



Inspection of  
Youth  
Offending

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Arolygiad ar y Cyd Cyfiawnder Troseddol

## A Joint Inspection of Youth Crime Prevention

**A Joint Inspection by HMI Constabulary, HMI Probation,  
Care Quality Commission and Healthcare Inspectorate Wales**

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## Foreword

This thematic inspection is one of several which, with the Core Case Inspections, form the three year 'Inspection of Youth Offending' programme' coordinated by HMI Probation. Led by HMI Constabulary, the team for this inspection included inspectors from HMI Probation, the Care Quality Commission, and Healthcare Inspectorate Wales – inspectorates that have a direct interest in the subject matter.

The inspection team visited seven local authority areas, examined 75 individual cases where children had been referred for interventions to prevent offending, and spoke to many practitioners and managers of children's services, police and health. We were left in no doubt that the personal lives of many children identified as more likely to offend are extremely challenging. It is easy to understand that the living conditions of some of them, and the influences to which they are exposed, make future offending by such children more likely than by children with less chaotic lifestyles.

The inspection focused on the 8–13 year age range. This spanned the age of criminal responsibility in England and Wales (10 years), and covered the age group where prevention schemes are most frequently initiated. State intervention, often based on research, aims to enhance the 'protective factors' and reduce the 'risk factors' present in a child's life which make anti-social and offending behaviour less or more likely.

The inspection concluded that there was impressive partnership work in operation and that a common strategic ethos about youth crime was present. However, the challenges should not be underestimated; it is very clear that many children who have been identified as more likely to offend than others were subject to multiple 'risk factors' and their future lives were likely to be adversely affected, possibly forever.

We saw many examples of prevention work that were having a positive impact on children's lives, but little coordinated evaluation of interventions which can be proved to achieve longer term success. Greater sophistication in measuring progress is required at both the local and national levels: a number of aspects of the underpinning processes and assessment frameworks are considered to be overly bureaucratic and unhelpful and, as we enter a period of constrained budgets, we believe there needs to be a fundamental review of their impact, value and costs.

The joint response to youth prevention is, however, encouraging, and many individual examples were found of excellent working practices. An investment in prevention services at this stage in a child's life is likely to be cheaper than trying to work with an individual once within the criminal justice system. However, resources in this area are often short-term and subject to withdrawal when budgets are cut. In our view, investment in this work has the potential not only to benefit the individual children but also society in the long-term. Whilst we were encouraged by the best practice we saw, a number of recommendations have been made to help create greater consistency and effective practice across areas. We hope these will be implemented both locally and nationally.

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## Contents

	Page
Acknowledgements	2
Foreword	3
Key Findings and Recommendations	5
Recommendations	7
1. EVIDENCE BASED PRACTICE	8
2. LEADERSHIP	11
3. IDENTIFICATION AND ASSESSMENT	15
4. DELIVERY	23
5. IMPACT	31
Appendix 1: Glossary	35
Appendix 2: Inspection Methodology	38
Appendix 3: Role of the Inspectorates and Code of Practice	39

## Key Findings and Recommendations

Many adults in the criminal justice system began their offending careers in their childhood or early teens, after being subject to factors which made their offending more likely. This inspection examined the approaches to child crime prevention.

The sections of this report explore evidence-based practice, leadership, the identification of children more likely to offend, their subsequent assessment, what actually was delivered and how success is measured.

When examining evidence-based practice, crime prevention work can be broadly grouped into four aspects, or domains: The family; School and work; Lifestyle, neighbourhood and community; and Self, personal and individual practices. Therefore, these provided reference points for our inspection. In general, we found that those involved in prevention work, including health workers, were aware of the components of effective practice even if they did not articulate them in a structured way. The focus was more on 'risk' than 'protective' factors and on occasions interventions were used because they were available rather than as a response to a structured assessment.

For leadership, we found in most areas visited a common strategic and partnership ethos relating to youth crime prevention amongst senior managers and practitioners and across both the crime and the children's agendas. Many of these incorporated (in England) the five *Every Child Matters* outcomes that were applicable at the time. Examples of integration included the pooling of funding, secondment of staff, chairing of meetings, and some alignment of plans between agencies. Health services were not integrated to the same extent and didn't always see themselves as being key to the prevention agenda – although operationally where they were integrated, some positive results were demonstrated.

