

YOUNG LIVES BEHIND BARS:

The health and human rights of
children and young people detained
in the criminal justice system

A British Medical Association report
BMA Ethics Department 2014

BMA 

Foreword

This report represents an intersection between two vital parts of the British Medical Association's work on improving and protecting health: our work on child health; and our work on health-related human rights, on both a national and international stage.

We believe that every child in the UK is born with an equal right to the conditions necessary for good physical, mental, and emotional wellbeing. We know, however, that this is not always realised. This is especially true for the huge numbers of children and young people who come into contact with the youth justice system every year. The scale of need experienced by this group makes for uncomfortable reading. They are, by almost every metric, some of the most vulnerable and disadvantaged members of our society.

Amongst the depressing statistics, however, lies a glimmer of hope: the opportunities we as healthcare professionals have to make a difference to the lives of children and young people who offend; to mitigate some of the underlying causes of offending; and to divert them away from the criminal justice system. This report makes a number of recommendations and provides guidance designed to support practitioners working with these children and young people, both in the community and within custodial settings.

Healthcare professionals do not and cannot work in a vacuum. If we are to meet the needs of these children and young people, there must be action from those involved in commissioning healthcare to address aspects of services that are currently failing, and from policy makers to tackle features of the secure estate that have a deleterious effect on health and wellbeing. In this respect, the recommendations made in this report must also inform the work of these agencies and institutions.

The report is realistic. Many of the problems facing these children and young people extend far beyond the reach of medical intervention by doctors. What cannot be ignored, however, are the opportunities for health-related interventions that can and must be taken. All too often, this group of children and young people are overlooked or let down by the very health and social care services meant to protect and promote their health and wellbeing. It is my hope this report will see the beginning of real change.



Dr Mark Porter
Chair of Council
British Medical Association

Foreword

The British Medical Association sets out with clarity and integrity the human rights principles that provide the foundation for good work with vulnerable children in trouble with the law. Its report comes at a time when the nature of child imprisonment is once more under Parliamentary scrutiny. New legislative proposals include the re-introduction of use of restraint, not only as a last resort to prevent harm, but also as a means to maintain good order and discipline.

The fundamental principle that governs a healthy prison system – that people are sent to prison as a punishment, not for punishment – all too often risks being undermined by political efforts to make regimes seem, or indeed become, more punitive and by a determined emphasis on ‘proper punishment’.

Yet most of the children and young people punished by imprisonment know about punishment already. Long before they get into trouble and become caught up in the criminal justice system, very many young offenders are used to punishment – not as a measured, proportionate response to wrongdoing but as random acts of cruelty or abuse often born of frustration and ignorance. What has not been part of their lives is consistent care, clear guidelines, a sense of wellbeing and an understanding of reparation and a means to make amends.

As this report makes clear, young offender institutions and other places of youth detention are not full of happy, healthy children and young people. The Prison Reform Trust commissioned a study of children in prison to learn more about the 6,000 children who went into some form of custody in the six months from July to December in 2008. Led by Professor Mike Hough and Dr Jessica Jacobson and colleagues then at King’s College, the study, *‘Punishing Disadvantage’*, focused on who are the children who end up in custody, and what crimes have they committed that necessitate being detained. Around 40 per cent of those children had been on the child protection register. About 70 per cent were already known to social services. High numbers had truanted and experienced parental neglect or untimely bereavement. Many had unmet mental health needs or a learning disability or difficulty. A depressingly familiar story for health and justice professionals and others who care for vulnerable young people.

Colin Moses gave his views as he stepped down as longstanding Chairman of the Prison Officers’ Association: *‘When it comes to lights out time and you then could stand outside those prison wings and hear the chatter that goes on from the windows and those who’ve been bullied at school, those who’ve been bullied in their homes, many of whom have been sexually abused before they’ve come to prison and you hear them themselves being bullied again or taunting and that is the 24 hour cycle in a prison. The cries for help, those young men who go to bed at night and become bedwetters. Those young men who go to the library and pick up the book with the biggest pictures in, because they don’t want people to know that they can’t read and write. They may have the muscles of an adult, but what they really are are young men crying out for help. Yes there are some bad offenders in there, there are people who’ve done some horrendous things, but what we have is a system that is totally overburdened and under resourced that will not work in those circumstances.’*

The BMA is right to challenge any policies, operational measures or institutional practices that do not meet exacting human rights standards. It asserts that ‘every child in the UK is born with an equal right to the conditions necessary for good physical, psychological and emotional health and wellbeing’. It points out that ‘tragically this is not always realised, not least for the thousands of children and young people who come into contact with the criminal justice system in the UK every year.’

This timely, authoritative report presents an overview of the complex reasons why children and young people offend, their multiple needs and the challenges they present. It enables practitioners and policy makers to reflect on their work with young people in trouble. And it asks the simplest of question which, in the context of criminal justice, are often the hardest to answer: 'How can children begin to thrive? What helps keep vulnerable children and young people safe?

Not all, but very many, of the solutions to youth crime lie outside prison bars in early intervention, support for troubled families, child and adolescent mental health, social care, treatment for addictions and ensuring that children and young people are supported to take responsibility and find solutions for themselves. An almost 60 percent reduction in child imprisonment over the last seven years, a resounding triumph across departments and for successive governments, offers a tremendous opportunity for health and justice professionals to focus on the most vulnerable children and help them to get out of trouble.

If you ever wanted to build up the adult prison population of the future, then you would lock up children and young people in bleak, unhealthy institutions. As outlined by the BMA, the need to take a consistent, professional approach underpinned by human rights principles cannot be over-stressed. Why? Because it is evidence-based, stands free of short-term political considerations and is the right thing to do.

Juliet Lyon CBE
Director of the Prison Reform Trust

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Executive Summary

The British Medical Association (BMA) is an independent trade union and voluntary professional association, representing over 152,000 doctors and medical students working in all branches of medicine across the UK.

As part of our commitment to upholding the dignity and integrity of the medical profession, the BMA has worked for many years both nationally and internationally to promote health-related human rights. In addition to drawing attention to global abuses of these rights, particularly where doctors are the victims, witnesses or perpetrators of abuse, we have long advocated on behalf of individuals and marginalised populations whose health-related rights are infringed, both in the UK and internationally. It is as part of this commitment that we have produced this report on the health and human rights of children and young people detained in the criminal justice system in the UK.

Every child in the UK is born with an equal right to the conditions necessary for good physical, psychological, and emotional health and wellbeing. Tragically, this is not always realised, not least for the thousands of children and young people who come into contact with the criminal justice system in the UK every year. Children and young people who offend are amongst the most vulnerable and disadvantaged members of our society. Despite their high level of need, they are all too often overlooked or let down by the very health and social care services designed to promote their health and wellbeing. Inevitably, this leads to further deprivation and to increased marginalisation from society.

The multitude of problems and hardships facing these children and young people, and the reasons underlying their offending behaviour, are complex. Not all of them can be addressed directly by health professionals. But despite their complex needs and the current pressures on services, there are clear opportunities for health professionals to help mitigate some of the underlying causes of offending and to help steer children and young people away from crime. Where children do end up detained, there are also valuable opportunities both to address their previously unmet health needs, and to help prepare them to leave the secure estate and lead healthier lives back in the community.

In addition to vividly illustrating the journey of children and young people into, through, and out of the youth secure estate, we make a number of recommendations intended to support individual practitioners, working both in the community and within custodial settings. We also demand action from commissioners to address those aspects of the healthcare service which are currently failing children and young people; and from policy makers to address features of the secure estate that are detrimental to health and well-being. Specifically, we identify:

- The crucial role health professionals can play at a very early stage in the lives of children and young people in recognising risk factors for future offending – both in the child and in their families – and seizing opportunities for intervention.
- The importance of ensuring health professionals are appropriately trained and supported in delivering care to children and young people.
- The importance of redoubling the commitment to achieving parity of care between the secure estate and the community.
- The vital role that health professionals can play as patient advocates; in raising standards of healthcare within the secure estate; in highlighting concerns about mistreatment of children and young people to the proper authorities; and in encouraging both healthy behaviour and interactions with health services beyond their time in detention.
- The importance of keeping the doctor's therapeutic and welfare role distinct from the disciplinary or punitive aspects of the secure estate.

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- The urgent need to develop planned approaches to meeting the specific health needs of children and young people, and to reshape or design services to meet those needs. We identify in particular the importance of commissioning high quality mental health, sexual health, and drug and alcohol services for children and young people, and we call upon commissioners to minimise cuts to these services in a time of austerity.
 - The need to ensure robust information-sharing systems and joint-working practices between custody and community services. This will ensure accurate assessment of the needs of children and young people entering custody, and support continuity of care after they leave detention.
 - The need to address, as a priority, practices in the secure estate – including the use of restraint, force and segregation – which are detrimental to health and wellbeing. Longer term, we call upon the government to carry out an in-depth review of the youth secure estate with a view to exploring more welfare-based alternatives to custodial detention.

The report highlights the crucial role that both health services and individual practitioners can play in fulfilling the state's fundamental responsibilities for the welfare of children and young people in contact with the criminal justice system, many of whom will have been let down at multiple levels prior to their detention. These concerns and recommendations must inform the decisions of commissioners and policy makers. Protecting, promoting and realising the health-related human rights of children and young people have the potential to change the trajectory of their lives; create safer communities; improve the health and wellbeing of the wider population; and ultimately, bring real benefits to us all.

Preface: Sara's story

The journey into detention

When Sara was 10 she was forced to leave the family home with her mother and sister because of domestic violence. Sara found the change difficult. She missed her father, at one point returning to live with him, but she had to leave when he again became violent. By the time she was 13 she was struggling at school, she was truanting, mixing with older men, drinking and taking drugs. Social services eventually took her into local authority care although she ran away and stayed with friends. She had also started to harm herself, sometimes quite badly.

Her mother tried repeatedly to get Sara a referral to mental health services and she was eventually given a short voluntary placement in a psychiatric hospital. Sara improved and was discharged with the promise of an intensive support package. Unfortunately the support did not materialise and Sara returned to her abusive and risky behaviour.

Following conviction for grievous bodily harm, Sara spent nine months on remand before a forensic psychiatric assessment was finally funded. The assessment concluded that due to her age, Sara's problems were not yet clear cut enough to meet the criteria of the Mental Health Act 1983. Despite the recommendation that she be given a therapeutic residential placement, Sara was given an extended sentence of three years in custody.¹

Complex lives, complex systems

Sara's journey into detention is not unusual. Many of the children and young people in the criminal justice system come from chaotic home lives, often characterised by violence, abuse or neglect, circumstances which can result in time spent in local authority care. In the months or years before a sentencing decision is made, or before offending behaviour emerges, they often exhibit an inability to cope. Poor performance and behaviour at school, including truanting, can result in exclusion from the mainstream education system. Alcohol and drug misuse, and self harm, are also common and can be indicative of underlying mental health problems. These behaviours can stem from abuse by adults, including sexual exploitation. In summary, many of the children and young people entering detention are not, for complex reasons, thriving, socially, emotionally or physically. Even before they are detained, they are among the most vulnerable individuals in our society.

The complexity and multiplicity of the disadvantage experienced by detained children and young people suggests that they will have had extensive contact with health and social care agencies prior to detention. But for many, this is not the case. The contact they do have can also fail to provide the support that is needed. For Sara, the promised support failed to materialise and opportunities for early intervention were missed. Some of these vulnerable children and young people can present with extremely challenging behaviour. Chaotic personal and home lives can also make continuity of care difficult, particularly where support is required from several agencies. Where mental ill-health is linked to anti-social or offending behaviour, interventions often focus on the behaviour itself rather than on its underlying causes, so that further chances for intervention are lost, as are opportunities to prevent the devastating consequences, for victims and wider society, of further offending behaviour.

As in Sara's case, there can be particular challenges in relation to mental health diagnoses for children. Uncertainties about child and adolescent development can also mean there are no obvious, clearly marked healthcare pathways for them. Put simply, inadequacies in the systems through which these children pass, combined with complex needs, mean that they often fall between the cracks, and time spent in custody becomes an almost inevitable consequence. As one young woman put it, "We've all been through social services, foster, children's homes, getting kicked out of school, secure unit...I'm sure we've all been through that road. It's like a journey and we've all collected our tickets on the way."²

Interaction with health and social care services means interaction with healthcare professionals. It is vital to identify and strengthen the part health professionals can play at this early stage in supporting and safeguarding vulnerable children who are not yet in custody.

The revolving door: into, out of and back into detention

Sara struggled in the secure training centre (STC). She refused to leave her cell for the first six weeks and was eventually moved to a smaller 15-bed female unit. After establishing a close relationship with the youth offending team (YOT) worker she improved, managing her anger better and she began to reflect on her future.

Sara was released on parole at the age of 17 but was recalled following an angry outburst at one of the YOT staff. She spent a further nine months in the same small unit and again made good progress. She was released into supported accommodation and was offered 25 hours intensive support a week from the YOT. She was also promised the support of a child-care social worker (because of her period spent in care) to help her look for independent accommodation. Again, little of the promised support materialised. In addition, Sara was unable to build on the educational progress made in custody because she was refused access to local colleges due to her history of violence.

After six weeks back home, Sara got drunk with an older male who then assaulted her. The YOT took the view that Sara was not vulnerable but just 'badly behaved' and had brought the assault on herself because she had been drinking. No new offences had been committed but Sara was taken back into custody.

Sara's custody worker felt that, among other services, Sara needed additional child and adolescent mental health service (CAMHS) input. The secure unit had itself struggled to commission a service from CAMHS, although this changed during Sara's second return to custody when they took on a specialist CAMHS worker for the first time.

Vulnerable people, fundamental rights

Custody is, in theory at least, a measure of last resort, imposed because of the risk the child presents to others and the state's obligation to protect the rights of those others to be free from harm. In the view of the sentencing judge in Sara's case, her serious violent offence warranted a significant period in custody. Yet Sara, as with all detained children and young people, retained fundamental interests that are protected by law. Incarcerated children still require protection from harm, the provision of treatment for health-related matters, and support for emotional wellbeing while in detention. When a decision is made to incarcerate a child or young person, the state becomes responsible for curtailing his or her fundamental liberty rights, and, in doing so, also assumes a protective role. The state is legally obliged to promote and safeguard the child's welfare and wellbeing. These obligations are set out in both the United Nations Convention on the Rights of the Child (UNCRC) to which the UK is party, the Human Rights Act 1998 and the Children Act 1989.

Human rights and the health needs of young people in detention

In custodial settings, where children and young people are separated from their families or other support networks and are less able to promote their own interests, obligations on the state and its employees become more emphatic. Among the binding obligations on states is the requirement to ensure that detained children and young people have access to healthcare that is appropriate for their age and health needs; obligations that, as we saw in Sara's case, are not always met. Children in secure settings, therefore, have fundamental rights both to health and to healthcare. In part this obligation is of course fulfilled by doctors and other healthcare professionals practising in secure environments and this is one reason why we frame this report in terms of human rights. But there are other factors at work that make a human rights approach productive. Tensions can arise between the state's obligations to protect the public and its obligation to protect the child in its custody. This

conflict can, in turn, be experienced by health professionals working in custodial settings where the primary obligation to promote the welfare of patients can come into conflict with obligations to the institution within which they work. This is sometimes described as the problem of dual or conflicting loyalties. There is also the more direct problem of the state's failure, in some instances, to protect and promote the health rights of detained children and young people. The Children's Commissioner and the Equality and Human Rights Commission have recently identified the unmet health needs of young people within the youth justice setting as a critical human rights challenge in England.³

Care and custody – tensions and opportunities

Delivering effective care and treatment to an already vulnerable and disadvantaged patient population can be challenging in the secure environment. The decision to detain is of course a significant step, but it does not represent a break with the past for the child or young person concerned. Their need for specialist support and help does not go away but must be met in an environment that is not always conducive to the promotion of health and wellbeing. As Sara found, going into detention can be an overwhelming experience that can exacerbate existing mental health problems and anxieties. When children are placed at long distances from their families, friends and carers, in institutions that are unfamiliar and intimidating, it is easy to see how the problems that may have led the child to offend can be intensified. Failures in the provision of appropriate support are just as relevant to the detention setting as to the child's experience prior to detention, and the cracks through which these children so often fall still remain. Being in custody may actually restrict access to certain services, depending on commissioning arrangements, as well as to education and training opportunities beyond custody. It can be very difficult for individual health professionals to try and ensure that the right services are available, and the right children and young people get access to them, when this requires systems, not just individuals, to work effectively and to share information.

If one section of this report addresses itself to the health needs of struggling children and young people in the community, the next focuses on how healthcare professionals can maximise the opportunities to protect and promote the health of children and young people who are in custody. Without dismissing the severity of the challenges outlined above, detention can also present a unique opportunity to begin to address the health needs of these children and young people properly. Detention can bring, for a period, structure and predictability to lives that have often been characterised by instability and uncertainty. Underlying, long-term health problems, both physical and psycho-social can, given appropriate resources and support, be identified and addressed.

This report is not about sentencing practice, yet sentencing decisions, like the one made by the judge in Sara's case and by the YOT who recommended recalling her into detention for a second time, have a direct impact on the delivery of healthcare services for detained children and young people, especially where behaviours indicating, for example, a mental health need are criminalised rather than treated. At times the tension between the demands of criminal justice, and the genuine health needs of those in custody, cannot be wished away. In spite of these challenges, as Sara's experience makes clear, genuine progress can be made in secure settings. Underlying mental and physical health problems can be constructively addressed. Lives really can be changed.

Beyond detention, beyond childhood

With her 18th birthday approaching, Sara faced a number of further potential setbacks, including the departure of her trusted YOT worker from the smaller unit and a move to an adult female unit within the same prison. Just before her move, having not self-harmed for years, Sara tried to take her own life. She didn't know why but said that everything had suddenly got on top of her. She was then assessed by a CAMHS psychiatrist and a mental health diagnosis was indicated for the first time.

Sara had by this time spent two and a half years in custody, and was likely to remain there for some time.

As the experiences of Sara and many others testify, times of transition, whether they are between the community and custodial institutions, or within and between institutions, can be difficult for vulnerable children and young people. The movement out into the community can be particularly fraught with difficulty as the structures of confinement and care are left behind. The state's responsibilities for children and young people who have been detained neither cease when a custodial sentence comes to an end, nor when an individual reaches 18. Care and support structured to meet the needs of vulnerable children and young people during these transitional times are essential. In Sara's case, her chances of accessing the support and services to enable her to live independently in the community without reoffending would be influenced by the fact that, in many areas, 16 to 18 year olds fall into the gap between children and adult mental health services. This can increase the likelihood that they will experience significantly reduced life chances as well as costly long-term mental health and sometimes behavioural problems as adults. Although some specialist services are beginning to emerge for adults with personality disorders, young women under the age of 18 will not meet the criteria for a diagnosis and will continue to face particular challenges.

Joining up the care and support – making rights a reality

Sara is by no means unique. Sadly there are too many young people in our society who, failing to thrive socially and emotionally, become, for complex reasons, involved in criminal behaviour and spend a period of time in the secure estate. Nor is this account of Sara's journey unique. The interplay of complex needs and multiple, overstretched and fragmentary services that have characterised her passage through detention will be all too familiar to those who work in the secure estate. We also have to be realistic: resources are limited and working with young people with complex needs can be challenging. There will always be some tension between the disciplinary needs of custodial institutions and the ability to support the wellbeing of the young people they house. Prison is, by its very nature, a punishment, and discipline is an integral part of it. The cultures of some juvenile institutions are also still far from healthy.⁴ But when a child or young person is confined by the state, the state takes on a legally and morally binding obligation to protect and to promote his or her health and wellbeing *in loco parentis*. Sara's story makes it clear that in a variety of ways this is not always happening. This report is designed to help health professionals help these young people. Because this is also about fulfilling the state's fundamental obligations we have configured it in terms of fundamental rights. These children and young people frequently have the worst possible start in life. In taking over responsibility for their wellbeing, the least the state can do is protect and promote their basic human rights.

Chapter One: Introduction

"When mothers hand over the care of their children to the state, they expect a role to be fulfilled."

(Mother of Joseph Scholes, who died in youth custody, aged 16.)⁵

What is this report about?

