty, deprivation and address the wider determinants of health

There is a strong association between income and health, with many health outcomes improving incrementally as income rises. Income can affect many aspects of health and in turn have a knock-on effect on other social determinants. For example, a parent's income may influence a child's early development and educational opportunities, which in turn can affect a child's employment opportunities and their income (103). Working to reduce poverty will benefit children and help to reduce vulnerabilities.

A life course approach means that action to reduce health inequalities starts before birth and continues throughout the life course. In 2010, Marmot emphasised how the wider determinants of health – the 'causes of the causes' – impact on people's lives,

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exacerbating inequalities (2). Marmot identified 6 policy areas, 4 of which act across the life course which would address some of the root causes of vulnerability:

- give every child the best start in life
- enable all children, young people and adults to maximise their capabilities and have control over their lives
- create fair employment and good work for all
- ensure healthy standard of living for all
- create and develop healthy and sustainable places and communities
- strengthen the role and impact of ill health prevention tackling problems such as poverty and drug and alcohol misuse are important, as well as making sure people have strong communities, healthy schools, good workplaces and strong relationships (2)

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8. Downstream prevention: reducing re-offending

8.1 Actions at individual and family level

Peer mentoring

Mentoring programmes provide trained mentors to work with young people either at home, at school, or in the community. Typically targeting disadvantaged youths, mentors provide non-familial adult role models that are able to share knowledge and skills with young people and offer psychosocial support (97). Mentoring is a key component of several programmes working with vulnerable youth in the UK with programmes delivered through youth justice. In many such cases, mentors will have lived experiences of gang involvement. Although there is some promising evidence on mentoring programmes, knowledge about "what works" is limited and predominantly USA-based, therefore evaluation and building the evidence base is important (31).

Case study: The Kendleshire Kids Foundation and Youth 8

The Kendleshire Kids Foundation and Youth 8 have formed a joint venture to deliver mentoring and youth engagement through golf, using a trauma informed approach. It is a family-based intervention which aims to give support and mentoring to vulnerable young children in the South Gloucestershire area. It takes a multi-agency approach working with local schools, local authorities, SEND teams, YOTs and social services to identify children who may need extra support. This includes anyone at risk of being excluded, or at risk of committing a criminal offence, having problems with drugs and alcohol, struggling at home or recently suffered a bereavement. It involves 2 coaching sessions a week with a golf professional, lunch and mentoring from trained volunteers. The mentoring is based on Maslow's hierarchy of needs and setting targets. There is also outreach from Youth 8 during the week for children who may need additional support. Families are openly encouraged to join and have free access to the club during the week. Golf members have donated sports equipment. There are family day outs also planned to ensure family engagement is central to the approach. For further information please contact: Ben Littleton at info@youth8.org

Family based interventions

Interventions at a family and individual level are important to support children already in contact with the youth justice system. Family-based interventions encompass programmes that focus on improving parenting skills and relationships within the family.

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Families must be recognised as a fundamental resource in facilitating children and young people to realise their potential through supporting parenting and attachment practices which promote speech and language development, educational attainment and emotional wellbeing, injury prevention and enable families to advocate as necessary for their children, including those with complex needs. This support may include parenting support programmes, including ones known to be effective for young people with specific disorders or interventions which focus on the whole family.

Building life skills

There is clear evidence that participation in sport can improve health and behaviour and also directly contribute to efforts to reduce reoffending, particularly by providing a route into education and employment. Evidence shows that prison based sport and physical activity can improve physical and mental health (110). It can provide access to pro-social network and positive role models and the opportunity to gain new experiences and achievements. An independent review, 'A Sporting Chance' has highlighted successful programmes already in prison such as Parkrun, Duke of Edinburgh scheme and Fight for Peace and other premier football and rugby club community outreach programmes, among a range of other initiatives promoting physical activity, however delivery is not uniform and access varies across the country (110). Communities can develop programmes which aim to encourage children who are already in contact or at risk of becoming in contact with the youth justice system to develop their self-esteem and essential life skills through sport and physical activity.

8.2 Actions at community level

Trauma informed services

Trauma-informed care has been defined as care that "realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re- traumatization" (111).