We considered that the probation service could be more involved; for example, they could make a valuable contribution as a result of their supervision of offenders who are now parents, especially during the identification and assessment stage.

All areas had a range of initiatives funded nationally and mainly targeted at areas of significant need. These provided a vehicle for joint work, but the short-term nature of the funding and the different requirements for reporting made their future continuation insecure. There were considerable administrative burdens that could be reduced if longer term planning and funding were better.

The majority of children assessed as being more likely to offend than others were identified as being so by either the school or the police. With the exception of school nurses, health referrals were rare.

The former Department for Children, Schools and Families had developed the Common Assessment Framework (CAF) as a shared assessment tool across all children's services in England. There was an expectation that it should have been adopted in England by March 2008. The inspection discovered, at least in respect of crime prevention issues, that the use of this framework varied widely, from none at all through to complete adoption and part of the day-to-day processes. There were still a significant number of practitioners across all agencies that knew little about the Common Assessment Framework and were unable to complete one. The police have previously challenged the value and cost of servicing the CAF. In the current climate of budget cuts across the public sector, and the Munro review (in England) focussing on minimising bureaucracy, there needs to be a clear evaluation of the impact, value and cost of continued engagement by partner agencies in this notification and assessment process.

Onset, the specialist referral and assessment framework published by the Youth Justice Board (2006) was generally completed and reviewed by key workers, although intervention plans required improvement.

There was considerable confusion with referral pathways and between the use of the pre-Common Assessment Framework, the Common Assessment Framework and the Onset. Many were uncertain about who completed what, at what point and to what extent. On the other hand, we saw effective examples of multi-agency meetings resulting in attention to the holistic needs of the children underpinned by appropriate information sharing.

General health concerns relating to 'risk' factors were less well understood and sometimes overlooked by key workers. Where health professionals were directly involved within the Youth Offending Team<sup>1</sup> setting, rather than in existing mainstream health services, thorough assessments of health issues were more likely to take place.

Once a child had been identified and suitably assessed, entry onto a prevention programme was generally found to be swift. We were impressed by the quality of key workers. This included their ability to involve children and parents or carers, to sustain that engagement, maintain frequent contact, and their knowledge of and commitment to the children they were working with. Some of this positive working extended into diversity work where two-thirds had considered the relevant issues and had taken steps to minimise the impact of these factors on the work being done.

With one exception, the prevention agenda was firmly embedded within the Youth Offending Team and was based primarily around the Youth Inclusion and Support Panel (YISP) and Youth Inclusion Programme (YIP) approaches. On occasions where a child, for whatever reason, was outside the panel catchment area, we were concerned that they may not receive the same intervention opportunities as children who were within the jurisdiction.

The scope of interventions varied widely and there were some very simple, inexpensive but successful interventions used, such as improving self esteem by providing a haircut and new clothes prior to transferring to secondary school. In some cases, however, it was difficult to understand why the choice of intervention was made as it did not appear to address the issues raised at the child's assessment.

The quality of intervention plans ranged from those which were clear, time bound and reviewed to having no plan at all. A significant minority lacked detail, outcome milestones and an exit strategy. This was particularly so with health interventions.

Measuring the impact of prevention activities is problematic. There was little evidence of any local evaluation either of individual interventions or of the longer term outcomes for children. For example, once a case became closed, the individual was not tracked to determine whether he/she had entered the criminal justice system at a later date. Whilst the framework used by the Youth Justice Board (Onset) has a scoring system, which does enable measurement of progress during contact with the child, this was not utilised as much as it could have been in order to assess the 'distance travelled' for that individual. Whilst this can include progress in health issues, we found some evaluation at an operational level but often not linked to data held by the Youth Offending Team and limited evidence of formal performance monitoring at a strategic level.

In addition, in our view, the reliance placed on National Indicator 111 (England) and the Wales Youth Justice Indicator 1- First Time Entrants into the criminal justice system, is largely misplaced as a 'single measure' gauge of the success of youth crime prevention work. It can be interpreted as a proxy measure of offending behaviour, but it actually measures entry into the system through reprimands and final warnings by the police. There are now a number of 'pre-reprimand' disposals such as the Youth Restorative Disposal, Fixed Penalty Notices, and other less formal ways of dealing with low level crime. Such disposals do not count towards National Indicator 111 or the Wales Youth Justice Indicator 1.