Joseph Scholes' mother expected the state to look after her son when he was placed in custody in a young offenders' institution after he was convicted of robbery. Sara, whose story is told in the preface, was also placed in a number of secure settings, first on remand, and later following conviction. In these settings, the state's role, its duties and obligations with regard to protecting the wellbeing of children, is performed by a number of different professionals – including prison officers, youth offending teams, social workers and health professionals. This report focuses specifically on the role and responsibilities of doctors and other health professionals in protecting, promoting and realising the health-related rights of children who have been removed from the community, and the care of their parents or guardians, and placed into secure accommodation. Although many of the issues will be the same, the focus of the report is on children and young people in the criminal justice system, not those held for procedural purposes in immigration detention.

The nature of the problem

In 2012/13 the average population of young people (under 18s) in custody was 1,544. In the twelve months to March 2013, 2,780 young offenders were placed in custody. The average length of time spent in custody was 85 days. On the positive side, the numbers of young people held in secure settings, and the numbers of those being given custodial sentences has been falling rapidly, with reductions of 21% and 31%, respectively, from the previous year.⁶

Despite these trends, child detention remains a significant feature of the UK's youth justice system. The decline in numbers suggests that a higher proportion of those children placed into custody have committed the most serious offences, or are multiple offenders. Sentencing guidelines indicate that custodial sentences should be reserved for the most serious cases, with the purpose of punishing offending behaviour, protecting and supporting the child concerned, and, where relevant, protecting the wider public. The drop in the total number of children in the secure estate highlights the extremity of the circumstances of those who are still being detained. Although the numbers may be small relative to the child population, that these children are detained at all tells us something about their levels of need.

From the child's point of view, the secure setting represents the end of a line. Custodial detention is the most extreme form of social exclusion that can be imposed by the state, and, as Sara's story indicates, is often preceded by exclusion from mainstream education, family breakdown and some degree of community isolation, often characterised by anti-social behaviour that has escalated to offending. The statistics make for uncomfortable reading. A 2007 study by the Youth Justice Board (YJB) showed that three quarters of children and young people in custody had lived with someone other than a parent and 40% had been homeless in the six months before entering custody.⁷ A more recent study of young people aged 15 to 18 in custody showed that 24% of boys and 49% of girls had been in care.⁸ Bereavement and separation also feature significantly among children and young people who offend. A 2010 study by the Prison Reform Trust of 300 children and young people in custody and on remand showed that 12% were known to have lost a parent or sibling.⁹ In addition, approximately 60% of children in custody have 'significant' speech, language and learning difficulties;¹⁰ 25% to 30% are learning disabled; up to 50% have learning difficulties;¹¹ and over a third have a diagnosed mental health disorder.¹² In short, it is no exaggeration to say that these are highly vulnerable young people, and the state takes over responsibility for them at precisely the point when their needs are most acute.

Health and wellbeing

Although these young people require support in many areas of life, meeting health need is a key state responsibility, not just through treating illness, but also by promoting general health and wellbeing. In a consensus statement on promoting the health of young people in custody, the World Health Organisation (WHO) outlined the following objectives which also inform this report:

- To promote the physical, mental and social aspects of the health of young people in custody;
- To help prevent the deterioration of young people's health during or because of custody;
- To help young people in custody develop the knowledge, skills and confidence they need to enable them to adopt healthier behaviours that they can take back into the community with them.¹³

The statutory aim of the youth justice system is the prevention of offending by children. There is no necessary contradiction in aim therefore between the system of youth justice and the health professionals who work within it.

We know that the secure environment – which, at its worst, can be hostile, understaffed and underfunded – can be detrimental to wellbeing. Achieving the goals we have outlined is therefore always likely to be difficult and this report recognises the scale of the challenge involved. It does not try to suggest that all of the answers to the problems experienced by these children lie in health, but it does contend that healthcare, and in turn health professionals, are central to the fulfilment of the state's role and responsibilities. It also asserts a simple and fundamental truth: that health professionals can make a difference to the lives of children and young people in detention.

A rights-based approach

By limiting the fundamental liberty rights of these children, and taking them away from those, such as parents and carers, whose role is to support them, the state takes on an obligation to actively promote and protect their wellbeing. The minimal requirements of this obligation are set out in a series of legal provisions and conventions that are given in more detail in the following chapter.

When a child enters a secure setting, the state, and the individuals who fulfil the role of the state in their day-to-day life, are placed in a unique, and potentially conflicting, position. At once the state is responsible for *limiting* the child's rights – imprisonment being the strongest sanction, and the greatest infringement of individual rights legally available to the state – as well as *realising* their rights. Taking this relationship between the state and the individual as a starting point, this report will look at the health of children in secure settings, and specifically at the role of the health professional, from a rights perspective. Although the language of rights may not be a natural one for many health professionals, we believe that it speaks most eloquently to the problems created by the fundamental conflict at the heart of the state's obligations – to punish and to protect – as well as to the potential solutions, and the doctor's role in realising those solutions. Although health professionals will be more accustomed to thinking through the kinds of value conflict we describe here using the languages of medical ethics, there is no necessary contradiction. Medical ethics and human rights both focus on the fundamental importance and dignity of patients and both highlight the importance of working to realise their best interests. Both also recognise the existence of additional side-constraints and institutional challenges in the secure setting.

Human rights and doctors with dual obligations

Another reason we have chosen a human rights approach is because of the sharpness of some of the dual loyalties or obligations that doctors and other health professionals are subject to in detention settings. Dual loyalties arise for doctors in the presence of simultaneous obligations, express or implied, both to the individual patient and to a recognisable third party – in this case the secure institution. Although all doctors have a variety of obligations in addition to promoting the wellbeing of individual patients, these are usually in the background. In secure settings there is always a potential risk that doctors will be under pressure to subordinate the patient's interests in favour of those of the institution.¹⁴ These can lead to insidious pressures that undermine the rights of individual patients. Although the UK is thankfully free of the more flagrant rights violations associated with repressive

regimes, problems do occur: rights of access to healthcare can be severely restricted due to shortages of qualified staff and resources; discrimination against minority ethnic groups and others can become institutionalised; rights to confidentiality and to consent can be subject to institutional erosion. In these circumstances a rights-based approach can help doctors and other health professionals focus on their primary professional duties.

This report is about much more than episodes of institutional failure. The fact that a child ends up in detention indicates that he or she has been failed in some way and there have also been numerous detailed accounts of the ways in which institutions fail detained children. While this report in no way regards such failures as acceptable or inevitable, it is concerned with looking beyond failings to see what doctors can and should be doing in order to ensure that, in challenging circumstances, these children can begin to thrive.

The following chapters do this by focussing on the role of health professionals in fulfilling, protecting and promoting the health-related rights of children in secure settings. The report starts by looking at what these rights are and outlining the legal responsibilities of doctors in relation to them. It then goes on to consider, in what we hope is a thoughtful, narrative and practical way, how those rights can be realised before children enter the secure setting, while they are detained, and in the period following detention.

Who is the report for?

This report is primarily aimed at health professionals who work with children and young people in secure settings, children who are at risk of going into detention, or children who are living in the community following time spent in detention.

Since June 2013 healthcare professionals have been guided by a defined set of healthcare standards specifically relating to children and young people in secure settings, applicable across the UK.¹⁵ The publication of these intercollegiate standards was a vital step towards ensuring equivalence of care and in providing quality benchmarks against which healthcare provision can be measured. This report is not intended as a substitute for these or any other clinical standards. Instead it provides discussion and analysis around particular points of tension and difficulty in the doctor's role – many of which are in fact flagged up by the clinical guidelines and rules – thereby supporting doctors' decision making and good patient care.

The report and its recommendations are also designed to help inform the decisions of policy makers and commissioners that affect the treatment and care of children and young people in secure settings.

Scope of the report

This report considers children under the age of 18 years. Throughout the report, we refer to both 'children' and 'young people' and, although the latter is used to describe older children, unless otherwise stated, in both instances we mean those under 18. While we recognise that, in secure settings, young adults remain vulnerable, and as such should not be treated as 'adults' simply by virtue of being over 18, this report focuses on those who meet the legal definition of a child* and only considers young adults in the context of the transition out of detention.

The report aims to be applicable to medical practice in a range of secure settings, namely young offenders' institutions (YOIs), secure training centres (STCs), and secure children's homes (SCHs). Although health professionals working in police custody suites and immigration detention centres will also find aspects of the guidance useful, the focus is not on these settings, although we hope to produce future guidance for health professionals working in these areas. Where possible we have

* There is no single law that defines the age of a child across the UK. Specific age limits are set out in relevant laws and guidance and there are differences between the UK nations. In relation to child protection policies and procedures however, there is agreement across the UK that a child is anyone who has not yet reached their eighteenth birthday. In addition, Article 1 of the UN Convention on the Rights of the Child (UNCRC) states that a child means 'every human being below the age of eighteen years unless, under the law applicable to the child, majority is attained earlier'.

used examples that are relevant across some or all of these settings, while recognising the significant variations in the way different types of establishment are run, in the needs of the children they accommodate and in the way in which healthcare is delivered there.

The vast majority of institutions which hold young offenders are located in England, and so at many points the report may appear anglocentric. However our aim has been to explore issues and include examples that are applicable across the four home nations, whilst acknowledging that the legal context and relevant organisational structures differ markedly across the UK.

Structure of the report

Children rarely end up in a secure setting without having had previous encounters with the youth justice system. Hence, as seen in the preface, young people often describe a ‘journey’ through a variety of public institutions and state agencies, towards custody. Similarly, a detained child’s health needs, although they may be exacerbated by detention, do not begin on entry to a secure setting. A child’s time in a secure setting is not an isolated event without links to his or her previous experiences. For this reason the report adopts a structure that aims to reflect the whole course of a child’s journey, albeit with a focus on the time spent in the secure setting itself. Chapter two sets out the health-related rights and responsibilities of children and doctors respectively. This is followed by three chapters looking at the journey into detention, the period spent in the secure environment, and the journey out of detention. The report concludes with a series of practical recommendations, for doctors and other healthcare professionals, for commissioners of healthcare, and for policy makers.

Why is the BMA producing this report?

The object of this report is, first and foremost, to support doctors, and other health professionals, in supporting children and young people in secure settings. There are, however, a number of reasons why the BMA is producing this report now. We are living through a period of heightened public anxiety about the provision of care and treatment in a host of public and privately-run *open* institutions housing vulnerable adults. For example, the reports of the public inquiries into events at the Winterbourne View Hospital and at the Mid-Staffordshire NHS Foundation Trust have, in recent years, documented profound failings in the delivery of health and social care in open institutions. The risk of similar failings occurring, and going unchecked, is of course far greater in *closed* institutions, such as prisons where patient populations are deprived of their liberty and consequently are especially vulnerable. These risks are greater still when the detained population consists of children and young people, a uniquely vulnerable group.

We are also living through a period of real economic constraint. The UK’s public services are under significant financial pressure. There has been a government undertaking to protect the NHS budget, largely due to its political sensitivity, but there is much less public concern about the quality of service provision in the secure estate. For the last decade, the NHS has had responsibility for delivering health services in public sector prisons across the four home nations, and although this has gone some way to ensuring ‘equivalence of care’ between the community and the secure estate, prison health services across the UK remain under considerable and increasing pressure. In 2007 the BMA published a dossier of case studies documenting first-hand accounts of prison and police doctors in England and Wales.¹⁶ It highlighted the difficulties doctors experienced in securing the resources, infrastructure and time required to assess and treat the large number of detainees with severe mental health and drug addiction problems. A 2010 joint Care Quality Commission (CQC) and Her Majesty’s Inspectorate of Prisons’ (HMIP) study found that prison healthcare still failed to match up to NHS standards.¹⁷ This study related to Primary Care Trusts (PCTs) as commissioners of prison healthcare. Although more time will be required to assess provision now that this responsibility has passed to NHS England, the combination of highly pressurised resources and closed institutions can put severe stress on the rights of already vulnerable young people. It is vital therefore that health professionals have the tools to enable them to protect and promote the rights of the children and young people for whom they have responsibility in the secure setting.

The BMA, human rights and the wellbeing of children and young people

Since the 1970s the BMA has passed a series of resolutions that demonstrate a continuing interest in questions of human rights, social justice and the rights of marginalised groups and individuals to access healthcare.¹⁸ In more recent years, the BMA has also expressed growing concern about health inequalities and the social determinants of health in the UK.¹⁹

All doctors and health professionals are also likely to have an interest in child health and wellbeing. Many will provide direct care to children, or work with patients who have long-term health conditions that have their origins in childhood. The BMA has carried out influential work on a variety of important issues in child health, including nutrition, exercise, mental and sexual health, smoking, and alcohol and drug abuse. It has also published a series of synoptic reports looking at the impact of broader, systemic issues on overall child health and wellbeing, starting in 1979 with the publication of *Our Children's Health*. In 2013 the BMA published a fully updated edition of its report *Growing up in Britain*.²⁰ The report makes a powerful call for continuing investment in children's services, based on a life-course approach, in order to give all children in the UK the best possible start in life. Nowhere is this more in need than in relation to the children and young people who end up detained.

Chapter Two: The structure of children’s rights – an overview

There are three basic sources of children’s rights in the UK. These are the Children Act 1989; the Human Rights Act 1998; and the UN Convention on the Rights of the Child (UNCRC). These legal instruments are of different origin and although they share a range of common concerns, there may be times when they have different emphases or pull in slightly different directions. In this section we give a brief overview of the main legal features of these instruments, particularly where they are relevant to the care, treatment and wellbeing of children and young people in detention. We also provide some information on medical care as set out in the United Nations Rules for the Protection of Juveniles Deprived of their Liberty.

The Children Act 1989

The Children Act 1989 is the main piece of legislation setting out the legal framework for child protection procedures in the UK. Although based on the assumption that children are best cared for within their own families, the Act acknowledges that this is not always possible, and accords duties to local authorities, courts and other agencies in the UK to ensure that children are safeguarded and their welfare promoted.

Part I contains a number of fundamental principles that apply wherever the Act is used. These include:

- *The welfare principle*: When a court determines any question with respect to (a) the upbringing of a child, or (b) the administration of a child’s property...the child’s welfare shall be the court’s paramount concern.
- *The ‘no order’ principle*: A court will not make an order in relation to a child unless it considers that doing so would be better for the child than making no order.
- *Delay is prejudicial*: In relation to questions concerning the upbringing of a child ‘any delay in determining the question is likely to prejudice the welfare of the child.’²¹

The Human Rights Act 1998

The Human Rights Act 1998 (HRA) is a crucial source of legal protection for children and young people, as it incorporates the rights contained in the European Convention of Human Rights (ECHR) into UK law. This Act makes it unlawful for any public body to act in a way which is incompatible with the ECHR. It also provides claimants of a breach a direct domestic remedy, meaning that breaches of human rights can be directly heard in UK courts, without the need to go to the European Court of Human Rights (ECtHR) – although in hearing the cases, UK courts must take account of any decisions, judgment or opinion of the ECtHR. Some of the key rights enshrined in the ECHR, and thus protected by the HRA include:

Art. 2	Right to life
Art. 3	Right to freedom from torture and inhuman or degrading treatment
Art. 8	Respect for private and family life, home and correspondence
Art. 9	Freedom of thought, belief and religion
Art.10	Freedom of expression
Art. 14	Protection from discrimination in respect of these rights and freedoms

The United Nations Convention on the Rights of the Child

The United Nations Convention on the Rights of the Child (UNCRC) is a comprehensive and definitive statement of the fundamental civil, political, social, economic, cultural and health rights of children – defined as all those under the age of 18. It has four main aims, sometimes known as the '4 Ps': *Prevention, Protection, Provision and Participation*. There are rights designed to *prevent* harms to children, such as avoidable ill-health, child-abduction and discrimination against children; rights designed to *protect* children from harms, such as cruel or inhuman treatment; rights relating to the *provision* of certain goods, such as education and welfare; and rights to ensure the fullest possible *participation* by children in society, including rights of access to freedom of information and expression of opinion.

The UNCRC was ratified by the UK in 1991, meaning that the country is bound to comply with it under international law. This means that whilst the UK is legally obliged to adopt policies that are in conformity with the obligations set out in the Convention, it does not accord legal rights in the sense of giving individual children a right to bring proceedings before national courts on the grounds of a breach²² – for this to happen, the Convention rights would have to be incorporated into English law, as has happened with the ECHR via the Human Rights Act. Having ratified the Convention the UK has assumed an obligation to 'respect, protect and to fulfil' the rights contained within it. The obligation to *respect* means that the State must refrain from interfering with the enjoyment of these rights by children. The obligation to *protect* means that the State must protect children from the abuse of their rights. And the obligation to *fulfil* means that the State must take positive action to enable children to enjoy their rights.²³ Compliance is assured by monitoring from the UN Committee on the Rights of the Child.

The Convention has 54 articles and most contain a basic right and corresponding obligation on behalf of the state. A brief selection, chosen for relevance to the secure setting, is given below.

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- Art. 3(1)* In all actions concerning children...the best interests of the child shall be a primary consideration.
- Art. 3(2)* A child has a right to such protection and care as is necessary for his or her well being.
- Art. 3(3)* The institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities.
- Art. 6(1)* Every child has the inherent right to life.
- Art. 6(2)* Every child has a right to survival and development.
- Art. 16* The right to privacy.
- Art. 19* The right to protection from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation.
- Art. 20* A child temporarily or permanently deprived of his or her family environment... shall be entitled to special protection and assistance.
- Art. 24* The right to the enjoyment of the highest attainable standard of health.
- Art. 28* The right to education.
- Art. 31* The right to rest and leisure appropriate to the age of the child.
- Art 37(a)* The right to be free from torture or other cruel, inhuman or degrading treatment or punishment.
- Art 37(c)* Every child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner which takes into account the needs of persons of his or her age.
- Art 40* Every child alleged as, accused of, or recognised as having infringed the penal law is to be treated in a manner consistent with the promotion of the child's sense of dignity and worth, which reinforces the child's respect for the human rights and fundamental freedoms of others and which takes into account the child's age and the desirability of promoting the child's reintegration and the child's assuming a constructive role in society.

The United Nations Rules for the Protection of Juveniles Deprived of their Liberty

Under the umbrella of the UNCRC, the United Nations General Assembly issued a series of rules relating to the regulation of the deprivation of liberty of children and young people. They provide an internationally recognised framework for the management of those under the age of eighteen who are deprived of their liberty, that are compliant with the Children's Convention. The Rules are based on the following fundamental principles:

- Deprivation of liberty should be a disposition of last resort and for the minimum period and should be limited to exceptional cases.
- Juveniles should only be deprived of their liberty in accordance with the principles and the procedures of international law.
- The establishment of small open facilities is encouraged to enable individualised treatment and to avoid the additional negative effects of deprivations of liberty.
- Deprivation of liberty should only be in facilities which guarantee meaningful activities and programmes promoting the health, self-respect, and sense of responsibility of juveniles. The facilities should also foster their skills to assist them in developing their potential as members of society.
- The detention facilities should be decentralised to enable access and contact with family members and to allow for integration into the community.
- The care of juveniles deprived of their liberty is a social service of great importance.
- All juveniles deprived of their liberty should be helped to understand their rights and obligations during detention and be informed of the goals of the care provided.
- Juvenile justice personnel should receive appropriate training including child welfare and human rights.
- All juveniles should benefit from arrangements designed to assist them in returning to society.²⁴

Although these are non-binding recommendations, they are of significant importance following the ratification by the UK of the UNCRC, and states will come under considerable scrutiny and pressure from the international community and the UN Committee on the Rights of the Child to comply. The Rules, whilst acknowledging that the wellbeing of children and young people who are detained depends upon a variety of factors, also set out a number of recommendations specifically relating to the provision of healthcare:

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49. Every juvenile shall receive adequate medical care, both preventive and remedial, including dental, ophthalmological and mental healthcare, as well as pharmaceutical products and special diets as medically indicated. All such medical care should, where possible, be provided to detained juveniles through the appropriate health facilities and services of the community in which the detention facility is located, in order to prevent stigmatization of the juvenile and promote self-respect and integration into the community.
 50. Every juvenile has a right to be examined by a physician immediately upon admission to a detention facility, for the purpose of recording any evidence of prior ill-treatment and identifying any physical or mental condition requiring medical attention.
 51. The medical services provided to juveniles should seek to detect and should treat any physical or mental illness, substance abuse or other condition that may hinder the integration of the juvenile into society. Every detention facility for juveniles should have immediate access to adequate medical facilities and equipment appropriate to the number and requirements of its residents and staff trained in preventive healthcare and the handling of medical emergencies. Every juvenile who is ill, who complains of illness or who demonstrates symptoms of physical or mental difficulties, should be examined promptly by a medical officer.
 52. Any medical officer who has reason to believe that the physical or mental health of a juvenile has been or will be injuriously affected by continued detention, a hunger strike or any condition of detention should report this fact immediately to the director of the detention facility in question and to the independent authority responsible for safeguarding the well-being of the juvenile.
 53. A juvenile who is suffering from mental illness should be treated in a specialized institution under independent medical management. Steps should be taken, by arrangement with appropriate agencies, to ensure any necessary continuation of mental healthcare after release.
 54. Juvenile detention facilities should adopt specialized drug abuse prevention and rehabilitation programmes administered by qualified personnel. These programmes should be adapted to the age, sex and other requirements of the juveniles concerned, and detoxification facilities and services staffed by trained personnel should be available to drug – or alcohol-dependent juveniles.
 55. Medicines should be administered only for necessary treatment on medical grounds and, when possible, after having obtained the informed consent of the juvenile concerned. In particular, they must not be administered with a view to eliciting information or a confession, as a punishment or as a means of restraint. Juveniles shall never be testees in the experimental use of drugs and treatment. The administration of any drug should always be authorized and carried out by qualified medical personnel.²⁵

Chapter Three: The journey into detention

What are the routes into detention?