Many services are designed to focus on the needs of individuals, and therefore a trauma-informed approach may require services to adapt and take a family-centred approach (112). In practice this means that the lens through which successful outcomes are viewed would account for childhood adversity. For example, if a service treating adults with substance misuse problems, supports their users with housing, employment, debt and other wider issues, this would not only improve health and wellbeing outcomes for the user, but if they are parents, then for their children and potentially other family members also. In addition, recognising that childhood adversity factors often co-exist and that their cumulative effect can be even more damaging, necessitates a

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collaborative, joined-up approach to recognising and responding to other potential sources of adversity.

Case study: Enhanced Case Management

The Youth Justice Board (YJB) Cymru and the Welsh Government worked with 4 (then reduced to 3) youth offending teams (YOTs) and the All Wales Forensic Adolescent Consultation and Treatment Service (FACTS) to trial a new enhanced case management (ECM) approach to working with young people who were in contact with the youth justice system. This approach was grounded in the Trauma Recovery Model (TRM) a 7 stage model that matches interventions/ support to presenting behaviours and to underlying health needs. The recommendation of the evaluation is that further implementation and evaluation is needed. A video describing this approach can be found at: www.youtube.com/watch?v=3FLv66cX0XY

Case study: West Midlands

Research in the West Midlands into the extent of childhood adversity in children in the youth justice system showed that the vast majority of children in the youth justice system in the West Midlands have experienced significant abuse and neglect. There is also a high correlation with structural poverty and other issues which can traumatise and disadvantage children. The sheer volume of school exclusions, disengagement and disenfranchisement from the education system was evident.

The adversity being evidenced is much wider than traditional ACE factors. Many children in the youth justice system in the West Midlands witness street or gang violence as well as discrimination and racism. Some have transitioned here from countries known for genocide or which have a poor human rights record. Others have been criminally or sexually exploited – or on occasion both. Some are parents themselves or have experienced the loss and trauma of a termination.

Within the West Midlands our ambition is that we will not only meet the UNCRC requirement to provide special help to children who have suffered childhood adversity but also, we will do so as a community with love and humanity. Youth offending teams in the West Midlands are working beyond current assessment frameworks to explore wider childhood adversities. They are also exploring new ways of working. This includes purchasing resources relating to neuropsychology and brain development including a model brain and building resilience informed practice. Others are translating practice into arts based therapeutic services and using sport as an intervention. One of the fundamental changes some practitioners have made is asking children, 'what has happened to you' rather than 'what have you done'. In some areas this has led to a reduction in those children breaching orders and being sentenced to custody.

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Nurturing environments

It is important that children both within the secure children's estate and those in contact with the youth justice system experience a nurturing environment which is caring and aims to build their confidence, life skills and resilience.

Case study: Great Expectations

Great Expectations is an intervention programme based in Gloucestershire aimed at preventing young people from making decisions that may have a negative impact on their future. The main programme runs in secondary schools and youth groups across the county and is based on 6 sessions that are delivered once a week lasting for 2 to 3 hours each. Sessions are delivered by police officers, police community support officers (PCSOs), youth support team, ex-offenders and current serving prisoners all of whom engage with young people in a non-judgemental and confidential environment building trust and respect and therefore enabling young people to speak openly and honestly about their experiences or ask questions about a specific matter that is concerning them.
www.ghll.org.uk/resources/great-expectations/

Identify and support children at risk

Improving timely access to services is a key issue for CYP identified with mental health and substance misuse needs. While there has been a significant increase in referrals for CYPMH nationally over the last 5 years, opportunities exist to increase access through current policy drivers including: Five Year Forward View (2015), Transforming CYPMH: a green paper (2017) the NHS Long Term Plan and Healthcare Standards for Children and Young people in Secure Settings (77, 113, 114). Delivering good outcomes for CYPMH requires a system wide approach as evident in Future in Mind (115). Local transformation plans provide a framework to consider the needs of local populations including vulnerable groups and how best to utilise existing resources across the system as well as additional funding.

THRIVE aims to replace the traditional tiered model of CYPMH services with a conceptualisation of a whole system approach. The THRIVE categories are needs-based groupings rather than focussing on mental health disorders. The THRIVE framework conceptualises 5 needs-based groupings for young people with mental health issues and their families and includes a focus on prevention and early intervention and therefore the role that each and every one of us has in supporting CYPMH: thriving; getting advice; getting help; getting more help and getting risk support. Each of the 5 groupings is distinct in terms of the: needs and/or choices of the individuals within each group, skill mix required to meet these needs, dominant metaphor used to describe needs (wellbeing, ill health, support), resources required to

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meet the needs and/or choices of people in that group. Training and supervision of practitioners working across specialist and community services is essential in improving access to evidence based treatments for CYP. Children and Young People Improving Access to Psychological Therapy (CYP IAPT) is being rolled out across England and seeks to combine evidence-based practice with user involvement and outcome evaluation to embed best practice in child mental health.

