Research report October 2023

Growing up inside

Understanding the key health care issues for young people in young offender institutions and prisons

Miranda Davies, Rachel Hutchings
and Eilís Keeble

nuffieldtrust

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Summary

There were 11,494 people under 25 years of age in young offender institutions and prisons in England and Wales as of 31 December 2022, representing 14% of the total population in custody. While the number of children (under 18) in secure settings has fallen sharply over the past 15 years, very serious challenges remain over the use of force in the children's secure estate, with ongoing concern over children being held in solitary confinement, some for extended periods.

From a legal perspective, young people are treated as adults from the age of 18 within the criminal justice system, but there is recognition of the needs of 18- to 25-year-olds as 'young adults' (see the work of t2a.org.uk), distinct from the needs of children or other adults.

This analysis uses routinely collected hospital data to look at the service-use patterns of children and young adults aged 25 and under in young offender institutions and prisons in England. We engaged with experts and looked at the literature to consider this in the context of the key health care needs of young people. Looking across the children's secure estate as well as the adult estate provides a novel perspective on the key health care issues for young people, allowing us to compare experiences in the so-called 'children and young people secure estate', which caters for those aged 18 and under and is run as a distinct part of the custodial estate, with those in the adult estate, which manages young adults alongside prisoners in older age groups. Understanding how health care access and needs differ is important, because the distinction between the two parts of the system is becoming increasingly blurred. Recently, population pressures in the adult estate have led to an increase in the number of young people aged 18 or over in the children's secure estate, which will drastically alter the age profile of the children's secure estate population.

A summary of the key findings and some considerations for policy-makers are provided below. We found that some of the biggest problems affecting the adult prison estate – violence and self-harm – have a disproportionate impact on young adults. We consider how the prison service can meet the needs of young people in custodial settings, and the benefits of providing tailored support for young adults in particular.

Key findings

42% of hospital admissions by young adult males in custody had a primary diagnosis of injury or poisoning. This was significantly higher than among the adult prisoner population, where injury or poisoning accounted for just 16% of hospital admissions.

We found that violence and self-harm were much more prevalent in younger age groups than older age groups. While mental health care needs partially drove this, we found that age group in itself was a significant predictor. This supports the need for tailored support and interventions for young adults to reduce violence and self-harm in prison, which are long-standing issues facing the prison estate, and impact on living and working conditions for everyone, regardless of age.

Some 60% (n=55) of hospital admissions for young adult males in prison where a diagnosis of attention deficit hyperactivity disorder (ADHD) was flagged had a primary diagnosis of injury or poisoning. This was significantly higher than for young adult males without ADHD, where it accounted for 41% of admissions.

We found that 6% (n=92) of hospital admissions by young adult males in prison had ADHD recorded as a diagnosis, compared with just 2% of admissions by young adult males in the general population, which may reflect a higher prevalence of ADHD among those in custody. Staff need to be trained in neurodiversity and providing appropriate support, management and access to care. This is particularly important in relation to ADHD as it may be linked to challenging behaviour.

Boys detained in young offender institutions had a higher proportion of outpatient appointments cancelled on their behalf (18%) than both young adult males (14%) and other adult males (13%) in prison.*

Access to hospital care for children in custody is a significant cause for concern. Children in young offender institutions have a higher proportion of hospital appointments cancelled on their behalf than both young adult males and other adult males in prison. There are various reasons why appointments may have to be cancelled (for example, people being transferred to another location or reaching the end of their sentence, or hospital appointments clashing with court appointments). Similar pressures exist within the adult estate, but these issues may be more significant within the children and young people secure estate and it is unclear why this is.

The children and young people secure estate has much higher staff–child ratios than is the case with prisoners in the adult estate, which affects the culture in each and makes the transition between the two more complex.

The children and young people secure estate makes the case for better resourcing in the adult estate, particularly in terms of staffing, which is integral to all aspects of day-to-day life in secure settings. Young offender institutions have a higher staff–child ratio than the ratio of staff to prisoners in the adult estate, which means that day-to-day activities in these institutions are less likely to be cancelled due to a lack of staff and staff are more familiar with those under their care and can potentially develop better relationships with them. At the most basic level, staff need to be in place to provide the tailored support for young adults that is so clearly needed.

But it's not just about staffing ratios, as a recent Urgent Notification invoked in relation to HMYOI Cookham Wood demonstrates (the centre reportedly has around 360 staff (including 24 senior leaders) managing a population of 77 boys). It is vital that staff with the right skills are employed and that they receive appropriate training and support to develop trusted relationships with young people.

* Girls are not routinely sent to Young Offender Institutions and instead should be placed in Secure Children's Homes or Secure Training Centres (see Figure 1 for more information).

Recommendations

We now set out our recommendations for signatories of the Children and Young People Secure Estate National Partnership Agreement,* signatories of the National Partnership Agreement for Health and Social Care for England† and for HM Prison and Probation Service specifically.

For Children and Young People Secure Estate National Partnership signatory organisations

Understand and address the reasons why outpatient appointments for children and young people in young offender institutions are cancelled much more often than is the case for people in prisons. Make data on reasons why hospital appointments are missed publicly available. This is important so that action can be taken, and national partnership members can be held accountable.

For National Partnership Agreement for Health and Social Care for England signatory organisations

Develop specific national guidance or standards relating to health care for young adults in secure settings. We support the need to address the key health care issues for young people as part of any future national strategy for young adults in the secure estate.

For HM Prison and Probation Service

Ensure all staff have sufficient understanding of, and training in, neurodiversity. This should be considered as part of staff recruitment, initial training, ongoing training and awareness-raising activities within secure settings.

* Signatories include Department for Education, Department of Health and Social Care, UK Health Security Agency, Ministry of Justice and NHS England. See reference no. 18 in reference list for further detail.

† Signatories include Department of Health and Social Care, His Majesty's Prison and Probation Service, the Ministry of Justice, NHS England, and the United Kingdom Health Security Agency. See reference no. 19 for further detail.

About this report

We spoke to a number of stakeholders to shape our understanding of the challenges facing young people in young offender institutions and prison and how these impact on their health care needs. Our stakeholders included young adults with lived experience of prison, as well as representatives from the Youth Justice Board, NHS England, the Royal College of General Practitioners' Secure Environments Group, HM Prison and Probation Service (HMPPS), the Transition to Adulthood Alliance, the Youth Endowment Fund, the Centre for Mental Health, and Diabetes UK. Where relevant, we refer to insight from stakeholders as well as the wider literature in this report.

We used Hospital Episode Statistics (HES) data to look at the use of hospital services in 2019/20 (1 April 2019 to 31 March 2020), by young people in young offender institutions and prisons (see the Appendix for more details on the locations and age ranges of the young people included in the research). We compare data on the children and young people secure estate and data on the adult estate where appropriate to consider the impact of the different systems and what this might mean for those people who have spent time in children and young people secure estate and adult custodial settings. Inpatient admissions, outpatient appointments and Accident & Emergency (A&E) attendances are all considered when exploring specific health care issues, to present a cumulative picture of what drives children's and young adults' use of hospital services. For some parts of the analysis we focus just on young adults, as the data relating to children do not contain a large-enough number of cases for us to report.

Language use: what do we mean by 'children', 'young adults' and 'young people'?

We acknowledge that there are challenges regarding the terminology used when referring to people in custody up to the age of 25, given that the age range covers the spectrum of children to young adults, who have different preferences for how they are referred to. For the purposes of this report, where our analysis looks at people aged 18 and under in young offender institutions, we refer to 'children'. For aspects of the work relating to people aged 25 and under in other settings, we refer to 'young adults'. For broader observations relevant to both groups, we refer to 'young people'.

The impact of Covid-19 on young people in custody

This report does not directly address the impact of Covid-19 on how young people used hospital services, as the data period only covers the very start of the pandemic. However, reviews of the impact of Covid-19 on prisons, such as the House of Commons Justice Committee's review,[1] have raised concerns about the impact of custodial regime restrictions on young people, and in particular the removal of education, employment and social interactions.