The majority of children and young people who end up in detention represent, at one level, a kind of failure. The origins of offending behaviour are complex, but many of the children and young people in detention represent a failure by the individuals and agencies whose job it is to care and support them and a failure by wider society to ensure their flourishing. This failure can be understood in terms of children's rights. One of the primary goals of the UNCRC is to 'promote the full and harmonious development of the child's personality, talents and mental and physical abilities.' It is also to help foster in them the ability to live 'an individual and responsible life in a free society.'²⁶ These are the ordinary goals of parenting and children in detention are clearly struggling in some degree to benefit from them. They are also unable to find or to enjoy the necessary conditions for them to flourish as citizens. In this section we look at some of the factors that put children and young people at heightened risk of offending and at the challenges and opportunities presented to health professionals in supporting these children and young people in the community long before they come to the attention of the criminal justice system. Whilst we cannot stop all offending, there are key opportunities throughout childhood, and even before birth, to intervene and change the path that a young person takes. There is also much to learn from those children and young people from difficult backgrounds who *do* go on to thrive, and we address this in a section on protective factors. It is manifestly clear however that children and young people seldom thrive in the secure estate. Keeping children and young people at risk of offending in the community, and providing them with the services they need to grow towards independence will transform their life chances.

Children and young people at risk of offending – addressing the social determinants

The reasons why some children and young people are failing to thrive in our culture are complex and multi-factorial. Although disadvantage by itself does not *cause* offending behaviour – the majority of children and young people from disadvantaged backgrounds do not spend time in custody – such behaviour is strongly correlated with disadvantage. The strength of the correlation does mean that the impact of deprivation on the life-choices of children and young people has to form part of this response. To a significant degree, the social conditions in which children grow up shape their life-chances. The influential *Cambridge Study in Delinquent Development*, for example, identified that a combination of low family income, poor housing conditions and large family size was consistently linked to an increased risk of offending. Boys who, at the age of eight, were living in the lowest income families were twice as likely to have a criminal record at the age of 18 as those whose family incomes were 'adequate' or 'comfortable.'²⁷

In his work on the social determinants of health, Sir Michael Marmot and his colleagues have drawn scientific attention to the remarkable sensitivity of human health to the long term impact of the social environment.²⁸ The World Health Organization identified 10 major social contributors to poor health outcomes. Of those ten the following five are particularly prevalent amongst children and young people who go on to offend:

- *Stress*: 'Continuing anxiety, insecurity, low self-esteem, social isolation and lack of control over work and home life, have powerful effects on health.'
- *Early experience of deprivation*: 'Observational research and intervention studies show that the foundations of adult health are laid down in early childhood and before birth. Slow growth and poor emotional support raise the lifetime risk of poor physical health and reduce physical, cognitive and emotional functioning in adulthood.'
- *Social exclusion*: 'Being excluded from the life of society and treated as less than equal leads to worse health and greater risks of premature death... People who live in or have left, institutions, such as prisons, children's homes and psychiatric hospitals are particularly vulnerable.'
- *Addiction*: 'Drug use is both a response to social breakdown and an important factor in worsening the resulting inequalities in health.'

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- *Poor nutrition.* 'Social and economic conditions result in a social gradient in diet quality that contributes to health inequalities.'²⁹

A rights framework recognises that all members of society have a minimum set of vital interests that must be met. Approaching the needs of these children and young people through a rights framework acknowledges that children with different degrees of deprivation have different needs, and that the causes of deprivation – the causes of the causes of offending – must also be addressed. Although health professionals cannot meet them alone, they have an essential role as part of the network of services seeking to protect, promote and fulfil the rights of these vulnerable children and young people. Before we look at how health professionals can best contribute, it is worth outlining in slightly more detail the complex inter-meshed needs of this young group.

Vulnerable people, complex lives

Considerable numbers of children who enter the secure estate will have been identified as at risk long before they are taken into custody or are known to law enforcement agencies. In 2012 the Prison Reform Trust (PRT) published *Punishing Disadvantage*,³⁰ a detailed profile of children entering custody. The report was based on a randomly selected group of 200 children given custodial sentences in 2008. An outline of the findings is given below. Given the shortcomings of the data, the authors suggest that it is very likely that the report represents an under-estimate of the actual scale of disadvantage.

The PRT's report presents a powerful picture of the impact of what it calls 'multiple layers of disadvantage' among children in the secure estate. It locates offending behaviour in 'broader cycles of familial, psychosocial and other disadvantage'.³¹ The report quotes the academics Sampson and Laub who describe how 'weak social bonding serves as a mediating and hence causal sequential link in a chain of adversity between childhood delinquency and adult criminal behaviour.'³² Laub and Sampson link the process to 'four key institutions of social control – family, school, peers, and state sanctions.' They are clearly institutions of support as well as control and some of them offer vital opportunities for intervention in support of children at risk of offending.

Family life

The levels of pre-trial deprivation of children entering the secure estate make for challenging reading. Over three quarters had, at least for significant periods, an absent father, and 1 in 3 had an absent mother. Over half lived in a deprived household – defined as being dependent on benefits – and/or in accommodation unsuitable for their needs. A high proportion had parents or siblings involved in criminal activities – a separate study carried out by Murray and Farrington found that 65% of boys with a convicted father would go on to offend.³³ Nearly four out of ten had been the victims of abuse or neglect. Children in custody are over twice as likely to have been victims of abuse as those in the general population and nearly four times as likely to be living in a deprived household. Out of a list of 19 indicators of family-level disadvantage identified by the PRT, three quarters of the sample had three or more indicators while two-fifths had in excess of five. (Indicators included: an absent father; living in deprived or unsuitable accommodation; parents with alcohol or drug problems.)

Although the sample only contained 17 girls, and caution in extrapolating therefore needs to be exercised, there was considerable evidence of gender differences. Over half (59%) of the girls had witnessed domestic violence, compared to 25% of boys; 35% of girls had substance abusing mothers compared to 9% of boys; and 18% of girls had substance abusing fathers compared to 5% of boys. There were also some marked differences in terms of ethnicity: 35% of white and 30% of mixed race children had witnessed domestic violence compared to 6% of black and 0% of Asian children. The fathers of 47% of mixed race children and 17% of white children had been involved in criminal activity compared to 0% of black and Asian children.

In a separate, more finely-grained study commissioned by the Youth Justice Board,³⁴ the following familial factors were also correlated, though in complex ways, with a risk of later offending:

- Poor parental supervision and discipline, including where parents are harsh, cruel, highly inconsistent, passive or neglecting;
- Family conflict, particularly in the absence of a good relationship between the child and one or more of the parents;
- A family history of criminal activity;
- A combination of low income, poor housing and large family size.

Born into detention

A number of children are born into secure settings because their mothers are in prison. Women who give birth in prison can keep their baby for the first 18 months in a Mother and Baby Unit (MBU) of which there are currently seven in England and Wales.³⁵ Women with a child under the age of 18 months at the time of sentencing can also bring their child to prison with them. If a child is over the age of 18 months, or will reach the age of 18 months before the sentence is over, social services will make arrangements for the child to be cared for outside of prison.

As of June 2013, there were 31 women and 28 babies in MBUs, with the discrepancy in numbers accounted for by the fact that pregnant women were accommodated there.³⁶

Bereavement

The experience of bereavement is also a significant feature of the lives of children and young people in custody, with 1 in 8 of the PRT's sample known to have lost a parent or a sibling.³⁷ Others from the same sample had experienced the death of a close friend, and several seemed to have been powerfully affected by the loss of another close relative, such as an uncle or grandfather, particularly where the father was absent. Given the complex, overlapping problems that confront some children and young people, their emotional resilience to bereavement can be compromised and the loss of someone close to them can intensify self-destructive behaviour. A failure to understand precisely the profound psychological impact of bereavement can therefore lead to offending behaviour and ultimately, detention.

Social, psychological and educational disadvantages

Nowhere are the multiple difficulties that confront many of the children and young people who go on to offend starker, or more entangled, than in relation to their social, psychological and educational thriving. The complex interplay of challenging family circumstances, peer group pressures, emotional conflict, mental health problems and poor educational achievement present enormous challenges, both to young people, and to those who work in the services designed to help them. The data from *Punishing Disadvantage* gives some idea of the scale of the challenge. Of the sampled group of children and young people sentenced to custody, 70% were known to associate predominantly with criminal peers; over half truanted from school regularly; and almost half had been subject to fixed term or permanent school exclusions. A separate study found that 42% of 15-18 year old young men were 14 or younger the last time they were in education.³⁸

Nearly a third of those surveyed by the PRT had problems associated with drug and alcohol abuse, with over a quarter viewing drugs and alcohol as being essential to their wellbeing. Over a quarter had literacy and/or numeracy problems. A separate study by the Youth Justice Board also identified bullying as a risk factor, quoting a Norwegian study that found that 60% of known school bullies had been convicted of criminal offences by the age of 24.³⁹

The community contribution

Children who grow up in economically disadvantaged areas associated with poor housing, low levels of employment and high population turnover seem also to be at increased risk of being drawn into offending behaviour,⁴⁰ although it can be difficult to distinguish the impact of the environment from other risk factors that cluster around families living in deprived areas, such as low income and single parent households. The influence of environment seems to be at its highest at the time children enter school and then peaks again in late adolescence.⁴¹ Higher levels of youth offending and drug abuse, as well as increased rates of adult offending, are also associated with neighbourhoods that have poor physical environments associated with vandalism, fly-tipping and extensive graffiti. These environments can make it difficult for local people to form supportive networks and can undermine the attempts of parents, schools and faith groups to build strong communities.⁴²

Personal risk factors

We have seen the various ways in which complex social and familial factors can interact to expose children and young people to a risk of offending. In addition, research has identified certain personal characteristics that are strongly associated with antisocial behaviour. Although health professionals are seldom in a position directly to address the structural contributors to offending, some of these personal factors may bring vulnerable children and young people into contact with health services and therefore present opportunities to offer support.

One set of characteristics strongly linked to offending behaviour relates to hyperactivity and impulsivity. Recent studies in the UK indicate that around 45% of young offenders in the youth justice system have a childhood history of Attention Deficit Hyperactivity Disorder (ADHD).⁴³ The combination of educational underachievement, occupational disadvantage and anti-social behaviour associated with ADHD can lead to offending and contact with the criminal justice system. Those with 'persisting' symptoms will tend to start offending earlier, and be repeat offenders. ADHD is also the single most reliable predictor of violent offending, greater even than drug misuse. A 2012 Swedish study following over twenty-five thousand individuals diagnosed with ADHD, found that when participants were taking medication for ADHD, they were between 32% and 41% less likely to commit a crime than when they were off their medication for six months or more.⁴⁴ Combined with psychological therapies that include a focus on developing pro-social competences, timely and focused interventions can help reduce the risk that children and young people with ADHD will go on to offend.

In addition to problems with attention and impulsivity, there are a number of other personal factors linked to offending behaviour. Among these are a cluster of biological, social and psychological vulnerabilities that are linked to stress. Social and familial factors can induce short and long-term stress responses which can strongly affect wellbeing. In addition to the biological impact of stress, psychological responses can include heightened levels of depression and anxiety. These can by themselves lead to attention problems, restlessness and difficulties with empathy and emotional cognition, leading to further difficulties forming ordinary social bonds.⁴⁵ Moffitt's influential work on youth offending also identified the importance of factors often outside the control of the young person – including foetal exposure to alcohol and neuropsychological deficits⁴⁶ – that, when combined with other risks such as social and economic disadvantage, are strongly correlated with long-term offending.

The neurobiology of deprivation

Rapid developments in neuroscience have enabled researchers to look in considerable detail at the impacts of environmental stimuli on child brain development. Although some of this work remains speculative and has been the subject of controversy, it nonetheless shows the potential impact of environmental, social and psychological stressors on the biological development of the growing child. Given the extreme plasticity of the young brain, these changes can have life-long implications. Looked at neuro-developmentally, it seems likely that early exposure to abuse or deprivation, particularly if it is sustained, can lead to brain alterations that are linked to emotional and behavioural difficulties that, as we have seen, are risk factors for offending, such as hyper-sensitivity to threat, hyper-vigilance, anxiety, restlessness and impulsivity.⁴⁷ By contrast, stable and supportive care-giving in the context of a secure

attachment relationship are associated with normal brain development, particularly in the limbic system which is linked to behavioural, motivational and emotional regulation.

The House of Commons Justice Committee examined reports on acquired brain injury, which showed that while less than 10% of the general population has experienced brain injury, it typically affects anywhere between 50 – 80% of the offender population.⁴⁸ A 2012 study of 197 young male offenders in the UK found that 60% reported some form of brain injury and 46% reported a loss of consciousness.⁴⁹ The consequences of this include memory loss, problems with concentration, poor judgment, and difficulty in empathising with others – all risk factors associated with offending. Despite this, the occurrence or implications of brain injury are rarely considered by criminal justice professionals, nor routinely screened for by healthcare professionals in the secure estate.

Looked-after children and offending

Children who have been looked after in the care system are at particularly high risk of offending: between a quarter and a half of children in custody have been in the care system at some point.⁵⁰ Of adult prisoners, slightly over a quarter are likely to have spent a period of time in care.⁵¹ Over a quarter of those involved in the PRT study had been in local authority care on one or more occasions, either through voluntary agreement with parents or subject to a care order. Nearly a fifth (19%) had been on the child protection register, with a total of 56% having been involved in some way with social services prior to sentencing.

Although these are profoundly worrying figures, it is important to recognise that almost every child who enters care has already been exposed to a wide range of risk factors, including social deprivation, abuse, neglect and dysfunctional parenting. Recent research suggests that as many as 9 out of 10 children who entered care in early or middle childhood had a history of abuse and/or neglect.⁵² The same study identified that of 230 children with long-term foster care plans, 59% of their mothers had mental health problems; 33% had misused alcohol; and 32% had misused drugs. Whether being in care is in and of itself an additional risk factor, above those that resulted in the care placement, is a matter of some debate. There is evidence that residential care, as opposed to placements in family-type arrangements can present risks, particularly for older teenagers although this may have something to do with its status as a ‘last resort.’⁵³

The goal of the care system is to provide a family structure with the stability to enable children to grow securely into adulthood. This can be through foster care, adoption, guardianship or a return to the birth parent or parents. While all of these options can prove effective, a number of factors that can lead to poor outcomes for children in care have been identified. These include the age at which children enter care, genetic risk factors, the nature and history of abuse and neglect and the prevalence of emotional and behavioural difficulties.⁵⁴ Additionally, systemic factors, such as a shortage of high quality placements, a lack of high quality support services such as education and health, and delays in court proceedings and placements, can all lead to adverse outcomes.⁵⁵

Sadly, many of the children and young people who end up in prison slip through the cracks of social services and end up homeless. A 2007 study by the Youth Justice Board found that 40% of a sample of 150 children and young people in custody had been homeless at some point in the six months prior to entering custody.⁵⁶

A key focus for multi-disciplinary support services, including those working in health, is to ensure, as far as reasonably possible, the development of a therapeutic care environment that will mitigate the problems associated with abuse, neglect, bereavement, loss and weak prior emotional attachments. In addition to mitigating risk, service providers also need to consider how protective factors can be enhanced in order to help build resilience in this vulnerable population, thereby combining a *deficit* model of offending with a *wellbeing* approach.⁵⁷ In the next section we look at what some of these protective factors might be.

Protective factors

What helps keep vulnerable children and young people safe?

Young people diagnosed with a conduct disorder prior to the age of 11 are 70 times more likely to serve a custodial sentence later in life, and far more likely to be involved in a violent crime.⁵⁸ However, only half of young people meeting the criteria for this diagnosis as children will go on and offend, highlighting the importance of early intervention in preventing adverse outcomes for children and young people.

In one sense, protective factors would seem to be the mirror images of those that put children and young people at risk: remove the risk and children are more likely to be protected. Research seems to indicate however that there are some positive factors that can directly help protect children who are otherwise exposed to a cluster of risks. Some of these may have a genetic contribution, such as being female (women are much less likely than men to become serious or repeat offenders, although the impact of gender roles on offending behaviour must not be discounted); having higher intelligence; an outgoing disposition or a more resilient temperament.⁵⁹ Other protective factors are either more amenable to external influence or are traits that can be reinforced. Evidence suggests that a strong and stable emotional bond with one or both parents can protect children otherwise exposed to a host of risk factors. There is also some evidence that the protective impact of social bonding can extend beyond those in parental roles. Healthy relationships with teachers, other adults or peers who model positive behaviour can all help protect otherwise vulnerable children.⁶⁰

Given the importance to a child's future wellbeing of both a stable pre-natal environment and of a stable and nurturing care relationship in the early years of life, there is clearly scope for the early identification by health professionals of children who may be at risk, and for whom the promotion of factors associated with increased resilience is indicated. The 2012 Report of the Chief Medical Officer found increasing evidence that early foetal and infant experiences are important shapers of robust child mental health and life chances.⁶¹ Various opportunities exist for limiting known risk factors for later conduct disorder or anti-social behaviour, thus changing the trajectories of children's lives. These include, most pertinently for health professionals:

- Timely and focussed pre-natal care to reduce the likelihood of premature birth and low birth weight;⁶²
- Appropriate support to limit both *in utero* and *post partum* exposure to alcohol, tobacco and drugs;
- The encouragement of healthy lifestyle choices and behaviours;
- Working to limit the impact of stress and toxic stress on child development;
- The development of good quality early communication between mothers and babies to 'jump start' electrical activity in the brain; and, *post partum*, the continuation of healthy attachment between mother and child.⁶³

Lone parents, particularly where they are very young, as well as parents who suffer from mental illness or who abuse drugs or alcohol may all struggle to provide the stability necessary for effective emotional bonding and good parenting. Early screening and identification of mental health problems and substance abuse amongst parents and carers, including post-natal depression can therefore play a critical role in addressing factors linked to the child's future resilience. Early referral to services designed to support both isolated and struggling parents, as well as to help develop positive parenting skills can also be a vital intervention in the life of a young person.

Safeguarding responsibilities

- Be aware of risk factors that have been linked to abuse and neglect and look out for signs that a young person may be at risk.
- Keep an open mind and be objective when making decisions. Work in partnership with families where possible.
- If you are not sure whether a child or young person is at risk or how best to act on your concern, ask a named or designated professional or lead clinician, or, if they are not available, an experienced colleague for advice.