Case study: The Troubled Families Programme

The Troubled Families is a programme of targeted intervention for families with multiple problems, including crime, anti-social behaviour, truancy, unemployment, mental health problems and domestic abuse. The core principles of the programme are: early intervention, focus on outcomes and data, whole family working, and multi-agency working. Local authorities identify families in their area and assign a key worker or lead professional to consider the problems of a family as a whole, and organise services to grip the family's problems and work with the family in a persistent and assertive way towards an agreed improvement plan. The programme's focus on addressing and tracking outcomes is reinforced through the payment by results system, which operates for the majority of local authorities taking part in the programme and drives local services to focus on outcomes rather than outputs.

In October 2018 the Secretary of State launched the Supporting Families Against Youth Crime Fund as an extension to the programme to respond directly to the needs of communities where young people are at risk of crime and violence. The fund supports the early intervention and prevention theme of the Government's Serious Violence Strategy and builds on the Troubled Families Programme's approach of targeted interventions, preventing and addressing offending behaviour, including youth and gang crime, by working with the whole family to tackle the root causes. In February the Secretary of State announced the 21 local authorities that will share this £9.5 million fund.

The latest evaluation shows that the Troubled Families Programme has helped to reform local services and has improved outcomes for families across a number of measures. As at 8 March 2019, the programme has funded areas to work with nearly 400,000 (380,426) eligible families. However, we know that local authorities are working in a whole family way with a far greater number of families. As at 8 March, 171,890 families had achieved significant and sustained progress across all their headline problems, 79,645 more families than a year ago. When compared to a matched comparison group, the programme was found to have: reduced the proportion of children on the programme going into care by a third; reduced juvenile convictions by 15% and juvenile custody by 38%; reduced the proportion of adults on the programme going to prison by a quarter, and; supported more people on the programme back in work with 11% fewer people claiming Jobseeker's Allowance.

As well as providing better support for families, the programme is designed to be a catalyst for local services to transform and work together in a more cost efficient and integrated way, and also reduce demand for high cost services such as children's social care. Ipsos Mori's

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independent evaluation of the programme shows local authorities are changing structures and processes, strengthening partnership working and promoting whole-family working. 67% of troubled families coordinators say it has been effective at achieving long-term positive change in wider system reform, 78% said the programme was effective in driving data sharing between agencies, and 86% say the programme is fairly or very effective in achieving a focus on early intervention (116).

Support identified health needs

SECURE STAIRS delivers a whole systems approach to a framework for integrated care within the children and young people secure estate in England. The implementation of this framework affects and include staff across the whole secure setting in their intervention with children and young people. The use of SECURE STAIRS interventions is driven by a 'formulation' based approach, enabled by clinical psychology, which takes into account the child or young person's life experience, rather than concentrating on labels, categories or diagnoses. A holistic comprehensive health assessment to include mental health and neurodisabilites. Drawing from evidence based interventions such as trauma systems therapy, enabling environments and psychologically informed environments, it provides an environment where the day to day care of children and young people is underpinned by a focus on their relationship with staff.

Support access to the right education and training, employment and housing

Children and young people need to be supported to access education and training opportunities that are appropriate. Constructive resettlement is an evidence-based approach to work with children within a secure setting and following release (116, 117) . It promotes collaborative work to build upon the child's individual strengths and capacities and links to the Standards for Children in the Youth Justice System 2019. It offers a common understanding, language and aim within policy and practice. If implemented effectively it will help to ensure children will have support to access housing, employment and education.

Constructive resettlement provides a theory of change for the child's journey towards a positive pro social future, namely a shift in their identity from a pro criminal to pro social identity. In recognising resettlement as a journey rather than a single transition event there is also the acceptance that the child may relapse. This concurs with previous 'desistance research' literature focused on (mainly) adult within the criminal justice system.

This approach is a two-stage process. While not necessarily linear, the first stage should always direct the second:

1. **Individualised personal support** to guide the shift. This includes identifying the pro-offending narrative, strengths and goals, a pro-social identity and the route to achieving this.