1 Introduction

In England and Wales, from the age of 10 years old, children can be charged if they commit a crime and can receive a custodial sentence.[2] Children who are sentenced up to the age of 18 are placed in secure children's homes, secure training centres or young offender institutions. This estate is collectively called the 'children and young people secure estate'. Where they are placed depends on a range of things, including their age, sex and how vulnerable they are.

The children and young people secure estate is run separately from the adult prison estate and the principle 'child first, offender second' should underpin how things operate on the estate. This means that:

- children's best interests should be at the heart of decision-making
- relationships with staff should be supportive
- the environment should be rehabilitative and safe.[3]

Despite this, the children and young people secure estate has a troubled past, and serious challenges remain that raise questions over the extent to which the estate as a whole can deliver on its 'child first, offender second' principle. For instance, in April 2023, HM Inspectorate of Prisons invoked an Urgent Notification in relation to HM Young Offender Institution (HMYOI) Cookham Wood in Kent, which highlighted that the solitary confinement of children had become 'normalised'.[4]

Population pressures in the adult estate are also having knock-on effects in the children's estate: 'Operation Safeguard', a policy put in place in response to capacity issues in the adult estate, has reportedly driven a rapid increase in the number of young people aged 18 or over being held in the children's secure estate. An open letter from over 30 signatories has raised concerns as to what this change in age-profile will mean for the risks children face, as well as the extent to which the needs of those aged over 18 can truly be met.[5]

There are also concerns surrounding the use of force to manage behaviour in children and young people secure estate settings. Children report that

restraint is used too frequently rather than de-escalation techniques.[6] In the year ending March 2022, there was a monthly average of 80 incidents of force for every 100 children and young adults in secure training centres and young offender institutions.[7]

Where are children and young adults in custody?

Figure 1 shows where children and young adults should be placed from age 10 to 18+, as well as highlighting possible reasons why children may be placed outside the normal placement principles. It is important to note that while our work focuses on children who are in custody in secure settings, some children are held in secure settings for welfare reasons, meaning they are there because they are considered to be a risk to themselves or others. The Nuffield Family Justice Observatory provides a useful summary of evidence regarding what is known about children deprived of their liberty for custodial and welfare reasons as well as those detained under the Mental Health Act 1983.[8]

Figure 1: Children and young adults in custodial settings

Older boys considered vulnerable may be placed in secure training centres.

Boys aged 15–17 in young offender institutions should be separated from those aged 18–21.

Some young offender institutions have special units for children with complex needs or those serving long sentences.

Young people transition to the adult estate at age 18, but they may remain in the youth estate past this point if they don't have long left to serve on their sentence.

The number of females aged under 18 in youth custody settings is very small (n=12 in November 2022).

Children can be placed in secure settings on welfare grounds, not all are in custody.

Wetherby Young Offender Institution is currently holding a small number of girls as two secure training centres have been closed.

The number of under-18s in secure settings has fallen sharply over the past 15 years. In August 2008 in England and Wales, 3,019 children were in custody across the different secure settings, but by December 2022 this had fallen to 436.[9] This reduction is attributed to changes in how children are managed within the youth justice system.[10] The number of children being arrested reduced by 67% between 2012 and 2022, from 160,123 to 52,953.[11] The majority of children are held in young offender institutions. In December 2022, 377 children were being held in five young offender institutions across England and Wales,* representing 87% of the children and young people secure estate population.[9] Just 12 females under 18 were in the children and young people secure estate as of December 2022.[11]

What happens once children reach the age of 18?

From a legal perspective, children are treated as adults from the age of 18 within the criminal justice system,[12] but there is wide recognition of the needs of 18- to 25-year-olds as 'young adults' being distinct from those of children or adults, and that they would benefit from tailored support (see the work of the Transition to Adulthood Alliance: https://t2a.org.uk). On 31 December 2022, 18- to 24-year-olds accounted for 14% of the prisoner population (n=11,172).[13]

What health care services should children and young adults in the secure estate receive?

We have previously described the health care services that people in prison should receive.[14] There are specific health care standards relating to children (covering ages 10–17) in secure settings.[15,16] But there are currently no specific national standards or guidance relating to the health care of young adults (aged 18–25) – despite stakeholders in our research and more widely highlighting the distinct needs of this group. HM Prison and Probation Service

* The five young offender institutions include: Cookham Wood, Feltham (covers up to the age of 21), Werrington, Wetherby and Parc. Parc is located in Wales so is out of scope for this research as the data covers England only.

has, however, committed to developing a national strategy for young adults in the secure estate.[17]

Alongside the need for specific guidance for young adults, stakeholders talked about the importance of health care that is accessible, confidential and compassionate, and the need for early intervention. They also stressed the importance of health care being dynamic and responsive to account for evolving needs.

The Royal College of Paediatrics and Child Health has published standards that outline the care that children in the children and young people secure estate should receive.[16] Originally published in 2013, these standards were refreshed in 2019 and then again in 2023 and contain several overarching principles.

Care provided to children in custody should be 'at least' equivalent to that available for children living in the community, recognising that this population has significant health care needs and may require additional, or more tailored, services. Particular emphasis is placed on:

- the importance of building trusted relationships between children and health care staff
- confidentiality
- continuity of care
- the need to consider the preferences of the child.

As well as these principles, there are specific standards covering, for example, information-sharing, health care and assessments when entering the secure estate, and access to physical and mental health care and neurodevelopmental needs while in custody.

Everyone entering the children and young people secure estate should receive an initial health screening to identify needs. The Comprehensive Health Assessment Tool (CHAT) is a semi-structured tool used to screen all children entering the secure estate to identify mental, physical and neurological health and substance misuse needs.[18] The Framework for Integrated Care (known as 'SECURE STAIRS') is an approach that aims to change culture and practices in

estate so that they are more trauma-informed, developmentally attuned and psychologically based.[19,20]

There are also requirements for public health practitioners who work within the children and young people secure estate. This includes ensuring young people are up to date with their immunisations, and offering advice about physical and sexual health, diet and exercise and dental health.

2 Health care for young people in custody

Stakeholders were clear that when young people are in custody, despite the challenges of being in these settings, they do present an opportunity to address unmet health care needs, particularly making sure vaccinations are up to date and undertaking regular screening, such as eye tests, hearing checks and dental care. This is important to mitigate the effects of poor health later in life.

In this chapter we consider how often and why boys and men aged 25 and under in young offender institutions and prisons access hospital services (see Table 1 for summary statistics). Chapter 5 looks separately at how women aged 25 and under in prison access hospital services.

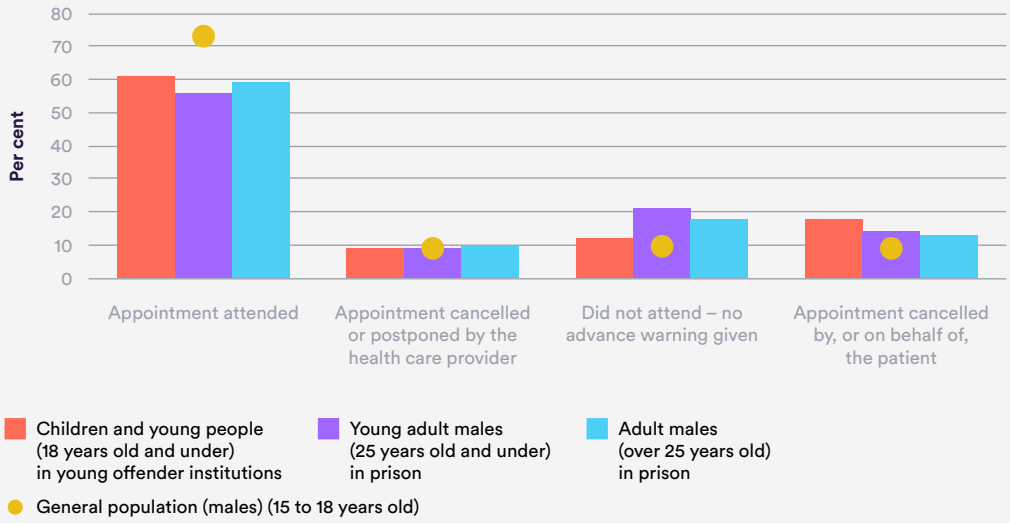
Table 1: Inpatient admissions, outpatient appointments and A&E attendances by children in young offender institutions (18 years old and under) and young adults in prison settings (25 years old and under), males, 2019/20

	Children in young offender institutions	Young adults in prison
No. of inpatient admissions (no. of people)	31 (29)	1,474 (1,051)
No. of outpatient appointments (no. of people)	676 (286)	10,047 (3,902)
No. of A&E attendances (no. of people)	291 (201)	4,194 (2,747)
No. (%) of A&E attendances resulting in an inpatient admission	22 (8%)	523 (12%)

Accessing hospital services as a young person

Similar to other age groups within the custodial population, we found that young people were missing around 40% of their outpatient appointments. Figure 2 shows the proportion of outpatient appointments for children in young offender institutions and young adults in prison that were attended and those that were missed.