Protecting children and young people: The responsibilities of all doctors. GMC, 2012

Reducing childhood neglect and maltreatment is critical to reducing childhood behavioural problems. Healthcare professionals working with children and young people should be aware of their safeguarding responsibilities and be alert to the signs of abuse and situations where a child is at risk of serious harm. They should also be familiar with referral and reporting structures. Following a number of high profile child protection cases, the NHS Mandate for 2014-15 has identified improving safeguarding arrangements as a key priority, and services will be developed to ensure a more “joined up” approach to safeguarding vulnerable children between health and social services.⁶⁴

Keeping vulnerable children and young people safe: working in partnership to reduce the risk of offending

We have seen the complex multi-factorial nature of the problems that some children and young people face in our society. We have also seen that the origins of deprivation can reach back in time, often arising long before the child at risk was born, or even conceived. We have identified the complex interplay of personal, social, economic and environmental factors that create the conditions in which struggling children and young people can turn to offending. We know that children and young people in the secure estate seldom thrive – that for some it can further entrench disadvantage. We have seen how, with some children, health deprivation lies close to the origins of their difficulties and how, for others, it is disadvantage itself, working directly or indirectly, that can undermine their physical, mental or emotional health. Yet these children and young people have the same rights as all children and young people in our society: the right to be cared for, to be protected, the right to health services appropriate for their needs, the rights to education and to welfare – the rights, in so far as they can be realised, of the ordinary conditions for human thriving and development. Of course no single service or professional can address all these factors single-handedly. Nowhere is the need for seamless and effective partnership between agencies more necessary or more compelling. In the next section we look at the kinds of health and health-related services that can make a difference in the lives of these young people.

Health rights and the accessibility of health services

Universal health services are available to everybody in the UK, including the most disadvantaged. A human rights framework nonetheless acknowledges that universal provision of services by itself is insufficient to fully realise the rights of all without discrimination. Different people, and different groups of people, have different abilities to access healthcare. Treating people with different needs and abilities exactly the same can be unfair: people with different needs may require different responses. A rights-based approach, seeking to ensure genuine equality of access therefore imposes positive obligations on health providers to improve the accessibility and availability of health services – and of the positive underlying conditions of health – for those who find it harder to gain access to them. Although the language of human rights here might be unfamiliar to some health professionals, concepts such as outreach, making services more attractive to those who use them, and the selective targeting of public health messages to different audiences will not be, and these are all examples of constructive responses to inequality that respect fundamental human rights.

The importance of early intervention in families in which children are at risk cannot be overemphasised.⁶⁵ Identifying problems as soon as possible in the developing child, and providing targeted services helps minimise risk factors and promote crucial resilience. We have seen all too clearly how parental deprivation can lead to emotional and behavioural difficulties for children. Children who suffer from poor parenting can themselves become poor parents and thus pass on deprivation to the next generation and even beyond. It follows that services and interventions designed to redirect the development of children onto more positive pathways can interrupt inter-generational cycles of deprivation and make cumulative differences to wellbeing that persist across generations.

Primary healthcare

Primary healthcare is a vital source of support for vulnerable children and young people. Even before they enter the education system and can be identified as struggling by teachers, primary healthcare providers can both identify those at risk, and offer early intervention to support their health and wellbeing. Although all UK residents have a right of access to primary healthcare, vulnerable children frequently come from families that have a poor or intermittent history of accessing services. Many of the most vulnerable are not registered with GPs and are therefore likely to miss out on vital early developmental and screening checks.⁶⁶ Many also suffer from easily remediable health problems, which although not themselves the cause of offending behaviour, can nonetheless compound feelings of low self-esteem and social isolation. The physical health of children and young people who end up in custody is significantly worse than their peers', and they report high levels of poor oral health, poor eyesight, sexually transmitted diseases, skin complaints, smoking, substance abuse and respiratory problems – all of which can serve to further isolate already marginalised children and young people.⁶⁷

Children and young people at risk of offending experience a double disadvantage in accessing health services by virtue both of their age and their social exclusion. In general, doctors report feeling under-trained and under-confident in dealing with adolescents.⁶⁸ GPs report particular anxiety and uncertainty in working with children and young people suffering from mental health problems, both in terms of communicating with them appropriately, and also in knowledge of services available for referral.⁶⁹ Young people, on the other hand, express a preoccupation with confidentiality, embarrassment at discussing matters with a doctor, and frustration with what they perceive to be rigid appointment structures. Despite this it is a common misconception that young people in general are low users of health services: the statistics indicate otherwise.⁷⁰ This assumption can stem from the lower visibility of young people in a health service that is dominated by the very young and very old, with few specialist services available for young people.

The BMA frequently receives queries from doctors concerning children and young people seeking medical care without an adult. Whilst there are some circumstances where it is reasonable to want a parent or carer present – e.g., where a serious medical condition warrants compliance with a treatment regimen – it is unacceptable for practices to impose a blanket ban on unaccompanied minors. It is absolutely vital for doctors to be able to establish a trusting relationship with their patients, which will not be achieved through banning children and young people from making appointments alone. Despite this, doctors may still feel anxious in seeing young patients alone – particularly if they are seeking help for potentially sensitive or complex reasons. Doctors should raise the issue of parental support for young patients, but ultimately, must respect their wishes. A chaperone may be offered – indeed, in the event of an intimate exam it is good practice to offer one – but as per the General Medical Council (GMC) guidance, doctors should consider what effect the presence of a chaperone might have, as their presence “can deter young people from being frank and asking for help.”⁷¹

Children at risk are far less likely than their peers to seek out health services.⁷² Where they do, it generally comes at a point of crisis, rather than as a primary or preventative measure. Even when they do seek healthcare, all too often their needs go unidentified. Many of their needs cannot be easily met by a physiologically-oriented healthcare provider. This is especially true of mental health, where

children and young people can be suffering from psychological distress that does not fit readily into a diagnostic model. Psychological conflict can be expressed in poor behaviour, social withdrawal and risky or self-destructive behaviours. All too often, these behavioural symptoms will be targeted, rather than the underlying mental and emotional needs. Even where a psychosocial need is identified, young people may struggle to qualify for treatment because individual problems are not in themselves serious enough to warrant attention, even though their combination puts them at risk.⁷³

As we have seen from the account of Sara's journey into detention, the multiplicity and complexity of need experienced by this group means that there can be further problems in identifying who is best placed to help. Children and young people can find themselves shunted between services, or simply falling between the cracks due to a failure to identify who is best placed to help them. Stories of young people and their families who have sought help only to receive substandard care, or worse, none at all, are all too common, and can lead to feelings of even greater social exclusion.

Health providers seeking to realise the health rights of children and young people should therefore continue to seek innovative ways to make clinical services, and public health messages, more attractive to disadvantaged children, young people and their carers. The flexibility given to local commissioners in England through the Health and Social Care Act 2012 offers a particular opportunity to make a real improvement to the health of this group. All those involved in designing and commissioning health services should examine prevailing health structures and explore the possibility of reshaping services in line with the needs of socially excluded groups. A list of quality criteria drawn up by the Department of Health for ensuring that health services are attractive to young people is given below.⁷⁴

Department of Health quality criteria for young people friendly health services

The Department of Health in England has set out a list of key quality criteria designed to help health services, both primary and secondary, become more attractive to young people. The criteria are grouped under ten themes. The eight relevant to general health services are given below with some illustrative examples. These criteria provide a strong working example of how health professionals can address the obligation contained in the human right to health to make services accessible to groups who may be marginalised.

Accessibility

Services should be accessible to young people and sympathetic to their needs. Where possible young people's reasonable preferences about who they are seen by should be respected.

Publicity

Services for young people should be effectively publicised to children and young people in a language that is approachable and understandable.

Confidentiality and consent

The nature and scope of young people's rights to confidentiality and consent, including any necessary limits to those rights, should be made clear.

Environment

Health services should be physically welcoming, comfortable and sensitive to the needs of young people.

Staff skills

All staff likely to come into contact with young people should be trained to understand, engage and communicate with young people.

Joined-up working

Where possible, health should be co-located with other relevant services to ensure joined-up delivery.

Involving young people

The experiences of young service users must be captured to inform service development and evaluation.

The transition into adulthood

Services must take into consideration the specific and general needs of all young people during their transition into adulthood.

Children and young people must also be encouraged to understand the services available to them, and be equipped with knowledge of their rights and responsibilities with regard to healthcare, in a manner appropriate to their understanding and levels of need.

The Health and Social Care Act 2012 in England is designed to strengthen working relationships between health and social care agencies, so that complex needs can be better addressed. The new structures are also designed to allow for users to have greater input into service provision. However, this will only bring benefits for children and young people if their voices are heard. The formation of Health and Wellbeing Boards – responsible for identifying priorities for commissioners – will go some way toward achieving this. Their statutory guidance explicitly lists offenders and ex-offenders as important groups for consideration.⁷⁵ Health Boards and Trusts elsewhere in the UK should also consider and detail how they engage with socially excluded groups.

Mental and emotional health and wellbeing

No discussion of children and young people at risk of offending can be complete without addressing the range of emotional, behavioural and mental health problems that they confront. As discussed earlier, the prevalence of these disorders among those who are in the secure estate and those who are at risk of offending is frighteningly high: studies estimate that anywhere between 25% and 81% of children and young people in contact with the criminal justice system suffer from mental health problems.⁷⁶ The contribution of these various disorders and disturbances to risky, anti-social or offending behaviour is also significant. Although there is growing evidence about interventions that successfully support healthy development among children and young people, the challenge is to find ways to ensure early, focussed, effective, multi-disciplinary interventions at a time of heavily constrained public spending. Throughout this report we focus not just on health as the absence of illness, but also on wellbeing: a positive state of physical and emotional thriving. The NHS Advisory Service has developed a widely adopted working definition of mental health:

- The ability to develop psychologically, emotionally, intellectually and spiritually;
- The ability to initiate, develop, and sustain mutually satisfying personal relationships;
- The ability to become aware of others and to empathise with them;
- The ability to use psychosocial distress as a developmental process so that it does not hinder or impair further development.⁷⁷

A commissioning framework for child mental health

Local authority and wider NHS disinvestment in Child and Adolescent Mental Health Services (CAMHS) has led to frequent reports of long waiting lists and high thresholds for referrals.⁷⁸ The new commissioning environment nevertheless offers an opportunity to address these deficits. The following should be key priorities for those involved in commissioning:

- *Information provision:* families need easy access to reliable information about children's emotional and mental wellbeing. In addition to information provided directly by service providers, signposting should be given to other authoritative sources of information. These should include mental health helplines and internet sites such as those provided by Young Minds, NHS Choices and the Royal College of Psychiatrists. Advice should also be given about library services, including those providing free access to the internet.
- *Integrated service provision:* austerity presents fresh challenges to service providers and can deepen existing ones. Service providers should actively explore how best to integrate services, including examining scope for pooling budgets, sharing strategic development and the use of shared service provision boundaries.
- *Perinatal/infant mental health services:* Given the importance of the critical first months of life for child wellbeing, identification of postnatal depression and other mental health issues among mothers is critical. Service providers should explore the development of multi-agency perinatal networks including midwives, health visitors, child and adolescent mental health workers, social workers and adult psychiatrists.
- *Support for families with infants and toddlers:* All children born in the UK have a health visitor allocated at birth. Health visitors are ideally placed to identify mental health issues among parents, to signpost treatment options and to help them with any early difficulties with sleep and feeding.
- *Positive parenting:* Stable, warm and nurturing relationships with parents or carers are a cornerstone of child wellbeing. Where parents are struggling, additional support should be offered. This can range from parenting classes, either face-to-face or via a range of media, through a variety of parenting programmes such as the NICE-recommended structured parenting programmes for families of children with ADHD. In some areas, first-time teenage mothers in difficulty can be referred to the Family Nurse Partnership that offers two years of structured home visiting during pregnancy and early life.

Substance misuse

In the year 2008-09 somewhere in the region of 24,000 young people received specialist drug and alcohol treatment in the UK.⁷⁹ Most of them were treated for cannabis (53%) or alcohol misuse (37%), with the remaining 10% using class A drugs.

The evidence is overwhelming that drug and alcohol misuse is a common feature of the lives of children and young people who are at risk of offending. Even before children are born, exposure *in utero* to drugs and alcohol can adversely affect the developing fetus.⁸⁰ Heavy use of drugs and alcohol can lead to chaotic home lives and can seriously disrupt the development of positive relationships between parents and children. Somewhere between 200,000 and 300,000 children in England and Wales live in families where one or both parents or carers have a serious drug problem, and between 780,000 and 1.3 million children are estimated as living with one or more parents who misuse alcohol.⁸¹ Where misuse by the parents of vulnerable children is widespread, children will frequently go on to misuse both drugs and alcohol themselves. Although they may be taken to soften, in the short term, unpleasant aspects of reality, their misuse can rapidly exacerbate underlying problems. The use of cannabis among young people for example is linked to mental health disorders,⁸² and dependence on drugs and alcohol can itself lead to criminal behaviour. Among the 24,000 young people already mentioned receiving specialist drug and alcohol support, involvement in shoplifting, theft and assault were all widespread.

Despite these figures, the evidence is strong that early, targeted intervention can make a substantial difference. Data from the NHS National Treatment Agency for Substance Misuse (NTA) indicates that the potential immediate effect of treatment can be as much as a 55% – 65% reduction in offending by young people.⁸³ The data also make it clear that the economic benefits of intervention are compelling.

Continuing to deliver high quality drug and alcohol treatment services to young people, and to parents and carers who misuse drugs and alcohol, is rendered an even greater challenge given current spending cuts. Drug charities have raised concerns about the 'devastating impact' on young people of cuts to front line services.⁸⁴ Given the Government's explicit commitment to promoting and protecting the rights of vulnerable young people, every effort must be made to ensure that cuts to frontline services are minimised. The NTA outlines the following 'essential elements' of successful treatment services:

- Establishing effective integrated care pathways for children and young people who misuse substances;
- Early identification of substance misuse and prompt referral;
- Co-operation and the lawful and ethical exchange of necessary information;
- Prompt assessment of the health needs of the child or young person;
- Inter-agency working and shared assessment of care needs;
- The development of substance misuse competencies among generic children's practitioners;
- Access to substance misuse services in a mainstream setting.

Sexual and reproductive health

Teenage pregnancies are at their lowest since 1969, dropping by 34% since 1998.⁸⁵ Given the association between young parents, particularly young single parents and vulnerability in children and young people, this trend is to be welcomed. Continuing to ensure high quality, confidential and easily accessible sexual health and contraceptive advice for young people must however remain a priority.

The Department of Health's *Quality criteria for young people friendly health services* includes a distinct section on sexual and reproductive health services which emphasises the importance of the provision of a range of sexual health services, including STI screening and the provision of contraception; the provision of appropriate information for young people on a range of sexual health issues; and ensuring that staff receive appropriate training, supervision and appraisal to enable them to interact with and support young people.⁸⁶

As part of their wider public health responsibilities, local authorities are responsible for commissioning most sexual health interventions and services. The Department of Health has published best practice guidance for local authorities on commissioning sexual health services and interventions.⁸⁷

Key messages and recommendations

For reasons not of their own making, some children in our society face grave difficulties on the road to adulthood. Even before they are born they are exposed to unhealthy environments and the stresses associated with them. The name we give to these cumulative difficulties is disadvantage. Disadvantage can get locked in over generations, passed down from parent to child and onwards in stubborn cycles. In this chapter we have attempted to give some idea of the reality of the disadvantage that children and young people can face that are strongly correlated with future offending behaviour. It is not easy reading. Partly in response to such entrenched disadvantage, the UK has explicitly committed itself, by signing up to binding international human rights treaties, to giving these children the help they need to enable them to thrive. But all too often, the support fails to materialise. During difficult economic times, it is easier for politicians to focus on high profile and short term political wins. There are few votes to be won in championing the interests of these young people. There is also a real danger that austerity, combined with the radical changes to commissioning arrangements, will lead to cuts in frontline services. A reconfiguration of services can also undermine progress toward the development of shared services, integrated care pathways and inter-agency working. The evidence is convincing though that early, targeted interventions can make a significant difference to vulnerable children and young people. There is also hard data that these interventions make long-term economic sense. It is essential that investment in frontline health services for supporting these vulnerable young people and their families continues. The Government's commitment to realising the rights of these young people must be more than empty promises.

Key messages for practitioners

- Identifying problems as soon as possible in the developing child and providing targeted interventions can minimise and mitigate the underlying causes of offending and promote resilience. Medical professionals should remain vigilant both in recognising risk factors and seizing opportunities for intervention.
- Early screening and identification of risk factors such as mental health problems – including post-natal depression – and substance abuse among parents and carers, and referral to appropriate services and support have a critical role in addressing factors linked to child wellbeing.
- Reducing childhood neglect and abuse is also crucial to reducing childhood behavioural problems. Doctors working with children and young people should be mindful of their safeguarding responsibilities and aware of the signs and symptoms of neglect and abuse.

Recommendations for policy makers

- No single service or professional can address all the factors underlying offending behaviour. Services and policies should be designed and operated in partnership with other relevant community agencies. In England, the provisions of the Health and Social Care Act 2012 should be used to strengthen working relationships between health and social care agencies.
- Health providers should continue to seek innovative ways to make clinical services, and public health messages, more attractive to disadvantaged children, young people and their parents or carers.
- In order to ensure user input into service design and provision, commissioning bodies must detail how they plan to engage with socially excluded groups such as children and young people who offend and their families.
- Healthcare providers must continue to deliver high quality and accessible drug and alcohol treatment services and sexual health clinics.
- Given the Government's explicit commitment to promoting and protecting the rights of vulnerable young people, every effort must be made to ensure that cuts to frontline services are minimised.
- Training and support should be of a level to ensure that every practitioner feels confident in treating children and young people.

Chapter Four: In detention

Juvenile crime is a high profile issue. We are all familiar with politicians promising to be “tough on crime, tough on the causes of crime”⁸⁸ or pledging to “transform” youth custody,⁸⁹ and with the storm of public outrage that follows the more notorious cases of juvenile offending.⁹⁰ We hear a lot about the financial costs: at any one time, somewhere between 1,300 and 2,000 children and young people are in jail,⁹¹ at an approximate cost of £215,000 per child.⁹² But behind the headlines and the conference speeches lies a different and far more complex reality. Earlier chapters of this report have shown that many of the children and young people who spend time in the secure estate are among the most troubled and disadvantaged in our society. More often than not they are multiply burdened: by poverty, by poor mental health, and by the disintegration of their families and support networks. Although many of the problems confronting these young people lie beyond the remedy of health professionals, at the heart of this report is a very simple truth: that health professionals can make a real difference to the lives of detained young people. In this chapter we explore the current arrangements for healthcare provision in secure settings; identify the opportunities for both individual doctors and the health service as a whole to protect, promote and fulfil the health related rights of young people in detention; examine the challenges of healthcare provision peculiar to secure settings; and provide recommendations as to how those challenges can best be addressed.

One of the big recent success stories in the provision of healthcare to detained people was the transfer of responsibility for commissioning from national justice departments to the NHS in the last decade. Few longitudinal studies have been carried out on prison healthcare post-2006 to assess whether the changes in commissioning arrangements have made a material difference to healthcare provision – although anecdotally, it is seen as a success.⁹³ Additionally, much of the evidence on healthcare arrangements in England discussed in this chapter was gathered prior to the implementation of the new commissioning arrangements introduced by the Health and Social Care Act 2012.

Who are the children and young people in detention?

Minimum age of criminal responsibility

The age of criminal responsibility is the age at which, in the eyes of the law, a child is deemed capable of committing a crime, and therefore old enough to stand trial and be convicted of a criminal offence. In England, Wales and Northern Ireland, the age of criminal responsibility is 10 years old.⁹⁴ In Scotland, the age limit for criminal prosecution was raised from 8 to 12 in 2010,⁹⁵ although the age of criminal *responsibility* remains 8. However, the law also states that “no child under the age of 16 shall be prosecuted for any offence except on the instructions of the Lord Advocate.”⁹⁶

The age of criminal responsibility in the UK is among the lowest in Europe, and has been the subject of criticism from the UN Committee on the Rights of the Child, which has repeatedly made calls for it to be raised.⁹⁷ Minimum ages in the UK for decision making – for example, voting, learning to drive, consenting to sex – are based on intellectual, emotional and mental maturity. The same should be true of the minimum age for criminal responsibility. However, the attribution of full criminal responsibility at such a young age runs counter to evidence on children’s cognitive and emotional development. An open letter published in *The Guardian* in December 2012, signed by a number of individuals and organisations with experience in youth justice issues, including leading psychiatrists and paediatricians, drew attention to this fact and called for a change of policy.⁹⁸ The House of Commons Justice Committee noted that the higher age of criminal responsibility in many other European countries meant that young people guilty of serious offending were usually institutionalised in a welfare facility.⁹⁹ In light of the evidence on developmental maturity, and available international guidelines,¹⁰⁰ we would welcome further investigation and reconsideration of the minimum age of criminal responsibility in the UK, with a view to dealing with young offenders in a manner more appropriate to their young age.