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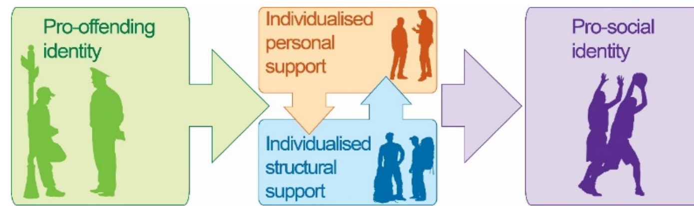
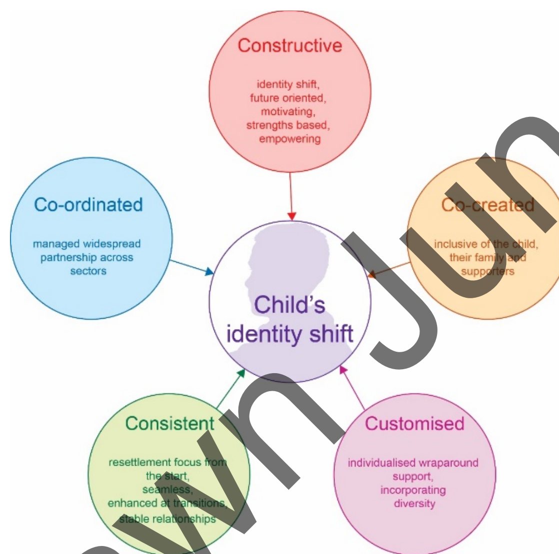
2. **Individualised structural support** to enable the shift by building the route identified in personal support. This ensures a child has suitable practical support required for their personal resettlement route, including accommodation, healthcare, education training and employment and constructive leisure.



The following 5 principles should underpin this process:



The personal nature of identity, and its relationship to background and culture, highlights the importance of recognising and embracing diversity when working with a child.

While predicated in work to resettle children from a secure setting the approach is equally applicable to work with any child to move them away from offending or anti-social behaviour.

Case study: Liam's story

Liam, a 22 year old male, who has offended on multiple occasions and been in and out of foster homes and care homes since the age of 7 years was excluded from school several times. He became homeless and his problems with substance misuse escalated.

At school, he felt that there was no obvious additional support or consideration for looked after children in the education system. Liam felt that his social worker "didn't really want to help me" and didn't seem to have much contact with the school, but felt that potentially she could have been in a position to make a difference to the course of

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his life. He found it an abrupt and distressing transition to being classified as an adult and losing the support which came with being considered a child, feeling that this support should have stayed with him for longer.

His experience of the judiciary also left an impression on him and was significant in determining the course of his life. He commented that he has "had some good judges and not so good ones" and that one in particular "was the fairest judge I've ever had" who looked at his history and gave a "less harsh sentence " as he "could see it [repeat custodial sentences] wasn't working".

Despite repeat encounters with the criminal justice system, including experiences where he felt that the probation plans were 'setting him up to fail', no sustained efforts had been made to engage him in drug rehabilitation.

A turning point came through integrated offender management and the efforts of "two really good officers" who connected him to the voluntary sector organisation and his now key workers. His key workers "tracked him down", engaged him with their service and he is now due to enter drug rehabilitation for the first time and sees this as a "fresh start".

His key workers described their experiences of looked after children often being without advocates, therefore "making it easier to exclude looked after children". They also highlighted the need for early identification of children at risk of later substance misuse, highlighting that there is a "reason why a child behaves a certain way". They emphasised the need for support as soon as children start a new school as well as the impact of transitions, saying that the "shock of secondary school is massive".

His key workers also describe drug rehabilitation as a 'gateway to services' but highlight that the path to rehabilitation requires engagement and commitment with the process.

Source: Focus group with looked after children and key workers

Liaison and diversion services

Liaison and Diversion (L&D) services exist to identify adult and children with mental health problems, learning disabilities and substance misuse problems at the earliest point after initial contact with the police and criminal justice system . The purpose of L&D is to ensure that adults and children receive support and treatment through the youth and criminal justice pathway in a way that addresses any underlying and possibly contributory health factors – in essence, better justice and better health. In some areas L&D has a lengthy history, although the national focus, including a standardised operating motel, has been driven in large part by the recommendations of the 2009 Bradley Report. Revolving Doors, as part of the Offender Health Collaborative, worked

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with NHS England to develop the national operating model for L&D, one of a suite of resources produced by NHS England, which commissions L&D services

Local leaders, working with NHS England commissioners can maximise the opportunities presented by L&D. Expert opinion suggests that where community services are unavailable, or where people requiring diversion are not prioritised, use of custody can result. This again emphasises the importance of local leaders across multiple systems working together to maximise access and achieve the best and broadest value for their investment. L&D is subject to a large scale, long-term evaluation (4).