Figure 2: Percentage of outpatient appointments attended, and not attended, categorised by reason, comparing children in young offender institutions, young adults and other adults in prison and young adults in the general population aged 15 to 18, all males, 2019/20



Note: For comparison, people aged 18–25 in the general population missed 29% of their outpatient appointments in 2019/20.

There were differences between age groups as to why appointments were recorded as missed. Children in young offender institutions had a higher proportion of appointments cancelled on their behalf (18%), than young adults (14%) and other adults (13%) in prison. There are various reasons why appointments may have to be cancelled (for example, people being transferred to a different location or being released, or hospital appointments clashing with court appointments). Similar pressures exist within the adult estate, but these issues may be more significant within the children and young people secure estate and it is unclear why this is.

The number of outpatient appointment escorts scheduled and the number of cancellations that result in escorts being reorganised are indicators of performance in the Children in Secure Settings Healthcare Provision Overarching Specification.[15] To reduce cancellations it is important to understand the issues that result in them and to be clear on the implications. If people wait longer for outpatient care, they may have more severe health care needs as a result.

Conversely, children in young offender institutions had a much lower proportion of appointments not attended on the day (so-called 'DNAs' – did not attend) (12%), than young adults (21%) and other adults (18%) in prison. One of the main reasons for DNAs is a lack of staff to provide escorts. This suggests that the children and young people secure estate does not face the same degree of pressure surrounding escort availability. The ratio of staff to children in young offender institutions is between 1:6 and 1:8, whereas the staff–prisoner ratio in prisons is approximately 1:12.[21]

It is also important to consider whether there is a relationship between the proportion of appointments not attended on the day and those that are cancelled in advance. It may be that the children and young people secure estate is more proactive at cancelling appointments in advance (hence the higher cancellation rate on behalf of the patient) rather than the child in custody simply not turning up. Even if this is the case, it is important to understand this further as the result is the same – the appointment is not attended.

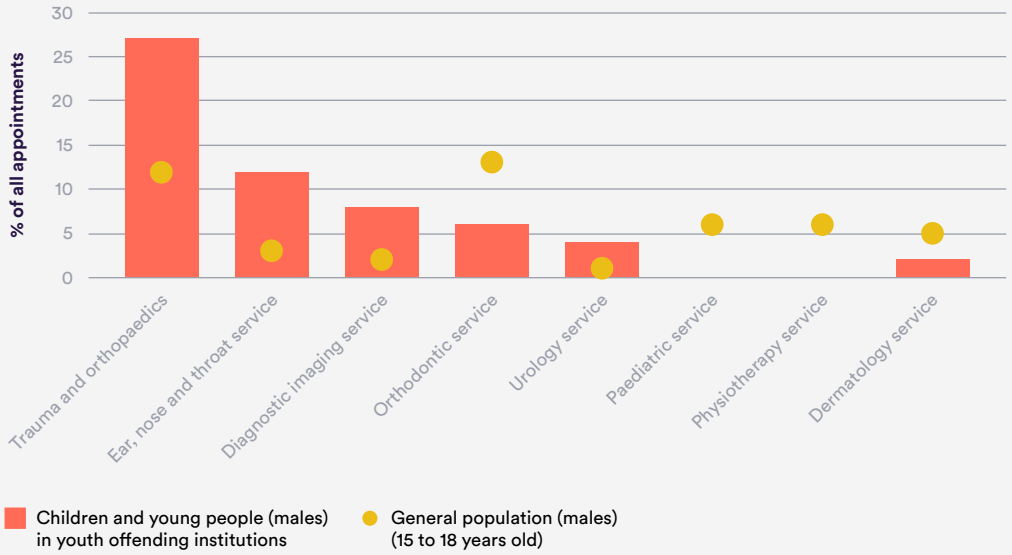
People with lived experience told us that accessing health care in custody can be a complex and time-consuming process, with people waiting a long time to get support or treatment for issues such as toothache, and receiving little to no information about whether their requests for help (or 'apps') had been received. There was a feeling that those with mental health or substance abuse needs were prioritised, in part because this often resulted in an acute or emergency situation affecting staffing and resources. This could also mean that other people's needs were overlooked, particularly if they were quiet or not seen to be 'making a fuss'. Other stakeholders were also concerned

that the focus on mental health care and support (while vital and necessary) could mean that other health care needs went unnoticed or unmanaged.

Comparing use of hospital services by children in young offender institutions with that in the general population

We looked to see how the most common outpatient treatment specialties for children in young offender institutions compared with those for children of the same age in the general population (see Figure 3). There were noticeable differences between the services that children in young offender institutions used and the services that children in the general population used. In relation to those in young offender institutions, more than 25% of outpatient appointments were for trauma and orthopaedic services. In the general population, orthodontic services (such as to fit braces) were the most common treatment specialty, followed by trauma and orthopaedics. It is particularly noticeable that children in young offender institutions had very few paediatric or dermatology outpatient appointments, while these made up about 12% of outpatient appointments for children aged 15 to 18 in the general population. It is unclear whether needs in these areas (such as paediatrics) are addressed in other ways in custodial settings, without requiring a hospital visit. There is also still a lack of clarity as to how decisions are taken about which appointments can and cannot be made (or attended) for those in custodial settings, given the challenges around staff availability to escort people to hospital. This may have an impact on the threshold for deciding whether appointments are necessary.

Figure 3: Percentage of outpatient appointments, by treatment specialty, for children in young offending institutions and young males in the general population, aged 15 to 18, 2019/20



Note: treatment specialties shown represent the five most popular treatment specialties taken from appointments arising from children and young people in young offender institutions and the five most popular from males in the general population aged 15–18.

Use of hospital services by young adults (aged 25 and under) in prison settings

We also looked to see what we would learn from hospital data about admissions by young adults in prison linked to four of the five clinical areas of focus specified in the children's Core20PLUS5 approach: asthma, diabetes, epilepsy and oral health (see Table 2). The fifth area, mental health, is addressed in Chapter 3. NHS England developed the Core20PLUS5 approach for children to identify key groups within the population who experience inequality (such as people in contact with the justice system) and to target specific health outcomes, such as reducing the number of asthma attacks, within these groups.[22] Although the age range of our work for this report covers young adults as well as children, we thought that it was appropriate to explore admissions linked to these clinical areas because broad consensus from discussion with our stakeholders was that young people in secure settings were generally in good health (particularly when compared with the adult prisoner population), but that long-term condition management

could be a challenge. We found that, except for oral health, the proportions of hospital admissions falling under these areas were similar between young adult males in prison and those in the general population.