Intervening early in a child's development can bring rewards both to that child and society. This is not always easy to do and can meet with parental obstruction and apathy. Nevertheless the inspection team believe that the processes in place, albeit that they can be refined and better managed, are working and the overall picture of prevention work is a positive one, although better means of measuring and evaluating achievement need to be found.

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<sup>1</sup> We use 'Youth Offending Team' as a generic term throughout the report even though some teams are known by other names such as "Youth Offending Service" or "Youth Justice Service" in certain areas. But when we refer to a specific team we will use their own preferred name.

## **Recommendations**

### ***The Department for Education and the Youth Justice Board should ensure that:***

- the generic Common Assessment Framework and the specialist assessments for children likely to offend are evaluated as to their value, cost and impact and are redesigned so that they can be used consistently and effectively without duplication.

### ***The Ministry of Justice and the Home Office should ensure that:***

- they work jointly to re-profile the funding for youth crime prevention work to enable a long-term planning approach to be taken.

### ***The relevant Government departments in both England and Wales should ensure that:***

- the use of National Indicator 111 and the Wales Youth Justice Indicator 1, the measurement of First Time Entrants to the criminal justice system, is reviewed.

### ***Probation Trusts should ensure that:***

- their compliance with the Children Act 2004 can be demonstrated through referrals and support to youth crime prevention services, where this is warranted for the children of those adults they supervise.

### ***Each Local Authority and its partners should ensure that:***

- the generic Common Assessment Framework, specialist assessments for children likely to offend and the subsequent pathways to intervention are non-bureaucratic and used consistently and effectively to identify potential harm and need
- all staff in child-centred roles understand and recognise crime 'risk' and 'protective' factors and related child protection issues and are able to complete a Common Assessment Framework or arrange for it to be so
- aggregated information from Onset assessments is used corporately to inform planning, delivery and commissioning of services
- the impact of local youth crime prevention work is appropriately evaluated and practice adjusted accordingly.

### ***Healthcare providers and staff working with children should ensure that:***

- they are able to identify indicators of possible future offending, make appropriate referrals, and contribute to assessments, intervention plans and reviews of children who are likely to offend.

### ***All prevention managers and key workers should ensure that:***

- all children subject to crime prevention interventions have a current Onset intervention plan which is appropriately detailed, is time bound, reflects the child's assessment, is reviewed regularly, has clear outcome measures and an exit strategy.

## 1. EVIDENCE BASED PRACTICE

### General Criterion:

The area works to the principles of effective practice

### **What we expected to see:**

- Evidence based practice and the principles of 'what works' inform practice
- The area maximises the protective factors and minimises the risk factors that influence potential offending
- The right children are targeted for assessment and intervention

- 1.1 There is a considerable amount of research that has attempted to identify 'what works' in preventing children offending. For example, in 2005, the Youth Justice Board for England and Wales (YJB) published a study, *Risk and Protective Factors*, that set out what constituted effective practice. In summary, the evidence suggested that in children's lives there were a number of 'risk' factors (that can make crime more likely), such as poor parental supervision, and a number of protective factors, such as a supportive school environment, that can make offending less likely. This means that in order to be effective, interventions need to ensure that 'risk' factors are reduced and 'protective' factors promoted. (see Appendix 3 for more details)
- 1.2 The risk and protective factors can be grouped under four broad 'domains':
- The family
  - School and work
  - Lifestyle, neighbourhood and community
  - Self, personal and individual practices.

In practice, the four domains are linked and it is not effective to address one factor and not the others. In addition, it is necessary to establish for each individual whether a factor is a risk or a protective factor *for that particular individual*. Finally, risk and protective factors are not fixed, they are dynamic and can evolve over time.

- 1.3 There are a number of implications for practice that result from this outline of effective practice that the inspection sought to explore. Most importantly, this included how effective the identification and assessment of risk and protective factors was. In order for this to happen the YJB introduced a specialist assessment and planning framework tool known as *Onset* to be used by prevention workers in YOTs. This framework focuses on the four main domains referred to above and steers workers into identifying the relevant risk and protective factors. Onset has a simple scoring system that enables workers to assess the level of a particular issue and to track progress over time. In all areas we found that Onset was well embedded and, for the most part, used well by individual workers. Despite this, there was little evidence that the data collected from the assessments were used

to inform planning, delivery and the commissioning of interventions at a strategic level.