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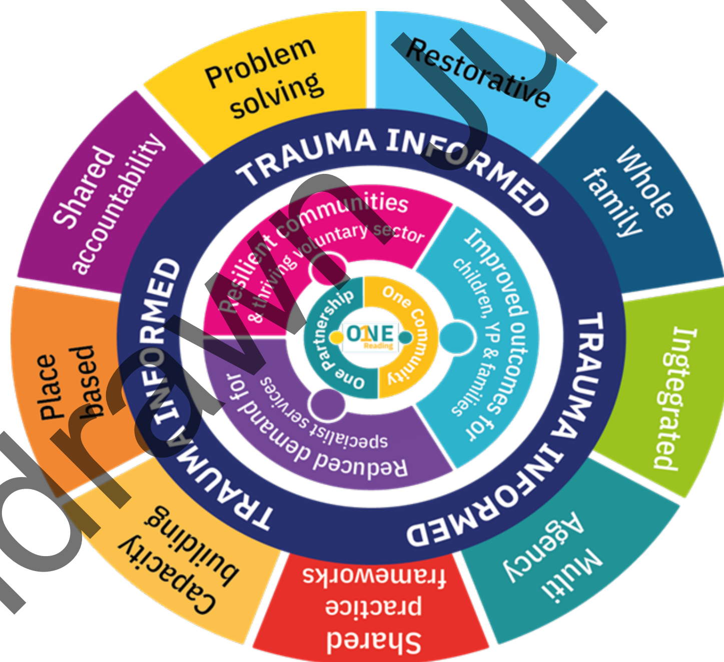
9. Bringing it all together

Areas from around the country have used a variety of approaches to implement a whole system approach which have been initiated by a range of stakeholders. Those associated with preventing offending and reoffending have been led by police and crime commissioners, chief superintendents of police, health and wellbeing boards and community safety partnerships. There is no one right answer as to how the whole system approach is structured, but what is essential is start the process and work collaboratively across organisations to develop an approach to preventing youth offending, violence and re-offending by placing children and young people at the heart of collective action.

Case study 1: The Reading Model

Figure 17: One Reading Prevention and Early Intervention Partnership Model



Reading has some of the most affluent and the most deprived neighbourhoods in the whole of the UK. The recent Cities Outlook report on the UK's largest city economies suggests that Reading is the 4th least equal city (after Oxford, Cambridge and London).

Tackling crime and exploitation in this environment needs coordination across sectors and the Reading-wide 'Joining the Dots' (JtD) project brings people together from public sector, business, and charity/voluntary organisations for weekly, and larger monthly, problem-solving meetings based on a distributed leadership model. JtD was established by the police with early and active participation by Reading Borough Council

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and the Royal Berkshire Hospital. Early scanning sessions identified assets within organisations and our communities whereupon a 'value' market emerged and groups were able to identify opportunities to link together across systems and exchange effort, space, information, and other resources for the common good. An important focus of the Reading Model is that it focuses on 'family' interventions.

Objectives
To reduce offending and re-offending by children in Reading by:

- reducing the threat, harm, and vulnerability of children and young people in Reading from exploitation by criminals
- ensuring that children and young people in Reading were not being criminalised through exploitation
- embedding a trauma informed and public health approach to policing these issues

Scanning
Scanning of information systems towards the end of 2017 revealed a small and sudden rise in antisocial behaviour, including street violence among children and young people in Reading.

Analysis
Analysis identified an emergence of social media representations of gang culture and the exploitation of young people by 'county lines' drug dealers. A link was identified between 'missing from home' reports and involvement in crime.

Response

Improve the data picture
Create a strategic management group (SMG) of cross-sector partners to drive an operational group with a focus on sharing information, knowledge, and data in order to identify vulnerability and opportunity. Wide use of data sharing agreements, with a whole family approach to understanding the issues. Capture emerging data from interventions to understand the needs and issues of those most affected, linking with the Reading Troubled Families Programme and the local youth offending service.