Table 2: Breakdown of inpatient admissions by young adult males in prison (25 years old and under) with a diagnosis that falls under one of the Core20PLUS5 clinical areas, 2019/20

	No. of admissions (% of admissions)	% of admissions for young adult males (aged 18–25) in the general population
Asthma	150 (10%)	10%
Diabetes	42 (3%)	3%
Epilepsy	46 (3%)	3%
Oral health[23]	120 (8%)	4%

Managing diabetes as a young person in a secure setting

We spoke to stakeholders about how diabetes affects young people in secure settings, as previous Nuffield Trust research highlighted broader concerns regarding hospital admissions due to ketoacidosis (a preventable condition caused by a lack of insulin) and what this highlights about the challenges of managing a long-term condition in a custodial setting.[24] Regarding diabetes admissions, there were 19 admissions by 11 young adult males in prison with a primary diagnosis of diabetic ketoacidosis in 2019/20. Young people in custody face some similar challenges to those seen for people of all ages in secure settings – such as access to food (in particular, snacks to control blood sugar levels) and whether they can attend regular diabetes check-ups. For young people coming to terms with a diabetes diagnosis, being in custody adds an additional layer of complexity. It can also be challenging for them when they move through the different diabetes services – paediatric clinics, transition services and adult services – as each service is different and people can get lost in the system. Diabetes UK advocates for patients with diabetes, in particular those who are children or young adults, to have access

to psychological support for their condition. And it has written a guide for prisoners and their families about having diabetes in prison.[25]

Moving from the children and young people secure estate to the adult estate

Life is very different in the adult prison estate compared with the children and young people secure estate. Discussions with stakeholders highlighted concerns about the difficulties that children experience as they move from the children and young people secure estate to the adult estate – this is commonly referred to as 'transition'. A review of restricted-status children highlighted this recently, with specific issues including children not being given information to prepare for their new placement, and being transferred close to their 18th birthday, despite it being policy not to do this for non-restricted-status children.[23] Although work is ongoing to improve the transition process,[26,17] it is still thought to be a clear point of risk.

Children experience a significant shock when they arrive in the adult estate, where there are fewer staff, fewer resources and a very different culture. Stakeholders highlighted that, despite a significant amount of work going into addressing children's health needs in the children and young people secure estate, when they move to the adult estate there is often not the resources to maintain a similar level of care or proactive support. There was particular concern around information-sharing (or the lack of it) and the impact this might have on ensuring continuity of care.

Added to this, the different cultures between the children and young people secure estate and the adult estate (both for those in custody and for staff) mean that children may be ill-prepared. Transition is therefore an important time both for managing health care needs and for supporting young people more broadly.

The difference in provision between the children and young people secure estate and the adult estate is acknowledged (albeit implicitly) in how the challenges surrounding transition are highlighted. For instance, the Female Offender Strategy Delivery Plan 2022–25 talks about 'bridging the gap between

the high level of support in youth custody services and adult custodial provision'.[27] This should be more explicitly acknowledged as an impact of the systemic challenges facing the custodial estate – funding and staffing being key.

Meeting the needs of young adults in prison

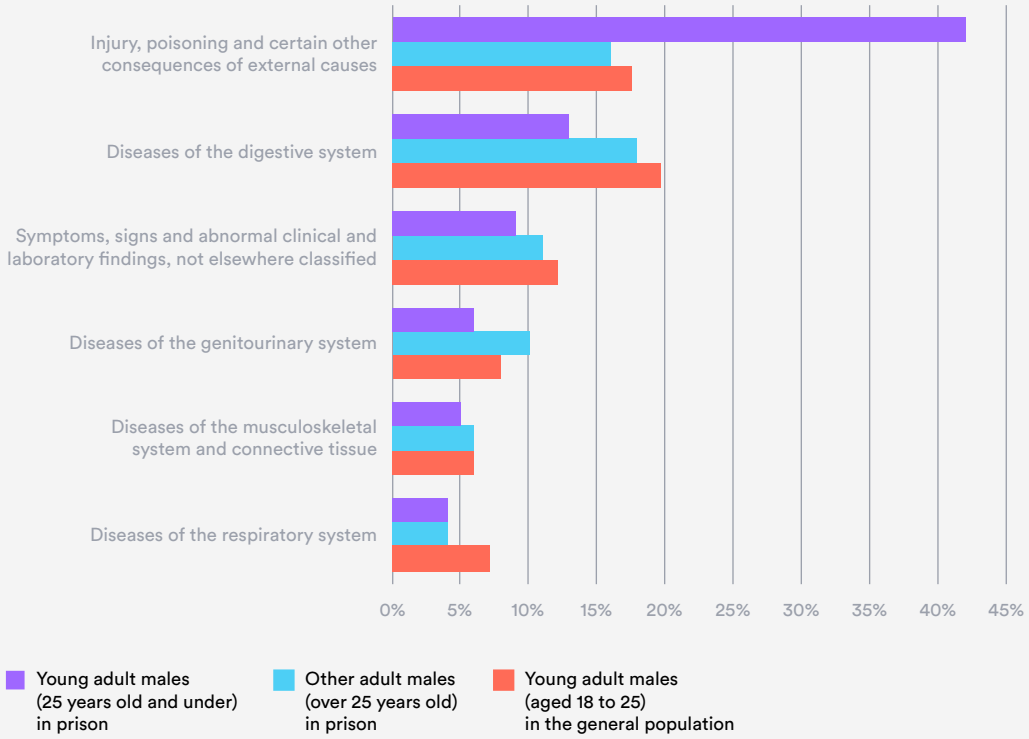
There have been continued calls for tailored support for those aged up to 25 in prison (see https://t2a.org.uk). While some prisons run specific initiatives for young adults, such as a course for young adults at Pentonville or a youth engagement workers at Exeter,[28] generally young adults are treated the same as all adults in custody, and age is not routinely considered as part of deciding where someone is placed.[17] This is despite the fact that there are crucial differences between young adults and other adults, the most noticeable being that the brains of young adults are still developing. The impact of the stage of brain development comes on top of a backdrop of wider issues that affect many people in prison – physical and mental health care needs, neurodiversity and experiences of trauma and abuse before custody.[28] While it is not necessarily appropriate to manage young adults alongside children, young adults are currently not well served within the adult estate (see https://t2a.org.uk). HM Prison and Probation Service has committed to developing a national strategy for young adults,[17] but this has not yet been published.

Stakeholders we spoke to highlighted challenges around services not being seen as appropriate or accessible for young adults (such as substance misuse services), and young adults' lack of engagement as a result of this. Initiatives such as Young People's Health Champions provide peer support, mentorship and other support within secure settings to help people engage in services, and to support health promotion campaigns around things such as testicular cancer and vaccinations.[29]

3 The impact of violence and self-harm

To investigate the impact of violence and self-harm in custodial settings, we began by looking at the most common primary diagnosis for young adult males in prison who were admitted to hospital in 2019/20. This highlighted that a large proportion of admissions among this age group (more than 40%) were linked to injury or poisoning (see Figure 4). This was more than double the proportion of admissions due to injury or poisoning among young adult males in the general population, as well as among other adult male prisoners. We have highlighted in previous Nuffield Trust work that injury and poisoning consistently make up around 20% of all prisoners' hospital admissions as a primary diagnosis,[26] but in this new work we can see that young adults are much more likely to be admitted to hospital for these reasons than older age groups. HM Inspectorate of Prisons, in previous work, has noted that young adults are more likely than other prisoners to be involved in violence.[30] Our work shows the impact this has on demand for health services.

Figure 4: Primary admitting diagnosis for young adult males (25 years old and under) and other adult males (over 25 years old) in prison, in 2019/20



Ministry of Justice and HM Prison and Probation Service safer custody statistics highlight the scale of the challenge relating to violence in prison more broadly across all age groups. In the year to September 2022, there were 19,555 assault incidents in prisons for males (256 per 1,000 prisoners).[31] Self-harm also presents an enormous challenge. There were 40,837 incidents of self-harm affecting male prisoners in the year ending September 2022 (534 per 1,000 prisoners).