Numbers of children in detention

In 2012/13 the average population of young people (under 18s) in custody was 1,544, down 21% from the previous year.¹⁰¹ In the twelve months to March 2013, 2,780 young offenders, 6.4% of those sentenced, were placed in custody. The average length of time spent in custody was 85 days. On the positive side, the numbers of young people held in secure settings, and the numbers of those being given custodial sentences has been falling rapidly, with reductions of 21% and 31%, respectively, from the previous year.¹⁰²

As a signatory to the UN Convention on the Rights of the Child, the UK is committed to the use of custody for under-18s only as a last resort. The youth justice system also has a target to reduce the use of custody. In 2012-13 there were 2,780 custodial disposals – a fall of 61% since 2002/3. This reduction is not attributable to any one single factor, but suggestions put forward include the removal of the 'offences brought to justice' target (a performance measure for police); changes to sentencing guidelines; and work by Youth Offending Teams and other groups to divert young people away from the criminal justice system.¹⁰³ This reduction has not applied uniformly to all children and young people in custody, however: the percentage fall in imprisonment in the numbers of black and minority ethnic children was 16% from 2007-8 to 2010-11, compared to 37% for white children and young people.

Despite these falling numbers, the UK still has one of the highest rates of child imprisonment in Western Europe.¹⁰⁴

Life after sentencing

A custody van drives into Ashfield juvenile prison outside Bristol just before 8pm and lets out the skinny, hunched figure of Ryan Lewis, who has just turned 16 and is stepping inside prison for the first time. His initiation begins in a windowless reception room, with harsh strip lighting, decorated with a small fish tank, a gloomy pot plant and posters warning new prisoners that if they bite the staff they can expect to get an extra 28 days added to their sentence.

Amanda Hitchens, security operations manager, in charge of reception for the night shift, asks him to give his name and date of birth, which he does with slurred words that suggest a serious speech impediment. He flicks his eyes around the room as the entry paperwork is completed, taking in the surroundings. A report from the courts says Ryan may have mental health problems and is a possible suicide risk. The form also states that he has spent much of his life in care. He is in prison for assaulting his mother.

A prison officer takes him to a side room where he removes his purple jumper for a search of his upper body, and then his black jeans for a lower body search. He is asked to sit on a big gray plastic Boss (Body Orifice Security Scanner) chair to do a body scan for concealed metal objects. Occasionally staff find mobile phones hidden inside a prisoner's bottom, or drugs tied with cotton thread to their testicles, but Ryan is new to the prison system and doesn't know any of these tricks.

...The driver of the prison van, employed by the private company GeoAmey, comments on how quiet Ryan was during the 104 mile journey from the court in Southampton...Ryan has travelled sitting on a moulded plastic seat in one of the van's six cubicles. There are no seat pads because they always get torn off, the driver says, and no safety belts in case prisoners try to hang themselves.¹⁰⁵

The transfer into detention

Ryan travelled 104 miles from court to the Young Offenders Institution (YOI) where his sentence would be served, a distance that is not unusual. In March 2011, 30% of all children and young people in custody were held over 50 miles from their home, with 10% being held over 100 miles away.¹⁰⁶ This can have a serious impact on the frequency of visits from family members – 42% of young men and just 19% of young women reported that it was easy for their family to visit them.¹⁰⁷ The physical distance and lack of contact with family and friends can fuel a young person's feeling of isolation, and further undermine their emotional well-being. It also creates potential problems in ensuring continuity of care once they leave custody. The welcome reduction in the number of children and young people being imprisoned has brought with it the unintended consequence of increasing numbers being held further from home. In response to the decreased demand, the government has already started to reduce the number of places available in the children's secure estate, meaning that more and more children and young people will be placed in an institution outside their local area.¹⁰⁸ The reduction in places available may also be reflected in changes to funding, which could have an adverse impact on health services available within the children's secure estate.

Ryan was also forced to travel over 100 miles without a seatbelt or seat pads. Colloquially, these transport vans are known as "sweatboxes."¹⁰⁹ Recent reports indicate that of those who had spent longer than two hours in the van, only 14% of young men were offered a toilet break, and 33% were offered something to eat and drink.¹¹⁰ The same report indicated that alarming numbers of children – 74% of young men and 67% of young women – were not informed of their destination before they arrived.

Children in Police Custody

A Freedom of Information request by the Howard League for Penal Reform in October 2013 found that 40,716 children and young people aged 17 and under had been held overnight in police cells in 2011, despite the Police and Criminal Evidence Act being clear that if children and young people are being kept in custody, they should be transferred to the care of the local authority. Concerns have been voiced over what one senior police officer has described as a "continued chronic breach" of the law.¹¹¹ The BMA calls for this practice to end immediately. As long as it continues, doctors attending police stations should bear in mind that they may be called to examine minors and so should be familiar with the specific issues this presents, for example, in relation to capacity and consent.

A recent High Court ruling held that 17 year olds must be treated as children when held in police custody.¹¹² The case, brought by a south London teenager held by police for over 11 hours as an adult, followed the suicides of two 17-year-olds after being arrested and detained as adults.¹¹³

Arrival at detention

Upon arrival at the YOI, and immediately after the long journey that followed a potentially traumatic court appearance, Ryan underwent a full body search. This is one of the first experiences most children have on entering custody – removing their clothes in front of strangers. For the large numbers entering custody who have experienced physical or sexual abuse, the experience will be especially traumatic.¹¹⁴ The Youth Justice Board has reported that children view the practice of full strip searches as "undignified" leading to "feelings of anger, humiliation and anxiety."¹¹⁵ Lord Carlile's 2006 inquiry into the use of restraint, solitary confinement and strip searching found that: "Within the custodial context a strip search is more than just the removal of clothes for a visual inspection. It is a manifestation of power relations... Forcing a person to strip takes all control away and can be demeaning and dehumanising."¹¹⁶ It can also undermine opportunities to build positive relationships between children and young people and prison staff. When used routinely, they can also be used as a way of punishing, intimidating or demoralising.¹¹⁷

The World Medical Association acknowledges that in the majority of cases, strip searches are “performed for security reasons and not for medical reasons.”¹¹⁸ However, in 2008, the European Committee for the Prevention of Torture (CPT) drew particular attention to one YOI where healthcare staff regularly carried out custodial officer tasks, such as strip searches. The CPT’s report stressed that this was inappropriate, and that healthcare services in facilities for young offenders should be discrete and independent.¹¹⁹ The BMA strongly supports the CPT’s findings, on the basis that allowing doctors to participate in a procedure that requires no medical skills makes the doctor a “wielder of force”¹²⁰ and distorts the role of healthcare professionals, aligning them more closely with the punitive aspects of the institution.

Lord Carlile’s review found that strip searching was by and large a disproportionate response, and that the use of searching could be reduced by at least 50% without any concurrent increased risk to security or safety, simply by applying a more evidence-based approach. The routine strip searching of female prisoners, including young women and girls, was phased out in 2009 following a review by Lady Corston in 2007.¹²¹

In March 2011, the Youth Justice Board pledged to stop the routine strip searching of incarcerated children, and stated that “the use of full searches should be kept to the minimum required to ensure the safety of young people and staff.”¹²² In spite of this, a recent study showed that over 43,000 strip searches were carried out over a 21 month period, sometimes on children as young as 12, with illicit items being found in only 275 searches – leading some children’s rights campaigners to call the practice “institutionalised child abuse.”¹²³

Intimate body searches

Intimate body searches for illicit items may take place following strip searching. Intimate body searches are lawful without consent, provided appropriate authorisation has been received.¹²⁴ The law is also clear that they can only be carried out on children and young people in the presence of an appropriate adult of the same sex, unless the child or young person requests otherwise.¹²⁵ The World Medical Association has stated that cavity searches “should not be performed by anyone other than a person with appropriate medical training.”¹²⁶ The rationale behind this is that untrained participation in intimate searches, which can include rectal and pelvic examinations, could cause harm. In the BMA’s view doctors should not carry out intimate body searches without consent.¹²⁷ Doctors working in an environment in which intimate searches are likely should seek agreement that they are always called when they are proposed. This does not commit them to carrying out searches, but allows doctors to ascertain the detainee’s wishes and establish whether consent has been given. Where consent has been given, doctors can go ahead and perform the examination. Where consent is withheld, doctors should record this in the notes and withdraw without participating.

In rare circumstances where a patient lacks capacity, doctors can undertake an intimate examination without consent where it is deemed to be necessary and in the best interests of the patient.

For doctors working in these environments, it is important to bear these initial experiences of entering custody in mind. A doctor seeing a child in the weeks after arrival in the secure setting might be the first health professional the child has encountered since arriving and being strip searched and assessed. Even if there is no direct involvement by medical staff in disciplinary proceedings, healthcare professionals should be aware of the potential for strip searching and healthcare assessments to damage perceptions of healthcare and those who provide it. They can erode trust, and undermine the child’s willingness to access necessary healthcare in the future. Evidence shows that children and young people in the secure estate draw a distinction between uniformed staff (e.g., prison officers and governors), who are perceived as being there to control them, and non-uniformed staff who are perceived as fulfilling a welfare role.¹²⁸ Other focus groups facilitated by the Royal College of Paediatrics and Child Health in the formation of their *Healthcare Standards* indicate that a similar distinction is made between staff who carry sets of keys and those who do not. It is crucial that doctors make clear that they are independent medical practitioners, distinct from the punitive aspects of the regime.

Health screening and assessment

During the reception process, young people will receive a health screening and assessment from a member of the health services team.

Reception is a key time for gathering health information to inform decisions about the support they will need during their time in custody, and for carrying out risk assessments. The intercollegiate *Healthcare Standards for Children and Young People in Secure Settings* state that a reception health screen and risk assessment should be completed within two hours of arrival, and that all young people should be treated as at risk of harm until this has been carried out.¹²⁹ This initial assessment can be fraught with difficulties, particularly in the case of late arrivals. The *Healthcare Standards* clearly state that assessment can be delayed according to the needs of the young person, for example, if they are too tired or distressed to complete the questions. However, very often reception assessments are delayed due to a lack of out of hours healthcare cover being available. Smaller Secure Children's Homes (SCHs) are known to use out of hours GP services to provide this service, with many having little or no experience of dealing with young people in these situations.

The difficulties of the initial reception assessment can be exacerbated by the fact that many young people arrive in custody with no accompanying medical history,¹³⁰ and as information sharing between services can be poor, this can be difficult to obtain. The sporadic contact with community-based primary care by this group of young people can mean that very often the information doesn't exist, or where it does, is extremely sketchy. Where young people have a GP, they can be contacted – with the young person's consent – but the transfer of information could still take considerable time. Developing clear pathways for information sharing between services, especially for vulnerable groups, is something that should be considered in the commissioning of any services. This is particularly important given that the average stay in custody is 85 days, so there is often a very short period within which any health related interventions can be delivered.¹³¹

Assessment tools

Initial assessments have ordinarily been carried out using a tool called ASSET, which was designed to look at a young person's offences and identify any relevant factors – ranging from educational attainment to mental health problems – which may have contributed to their behaviour.¹³² It was last updated in 2006, and has attracted various concerns about its usefulness and reliability. It has been criticised for underestimating the health needs of those entering custody, either because it relies too much on self-reporting, or because it assesses health primarily in relation to offending behaviour – by, for example, overlooking dental health which is a source of distress for many entering custody, but not one related specifically to offending.¹³³ There are also concerns about the usefulness of ASSET in identifying and addressing mental health problems. A 2005 study by the Youth Justice Board found that the most common reason for unmet mental health needs was simply a failure adequately to assess and identify them.¹³⁴ A separate 2005 study showed that ASSET identified mental health problems in only 15% of a sample, compared with 31% identified through fuller assessment.¹³⁵ Specific concerns have also been voiced about the failure of the ASSET tool accurately to identify and assess risks of self harm and suicide – in half of the deaths of 98 children and young people in custody examined by the Prison Reform Trust, there was a known history of self harm and mental illness, but this had triggered an ACCT (Assessment, Care in Custody and Teamwork) plan in only 17% of cases.¹³⁶

A new tool designed to address many of these criticisms has already been rolled out across YOIs, and is in the process of being introduced into STCs and SCHs. The Comprehensive Health Assessment Tool (CHAT) is a method of providing standardised holistic screening and assessment for all young people, with the aim of aiding early identification of needs; improving continuity of care; and reducing duplication during transition periods within the youth justice system.¹³⁷ It includes an initial reception health screen, to be completed within the first two hours of arrival into custody, followed by a more in-depth assessment of physical and mental health; substance misuse; developmental disorders, including learning disabilities, autism, and communication needs; and significantly, traumatic brain injury. Some concerns remain over this new system – for example that it is still verbally mediated, which can be difficult if a young person struggles with communication.

The *Healthcare Standards for Children and Young People in Secure Settings* state that in addition to an initial screening and risk assessment, all young people should receive a “timely, comprehensive, and holistic health assessment”,¹³⁸ including physical and mental health (both within three days of arrival); substance misuse (within five days of arrival); and neuro-disability (within ten days of arrival). Where doctors are involved in these assessments, they should be aware of the limitations of initial health screening and assessment, and ensure that a full and in depth healthcare assessment is carried out.

Part of the rationale for these assessments is to create a healthcare plan for the young person for their stay in custody, which takes into account their lifestyle and health prior to entering custody and to formulate health objectives, agree actions and timescales for completion, and assign a responsible person. The *Healthcare Standards* recommend that each young person has a named lead healthcare professional who coordinates their care. A comprehensive and coherent healthcare plan is an important element of promoting the health and wellbeing of young people not only whilst in detention, but beyond, following their release.

In the weeks following their arrival in custody, in accordance with HM Inspectorate of Prisons criteria, all children and young people should receive an induction to the institution, which should include information about the health services available and how to access them.¹³⁹ The current effectiveness of these programmes is disputed: only two thirds of young men and half of young women surveyed felt that it covered everything they needed to know.¹⁴⁰ Conversely, a separate study showed that many felt that they received an overload of information, and that they struggled to understand and absorb the written information provided – attributable in part to the high levels of literacy problems and learning difficulties in the young offender population.¹⁴¹ In the preparation of information about healthcare provision in the secure estate, doctors should be mindful both of the content and presentation of any information about healthcare provision, and ensure that it is communicated as effectively as possible.

Life in the secure estate

Staff are expecting a fight. Since early morning, two boys have been shouting through their cell doors that they are going to smack each other. One has been locked back in his cell. But the desire to fight is contagious and as the boys mill around after breakfast, there is a sudden commotion as one prisoner punches another on the side of his face.

“We fight because they don’t keep you occupied. Or because we are sexually frustrated,” a prisoner says.

Both boys are put back in their cells, one with a bleeding lip; the rest are ushered back to their cells or into the yard for exercise, where it is still pitch black and drizzling. No one goes near the exercise devices in the corner of the fenced yard; instead they stand in cold huddles, complaining that the staff won’t give them a football to play with.¹⁴²

Day to day life

Day to day life within the children’s secure estate varies due to the different aims and functions of individual sites. For example, as much smaller facilities which provide for the physical, mental and emotional needs of children and young people assessed as vulnerable, Secure Children’s Homes will be run differently to a much larger Young Offenders’ Institution. The one thing they all have in common, by virtue of being a secure estate, is that they deprive young people of their liberty, and, universally, life in the secure estate will be restrictive and regimented.

There is wide variation in the amount of time young people are allowed out of their cells. The national target is that young people should be allowed a minimum of 10 hours a day outside of cells, but it was found that they received, on average, 9 hours and 24 minutes a day out of cells – with a low of 7 hours and 24 minutes reported at one site.¹⁴³ This means that children and young people will

experience long periods of isolation and boredom, which can exacerbate poor behaviour and impact on emotional wellbeing.

There is also wide variation in the living environment across the children's secure estate. Some sites have individual showers in cells, whilst some use communal blocks. Many young people report restricted access to washing facilities and cleaning supplies,¹⁴⁴ which can undermine emotional wellbeing.

In many establishments bullying and violence is endemic – both on the part of inmates and prison staff. A recent inspection of Feltham Young Offenders Institution deemed it “unacceptably violent”.¹⁴⁵ However, only 37% of inmates said they had ever felt unsafe there, suggesting that some may be resigned to accepting violence and bullying as everyday occurrences.¹⁴⁶

Health practitioners, in addition to their role as physicians, have a responsibility to ensure that they take steps to ensure that the secure setting actively promotes, as far as possible, the health and wellbeing of the young people confined within it.¹⁴⁷ Part of this includes ensuring that frontline staff are adequately trained and supported in recognising and acting on health warning signs. Whilst health professionals are only able to spend a limited amount of time with each young person, care staff and officers will be present day and night. A failure to identify and respond to health warning signs by staff can be illustrated to devastating effect by the suicide of an 18-year-old in a YOI, and the subsequent inquiry which found that prison officers had not attempted to ascertain his state of mind. One officer stated that this was something they would not attempt themselves as they were not qualified to do so, and that they would always contact medical staff for this purpose.¹⁴⁸ It is crucial that the health and wellbeing of children and young people are not seen as the sole domains of healthcare professionals, but as concerns for all those working within the secure estate.

Additionally, healthcare professionals have a responsibility to report practices which undermine health. Health professionals cannot, single-handedly, change the entire ethos of an establishment. But they may be among the first to identify symptoms of abuse and the impact of a toxic culture on health and wellbeing. In addition to their role in the direct provision of health services, they may also therefore have a part to play in identifying and reporting concerns. As in the community, all health professionals working in the juvenile secure estate should have up to date knowledge of their child safeguarding responsibilities, and be familiar with the reporting structures within their establishment. Where there are concerns regarding institutionalised violence or abuse, it may become necessary to contact an external body, something we discuss below in the section on whistle-blowing.

General health and wellbeing

In YOIs, as little as £2.48 a day is spent on food for each young person.¹⁴⁹ Young people frequently complain about the quality, variety and quantity of food they receive.¹⁵⁰ Common complaints are that they are frequently hungry (which affects concentration and behaviour) and that the meals are not nutritionally balanced and lack fresh fruit or vegetables.

Whilst facilities for exercise were generally available to children and young people, uptake and use varied – 36% of young men in YOIs reported using the gym only 1-2 times a week, and less than half reported that they were able to go outside to exercise daily.¹⁵¹ The *Healthcare Standards* make it clear that a doctor's role in secure settings goes beyond purely managing conditions, to include promoting health and wellbeing. This means supporting young people to make positive choices about their health and lifestyle, and ensuring that they have access to what they need to live a healthy life, including “healthy food, a gym and fresh air.”¹⁵² Unlike patients in the community, prisoners are reliant on prison staff for almost every aspect of their day to day life, and accordingly, have an extremely limited ability to influence the various factors which affect their health. In these circumstances, health professionals working in the secure estate are under an obligation to work with senior management to ensure that the conditions are in place to enable young people to make positive choices.

Commissioning health services in secure settings – challenges and opportunities

Dan Leary, an officer in the substance-abuse wing, has just found a ligature made from torn up bed sheets hidden in a boy's cell. Although there has never been a suicide in the prison, there has been a recent rise in attempts.

The boy, who is in jail for the first time, is very worried about a looming court appearance for sentencing. Outside prison, he was a heavy drinker and a regular user of benzodiazepines. Inside he will have very little access to drugs.

...This morning the boy has been transferred to the healthcare wing for closer supervision. The bars on the entrance door to the ward are painted in cheerful primary colours in an attempt to make it feel child-friendly and welcoming. Television monitors in the nurses' station show boys huddled under duvets, occasionally stirring.