Improve leadership and engagement
Identify leadership of thematic areas to increase engagement with organisations and communities. The Multi-Agency Support Team (MAST) was created to generate collective impact. Engagement officers established for e.g. schools, antisocial behaviour, mental health, youth engagement, enforcement and neighbourhood policing teams restructured to provide more focus on building community resources e.g. safer neighbourhood forums and police/community groups e.g. MiniPolice. increase social media presence via dedicated Facebook, Twitter and Instagram accounts.

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Improve organisational capacity and capability
Use the outputs from the scanning and analysis exercises to identify areas of need and make improvements to knowledge, practice, and resources e.g. bringing youth workers into the MAST and restructuring some partnership meetings e.g. missing from home risk meeting. Briefings on resilience and trauma informed practice for all agencies and community members.

Outcomes
Although there has been a general rise in recorded violent crime across Thames Valley, Reading Local Policing Area is bucking the trend with lower increases and vastly improved outcomes. Missing from home episodes for the most vulnerable children and young people are down 80% and involvement in crime is trending towards zero. Work is ongoing to develop a return on investment model to support further investment across organisations on early intervention.

For a more detailed review of practice see:
https://cleph.com.au/application/files/6815/3249/4877/Reading_PPH_July_2018_Stan_Gilmour.pdf

Case study 2: Building resilient communities to take action on ACEs in Gloucestershire

In November 2017, Gloucestershire's health and wellbeing board held a special meeting on the impact of adverse childhood experiences (ACEs) and resolved to bring communities and organisations together to develop an informed, county-wide approach. As a result of the meeting an ACEs panel was formed, bringing together representatives from local voluntary sector organisations, elected members and statutory agencies to develop an ACEs strategy for Gloucestershire.

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Figure 18: Summary of Gloucestershire's Strategy on ACEs

The ACEs strategy sets out a vision for a resilient Gloucestershire where communities and organisations are aware of, able to talk about and take action on ACEs. It gives a message of hope; that the potential negative effects of ACEs can be overcome by building resilience, and that ACEs can be prevented in future generations. It encourages people to change the question from 'what's wrong with you' to 'what's happened to you'. It gives people a common language for talking about adversity and resilience. The full strategy (along with other resources) is available on our website www.actionaces.org

Three specific examples from the strategy that are most relevant to reducing offending and re-offending in young people are as follows.

The Aston Project

The Aston Project is a police-led project working with children by utilising a work for reward ethos. The referral form includes ACEs questions which helps to inform the staff working with the children from the start, with staff then briefed to be ACE aware in all of their interactions with the children. Children take part in constructive activities for which they earn credits, such as volunteering at community events.

This gives them the opportunity to build positive peer connections, connect with wider community in a positive way, work alongside PCSOs and volunteers who act as trusted adults and positive role models, and to feel a strong sense of inclusion – or in other words to build resilience. They then get the opportunity to spend their credits and enjoy a reward activity of their choice. Further information can be found at www.astonproject.co.uk

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Children First

Children First is a diversion scheme that aims to divert children away from the formal criminal justice system. Its objectives are early intervention, practical and effective partnership working, information sharing, and the progressive replacement of criminalising sanctions with restorative practice approaches in child offender cases.

A joint decision-making panel (JDP) consisting of police sergeants, youth support team managers and an NHS mental health colleagues accesses information from across the partnership, in order to make informed decisions on sentencing options. The vast majority of cases are dealt with through a Youth Restorative Intervention (YRI) although the JDP are also able to recommend youth cautions or charging where appropriate.

The YRI does not attract a criminal record. In the first year of the scheme, the JDP has considered a total of 331 cases, with 243 YRIs being given as a direct alternative to a formal criminal sanction.

Operation Mamushi

An understanding of ACEs is being used in partnership work on Operation Mamushi, targeting young people being criminally exploited. The majority of these young people have an ACEs score of 4 or more. By taking an ACEs approach support plans can be developed that focus on building resilience and reducing the impact of their experiences of trauma.

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11. Appendix

This resource has been developed with a range of stakeholders across academia, national and local government and the third sector. A steering group committee and focus groups were set up with representation from policy, commissioning and provider organisations, including:

- Public Health England
- Ministry of Justice
- Home Office
- Youth Justice Board
- Department of Health and Social Care
- Ministry of Housing, Communities & Local Government
- NHS England and NHS Improvement
- The Office of the Children's Commissioner
- Thames Valley Police
- Revolving Doors
- Exeter University
- Gloucestershire County Council

Methodology

This resource was developed using a range of methodologies: a structured literature review to underpin the development of the framework, qualitative stakeholder interviews, a stakeholder workshop and expert committee to review the framework and a focus group with experts by experience.