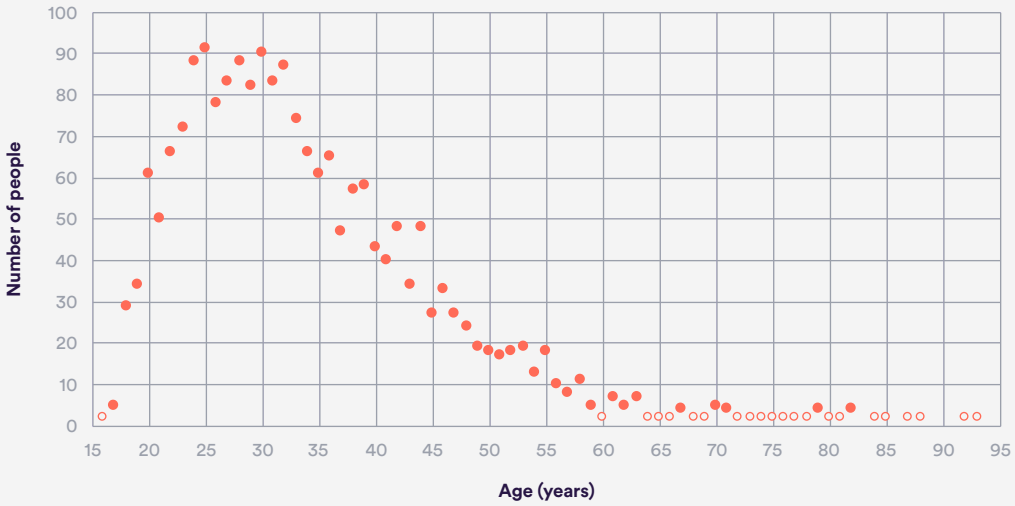
While the impact of the Covid-19 pandemic on the prison regime as well as changes in how data are captured make assessing changes over time difficult, before the pandemic there was a general trend of incidents increasing. The rate of violent incidents was 224 per 1,000 male prisoners in the year ending September 2015, increasing to 374 per 1,000 in the year ending September 2019.

It is important to note that our work only captures violence and self-harm in prison that ends in a hospital attendance. Health care services onsite manage

many more incidents within the prison setting. Official figures provide limited data to demonstrate this point, noting that 6% of self-harm incidents affecting male prisoners in the year to September 2022 required hospital attendance.[33,*]

Figure 5 explores prisoners' admissions to hospital that were related to injury or poisoning in more detail. It shows that admissions for these reasons peaked for those aged in their early 30s and then declined sharply with age. This accounted for the much lower proportion of all admissions by adults related to injury or poisoning (16%, n=1,975) (95% CI, 15.7%, 17.0%) when compared directly with young adults in prison aged 25 and under (42%, n=624) (95% CI, 39.8%, 44.9%). The proportion of admissions by young adults was 26 percentage points higher, and this difference was significant (95% CI, 23%, 29%).

Figure 5: Males in prison with a primary admission diagnosis of injury or poisoning, by age, 2019/20



Note: unfilled circles denote very small numbers: n = 1, 2 or 3, all of which have been standardised to 2 in the chart.

* These data are not directly comparable to our Nuffield Trust work because of differing methodologies, a key difference being that the safer custody statistics only record hospital attendances immediately linked to self-harm or assaults and do not capture attendances for follow-up care.

We looked at both A&E attendances and inpatient admissions to understand the potential impact of violence and self-harm on children in young offender institutions as well as young adults in prison. Focusing first on hospital attendances not leading to a hospital admission (A&E attendances), Table 3 and Table 4 show that children and young adults attended A&E for similar reasons, including dislocations and lacerations. Table 4 shows that more than 500 young adults in prison went to A&E in 2019/20 with a recorded diagnosis of a laceration (a deep cut or tear) and more than 250 attended due to poisoning.

Table 3: Breakdown of A&E attendances by children (males) in young offender institutions (18 years old and under) (does not include attendances that led to hospital admissions) (diagnosis categories with more than 20 attendances), 2019/20

A&E diagnosis	N	% (excludes where diagnosis is missing)
Dislocation/fracture/joint injury/amputation	55	22%
Contusion/abrasion (bruise or wound)	53	21%
Laceration (deep cut or tear)	40	16%
Sprain/ligament injury	22	9%

Table 4: Breakdown of A&E attendances by young adult males in prison (25 years old and under) (does not include attendances that led to hospital admissions) (diagnosis categories with more than 250 attendances), 2019/20

A&E diagnosis	N	% (excludes where diagnosis is missing)
Laceration (deep cut or tear)	513	18%
Dislocation/fracture/joint injury/amputation	371	13%
Contusion/abrasion (bruise or wound)	321	11%
Poisoning (including overdose)	258	9%

In terms of prisoners admitted to hospital, head injuries were the most common reason for admission, representing 28% of admissions where injury or poisoning was the primary diagnosis category (see Table 5). There were 18 admissions by 16 young adult males that were severe enough to be classified as traumatic brain injuries.*

Table 5: Breakdown of admissions by young adult males in prison (25 years old and under) with a primary diagnosis of injury or poisoning (diagnosis categories with more than 10 admissions) (total chapter n=624), 2019/20

Diagnosis	N	%
Injuries to the head	174	28%
Effects of foreign body entering through natural orifice	104	17%
Poisoning by, adverse effect of and underdosing of drugs, medicaments and biological substances	102	16%
Injuries to the wrist, hand and fingers	63	10%
Injuries to the elbow and forearm	38	6%
Complications of surgical and medical care, not elsewhere classified	37	6%
Injuries to the knee and lower leg	24	4%
Burns and corrosions	19	3%
Injuries to the thorax	15	2%
Injuries to the shoulder and upper arm	10	2%

* Diagnosis anywhere within a hospital spell.

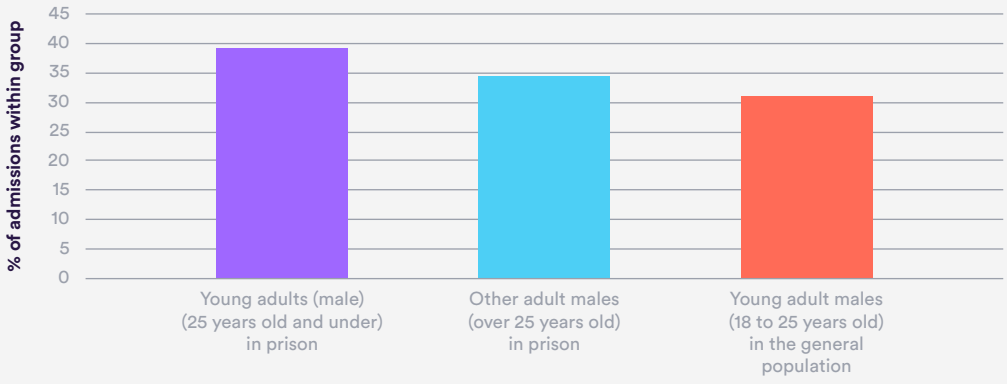
Why are violence and self-harm particularly prevalent in young people?

Mental health

All stakeholders who we spoke to as part of this project highlighted the needs of young adults in prison relating to mental health and the association between poor mental health and violence and self-harm. To investigate this further, as an initial starting point, we looked to see how often mental health was recorded as a diagnosis anywhere for young male adults in prison on an inpatient hospital spell, and compared this with corresponding data for other male adults in prison and for young male adults in the general population.

In the general population, mental health was flagged as a diagnosis in 31% of admissions by young adults, but for young adults in prison this was close to 40% (see Figure 6). Within prison, mental health was more commonly flagged as a diagnosis for young adults than for other adults (39% compared to 34%). This difference of 5% was statistically significant (95% CI, 2.0%, 7%).

Figure 6: Proportion of hospital admissions where a mental health diagnosis was recorded anywhere in a spell for young adult males in prison (25 years old and under), other adult males in prison (over 25 years old) and adult males in the general population (aged 18 to 25), 2019/20



Because, at the broadest level, mental health diagnosis coding captures disorders due to psychoactive substance use as well as specific mental health conditions, such as schizophrenia and personality disorders, we looked at the breakdown by sub-category (see Table 6). Table 6 shows that, for both young

adults and other adults in prison, psychoactive substance use is an important issue. Previous work by the Nuffield Trust has highlighted that a large proportion of this activity is coded as nicotine dependency.[26]

Table 6: Breakdown of inpatient admissions by young adult males in prison (25 years old and under) and other adult males in prison (over 25 years old) with a mental health diagnosis, 2019/20 (diagnosis categories with more than 10 admissions)

	Young adult males (25 years old and under) in prison		Other adult males (over 25 years old) in prison	
	N	% of all inpatient hospital spells	N	% of all inpatient hospital spells
Mental and behavioural disorders due to psychoactive substance use	304	20.6%	2,387	19.8%
Mood [affective] disorders	201	13.6%	1,463	12.1%
Neurotic, stress-related and somatoform disorders	155	10.5%	1,057	8.8%
Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	95	6.4%	132	1.1%
Disorders of adult personality and behaviour	78	5.3%	368	3.1%
Schizophrenia, schizotypal and delusional disorders	55	3.7%	439	3.6%
Disorders of psychological development	38	2.6%	72	0.6%
Unspecified mental disorder	15	1.0%	46	0.4%
Mental and behavioural disorders (total)	575	39.0%	4,148	34.4%

Note: The individual categories sum to higher than the total as admissions may have more than one mental health diagnosis flagged.