- 1.4 A number of children were involved in projects run by organisations outside the YOTs, for example, voluntary sector projects and some services that were part of universal services i.e. those that were available for all children. Here there was a slightly different picture with Onset not used for assessment. For the most part the Common Assessment Framework (CAF) was used in these settings along side any individual agency assessment. The CAF is broadly compatible with Onset, in that the domains are similar (and the YJB had issued guidance about 'mapping' one approach to the other), however crucially, Onset provided a means to evaluate progress over time, whereas this is not as easily achieved through the CAF. The CAF is voluntary in Wales.
- 1.5 The range of services for children deemed more likely to offend is complex and is not consistent across England and Wales. The main services overseen and funded by the YJB are:
  - Youth Inclusion and Support Panels (YISP) aim to prevent antisocial behaviour and offending by 8-13 year olds by making sure that they and their families can access mainstream services. YISPs are made up of representatives of different agencies who work out a mutually agreed plan to support the child and his or her family
  - Youth Inclusion Programme (YIP) works with 8-17 year olds in some of the most deprived and high crime areas. In practice we found that YIPs cater mostly for the older child – i.e. over 13 years.
- 1.6 In addition, in England, Family Intervention Programmes (FIP) are in existence which are supported by ring fenced central government funding designed to work intensively with vulnerable families deemed to be at risk of antisocial behaviour and offending. In Wales, a similar approach is being developed known as the Integrated Family Support Team.
- 1.7 In all areas visited, some form of Police and School partnership had been introduced. In England, this was found to be some form of Safer School Partnership (SSPs). SSPs are formal arrangements between schools and police to work together to keep young people safe, reduce crime and improve behaviour. As part of these arrangements, a police officer or police community support officer works at a school or a cluster of schools with pupils and staff. The actual model adopted in each area varied from the intense model whereby there is one dedicated officer attached to one school, to a more fluid, and occasionally vague approach, whereby schools are overseen by the Neighbourhood Policing Team. We found that in the English areas visited the model adopted generally reflected the police resources available and not necessarily any particular local need in a specific school or local area. In Newport (the only Welsh area visited) the 'All Wales schools liaison core programme' was in use. This was more focused on an intensive lesson delivery programme by accredited police officers. This structure appeared to give little time for those police officers to engage with children outside the formal lesson approach. Many schools were, however, engaged with Neighbourhood Policing Teams.

- 1.8 We found that key workers were aware of the components of effective practice, even if they did not articulate this in a structured way. Workers tended to focus more on risk rather than protective factors and on occasions interventions tended to be used because they were available, rather than they had been identified as a response to a structured assessment (see delivery). Nevertheless, there were many good examples of interventions that had been subject to scrutiny in terms of the principles of effective practice such as after-school clubs, peer mentoring and parenting courses.
- 1.9 There was generally a good understanding by health workers within YOTs of the principles of effective practice and the risk and protective factors relating to offending behaviour. This was particularly evident where health professionals were directly involved with the YOT rather than those who were being used within mainstream services. General health concerns, however, were sometimes less well understood by generic key workers which could delay or obstruct access to essential health services.

## 2. LEADERSHIP

### General Criterion:

There is effective local leadership in youth crime prevention

#### **What we expected to see:**

- That national strategy gives clear direction to areas in developing their approach to youth crime prevention
- That there is a strategic approach to crime prevention in the area

*'We are looking at different ways of saying yes, not one simple way of saying no'*

Senior Children's Services manager

- 2.1 The development of a coherent approach to the prevention agenda relies heavily on strategic vision and leadership from partner agencies, led by knowledgeable, visible and committed managers, coupled with the enthusiasm of staff. We were pleased to see that all children and young people plans and crime and disorder reduction strategies/community safety plans examined had references to the prevention agenda which were both implicit and explicit. The police service through the Association of Chief Police Officers (ACPO) had a business area dedicated to children and young people and all police forces visited had some form of children and young people intervention plan.
- 2.2 Whilst a coherent approach was apparent in most agencies there was one significant exception in the case of the probation service. There was little input to the development of a strategic approach to youth crime prevention amongst senior probation managers and this was reflected at an operational level. For example, prevention workers involved with a child and family rarely had contact with probation staff who may be working with a parent or sibling. This was disappointing and did not reflect the guidance in Probation Circular 22/2005 *Implementing Section 10 of the Children Act 2004: Inter-Agency co-operation to improve the well-being of children – Children's Trusts*. This circular reminded Chief Officers (as they then were) that the 2004 Act established a duty for the probation service to cooperate and make arrangements with local authorities and other relevant partners to improve children's well-being.
- 2.3 Without exception, the fieldwork sites were benefiting from broader guidance and initiatives, such as the FIP, YIP, YISP, the National Drug Strategy, and the Youth Crime Action Plan (YCAP)<sup>2</sup>.