Since the prison has opened, far more attention has been paid to mental health problems, as staff realised how many inmates were arriving with serious issues. A third of the prison population are on the mental health team's books, a large number are taking drugs for ADHD and depression, a significant number have low IQ, and very high levels of anxiety.¹⁵³

Commissioning responsibility

In 2006 the NHS became responsible for commissioning and providing health services to Young Offenders Institutions in England and Wales, followed by Northern Ireland and Scotland in 2008 and 2011 respectively, making the UK one of the few countries where offender healthcare is under the remit of a health department, rather than a justice department.

Prior to 2012, the Youth Justice Board funded health provision in Secure Training Centres and Secure Children's Homes in England. Establishments negotiated their own commissioning arrangements. As a result there was huge variation in approaches and standards of healthcare across the secure estate, as exemplified by the experiences of children and young people using them. In a survey conducted prior to healthcare reforms coming into force, 62% of young men and 63% of young women who had used health services rated them as good or very good, but only 53% of those young men and 33% of young women said they found it easy to access a doctor.¹⁵⁴ Following recent healthcare reforms, NHS England – formerly the NHS Commissioning Board – has now assumed responsibility for commissioning healthcare for offenders in all secure accommodation, including SCHs and STCs.

NHS England's mandate charges them with developing better healthcare services for offenders which are "integrated between custody and the community".¹⁵⁵ This will require NHS England to work closely with providers and partners to ensure that services are designed with clear pathways between detention and the community. This presents an opportunity to improve access to mainstream services, which is again likely to promote equivalence of care between community and secure settings.¹⁵⁶ It will also assist in ensuring continuity of care for young people leaving prison and returning to the community. In *Securing Excellence in Commissioning for Offender Health*, NHS England acknowledges that partnership work is vital to the delivery of a high standard of healthcare. It also notes that fully realising health outcomes is dependent on integrating and aligning design and delivery of service with non-health services.¹⁵⁷

The new structures also have the potential to alleviate some of the professional isolation reported by many doctors working in secure settings as they enable greater engagement with a spread of colleagues across various sectors in the community. For that reason it is essential that doctors working on both sides make the effort to engage with the new structures and work collaboratively.

The fact that detainees are entitled to an equivalent standard of care does not mean that they have a right to every possible medical intervention – it would be obviously unjust for prisoners to have special access to medical interventions which are unavailable or scarce for others in society. This was determined in the legal judgment of *Mellor*¹⁵⁸ where a prisoner had his application for fertility treatment for his wife refused, on the basis that it would not prevent the founding of any family, only delay it. In contrast, an application for fertility treatment was granted in the case of *Dickson*¹⁵⁹ where it was held that it represented the only opportunity for the couple concerned to have their own child.

Physical health complaints

There is a shortage of data on physical health complaints amongst the young offender population, and as such there is no clear evidence as to whether there is a higher incidence of physical health complaints amongst children and young people in the secure estate. A failure to address long standing problems may be more prevalent due to this group's sporadic contact with health services: young offenders typically have low rates of routine health checks and immunisations.¹⁶⁰ Custody, and the structure and security that this brings with it, presents a key opportunity to promote positive health behaviours and to develop confidence and build trust for the effective use of health services and interaction with healthcare professionals beyond detention.

The data which do exist indicate that physical health needs among this group must not be overlooked. In 2005, HM Inspectorate of Prisons indicated that around 14% of boys and 12% of girls reported physical health problems which required immediate treatment when they arrived in custody – although the precise nature of these conditions was not disclosed.¹⁶¹ A widely quoted study based on an analysis of 1997 Office of National Statistics data of around 600 young people in Young Offenders Institutions indicated that a quarter of young men and a third of young women reported a long standing physical complaint.¹⁶²

Access to healthcare

Due to the secure nature of detention, all of a young person's requests for medical care must be mediated through a member of prison staff – including requests for doctor's appointments. Arrangements for accessing primary care vary across the secure estate. The majority of sites operate a form system, where children and young people can self-refer by completing a form on their residential wing which is collected by staff. Given the high rates of literacy problems amongst those in detention, healthcare professionals may wish to consider whether this is the best method of encouraging interaction with health services. The involvement of (non-medical) prison staff in the appointment process might also give rise to concerns about confidentiality, which will be explored further below. Additionally, being forced to make requests through staff members can exacerbate what is already an anxiety-inducing and potentially embarrassing experience, which again may discourage young people from making contact with healthcare services.

There is some tension in the youth secure estate between the two aims of health and education, particularly in STCs. Institutions can be penalised for young people not attending education, and this applies even where they may have a healthcare appointment. As far as possible, healthcare appointments should be provided at times convenient for young people.

All establishments in the children's secure estate have access to a GP, although provision varies across sites. Inspection reports show that access to a female GP is not always available in units accommodating girls and young women.¹⁶³ Larger establishments, such as YOIs, typically tend to hold daily GP surgeries, which is not always an option in other smaller sites.¹⁶⁴ Reports indicate that regular specialist clinics, for example, for asthma, diabetes, or dermatology, are dependent on skill mix and specialist interests of healthcare staff, leading to wide variation in provision across sites.¹⁶⁵ In some areas, this was addressed by seeking PCT specialists to provide in-house clinics – a practice which may increase following the advent of the new commissioning arrangements in England.

Due to the limitations of healthcare provision in secure settings, it may be necessary in some circumstances for offenders to use external services. This has many implications. Transferring an offender to an external service can require an escort and in some instances restraint. Young people themselves have commented on the indignity of appearing in public wearing handcuffs.¹⁶⁶ Use of restraint in medical treatment is explored in greater detail below.

There are many associated costs in providing transport and escort for prisoners, and doctors may meet resistance from prison officials on the basis of financial considerations. Whilst security and use of resources are appropriate concerns for those running the prisons, they should never be used to challenge a clinician's independent judgment on a purely health related matter. Doctors working in secure settings must be able to exercise independent clinical judgment, and it would be wholly unacceptable for doctors to be overruled by a management decision which discounts medical opinion and ignores the patient's best interests.

Mental health and emotional well-being

The previous chapter identified the high prevalence of mental disorders amongst children and young people detained in the secure estate: studies estimate that as many as 95% of imprisoned young offenders have a mental health disorder.¹⁶⁷ As with physical conditions, the secure estate is a less than ideal setting in which to tackle mental health problems, but at the same time presents an opportunity for diagnosis, treatment and management.

Studies into the mental health of children and young people in contact with the Youth Justice System show alarmingly high rates of co-morbidity – a national study of psychiatric morbidity amongst young offenders found that 80% of 16-20 year olds showed more than one of five mental health disorders (personality disorder, psychotic disorder, neuroses, hazardous drinking and drug dependence).¹⁶⁸

Despite this, the mental health needs of children and young people are very often not being met. A survey of 15-18 year old young men in custody found that only half of those who had reported a mental health problem said that they were actually receiving help at their establishment.¹⁶⁹

A 2008 Youth Justice Board national review of mental health provision in the children's secure estate identified various problems with mental health provision, including overreliance on the personal skills and interests of individual practitioners, leaving provision vulnerable to changes of personnel and priorities; reliance on previous mental health assessments accompanying children and young people which were either missing or underestimated need; a lack of appropriate intervention packages; and resource problems in delivering interventions.¹⁷⁰ In general, mental health treatments are underfunded by the NHS,¹⁷¹ but mental health service provision in the youth secure estate is particularly susceptible to the vagaries of funding and resources.¹⁷²

A 2011 study by the Children's Commissioner for England corroborated many of these findings about the quality and variation in standards of mental healthcare for children in the youth justice system.¹⁷³ It described a system too focused on minimising the risk offenders presented, either to themselves or others, rather than helping them. It was too centred on using tactics such as restraining difficult offenders rather than tackling the reasons for their behaviour. Many of its recommendations were high-level, calling for improvements in training and for commissioning arrangements to make allowances for greater access to services in the community.

Previous chapters have highlighted the disproportionately high number of individuals with ADHD in contact with the youth justice system – UK studies suggest that 45% of young offenders screen positive for childhood history of ADHD.¹⁷⁴ Despite this, treatment in the youth secure estate is highly variable and geographically inconsistent, often as a result of a lack of understanding or awareness of ADHD. ADHD is a factor that should be considered in delivery of treatment services for offenders including rehabilitation with multi-agency working.

The high rates of mental health problems in the juvenile secure estate have led to an emphasis on the promotion not only of good mental health, but also positive emotional well being. The stress and toxicity of the prison environment, combined with a lack of family contact and uncertainty about the future can undermine mental health and emotional wellbeing. There is a substantial body of literature which shows that the prison environment, with its long periods of isolation, lack of mental stimuli, and often hostile culture, can worsen existing mental health problems.¹⁷⁵

Little explicit research has been carried out on the emotional wellbeing of children and young people in the secure estate in comparison to the work carried out on mental health, self harm, and suicide.¹⁷⁶ Evaluation of a mental health campaign in the late 90s found that healthcare staff and prison officers viewed emotional wellbeing as a “soft” area, and peripheral to their main jobs.¹⁷⁷ Mental health services tend to focus their limited resources on young people with more serious mental health problems, leading to the neglect of those with “less serious” problems.¹⁷⁸

Health professionals: listening and advocating

Health professionals have a critical role to play as listeners and patient advocates. It is in this sense that the attitudes and behaviour of medical professionals are particularly important. Doctors should behave in an approachable and non-judgmental manner, treating the patient as a young person first and foremost, rather than as an offender.

Children and young people may see doctors as concerned more with their welfare than many others in the prison system, and so may identify doctors and other healthcare staff as confidants. Some of the young people surveyed during the formulation of the *Healthcare Standards for Children and Young People in Secure Settings* noted that healthcare staff were easier to talk to, as it “did not feel like [they] were part of the prison”¹⁷⁹ Another respondent said that “they [health staff] should just sit down for a cup of tea with us, chat and stuff, then they’ll find out how we are.”¹⁸⁰

I feel, I still do feel, that I've got problems. I wouldn't call it proper depression but I... it's loneliness really more than anything else, and that's what gets to me. I've had to fend for myself and I've had to survive by myself, and that's how it will always be for me. But I felt like I needed help and I was in there for three weeks. I seen a doctor three, four times in them three weeks and he said 'you're fine, you can go.' I even told the doctor, I said 'I've got problems' and he said 'no, you're fine.'¹⁸¹

In smaller settings, in particular, STCs and SCHs where there is a higher staff to child ratio, strong relationships and particular attachments can form. When developed appropriately, these relationships can be beneficial for the overall health and wellbeing of the young person.

Suicide and self-harm

Suicide and self harm in the secure estate are a major cause for concern: young people in prison are 18 times more likely to take their own lives than others of the same age.¹⁸² Twenty-nine children and young people have died in custody since 1990, all but one of whom committed suicide.¹⁸³ In 2011 there were 722 reported incidents of self harm, with 326 individuals harming themselves. The discrepancy between incidents and individuals reflects the tendency of individuals to injure themselves repeatedly. The small minority of girls in prison account for a disproportionate number who harm themselves, and girls who self harm do so with greater frequency than boys and young men.¹⁸⁴

Between 2003 and 2011, six young people under the age of 18 died in the children's secure estate.¹⁸⁵ Five of those deaths were ruled as self-inflicted by hanging; the other was the result of “positional asphyxia” during the use of restraint. The Youth Justice Board calls deaths in custody “tragic and rare”,¹⁸⁶ but taken collectively, their experiences and treatment prior to death amount to a separate tragedy. The Prison Reform Trust's report into the deaths of children and young people in custody, *Fatally Flawed*, found that almost universally, the children and young people who died:

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- were amongst the most disadvantaged in society, with a history of mental health problems, substance misuse, and/or self-harm;
 - had had significant interaction with community agencies before entering prison, yet in spite of identified vulnerability, had neither been diverted from the criminal justice system nor had this information communicated or shared with the secure estate;
 - had experienced poor medical care and limited access to therapeutic services;
 - had been exposed to bullying and treatment such as restraint and segregation.

The PRT report concluded that these children and young people had been failed by the systems designed to protect them from harm. In one instance, a visiting psychiatrist conducted an assessment through a cell door – which, whilst hopefully a one off incident, shows how easy it is for children and young people in detention to become dehumanised and to receive a standard of care which would be wholly unacceptable in the community. The Government has since announced an independent review to investigate the number of young people committing suicide in prison.¹⁸⁷

Given the potentially devastating consequences of unchecked or untreated mental health problems, it is vital that all health professionals in the secure estate are adequately trained in at least a basic level of psychiatric care, and are familiar with the interventions and care available elsewhere. We also call for all those involved in delivering healthcare in prisons to review the provision and quality of mental healthcare as a matter of urgency.

A study into the mental health needs and effectiveness of provision for young offenders also highlighted a shortage of appropriate or timely support for staff involved in major incidents, something doctors working in these environments may wish to bear in mind for themselves and their colleagues.¹⁸⁸

Substance misuse

A very high proportion of young people in secure settings have a history of substance misuse prior to entering custody, with 66% reporting regularly binge drinking, and 80% using an illegal drug at least once a month.¹⁸⁹ A pilot drug testing scheme at one YOI in 2005 screened all incoming young men for drugs and found a positive rate of 80%.¹⁹⁰ Where drugs tests are administered, healthcare professionals and institution staff must make it clear as to whether they are being administered for medical or disciplinary purposes, and the consequences if a positive result is returned.

Not all YOIs have facilities to provide detox programmes, but young people who require more than symptomatic relief are usually transferred to an establishment which can provide that facility.

In accordance with current UK law, YOI are non-smoking environments. Many institutions offer assistance for smoking cessation, although there are sometimes problems with access to support for under 16s. Initial concerns that a smoking ban would lead to disruptive behaviour have largely failed to materialise.¹⁹¹

The prevalence of substance abuse and the closed prison environment can pose challenges for doctors. 18% of young men said it was easy or very easy to get illegal drugs in their establishment.¹⁹² With this in mind, doctors working in the children's secure estate should remain alert to the possibility of substance abuse. The potential market for a trade in prescription drugs has implications for prescribing practices. Although the prescribing criteria in secure settings should be the same as those applied to the treatment of patients in the community, in light of the potential for abuse within the prison population, doctors may be more reluctant to automatically renew prescriptions, or prescribe in large quantities. Guidance is available from the Royal College of General Practitioner's Secure Environments Group on safer prescribing in secure settings,¹⁹³ and from Public Health England on the management of persistent pain.¹⁹⁴

Sexual health

Children and young people entering custody display high levels of risky sexual behaviour, including multiple partners.¹⁹⁵ Nearly a quarter of young people in the secure estate have had at least one sexually transmitted infection.¹⁹⁶

Doctors working in the secure estate need to be able to identify and treat sexual health problems, although a study carried out prior to the transfer of prison healthcare commissioning found that less than half of all YOIs in England and Wales held regular sexual health clinics run by GUM specialists. Many establishments also reported long waiting lists for services.¹⁹⁷

Sexual health is another area in which doctors can play an important public health and education role. The scale of the problem indicates the importance of health information and education to promote healthy sexual behaviours both inside and outside the prison environment. This should extend beyond physical pathology to include information on the emotional aspects of sexuality, including the drivers of risky and abusive behaviour. This is particularly important given the high rates of sexual abuse experienced by many of those in the secure estate: a 2008 Youth Justice Board report found that 1 in 20 boys and 1 in 3 girls had experienced sexual abuse.¹⁹⁸

Doctors and discipline

Restraint

The use of restraint is highly controversial. There have been numerous calls for independent investigations into the use of restraint in the children's secure estate, the most recent being in March 2013,¹⁹⁹ with some organisations calling for a complete ban of the practice, or at least severe restrictions and rigorous safeguards on its use.²⁰⁰

According to the Ministry of Justice, restraint should only ever be used on children as a last resort where it is absolutely necessary to do so, and where no other form of intervention would be appropriate.²⁰¹ The Ministry of Justice also states that it should only be used to prevent them causing harm to themselves or others, and should never be used as a form of discipline or for securing compliance. The use of restraint other than out of absolute necessity is in direct contravention of Article 3 of the European Convention of Human Rights, which protects the freedom of people from torture and inhumane and degrading treatment and punishment.²⁰² The European Court of Human Rights affirmed this in *Keenan v UK*, stating that the use of physical force on a prisoner which has not been made strictly necessary by his own conduct diminishes human dignity and is an infringement of Article 3 rights.²⁰³

In spite of this, there is growing evidence that restraint is routinely used as punishment or as a way of managing challenging behaviour. In 2011-12, 8,419 incidents of physical restraint were recorded – an increase of 17% on the previous year.²⁰⁴ The House of Commons Justice Committee expressed concern that this was the case, despite the fact that use of restraint has now been definitively linked to the death of at least one young person in custody.²⁰⁵ Of the 2011-12 incidents, 254 led to injuries, 7% of which were classified as serious – that is, warranting hospital treatment.²⁰⁶ Aside from its physical effects, the use of restraint can also have a profound psychological impact. Lord Carlile's review found that children and young people felt "violated and abused" following experience of restraint, while patients with a history of mental disorder linked to abuse often associated restraint with earlier traumatic experiences. Even witnessing the use of restraint led to a divisive "us and them" attitude between staff and children.

The links between the use of restraint and self-harm and suicide are unexplored and unsubstantiated. However, the evidence which emerged during the inquests of the deaths of some of those in custody points to the severe distress caused by the use of force against vulnerable children, particularly those who have suffered physical or sexual abuse.²⁰⁷

As long as it continues, the use of restraint within the children's secure estate can pose multiple problems for doctors. There can often be an assumption on the part of the prison that doctors can attend a situation and advise whether a particular method of restraint should proceed. This is problematic, as it is unclear whether the doctor is there to witness the restraint and ensure that the prisoner is not harmed, or whether he is effectively sanctioning punishment. In the BMA's view, restraint should be used only where absolutely necessary, and be removed at the earliest opportunity.²⁰⁸ Additionally, all children and young people should be offered the opportunity to be seen by a member of the healthcare team after any restraint incident, rather than being left alone in their rooms. The Prison Reform Trust's report *Fatally Flawed* highlights a number of investigations into deaths in custody which found that young people had been left alone after restraint incidents.

Whilst health professionals working in these environments should distance themselves from the more punitive aspects of the system, they must receive training in and understand the security and emergency procedures of their place of work.

In light of the evidence of the increased use of restraint, and the potentially serious consequences of its use, the BMA calls for a fundamental culture shift in the use of force and restraint in the children's secure estate, and calls on the Youth Justice Board and individual institutions to take steps to address this.

Restraint in medical treatment

As outlined above, prisoners are entitled to the same rights of healthcare as wider society. This includes a right to dignity and privacy. Despite this, there have been a number of high profile cases where seriously ill prisoners were routinely restrained in hospitals.²⁰⁹

When receiving medical treatment outside a secure setting, there should be a presumption that prisoners should be examined and treated without restraints, and without prison officers present, unless there is a high risk of escape or the prisoner represents a risk to themselves or others. Discussion and assessment of this risk should take place between the health team and prison officers on a case by case basis. Healthcare professionals are entitled to ask for handcuffs to be removed during assessment and treatment, and for accompanying officers to leave the room.

This presumption was confirmed by the courts in *FGP v Serco*, a case involving the use of restraint on an adult immigration detainee.²¹⁰ FGP had been taken to hospital on multiple occasions in a period of three months. On each occasion, a risk assessment was carried out which concluded that the use of restraints at all times was necessary due to his history of violent offending and self harm; the likelihood of him absconding; and the low level of security at the hospital. He was therefore escorted to hospital in handcuffs and remained in restraints throughout the duration of his stay in the hospital – including one eight day stretch. The Court held that whilst the decision to restrain him during hospital visits was justified given his history, the continued use of restraints could not necessarily be justified. It affirmed that there is a presumption that restraints will not be applied during medical treatment and that there should be no attendance of prison staff within earshot of a consultation unless it was agreed on proper grounds that such restraints or attendance were necessary.

More detailed information on the restraint of detainees in NHS facilities can be found in the BMA's guidance *The medical role in restraint and control: custodial settings*.²¹¹

Segregation

A range of international instruments state that solitary confinement should not be used other than in exceptional circumstances.²¹² Whilst there is no clear consensus on whether it amounts to inhuman or degrading treatment, both the UN Human Rights Committee and the European Committee for the Prevention of Torture have expressed concerns that "in certain circumstances" it may.²¹³

Lord Carlile's review found that there was a range of terms and usage for solitary confinement across the youth secure estate – including segregation, single separation, isolation and "time out." It also acknowledged that it can be a very useful tool for diffusing tension and possible conflicts.