The interaction between age and mental health

To investigate the interaction between age and mental health, we first looked at the number of hospital admissions linked to injury or poisoning for young adults and other adults in prison with and without a mental health diagnosis recorded as part of their hospital admission (see Table 7).

Table 7: Number of hospital admissions linked to injury or poisoning for young adult males (25 years old and under) and other adult males (over 25 years old) in prison with and without a mental health diagnosis, 2019/20

		Hospital admission with a primary diagnosis of injury or poisoning	
Age group	Mental health diagnosis	No	Yes
Young adults	No	557	342
	Yes	293	282
	Total (%)	850 (58%)	624 (42%)
Other adults	No	7,103	809
	Yes	2,982	1,166
	Total (%)	10,085 (84%)	1,975 (16%)

We then conducted logistic regression to explore the relationship between age group, a recorded mental health diagnosis and hospital admissions linked to injury or poisoning. While there was proportionally fewer injury and poisoning cases affecting prisoners over the age of 25 (16% compared with 42%), the odds of prisoners over the age of 25 with a mental health diagnosis being admitted to hospital due to injury or poisoning was 3.43 times higher than for those without (95% CI, 3.11, 3.79). For young adults with a mental health diagnosis, the odds of a hospital admission due to injury or poisoning was 1.57 times higher than for those without (95% CI, 0.16, 0.22).

This suggests that while mental health is an important driver of violence and self-harm in secure settings for all age groups, for young adults there are unique challenges. This supports the need to develop tailored support and interventions for young adults to reduce violence and self-harm.

4 Neurodiversity in custodial settings

There is growing interest in neurodiversity within the justice system, recently galvanised by a review of evidence by HM Inspectorate of Constabulary and Fire and Rescue Services, in 2021.[32] The review recommended the development of a national co-produced strategy for neurodivergent children and adults within the criminal justice system, alongside more systematic screening, better data collection and staff training.

What is neurodivergence?

Neurodivergence is a broad term that is used to refer to a number of conditions classified as neurodevelopmental disorders. It is used in relation to autism spectrum disorders and attention deficit hyperactivity disorder (ADHD), as well as in relation to learning disabilities such as dyslexia and dyspraxia, brain injury and speech, language and communication needs.

Although the focus of the evidence review introduced above was on provision for people in the criminal justice system aged over 18 years old, the authors noted that some contributors considered services for children in the children and young people secure estate generally to be more 'attuned' to issues around neurodivergence than within the adult estate. However, consistent with the issue that our stakeholders raised about the challenges when people transition from the children and young people secure estate to the adult estate, concerns were raised about poor transfer of information when people leave the children and young people secure estate.

Actions have been taken following this review. There is now a central HM Prison and Probation Service neurodiversity team to provide specialist advice to prisons, and in December 2022, neurodiversity support manager roles were

established in 51 prisons in England and Wales to better support prisoners with neurodivergent needs. The aim is to roll out these posts within all prisons by 2024.[33]

There are no official figures on how many prisoners have neurodivergent needs, but it is estimated that levels are as high as one in three people in prison,[34] compared with just 15% of people in the general population.[35,36]

Some neurodivergent conditions, such as dyslexia and dyspraxia, are less amenable to identification in hospital data as they are less likely to be recorded as part of a hospital admission. We therefore decided to focus on attention deficit hyperactivity disorder (ADHD) and autistic spectrum disorders as these are the neurodivergent conditions most likely to be clinically recorded. We looked to see how often these conditions were flagged in inpatient spells among young adult male prisoners. Admissions by other adult males in prison and young adult males in the general population were also measured to provide two points of comparison.

We found that 6% of young adult males in prison had a diagnosis of ADHD recorded in a hospital admission, compared with just 2% of admissions by young adult males in the general population (see Table 8). This may reflect a higher prevalence of ADHD in the prisoner population. There is no up-to-date data on the prevalence of ADHD in the prisoner population of England and Wales, but it is consistently reported to be more prevalent than in the general population. A commonly cited figure is that 25% of prisoners have ADHD, compared with around 4% of the general population.[37,38]

Table 8: Breakdown of inpatient admissions by young adult males in prison (25 years old and under), other adult males in prison (over 25 years old) and young adults in the general population (aged 18 to 25) with a neurodivergent condition, 2019/20

	Young adult males in prison (25 years old and under)	Other adult males in prison (over 25 years old)	Young adult males in the general population (18 to 25 years old)
ADHD – no. of admissions (% of all admissions)	92 (6.2%)	124 (1.0%)	5,107 (1.8%)
Autistic spectrum disorders – no. of admissions (% of all admissions)	31 (2.1%)	32 (0.3%)	7,823 (2.8%)
Childhood autism or atypical autism – no. of admissions	20	18	5,874
Asperger's syndrome – no. of admissions	15	15	2,221

Staff require training to understand ADHD and provide appropriate support and access to care. This is particularly important as challenging behaviour may be linked to ADHD (diagnosed or undiagnosed).[39] We saw this in our work when looking at the reasons why people with an ADHD diagnosis were being admitted to hospital. In our sample of 92 young adults with a hospital admission where an ADHD diagnosis was flagged, 60% (n=55) had a primary diagnosis of injury or poisoning (95% CI, 49%, 69%), which may reflect instances of violence or self-harm. For young adults without ADHD, 41% had a primary diagnosis of injury or poisoning (95% CI, 39%, 44%). So the proportion of injury or poisoning admissions among prisoners with ADHD was 19% higher (95% CI, 8%, 29%), and this difference was significant.

Wider evidence suggests that ADHD often co-occurs alongside mental health care needs,[40] and so we looked to see what proportion of young adults with ADHD had an additional mental health diagnosis. We found that in 76% of admissions (n=70) where ADHD was flagged, there was an additional

flag for a mental health diagnosis. Although the number of admissions is relatively small, this supports calls to consider health conditions that occur alongside ADHD.

More generally, stakeholders in our work raised concerns about how well neurodivergence was managed in relation to children and young adults. There were concerns around access to appropriate medication (particularly if someone was placed in a different location from where they had been receiving care initially), and the relationship to violence and self-harm. We heard of issues around some establishments not having access to onsite psychiatrists, and difficulties in ensuring continuity of support for young people placed away from their local support services. The National Institute for Health and Care Excellence (NICE) has produced guidance on managing ADHD, which includes the importance of skills-based strategies, and an autism accreditation toolkit has been developed for prisons to identify and address challenges within the prison environment.[41] But it is important that these are implemented consistently across the children and young people secure estate and the adult prison estate.

5 Young women in prison

This chapter focuses on young women in prison settings, aged 18–25. There are very few girls under the age of 18 within the children and young people secure estate – there were just 14 in April 2023.[9] Although we have not looked specifically at girls under 18 for this project, wider evidence from this younger age group provides valuable insight for understanding the potential areas of need for young women in prison. A literature review conducted by the Centre for Mental Health highlighted that girls in the secure estate are often highly vulnerable, having been exposed to multiple traumatic events such as sexual abuse.[42] They are also more likely to have co-existing mental and physical health needs, which may have been overlooked, as well as higher levels of neurodiversity.

We began by looking at the number of hospital admissions, outpatient attendances and visits to A&E by young women in prison in 2019/20 (see Table 9).