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<sup>2</sup> See Glossary for more details

- 2.4 The FIP, YIP and YISPs are intensive programmes and are often focused on restricted geographical areas, for example, a particular housing estate or clusters of wards. In some areas, this had resulted in smaller catchment pools and some interventions focusing on older children or post-offending.
- 2.5 Whilst it was clear that funding for many prevention projects was thoughtfully targeted at areas of significant need, much of the funding (including that provided by the YJB) for these projects was often of a short-term nature. The challenge for strategic managers was to ensure that resources were mainstreamed into long term budget streams. Some areas had been more successful than others in achieving this. Where local authorities were able to contextualise prevention work within the *Every Child Matters* in England or *The Seven Core Aims for Children* (Wales) suite of outcome measures there was more sense of integration of prevention work into the overall strategic vision for children and young people.
- 2.6 All areas visited claimed to have strong partnership approaches to child crime prevention issues. Some areas were more visible in this than others. Those that were better, tended to have the issue as a regular item within the Crime and Disorder Reduction Partnership/Community Safety Partnerships and Children Trusts/Boards. This was particularly evident in Hartlepool and Bristol. These areas promoted a common purpose ethos amongst partners. There were effective links between the Antisocial Behaviour units, YOTs and children's services and work was not carried out in separate 'silos'.

**In Stoke-on-Trent, the local authority targeted youth provision by putting in services at certain times in crime and antisocial behaviour hot spots, such as on Friday and Saturday nights when other provision was unavailable. This included impressive mobile services and the significant refurbishment of existing youth club and community centres. As a result, the local police had reported reductions in antisocial behaviour.**

- 2.7 In most areas a sense of strategic integration was apparent. This was achieved by helping to ensure that all children deemed more likely to offend were able to have access to some universal services (in-line with *Every Child Matters* and *the Seven Core Aims for Children*), e.g. youth services. It is questionable whether that particular service was always appropriate. Whilst at the other end of the spectrum the thresholds for access to very specialist services e.g. the Child and Adolescent Mental Health Service (CAMHS) was lowered or the service adapted, for example, specialist workers providing advice to other workers rather than taking the referral themselves. The integrated approach was most marked in North Yorkshire but was being developed in other areas, notably in Bristol.
- 2.8 With the exception of North Yorkshire, the prevention agenda was firmly managed within the YOT base.

**North Yorkshire had taken a wider view in that it had pooled several budgets and developed an Integrated Youth Support (IYS) approach. This had totally replaced its previous targeted approach (YISP, YIP etc) and had enabled all children in the county to be eligible for positive activities.**

This was similar to the Hartlepool model where multi-agency groups, known as 'Teams Around the Secondary School' and 'Teams Around the Primary School', provided the bedrock for initial identification and assessment.

- 2.9 These approaches required significant partnership agreement and commitment between the major partners, such as children's services and the police. The latter, in some cases, have had to become more flexible in their approaches to children offending. The neighbourhood policing model had enabled many police officers and police community support officers to become more focused on prevention and less on enforcement. This was particularly evident in the Safer School Partnership approach.
- 2.10 In addition, in a number of areas, additional funding had been secured to deliver aspects of the Youth Crime Action Plan. In these English areas, agencies worked well together, especially around the 'Operation Staysafe' approach. Operation Staysafe was a coordinated effort, which included the police and children's services. This project aimed to protect vulnerable children out late at night and who may be at risk of becoming victims of crime or being drawn into criminal behaviour. These children were approached by the police and children's services, and taken home or to a place of safety and may be offered voluntary interventions. Furthermore, several police forces had supported police officers being involved in impressive youth crime diversionary schemes, such as Derbyshire's Ozbox.