Whilst the use of segregation was time limited in both STCs and SCHs, the review found that it was routinely used in YOIs, and seen primarily as a tool for punishing poor behaviour rather than dealing with an immediate threat. The review described the most basic conditions of segregation units as “inducements to suicide.”²¹⁴ It also expressed concern over its use on children with mental health problems. Clear policy and monitoring procedures should be developed for the use of segregation across the youth secure estate, with particular regard to safeguards for use on those with mental health problems.

Problems can arise where doctors are asked to certify whether an individual is fit to withstand solitary confinement for punishment or disciplinary purposes. The UN Standard Minimum Rules for the Treatment of Prisoners in fact state that “punishment by close confinement...shall never be inflicted unless the medical officer has examined the prisoner and certified in writing that he is fit to sustain it.”²¹⁵ We would caution against doctors doing so. Considering the fact that in certain circumstances solitary confinement can amount to inhuman and degrading treatment, certifying it would lead doctors to breaching both the Human Rights Act, and their professional obligations under the World Medical Association’s Declaration of Tokyo.²¹⁶ Additionally, as highlighted above, physician involvement in disciplinary matters can blur the line between welfare and punishment, with negative consequences for the doctor-patient relationship. Where solitary confinement goes ahead, it should be administered for the shortest time possible and carefully monitored. Where prisoners are segregated, they should still have access to a doctor. Doctors should also speak out if they consider solitary confinement to be detrimental to a prisoner’s health.²¹⁷

There is less difficulty where a doctor oversees the segregation of someone where it is considered necessary for therapeutic reasons, or for their own protection, such as where they represent a suicide risk.

Challenges to medical professionalism in the secure setting

It is well-established that children and young people in secure settings are entitled to the same standard of care they would receive in the community. Despite being incarcerated, they retain their ordinary rights to medical care. It is also well established that doctors practising in secure settings are governed by the same rules and professional guidance as they would be if practising in the community. Much of this report has looked at the health needs of children and young people in the secure estate, and the kinds of services required to meet them. Working in secure settings can nevertheless present doctors with unique challenges to their professional ethics. In this section we identify some of the pressures that doctors can be subject to in the secure estate that can undermine their primary ethical commitments.

Dual loyalties

Traditionally, codes of medical ethics have centred on the notion that a doctor’s primary loyalty is to the welfare of the patient. The GMC’s *Good Medical Practice* states that doctors should make “the care of their patients their first concern.”²¹⁸ The World Medical Association’s Declaration of Geneva states first and foremost that “the health of my patient will be my first consideration.” Whilst all doctors have multiple professional loyalties – for example, to colleagues, to employers, or to society at large – these generally remain in the background to their primary duty to the patient. For many doctors working in secure settings, this balance can be disrupted where ordinary obligations to individual patients come into conflict with the demands of the secure setting. Dual loyalties arise where a conflict emerges between professional duties to a patient and obligations, express or implied, to the interests of a third party, such as an employer, insurance company or government.²¹⁹ Doctors who work in secure settings are particularly vulnerable to dual loyalties due to the structure in which they work, and the balance that needs to be struck between providing an appropriate secure setting, and ensuring that children receive the help and welfare they need.

The UK is free from some of the more obvious human rights abuses which permeate the justice systems in many other countries, for example, using medical skills on behalf of the state to inflict harm or the denial of medical treatment to those in need. However, the danger in the UK of subordinating a patient’s interests in favour of those of the institution can lead to more subtle pressures that undermine the rights of individual patients.

Patient confidentiality

One common area of concern relates to patient confidentiality, with doctors at times feeling pressurised to disclose confidential patient information to manage risk, for administrative purposes or for other non-health related reasons. A right to confidentiality is never absolute, and doctors can disclose information in a limited number of circumstances – for example, where it is required by law; where disclosure is in the public interest; or where consent to disclosure has been given by the patient concerned. Having said this, all patients are owed a general duty of confidentiality, and doctors must resist pressures to disclose information unless the patient gives consent or where it is necessary to protect the security or safety of prisoners or staff. If a decision is made to breach confidentiality, and the patient is unwilling to consent to the disclosure, it is necessary to weigh up the likely benefits of disclosure against the harms of overriding a refusal by the patient. Only relevant information should be disclosed, and on a strictly ‘need to know’ basis.

Consent to treatment

It is a well-established principle in medical ethics and law that, as part of respect for a person’s right to determine what happens to their own bodies, patient consent is required whenever a doctor wishes to examine or treat a patient. It is an expression of a fundamental autonomy right, a right that is also strongly protected by human rights legislation. The disturbing history of medical experiments being carried out on unsuspecting and non-consenting detainees has shown the vulnerability of detained people to abuse.²²⁰

For consent to be valid, the patient must have the capacity to make the decision, be given the information relevant to the decision and be consenting voluntarily. This applies to children and young people as it does to adults – although there are a number of specific issues with regards to capacity and consent for young people. Legally, competent young people are able to consent on their own behalf – but they may not always be able to refuse an intervention if it is not in their best interests. In these circumstances, people with parental responsibility, or the courts, can consent on their behalf. This is so even where the relationship between parents and the young person is strained, as can be the case for detainees.

Where a child or young person refuses to consent to a medical intervention that is clearly in their interests, health professionals should seek to identify why they object, and to ensure they fully understand the implications of their decision. Although in some circumstances, consent can be sought from the courts or from someone with parental responsibility, imposing medication or treatment that a young person refuses has the potential to severely damage the doctor-patient relationship. In the secure setting, it can also distort the role of medical professionals, aligning them more closely with the punitive aspects of the prison regime.

Further information on assessing capacity and seeking consent can be found in the Mental Capacity and Consent toolkits, available on the BMA Ethics homepage.²²¹

Raising concerns

By the very nature of their work, doctors in secure settings may be among the first to witness the results of an abusive system – whether through the physical evidence of abuse or because prisoners confide in them. 4% of young men and 12% of young women surveyed said they would report being victimised to a doctor.²²² Medical staff should therefore be aware that they may be the recipients of information from a patient concerning the behaviour from another inmate or staff member, and familiarise themselves with the institutional processes for raising or sharing such concerns. All organisations should have clear mechanisms in place for reporting concerns. However, where authorities are thought to be complicit in abuse or maltreatment, it may be necessary to seek alternative reporting mechanisms. Respect for confidentiality should never be regarded as an insuperable barrier to raising concerns or reporting evidence of maltreatment – although again, wherever possible, the patient’s consent should be sought before information or suspicions of abuse are reported to a responsible authority.

Unfortunately, history suggests that opportunities for abuse, and for covering it up, are rife in secure estates by virtue of their isolation. The scandal at Medomsley Detention Centre in the 1970s where boys were routinely abused by a prison officer – to the knowledge of other prison staff – demonstrates how easy it is for abuse to carry on unreported.²²³ A number of other recent high profile abuse scandals, where vulnerable children and young people were failed by the social care system, has led to an increased focus on safeguarding children and young people, and all health professionals working with children and young people in secure settings must be properly trained in child protection and safeguarding.

Doctors have a professional duty, under the GMC's *Good Medical Practice*, to raise concerns if they are aware of misconduct that has or may lead to harm to others. This includes protecting patients from a risk of harm posed by another colleague's conduct, performance or health. Health professionals must not be victimised for raising a concern, and should receive protection in law from harassment and bullying. Continued employment and opportunities for future training or advancement should not be prejudiced because a legitimate concern has been raised. The BMA has produced guidance on raising concerns and whistleblowing.²²⁴ Additionally, BMA Employment Advisers can offer support and advice to members wishing to raise concerns.

Although not working in the children's secure estate, in 1995 Dr Simon Danson was suspended from his practice as a prison doctor at Barlinnie Prison in Scotland, and faced disciplinary proceedings on the basis of "gross misconduct" after he publicly revealed information about the mistreatment of prisoners by prison staff. Defending Dr. Danson, the BMA made it clear that "a doctor's first duty is to his patients, and although a patient loses liberty, he does not lose the right to a proper standard of medical and ethical care."²²⁵

Professional detachment, isolation, and morale

The nature of prison medicine can make it all too easy for doctors to become detached from their clinical role and find themselves absorbed uncritically into the prison machinery. Many doctors working in secure settings report a sense of professional isolation – including a lack of peer support and clinical supervision – from their colleagues and professional bodies in the community, either because little is known about their practice, or it is generally misunderstood. This means that they can lack both the support and scrutiny of others in their day to day practice. This lack of support can lead to doctors seeking approval, affirmation, or respect through relationships with prison staff, and this can make it harder for them to protest or speak out about negligent or abusive practices. Alternatively, there is a risk that doctors can become subsumed by the general machinery of the establishment and subsequently become inured to abusive or negligent practices. The new arrangements for commissioning healthcare in England should go some way in alleviating this, providing a more joined up approach to healthcare, creating opportunities for engagement with colleagues in the community and opening up the secure estate to a wider audience of healthcare professionals.

Many doctors working in custodial settings report feeling to some degree professionally marginalised and undervalued. They complain that colleagues working in the community and in non-detention settings sometimes view theirs as a "Cinderella service": under-skilled and under-funded. There is a risk that the morale of doctors working in detention settings can be undermined, both by external perceptions and by some of the challenges inherent to working in custodial settings. Working in networks with colleagues, and taking full advantage of opportunities for personal and professional development can all help support morale. Advice and support can also be sought from professional bodies such as the BMA.

Key messages for practitioners

- Doctors attending police stations should be aware that they may be called upon to examine minors, and should ensure that they are confident in the specific issues pertaining to capacity and consent that this raises.
- Imprisonment presents a rare opportunity to address the previously unmet health needs of a population with high rates of ill-health and to help them develop healthier behaviour and attitudes. However, the secure estate can be a less than ideal environment in which to provide care, as the health of inmates can be subordinated to the security needs of the institution.
- We acknowledge the importance of security and discipline to the secure estate. The dual aims of ensuring security and promoting health can come into conflict, and doctors can be put under pressure by competing obligations to their patient, and to their employer. It is only by acknowledging that these pressures exist, and recognising and understanding situations in which they might arise that they can be properly managed.
- The aim is to provide healthcare of an equivalent standard to that in the community. It follows that children and young people who have been detained have the same rights as patients in the community, including the same rights to confidentiality and consent.
- In addition to their role as healthcare providers, doctors should also be mindful of their roles as patient advocates, in raising standards of healthcare and in raising concerns about the treatment of children and young people. To this end, doctors have a positive obligation to work with senior management in secure settings to ensure that conditions are in place to enable young people to make healthy choices.
- Health professionals working in secure settings should consider how to encourage involvement and interaction with healthcare services in a manner that is best suited to the needs and concerns of children and young people in custody.
- Doctors working in the youth secure estate should make clear that they are independent from prison officers, and should not carry out custodial officer tasks or be directly involved in disciplinary proceedings. Doctors are in prisons in a clinical and welfare capacity, and acting outwith this can erode trust, undermine the willingness of a young person to access healthcare, and damage the doctor-patient relationship.
- Doctors should only carry out intimate body searches if they have obtained the consent of the detainee. The only exception to this where a patient lacks capacity and an intimate examination is deemed to be necessary in the patient's best interests.
- Doctors should not be involved in solitary confinement procedures, other than those necessary for therapeutic reasons, or for prevention of harm, e.g., where a young person poses a suicide risk.
- Doctors working in the secure estate should be aware of the limits of assessment tools used for reception health screening, and ensure that a full and in depth healthcare assessment is carried out.
- Doctors should work in networks with colleagues as far as possible, and take full advantage of opportunities for personal and professional development in order to alleviate some of the isolation associated with working in secure settings. The new healthcare structures in England especially should enable greater engagement with a wide range of colleagues across different sectors in the community.

Key recommendations

- The guiding principle for commissioning healthcare in the youth secure estate should be that children and young people are entitled to receive healthcare of an equivalent standard to that in the community.
- Consideration should be given as to how best to encourage young people to access health services, and to ensure that it is as easy as possible for them to do so.
- Arrangements should be in place to ensure that young people can access specialist services if necessary, including substance misuse services.
- Due to the prevalence of mental illness in the young offender population, and the high rates of suicide and self harm, the development of high quality mental health services should be a key priority for those responsible for commissioning healthcare in the youth secure estate.
- Healthcare providers should have clear information sharing strategies and opportunities for joint working to ensure:
 - accurate assessment of health needs of children and young people at the point of entry;
 - continuity of care upon release and resettlement.
- Health and wellbeing of children and young people should be seen as concerns for all those working in the secure estate, not just healthcare professionals. To this end, all staff working in the secure estate must be adequately trained and supported in identifying and reporting health concerns.
- Managers of secure settings should take steps to end the casual use of restraint and force, including, but not limited to, developing clear policies with mechanisms for policing its use.
- Clear policy and monitoring procedures should be developed for the use of segregation across the youth secure estate, with particular regard to safeguards for use on those with mental health problems.

Chapter Five: Beyond detention, beyond childhood

“Will they hold me back?” Martin asks; he is due to be set free in eight days...it won’t be clear whether extra time will be added to the sentence until the police have done an investigation. It isn’t clear whether Martin, who comes from a troubled family, was actually hoping for an extension to his stay.

Prisoners often start misbehaving in the days leading up to their release, staff say. “When they are in here they get food and clean clothes and a warm cell. They worry about losing that.”

The prison’s deputy director, Brian Stewart, recalls at least three prisoners who simply refused to leave. “One was released, walked to the car park and smashed the windows of five staff members’ cars; he was back here within a few days. He was homeless, living in a wheelie-bin before he came to us.”²²⁶

The end of a custodial sentence does not mean the end of the journey for children and young people in the criminal justice system. In many ways, it can signal the beginning of a sentence of another kind – that of a struggle to readjust to a life back in the community, where the problems that led to them offending in the first place await them. At the same time, not all children and young people will leave custody, and for some, leaving the youth secure estate will mean transition to an adult prison.

The rights of children and young people detained by the state extend beyond incarceration. Article 40 of the UN Convention on the Rights of the Child draws particular attention to the “desirability of promoting the child’s reintegration, and the child’s assuming a constructive role in society”, whilst Article 79 of the International Rules for Juveniles Deprived of their Liberty states that “all juveniles should benefit from arrangements designed to assist them in returning to society, family life, education or employment after release.” Additionally, in contrast to the voluntary nature of services for adult offenders, the resettlement of young people under the age of 20 has been a statutory requirement, irrespective of the length of sentence, for many years.²²⁷ The statutory aim of the youth justice system is to prevent offending and re-offending,²²⁸ and transition to the community is a crucial opportunity to do so – when surveyed, 89% of young men and 100% of young women said that they wanted to stop offending. Despite the combination of this willingness to change, plus the statutory rights in place, the release and resettlement of children and young people from custody so often ends in failure, with nearly three quarters re-offending within 12 months of being released.²²⁹

The increasing rates of recidivism hint at both the inadequacy of detention as a means of preventing re-offending and the difficulties children and young people experience in being successfully resettled. Effective resettlement is a complex process which draws together many different agencies in the community, and research has indicated that the poor figures for re-offending are largely attributable to a failure to engage in joint working –both between secure institutions and those responsible for community supervision; and between agencies in the community.²³⁰ The Youth Justice Board’s (YJB) framework for resettlement identifies five pathways that underpin effective resettlement provision: accommodation, education, training and employment; substance misuse; the involvement of families; financial stability; and critically for the purposes of this report, health.²³¹ Health is acknowledged as encompassing physical and, mental health, and health promotion – with a targeted focus on mental health. Accordingly, this section will focus on the continuing role of healthcare and healthcare professionals in delivering treatment and interventions for ex-young offenders in the community and in supporting them to lead healthy lives. When delivered in conjunction with services that meet the other needs of children and young people leaving custody, timely intervention and support can prevent them from returning to the youth secure estate, or to the criminal justice system as an adult.

Resettlement

“I don’t think the prison system works. It just puts a hole in people’s lives.”²³²

The terminology of “resettlement” suggests that young people will return to a life which was settled before they entered custody, and as we have seen, for many, this could not be further from the truth. Too many children and young people going into custody have suffered a turbulent or chaotic home life, with a 2010 Prison Reform Trust study showing that over half had grown up in a deprived household;²³³ 39% had been on the Child Protection Register or experienced neglect or abuse; and nearly half had run away or absconded from home at some point.²³⁴ For many, leaving the secure estate means leaving the security, routine and constancy that might have eluded them for much of their young lives. For others, it means returning to the environments, circumstances and influences which may have led them to offending in the first place. As such, effective resettlement is fraught with difficulties.

Finding accommodation

Given the often chaotic nature of their upbringing, finding accommodation upon release is a prominent concern amongst 15-18 year olds leaving custody: 26% of young men and 48% of young women felt that they would have problems in finding accommodation upon release.²³⁵ All too often these concerns translate into reality. In a Youth Justice Board survey carried out in 2007 into the accommodation needs and experiences of young offenders, over a quarter of the young people interviewed in custody said they did not have a place to live arranged for their release.²³⁶ A 2011 study carried out by Barnardo’s drew attention to the large numbers of children being released from custody without a safe place to live, forcing them into a cycle of homelessness and reoffending.²³⁷ They reported that in 2009-10, 4,147 young people were referred to the charity by young offender institutions, all of whom said housing was among their top five concerns upon release.

The YJB’s framework for resettlement states that wherever possible, efforts should be made to ensure that young people return to live with their family, with additional support being provided where necessary. Given the huge numbers of children and young people who were either in local authority care or homeless prior to entering custody, this will be impracticable in a large proportion of cases. There is a statutory duty on local authorities with social services responsibilities to provide accommodation and related support for those under the age of 16 unable to live in the family home or with relatives.²³⁸ For those aged 16-17 it is more complicated, and responsibility will rest with social services dependent on their status as either “eligible” or “relevant” children under the Children (Leaving Care) Act 2000. For young people who find themselves homeless through no fault of their own, the local housing authority has a duty to ensure that accommodation is available.

There are no minimum standards for accommodation, but B&B accommodation and “sofa surfing” are considered unsuitable by the YJB, due to their failure to provide structure or support for independent living.²³⁹ Structure and support for independent living can be conspicuously absent even where children and young people are released to their families, as they can find themselves experiencing the chaos, neglect or abuse which was a factor in their initial offending. This can make a successful transition to independent living in the community completely unrealistic, and dramatically increases the chances of reoffending – 69% of offenders with an accommodation need reoffended within two years, compared with 40% who were in suitable accommodation.²⁴⁰

A note on looked after children

In its 2012-13 report to the House of Commons, the House of Commons Justice Committee expressed particular concern over what they described as the “effective abandonment” in prison of children who had been in care. Children or young people who have been in care or are care leavers are entitled to additional statutory protections. Guidance and regulations state that “where a... former relevant child enters custody, pathway planning must continue. The young person must be visited on a regular basis and it is good practice for the first visit to take place within ten working days of their placement.”²⁴¹ A 2011 review of looked after children in custody by HM Inspectorate of Prisons found that this was not always the case – only half of young people interviewed said that they have received a visit from their social worker during their time in custody.²⁴² The same report also found that there was a lack of clarity in most establishments about where the responsibility for looked after children should lie, and three quarters of safeguarding teams surveyed felt this was complicated by the presence of barriers preventing effective communication between YOIs and local authorities. This has very serious implications for these young people upon release and resettlement back into the community as their lack of support will lead to immense problems in securing accommodation, education, training or employment, and thus leading a healthy and non-offending life. The BMA finds it deeply concerning that an already vulnerable group are being neglected whilst in custody, further undermining their ability to lead a meaningful and healthy life in the community and exacerbating already entrenched health inequalities. We call on the government urgently to address the treatment and care of looked after children in the secure estate.

Education, training and employment

The difficulties associated with securing suitable accommodation impact on a young person’s ability to access education, training or employment opportunities, the lack of which can lead back to offending behaviour. Having a job or getting into school or college was in the top six most common motivations sentenced young men and women identified as being most likely to stop them from offending in the future.²⁴³ However, these young people will experience particular difficulties in gaining employment with a criminal record which includes a custodial sentence – something compounded by the current economic recession and austerity, with levels of unemployment amongst young people particularly high.