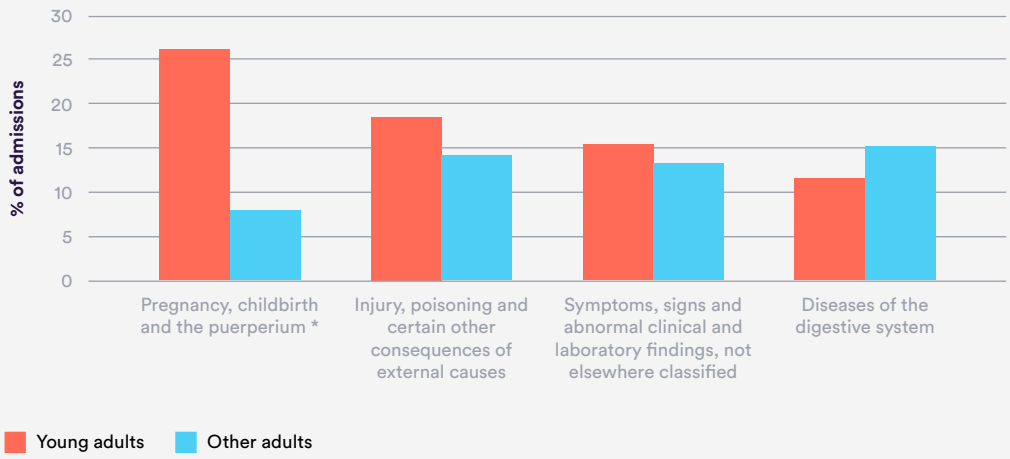
Table 9: Hospital admissions, outpatient appointments and A&E attendances by young women in prison (aged 18 to 25), 2019/20

Inpatient admissions	
No. of admissions	130
No. of people	87
Outpatient appointments	
No. of appointments	922
No. of people	279
A&E attendances*	
No. of attendances	235
No. of people	122

Figure 7 shows that the most common reason why young women in prison were admitted to hospital in 2019/20 was due to pregnancy and childbirth; 26% of all admissions (n=34) by women in this age group had a primary diagnosis of pregnancy, childbirth and the puerperium (95% CI, 19%, 34%). For adult women in prison who were over the age of 25, the equivalent figure was just 8% (95% CI, 6%, 10%). The proportion of admissions related to pregnancy or childbirth was therefore 18 percentage points higher for young women (95% CI 11%, 26.0%), and this difference was significant. While the age ranges of the two population groups obviously affect the relative rates of admissions (the prisoner population over the age of 25 includes those who, due to their age, would not require hospital treatment due to pregnancy or childbirth), it is important that pregnancy and childbirth provision in prison takes into account that the majority of need is in the young adult population, and reflects this in the type of support provided.

* A&E attendances that did not result in a hospital admission.

Figure 7: Primary admitting diagnosis for women aged 25 and under (young adults) and women over the age of 25 (other adults) in prison, 2019/20



* = difference is significant at the 5% level.

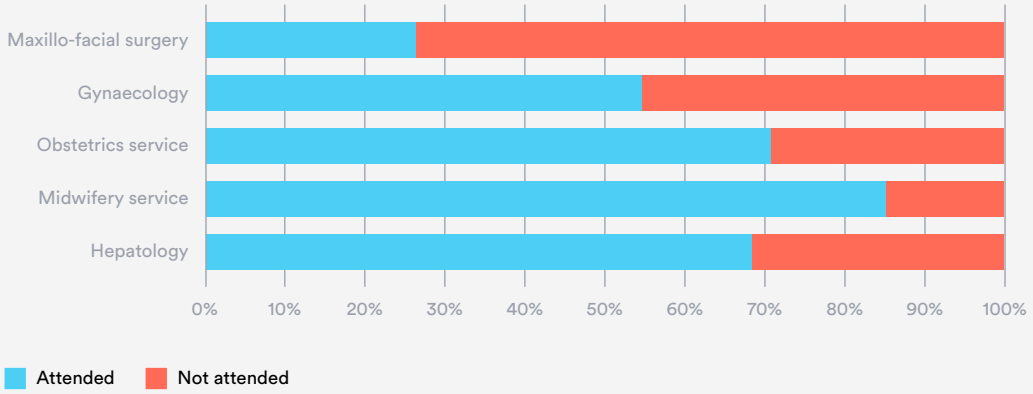
Admissions relating to pregnancy and childbirth also feature heavily in outpatient activity for young women. Of all scheduled outpatient appointments for this age group, 8% were for obstetrics (n=72) and 7% were for midwifery services (n=61). We have highlighted in previous Nuffield Trust research[26] that prisoners sometimes face struggles accessing secondary care and have a high proportion of missed outpatient appointments. To explore the proportion of appointments young women missed, we looked at outpatient treatment specialties with the most appointments scheduled, and compared the proportion of appointments attended against the proportion not attended.

We found that midwifery and obstetrics appointments were relatively well attended by young women (see Figure 8). In comparison, 74% of maxillo-facial surgery appointments were missed (n=95) and 45% of gynaecology appointments were missed (n=34).

Maxillo-facial surgery was the treatment specialty with the highest number of appointments scheduled (n=129), but outpatient data do not provide sufficient details to determine the reason for this. It may reflect dental health care needs (such as impacted wisdom teeth) or it could also reflect care needed to address facial injuries. There is wider evidence from the male prison estate that maxillo-facial trauma affecting prisoners can be challenging to manage due to poor underlying health, co-morbidities and the delay in time

taken to be seen increasing complications.[43] In this context, the high proportion of missed maxillo-facial appointments by women in prison is particularly concerning and is worth understanding and exploring further.

Figure 8: Proportion of outpatient appointments for young women in prison attended and not attended, by specialty (five specialties with the most outpatient appointments scheduled in total)



Young women and self-harm

Although the proportion of young women in prison is relatively low (9%),[13] in 2022, women aged under 25 accounted for 40% of all incidents of self-harm (n=6,480).[44] The Female Offender Strategy Delivery Plan 2022–25[29] has committed to developing and publishing a young women's strategy to better support the needs of young women, with the hope that this will reduce self-harm.

We looked at A&E attendances to see whether we could learn anything about hospital visits potentially linked to self-harm. Although it is not possible to ascertain whether admissions with a diagnosis category such as 'laceration' are associated with violence or self-harm, Table 10 shows that, in 2019/20, young women in prison attended A&E as a result of poisoning as well as to have cuts and tearing dealt with. It is also important to note that many instances of self-harm requiring medical treatment will be dealt with inside the prison – therefore outside of what can be captured in secondary care data.

Table 10: Breakdown of A&E attendances by young women in prison (aged 18 to 25) (does not include attendances that led to hospital admissions) (diagnosis categories with more than 10 attendances), 2019/20

Diagnosis	No. of attendances	% of all attendances (excludes where diagnosis is missing)
Diagnosis not classifiable	25	14%
Laceration	22	12%
Nothing abnormal detected	22	12%
Contusion/abrasion	13	7%
Poisoning (including overdose)	12	7%
Psychiatric conditions	10	6%

6 Ethnic disparities in custodial settings

Despite the fall in the number of children in children and young people secure estate settings,[9] children from minority ethnic groups continue to be overrepresented. Ethnic disparities affect people of all ages across the criminal justice system, from sentencing to custody,[45] but the effects are more pronounced for younger ages. In 2022, 14% of the prison population were Black or Black British.[13] This is much higher than the proportion in the general population (which is around 3%), while 26% of children in the children and young people secure estate were reported to be Black.[9]

We have reported previously that there is a high proportion of missing information regarding patient ethnicity in prisoners' hospital data, where ethnicity is listed as either 'not known' or 'not stated'.[26] A third of inpatient admissions by all prisoners in 2019/20 had missing ethnicity information, compared with just 13% in the general population.[26] This makes it challenging to look at the use of hospital services by different ethnic groups in prison, but it is important to understand potential disparities in terms of access to hospital services and how they are used.

To try to improve the quality of information on prisoner ethnicity, we adapted a methodology used in a Nuffield Trust project exploring the elective care backlog and ethnicity.[46] Applying this methodology enabled us to reallocate patient ethnicity codes by drawing on hospital data from previous years as well as looking between datasets. Using this broad set of information, each patient is assigned their most frequently recorded ethnic category, excluding 'not stated' and 'not known'. We used Admitted Patient Care, Outpatient and Accident and Emergency data from 2016/17 to 2019/20 to reallocate ethnicity codes for all young adults in prison who were admitted to hospital in 2019/20 (see Table 11). We have provided the ethnicity breakdown of the prisoner population aged 18–24 as a broad comparison. We have not provided a breakdown by sex as the number of females is too small to report at sub-group level.