Two structured literature reviews were undertaken to identify key area; one on identifying the risk factors associated with youth offenders and effective interventions and the second on youth offending and school exclusion.

This has been complemented by a 'deep dive' approach informed by qualitative interviews with key stakeholders (see Table 1), a series of workshops at a national and local level to gain insight from main stakeholders who work in the system as well as qualitative interviews with children in contact with the criminal justice system and. A small expert editorial committee reviewed the development of the framework. A focus group was also held with experts by experience. A limitation of this resource is the difficulty experienced in engaging a wide range of children and young people who have had experience with the youth justice system.

This report highlights relevant literature and guidance which is applicable to taking a public health approach to preventing youth offending and re-offending and violence. It

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provides an overview and helps to point readers who wish to have a more comprehensive understanding into different action areas to the relevant more detailed guidance.

Table 1: Qualitative Stakeholder Interviewees

Name	Job Title/ Organisation
Nick Hunt	Head of Tackling Crime Unit, Home Office
Colin Wilson	Deputy Director, SOC Prevent & Partnerships
Charile Taylor	Chair of the Youth Justice Board for England and Wales
Caroline Twitchett	Children Quality Lead, NHS England
Sue Sylvester	Senior Development Lead, NHS England
Clare Toogood	Director Youth Justice Policy
Prathiba Chitsabesan	(Consultant Child and Adolescent Psychiatrist and CAMHS Strategic Lead (PENNINE Care NHS Foundation Trust) and Associate National Clinical Director for Children and Young People's Mental Health (NHS England)
Christina Marriott	Chief Executive, Revolving Doors
Cecil Sinclair	Troubled Families, Policy advisor
Superintendant Stan Gilmour	LPA Commander, Reading Police
Claire Dhami	Implementation Director Public Service Reform & Inclusive Growth, West Midland Combined Authority
Professor Huw Williams	Professor in Clinical Neuropsychology, Co-Director - Centre for Clinical Neuropsychology Research (CCNR). Exeter University
Professor Mark Bellis	Director of Policy, Research and International Development, Public Health Wales

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Literature review

Two structured literature reviews were undertaken to identify key area; one on identifying the risk factors associated with youth offenders and effective interventions and the second on youth offending and school exclusion. Thirteen databases were included in the first search outlined in the table below. Search terms were developed to identify relevant papers but have not been included due to their length, 214 papers were reviewed.

Summary of resources searched and results: Identifying the Risk Factors associated with Youth Offenders and effective interventions

Source	Initial Results	De-Duplicated Results	Screened Results
BASE	255	196	13
CINAHL	228	102	9
Cochrane Library	7	7	3
Cochrane TRIALS	136	134	13
Embase	687	292	12
ERIC	336	295	15
HMIC	16	9	3
Medline	708	708	32
NICE Evidence	248	190	33
Other (specify)	6	6	9
Scholar	0	0	0
SCOPUS	724	465	24
Social Care Online	286	260	34
Social Policy and Practice	188	93	13
TOTAL	**3825**	**2757**	**214**

For the second literature review 10 databases were searched which resulted in 98 papers being reviewed. The table below summaries the results.

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Summary of resources searched and results: Youth Offending and School Exclusion

Source	Initial Results	De-Duplicated Results	Screened Results
Cochrane Library	0	0	0
Cochrane TRIALS	27	7	0
Embase	211	132	17
Emcare	206	205	11
HMIC	1	0	0
Medline	98	27	9
NICE Evidence	110	99	25
SCOPUS	76	63	20
Social Care Online	19	16	3
Social Policy and Practice	11	9	6
TOTAL	**759**	**558**	**98**

For each search, duplicate records were removed before titles were screened for relevance. Abstracts and full articles were then reviewed for eligibility by 2 researchers. Reference lists of included papers were screened for relevant articles and a search of the grey literature was performed using the Google search engine. Documents and papers recommended by experts in the field were also reviewed.

No limit was placed on type of publication, study design, or location of study. Limits were set to include publications from 2000 onwards. The types of articles ranged from opinion pieces and simple observational methods to systematic reviews and existing guidance.

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