Planning for resettlement

A lack of joint working between secure institutions and those responsible for community provision has been highlighted as one of the major reasons for the failure of resettlement. Given the fundamental importance of maintaining health interventions started in custody, there is much that healthcare professionals working in the secure estate can do to improve health outcomes upon release and thus contribute to overall effective resettlement.

The *Healthcare Standards for Children and Young People in Secure Settings* adopt a pathway approach which follows the journey of a young person throughout the youth justice system.²⁴⁴ They state that the healthcare plan which is formulated for every child and young person upon their arrival in custody must take account of time after custody – meaning that resettlement, and the preparations for it, are considered from the outset. The Standards also state that a lead named healthcare professional should be responsible for reviewing the healthcare plan prior to release, and for developing a healthcare transition plan to ensure continuity of care into the community and throughout resettlement, and thus that this should be integrated into a young person’s overall transition plan.

Only 21% of young men and 18% of young women said they knew who to contact for health support on leaving custody. It is vital that children and young people leaving prison are equipped with the necessary information to enable them to access healthcare services in the community. The *Healthcare Standards* state that all young people, and, where appropriate, their parents or carers, should be

provided with information about how and why they should register with a GP or access community health services, including sexual health and substance misuse services. As with healthcare information provided in prisons, it should be in a format that is easily accessible and understood.

In addition to the provision of information to young people and their families, information also needs to be shared with the relevant community services in order to facilitate ongoing treatment and intervention. The *Healthcare Standards* note that a summary record of the young person's health, including any recommendations for future treatment, should be sent to the young person's GP, and that a copy be shared with the young person themselves. Doctors working with young people in secure settings may also wish to consider the sharing of other relevant information where appropriate. Children and young people in custody retain their rights to consent and confidentiality, and accordingly, any information will need to be shared with their consent. As the information flow between custody and community has been identified as chiefly responsible for many of the problems in resettlement, those involved in commissioning and delivering services may wish to pay close attention to the development of clear information sharing protocols and pathways between custody and community services.

“...a big meeting where people talk about you. I told them I couldn't comply with my licence conditions. Now I've breached and I'm going back in.”²⁴⁵

Children and young people leaving custody should be involved in decision making and fully engaged with the resettlement process. Less than half of young men and women felt they had a say in what would happen to them upon release,²⁴⁶ despite studies overwhelmingly indicating that chances of successful resettlement are far higher if they are engaged and motivated to comply.²⁴⁷ Healthcare professionals should ensure as far as possible that young people actively participate in their own care. While there is little equivalent evidence for young offenders, adults are less likely to re-offend where they see themselves as in control of positive changes in their lives.²⁴⁸ A study by the Children's Society in 2010 reported that in qualitative research children emphasise repeatedly the importance of being allowed to make decisions about their own lives.²⁴⁹ This suggests that young people should be encouraged, as far as possible, actively to participate in decisions that affect them.

Return to community healthcare

A lack of stability and security in a young person's life has obvious implications for healthcare. Aside from undermining healthy behaviours that may have been developed during custody, it creates difficulties with meaningful engagement with both local primary care services and specialist health services.

Access to general health services

The return to the community means a return to mainstream health services. Accordingly, many of the same challenges and considerations for healthcare provision prior to entering custody apply. As explored in previous chapters, the turbulent lives of these children and young people can make it difficult for them to access mainstream health services, and so those responsible for commissioning and designing health services should consider how best to design and co-ordinate services in the interests of these children and young people and their families. Designing the best possible service requires input from this often overlooked group. It is difficult to exaggerate the importance of developing mechanisms to engage these service users and ensure their interests and needs are well represented.

The complex needs of children and young people leaving custody will often require a multi-agency approach. Health services should therefore work collaboratively with other organisations and develop strong partnerships with other relevant bodies.

On an individual level healthcare professionals need the training and experience to feel confident in dealing with children and young people in order to deliver the highest standard of care possible.

Positive experiences of mainstream healthcare services can go some way to alleviating the sense of disenfranchisement and detachment from society that time in custody can so often engender.²⁵⁰

Access to specialist services

For both young men and women, staying off drugs was identified as the third most important factor for stopping offending.²⁵¹ Substance misuse has a major impact on resettlement: after violence in the home it is the most important contributory factor towards homelessness for young people, leading to a vicious circle that loops back to offending.²⁵² Substance misuse should have been tackled in custody, and arrangements must be made to ensure continued support on release. Under the new healthcare reforms in England, local authorities have been tasked with commissioning substance misuse services. We encourage NHS England to work closely with them in designing services – particularly taking advantage of the opportunity to design clear service pathways between detention and the community.

Despite the government's pledge of "no health without mental health",²⁵³ the 2011 report on youth offending from the Children's Commissioner drew attention to the lack of ongoing provision and support for mental health needs.²⁵⁴ Several problems have been identified with Child and Adolescent Mental Health Services (CAMHS). Many of those surveyed expressed frustration over the inflexibility of the system and a lack of understanding of the lives of children and young people in contact with the youth justice system. For example, where appointments were not kept – often as a result of the accommodation difficulties outlined above – the referral would be closed, meaning that the entire referral process would have to start again, causing an obvious delay to treatment.

Funding and resource difficulties have led to some CAMHS services refusing to accept referrals for disorders such as ADHD and other conduct disorders – which have an extraordinarily high prevalence amongst children and young people in contact with the youth justice system – despite NICE guidelines indicating that this should be included in the work of CAMHS. Similar limitations often lead to CAMHS struggling to accept referrals of young people aged 16-17 years old, despite national guidelines stating that CAMHS services should be available to all those up to the age of 18. Despite such services already being overstretched, there is evidence that cuts are being made to the funding of CAMHS. A freedom of information request made by *Pulse* in early 2014 found that 33 out of 43 CCGs (77%) were making cuts to CAMHS budgets in 2014-15.²⁵⁵ The inordinately high prevalence of mental health conditions amongst this group of young people means the importance of ensuring that cuts to these vital services are minimised cannot be overstated.

Transition to adulthood

Access to appropriate health services can be complicated further if a young person turns 18 either shortly before leaving detention or upon their return to the community. In these cases, transition to adult services must be carefully planned to ensure access to age appropriate services and the continuation of any treatment which may have been initiated in paediatric services. Planning for transition should include consideration of a young person's whole life and any difficulties they may have in accessing services.²⁵⁶ Staff should also work collaboratively with other health, social care and voluntary services in order to ensure minimal disruption to treatment, and to keep children and young people informed and involved throughout the process.

Although the end of a young person's time in custody will not always be marked by a return to the community, many of the same principles apply for those who will serve the remainder of their sentence in an adult institution. Continuity of care must be assured so that interventions which have been yielding positive results are not lost. In order to facilitate this, clear information sharing protocols should be developed between institutions so that treatment is not delayed or assessment repeated unnecessarily.

The House of Commons Justice Committee noted the practice of holding some individuals in the youth system beyond their 18th birthday because of their circumstances, particularly if they only had a short part of their sentence remaining.²⁵⁷ In giving evidence, the Royal College of Psychiatrists noted that the transition to adult services is "frequently abrupt and inadequately planned", which can pose particular

risks for young offenders with mental health needs, particularly given the inadequate facilities for supporting vulnerable people in the adult prison system. The College expressed concern over the lack of input clinicians had into the transition decision, even where they might be aware of establishments – including the youth secure estate the offender is already in – that are better suited to the needs of young people with mental health problems. The BMA shares this concern, and encourages greater clinician involvement in the planning process and transfer to adult prisons.

Just as the transition to life in the community can be fraught with difficulties, so too can the transfer to adult prisons give rise to serious anxiety and stress. Young people have spoken of the huge leap between youth institutions and adult settings.²⁵⁸ Doctors working in the secure estate should be aware of their role as listeners and of their responsibility for ensuring the emotional wellbeing of those young people being detained. The anxiety felt by a young person may manifest itself through other disruptive behaviours, and so it is vital that doctors feel confident in dealing with the psycho-social aspects of adolescent health, and be able to refer to other services where appropriate.

Key messages for practitioners:

- The literature demonstrates that in order for it to be effective, consideration should be given to resettlement from the outset of a custodial sentence. Doctors working in secure settings should ensure that a young person's healthcare plan for their time in custody takes into account and plans for release.
- The factors affecting youth offending are complex and multi-faceted and require a multi-agency approach. Healthcare is but one part of this, and so healthcare professionals in the community must work together with other interested parties and develop clear information sharing strategies and joint multi-agency working to ensure that resettlement is successful.
- Doctors in the secure estate should ensure that children and young people leaving custody are equipped with the necessary information, in plainly accessible form, for accessing healthcare services in the community.
- A summary record of a young person's health, including recommendations for future treatment, should be sent to the young person's GP. Doctors may also wish to consider the sharing of other relevant information where appropriate. Any information being shared must be done with the consent of the young person in question.
- Arrangements should be made to ensure the continuation of specialist interventions upon release, such as substance misuse services and mental healthcare.

Key recommendations:

- We call on healthcare providers to examine current services and, where appropriate, to reshape services in line with the specific needs of children and young people.
- We ask for those responsible for designing and delivering health services to have clear plans in place on how to engage this socially excluded group in order to ensure their needs and interests are represented.
- We call for improved training for healthcare professionals in dealing with young people, particularly in the area of mental health to ensure that they are as confident as they can be in meeting their health needs.
- We call for the government and Youth Justice Board to address the treatment and care of looked after children in the secure estate, and to ensure that they receive the necessary support required to thrive.
- Those responsible for commissioning services in custody should ensure the development of clear information sharing protocols and pathways between custody and the community, to enable continuity of care.
- We are concerned about the lack of flexibility and the lack of clinical input into transition to adult prison decisions. Greater clinician involvement should be sought in the planning process and transfer to adult prisons.

Chapter Six: Conclusions and recommendations

Every child in the UK is born with an equal right to the conditions necessary for physical, psychological and emotional wellbeing. Tragically these rights are not always realised – least of all for those children and young people who come into contact with the Youth Justice System each year. By just about every metric they are amongst the most vulnerable and disadvantaged in our society.

This report was driven by the BMA's growing concern about health inequalities and the social determinants of health. Conceived primarily to support and advise doctors and health professionals working with children and young people in secure settings, it also takes into account life before and after a custodial sentence. It makes it clear that a child's time in a secure setting cannot be viewed as an isolated incident. In addition to practical guidance for health professionals working in these environments, we also make recommendations to other agencies with a role in supporting the health and wellbeing of children and young people in custody. We explored the role of health professionals from a human rights perspective and identified what individual practitioners, institutions, and commissioners can do to realise, protect, and maximise the health related rights of children and young people in custody – starting with an outline of the basic sources of children's rights in the UK in **chapter two**.

The health needs of children and young people do not arise at the point of detention. Long before any contact with the criminal justice system, many of these children and young people are exposed to multiple disadvantage, victims of some of our most entrenched health and social inequalities. **Chapter three** explored the specific health needs of children and young people who end up in custody, drawing attention to the high rates of mental illness, substance abuse, and the lack of any meaningful contact with the health service and healthcare professionals. Studies highlighting the effectiveness of early intervention have been well documented, and there is a key role for health professionals to play, even before birth, in identifying children who may be at risk of future offending behaviour, and in providing dedicated support. Those involved in designing and delivering services must be mindful of the specific needs of children and young people and create responsive services and pathways, and so ensure that there are clear plans in place to guarantee that the interests of children and young people who offend are represented and met by future service provision.

For those children and young people who fail to be diverted away from the criminal justice system, **chapter four** addressed the provision of healthcare in the secure estate. The NHS has responsibility for commissioning and providing health services in the children's secure estate, which will go some way to ensuring equivalence of care with the community. Despite this, there is still significant variation in the provision and quality of services across sites, and we call upon healthcare providers to continue to work to drive up standards of care in detention settings and improve the health and health prospects of the children and young people detained within them.

Imprisonment is a key opportunity to address any serious and previously unmet health needs of children and young people. At the same time, the secure estate can be a less than ideal environment in which to provide that care: all too easily health comes a poor second to security. These different aims can easily come into conflict and doctors may find themselves under pressure from competing obligations to their patients, and to their employers. In these circumstances a rights-based approach can help doctors focus on their primary professional duties.

Health professionals in detention settings do more than provide treatment and intervention. They play an essential role in health education and promotion, helping young people in custody develop the tools they need to live healthy lives when they leave. They are also patient advocates, raising standards of healthcare and highlighting concerns about the treatment of children and young people. They also have a role to play in identifying and reporting human rights abuses where they occur: genuine concerns still remain, for example, about the use of force, restraint and strip searching in the children's secure estate, and the prevalence of self harm and suicide amongst young people. There is a need for

a widespread review of the use of detention for children and young people, with a view to shifting the focus from managing criminogenic risk, to a more welfare based approach for offenders.

In **chapter five** we highlighted that neither the duties of the state, nor the challenges of dealing with offending behaviour end at the conclusion of a sentence. Preparations for release and resettlement should begin at the outset of any sentence, with doctors ensuring that a young person's healthcare plan takes into account plans for release. Widespread failures in successfully resettling children and young people in the community stem largely from a failure of joint working – both between secure institutions and community services; and between agencies in the community. Commissioning must address these issues as a matter of priority and develop clear information sharing protocols and establish good working relationships with relevant agencies.

Not all children and young people will leave custody for the community. In some cases, a young person will turn 18 before the end of their sentence, and be transferred to an adult prison. As with release back into the community, this requires clear information sharing both to ensure that health interventions started in custody continue in the adult institution, and to ensure that appropriate care and support is provided. We strongly reinforce the concerns of the Royal College of Psychiatrists over the abruptness of transfer to adult prisons, which poses significant risk for young offenders with mental health needs, and we call for greater flexibility and clinical input into transfer decisions.

The problems and hardships which children and young people in the secure estate face are complex and multi-faceted. Not all of them can be remedied by health services and the individual professionals working within them. Nevertheless, this report highlights the central role of healthcare, and the healthcare professional, in fulfilling the state's fundamental duties. Our concerns and recommendations must inform the decisions of policy makers and commissioners. Realising the health related human rights of children and young people has the potential not only to change the future trajectory of their lives for the better, but also to create safer communities, improve the health and wellbeing of the wider population, and ultimately to bring benefits to all of us.

Recommendations

For doctors working in the community

1. Children and young people who enter the criminal justice system are an extremely disadvantaged group, who, prior to detention, present with multiple and complex health and social needs. Identifying problems as soon as possible in the developing child can minimise and mitigate the underlying social causes of offending and promote resilience. Medical professionals should remain vigilant in recognising risk factors and seizing opportunities for intervention.
2. Early screening and identification of risk factors such as mental health problems – including post-natal depression – and substance abuse amongst parents and carers, and referral to appropriate services and support have a critical role in addressing factors linked to child wellbeing.
3. Reducing childhood neglect and abuse is crucial to reducing childhood behavioural problems which might manifest themselves in offending behaviour. Health professionals must be aware of the signs of neglect or abuse and of their safeguarding responsibilities.
4. Health professionals should have access to appropriate training and support to ensure they are confident in dealing with children and young people.
5. Doctors attending police stations should be aware that they may be called upon to examine minors, and should be familiar with the specific issues pertaining to capacity and consent.

For doctors working in the secure estate

6. Children and young people in secure settings are entitled to receive healthcare of an equivalent standard to that in the community, and have the same rights as patients in the community to dignity, privacy, confidentiality and consent.
7. Doctors should be aware of the limits of the assessment tools used for reception health screenings, and ensure that a full and in depth health assessment is carried out.
8. In secure settings, the aims of security and health can come into conflict. Doctors can be put under pressure by competing obligations to their patient and their employer. It is only by acknowledging that these pressures exist, and being sensitive to the human rights of children and young people, that these conflicts can be properly managed and doctors can focus on their primary duties to patients.
9. In addition to their role in providing healthcare, doctors are patient advocates. They have an important role to play in raising standards of healthcare and in highlighting concerns about the treatment of children and young people, and a positive obligation in working with senior management to ensure conditions are in place to enable young people to make healthy choices.
10. Practitioners should consider how best to encourage involvement and interaction with healthcare services, in a manner that is appropriate to the needs and concerns of children and young people in custody.
11. Doctors should make it clear that they are independent from prison officers and should not carry out custodial officer tasks or be directly involved in disciplinary proceedings. Doctors are in prison to act in a clinical and welfare capacity, and acting outwith this can erode trust, undermining the willingness of a young person to access healthcare and damage the doctor-patient relationship.
12. Doctors should only carry out intimate body searches with the consent of the detainee. The only exception to this is where a patient lacks capacity and an intimate examination is thought to be in his or her best interests.
13. Doctors should not be involved in solitary confinement procedures, other than those necessary for therapeutic reasons, or for prevention of harm, such as where a young person poses a suicide risk.
14. The new healthcare structures enable greater engagement with a variety of colleagues across different sectors in the community. Doctors should take advantage of the opportunities for joint working these new structures present, in order to alleviate much of the professional isolation often reported by those working in secure settings.
15. To ensure effective resettlement in the community, doctors working in secure settings must ensure that a young person's healthcare plan takes into account and plans for release from the outset.
16. Children and young people leaving custody should be equipped with the necessary information, in plainly accessible form, for accessing healthcare services in the community.
17. A summary record of a young person's health, including recommendations for future treatment, should be sent to the young person's GP. Doctors may also wish to consider the sharing of other relevant information where appropriate. Information must be shared with the consent of the young person in question.

For commissioners

In the community

18. No single service or professional can address the factors underlying offending behaviour. Services and policies should be designed and operated in partnership with other relevant community agencies.
19. Those involved in commissioning services must address the specific needs of adolescents, and reshape or create services and pathways which are responsive to them. Active steps should be taken to ensure that children and young people are fully informed of their rights and responsibilities with regard to healthcare.
20. Those responsible for designing and delivering health services must have clear plans in place to engage socially excluded groups, such as young offenders and ex-offenders, and to ensure their needs and interests are met in service design.
21. Healthcare providers must continue to deliver high quality and accessible drug and alcohol treatment services and sexual health clinics.
22. Every effort should be made to ensure that cuts to frontline services are minimised.

In custody

23. Children and young people in secure settings are entitled to healthcare of an equivalent standard to that in the community, and this should be the guiding principle for those commissioning healthcare in the secure estate.
24. Consideration should be given as to the most effective way to encourage young people to access health services, and to ensure that it is as easy as possible for them to do so.
25. Arrangements should be in place to ensure that young people can access specialist services if necessary.
26. Due to the prevalence of mental illness in the young offender population, and the high rates of suicide and self harm, the development of high quality mental health services should be a key priority for those responsible for commissioning healthcare in the youth secure estate.
27. Healthcare providers should have clear information sharing strategies and opportunities for joint working between community and custody services to ensure:
 - accurate assessment of the health needs of children and young people at the point of entry and;
 - continuity of care upon release and resettlement.
28. Healthcare must interact with other relevant bodies in the community, and commissioners should develop clear information sharing strategies and joint working to ensure that resettlement is effective.

For policy makers

29. We express concern over the low age of criminal responsibility currently in place in the UK, and ultimately, concern over the suitability of imprisonment in dealing with youth offending. Long term, we call on the government to carry out an in-depth review of the youth secure estate and conduct further research into more welfare based alternatives.
30. We call for an end to the practice of holding children and young people aged 17 and under overnight in police cells.
31. We call on the Youth Justice Board and individual institutions to take steps to effect a culture change to end the casual use of restraint and force, including, but not limited to, developing clear policy with mechanisms for policing its use.
32. Clear policy and monitoring procedures should be developed for the use of segregation across the youth secure estate, with particular regard to safeguards for use on those with mental health problems.
33. Health and wellbeing of children and young people should be seen as concerns for all those working in the secure estate, not just healthcare professionals. To this end, all staff working in the secure estate must be adequately trained and supported in identifying and reporting health concerns.
34. The government and Youth Justice Board should address the treatment and care of looked after children in the secure estate, and ensure that they receive the necessary support required to thrive.
35. Greater clinician involvement should be sought in the planning process and transfer to adult prisons.

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