Table 11: Ethnicity of young adults in prison (aged 25 and under) admitted to hospital in 2019/20 and ethnicity in the prison population aged 18–24, as of 30 June 2020

Ethnicity	Admitted patient care – no. of young adults admitted (%)	England and Wales' prison estate, no. of young people aged 18–24*
Asian or Asian British	50 (4%)	10%
Black or Black British	118 (10%)	21%
Mixed	39 (3%)	8%
Other ethnic group	37 (3%)	2%
White	698 (61%)	59%
Not known	88 (8%)	
Not stated	108 (9%)	

* Figures from the Ministry of Justice, 2021[47]

Using this new approach, we were able to reduce the proportion of data where ethnicity was either 'not known' or 'not stated' to 17%. The proportion of hospital admissions by young adults from a White ethnic background was broadly similar to the proportion they represented in the population as a whole (61% compared with 59%) but admissions by patients from Asian or Asian British, Black or Black British and Mixed were much lower than would be expected. Without improvements to the completeness of ethnicity data, it is difficult to discern whether this reflects true differences in the use of services by ethnicity or whether these patients' ethnicity is more likely to be recorded as 'not known' or 'not stated'.

7 Discussion

Violence and self-harm are long-standing issues facing the children and young people secure estate and the adult prison estate, and they have a far-reaching impact on living and working conditions for everyone in young offender institutions and prisons, regardless of age.

Our research findings show the significant impact of violence and self-harm on young people's use of health care services. We found that young adults in prison were admitted to hospital due to injury or poisoning much more often than other prisoners. This supports wider evidence that young adult prisoners are much more likely to be involved in violent incidents than other prisoners.[32] Crucially, though, while mental health is often cited as a key factor contributing to levels of violence and self-harm in prison, age is mentioned less often. Our work shows that while addressing mental health care needs is vitally important, this is just one part of the picture.

Growing up in secure settings

Discussions with our stakeholders highlighted that, for young people with a long prison sentence who effectively grow up living in secure settings, points of transition, whether this be moving from the children and young people secure estate to the adult estate, or from the children and young people secure estate to the community, are a clear point of risk.

The differences between the children and young people secure estate and the adult estate, particularly in terms of staffing and resources, highlight the extent to which services rely on staff, in terms of both quantity and quality. At the most basic level, staff need to be in place to provide the tailored and age-appropriate support for young adults that is so clearly needed. This is not just a numbers game though – it is important that staff with the right skills are employed and that they receive appropriate support and training to develop trusted relationships with young people. The recent Urgent Notification invoked in relation to HMYOI Cookham Wood is an important reminder

that problems can't be fixed purely by adding more staff: Cookham Wood reportedly has around 360 staff (including 24 senior leaders) managing a population of 77 boys.[48]

The need to take into account the age of young adults

In addition to specific needs relating to violence and self-harm, our work provides other examples of why there is wider value in recognising the impact of age on the support that young adults require in prison, such as to meet the needs of young women. We found that young women have specific health care needs relating to pregnancy and childbirth as well as the management of self-harm. Self-harm is a long-term issue within custodial settings and there may be value in considering how the responses to self-harm can be tailored to meet the needs of young women in particular. HM Prison and Probation Service has committed to developing a national strategy for young adults,[17] but this has not yet been published.

Learning lessons from the children and young people secure estate

More broadly, there are lessons to be learnt from the children and young people secure estate that make the case for better resourcing in the adult estate, particularly in terms of staffing. While the children and young people secure estate faces many serious challenges, stakeholders reflected that, in terms of meeting health care needs, it was relatively easy to get things done. For instance, if someone needed to see a specialist for treatment, this could be arranged. The children and young people secure estate has a different culture and different system from the adult estate, alongside having to follow different guidance and using different assessment tools and procedures. It clearly benefits in some ways from enhanced resources though – in terms of both staffing and levels of finance available.

The impact of staffing levels should be considered at an early stage as part of the commissioning cycle. Cutting staff numbers is a way to reduce costs, but

there are longer-term implications of this decision-making. Commissioners need to appreciate the distinct differences between the children and young people secure estate and the adult estate. NHS England and the UK Health Security Agency are developing a needs assessment for the whole of the children and young people secure estate to provide a national picture of needs. As need varies locally, tools are also being developed to enable individual institutions to undertake their own needs assessments. It is important for commissioners to have a comprehensive understanding of the needs of young people within their area, but also to be clear that staff are at the heart of providing care for young people.

We now set out our recommendations for national partnership signatory members and for HM Prison and Probation Service specifically.

Recommendations

For Children and Young People Secure Estate National Partnership signatory organisations[18]

Recommendation 1: Understand and address the reasons why outpatient appointments for children and young people in young offender institutions are cancelled much more often than is the case for people in prisons. Document and make publicly available data regarding why hospital appointments are missed. These data should cover all secure settings so that the challenges of accessing secondary care are clear and national partnership members can be held accountable to act. While there are various legitimate reasons why appointments may be not attended (such as staffing issues or clashes with court appointments), it is important to understand why appointments are being cancelled and whether there is any potential for this to be avoided.

For National Partnership Agreement for Health and Social Care for England signatory organisations[19]

Recommendation 2: Consider health care for young adults as part of specific national guidance or standards relating to young adults in secure settings. HM Prison and Probation Service has committed to developing a national strategy for young adults in the secure estate, but given that the publication of many national guidance documents is currently delayed (including at the time of publication the Ministry of Justice's Ageing Population Strategy, which was due to be published in autumn 2022), this remains a long-term prospect. We support the need to address the key health care issues for young adults as part of this future strategy, including tackling the root causes of violence and self-harm affecting young adults in prisons. This will require partnership working and a consistent approach as to how both health care and prison staff respond to young adults.

For HM Prison and Probation Service

Recommendation 3: Ensure staff have sufficient understanding of, and training in, neurodiversity. Stakeholders told us that the staffing challenge in the secure estate is not just about hiring more staff – it is also about hiring staff with the right skills. While we would not expect all staff to have a nuanced understanding of neurodiversity when they enter employment, the fact that the job role will involve working with young people with neurodiverse needs should be highlighted as part of the recruitment process and candidates with an aptitude for this should be encouraged to apply. More broadly, neurodiversity awareness should be part of the initial training that staff receive as well as ongoing training and awareness-raising activities within secure settings.

Appendix: Locations and age ranges of the young people included in the study

The locations and age ranges of those within the children and young people secure estate who were included in our analysis of hospital activity, as well as the age ranges of young adults who were included, are shown in Table 12. There is no clear age split between the two parts of the work, as an 18-year-old may be held either in a young offender institution in the children and young people secure estate (increasingly the case) or in a prison, dependent on factors such as how long their sentence is, and whether there are other specific considerations that have an impact on where they can be held. Activity from Feltham Young Offenders Institution is split between the children and young people secure estate and the adult estate, dependent on age on admission to or attendance at hospital.

Table 12: Locations and age ranges of children and young adults in the analysis

Children's hospital activity	Young adults' hospital activity
Cookham Wood Young Offenders Institution (15- to 18-year-olds)	Young adults in prison up to the age of 25, not held in young offender institutions
Feltham Young Offenders Institution (15- to 17-year-olds)	Feltham Young Offenders Institution (18- to 21-year-olds)
Werrington Young Offenders Institution (15- to 18-year-olds)	
Wetherby Young Offenders Institution (15- to 18-year-olds)	

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5 Alliance for Youth Justice (11th July 2023) Open letter calls for urgent Government action to prevent crises in the children's secure estate. www.ayj.org.uk/news-content/open-letter-calls-for-urgent-government-action-to-prevent-crises-in-the-childrens-secure-estate

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59 New Cavendish Street
London W1G 7LP
Telephone: 020 7631 8450
www.nuffieldtrust.org.uk
Email: info@nuffieldtrust.org.uk

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