**The Ozbox diversionary scheme introduced youngsters into the world of exercise and into non-contact boxing. It was operated by Derbyshire Constabulary as part of the force's youth involvement strategy. The constabulary had supplied vehicles to the team of police instructors, so they could travel around the county whilst local councils and community partners had purchased boxing equipment. The Ozbox sessions lasted for an hour and were based on a boxercise theme.**

- 2.11 The introduction and use of the CAF was a pivotal issue (see Identification and Assessment). The deployment of this assessment was extremely varied, from almost nil use to being fully implemented, with plans to develop further into an electronic version (eCAF). In general, the usage mirrored the level of visible commitment of senior partners to the prevention agenda. The varied use of the CAF was disappointing considering that the then Department for Schools, Children and Families guidance had indicated that the CAF should be in use by March 2008. Further guidance in March 2010<sup>3</sup> outlined that reasons should be given for non compliance (England only). Firmer leadership is certainly required to ensure that this tool continues to be introduced and managed in areas where it is less visible.
- 2.12 The commitment of health services, especially English Primary Care Trusts, and Welsh Health Boards to the prevention agenda in youth offending is critical, particularly in those areas where there is not a specifically designated resource for prevention. Some health services at a strategic level did not consider themselves to be integral to the prevention of offending. But there can be a strong strategic

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<sup>3</sup> DCSF CAF Guidance 2007, supplemented by further guidance in March 2010

approach<sup>4</sup> and we have also seen good examples of close working relationships between health workers, YOT workers and schools – although, the links with the police and social services were more variable. There was a lack of consistency across the English regions.

**In Derby, good partnership links to promote effective working was found where a report had been prepared for the Community Safety Partnership on alcohol and related violence. Significant contributions had been made by the YOT health worker and the Healthy Schools Project worker to provide a clear baseline for measuring intervention performance and the correlation between alcohol use and violence.**

### **RECOMMENDATIONS**

*The Ministry of Justice and the Home Office should ensure that:*

- **they work jointly to re-profile the funding for youth crime prevention work to enable a long-term planning approach to be taken.**

*Probation Trusts should ensure that:*

- **their compliance with the Children Act 2004 can be demonstrated through referrals and support to youth crime prevention services, where this is warranted for the children of those adults they supervise.**

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<sup>4</sup> HM Government published a strategy document *Healthy Children, Safer Communities* in December 2009.

### 3. IDENTIFICATION AND ASSESSMENT

#### General Criterion:

There are clear systems for the identification and initial assessment of children likely to enter the criminal justice system

#### **What we expected to see:**

- All staff involved with children to be alert to risk and protective factors
- Use of the Common Assessment Framework and Onset, with particular attention to diversity and other individual needs
- Appropriate information, recording and exchange between agencies
- Education, Health and Safeguarding issues are accurately assessed and appropriate referrals made
- Prompt access to good quality assessment and advice and on-going effective engagement with the child, parent or carer.

*'...we are working with the kids too late, often the harm seems already to have been done'*

Police Officer

#### **Identification:**

- 3.1 The research referred to earlier provides a plethora of social theory as to who is *more likely* to commit crime than others and identified the importance of risk and protective factors. The emphasis is just that: they are *more likely*, not that *they will*.
- 3.2 It is these factors that were mostly considered by practitioners when deciding which children should be offered interventions. Just because a child presents several of these risk factors does not mean that future offending is unavoidable. There will be many adults today who may have been exposed to these factors in childhood but still went on to live successful and law abiding lives. This is not an exact science. It follows, therefore, that the identification of those children 'more likely to offend' can sometimes be very difficult, especially when this is balanced against the resources available to meet any interventions required.
- 3.3 Almost 25% of children in the case sample were the subject of a child protection plan, or subject to s47 Children Act 1989 inquiries (duty to investigate due to risk of serious harm), and several others had previously been so. We read and heard numerous examples of poor parenting and descriptions of poor, if not squalid, conditions that some children were living in. The challenges that some of these children faced were considerable.
- 3.4 Most areas visited had adopted the YISP and YIP approach to child/youth crime prevention. The YIP approach was geographically focused, often on one housing

estate which research had shown had a high incidence of youth crime. YISP, however, could be somewhat wider, occasionally borough-wide, but more commonly district-wide. There were still parts of a local authority area where a child identified as being more likely to offend would not necessarily benefit from his/her inclusion in YISP interventions. In other words, a child may be identified as having an increased likelihood of offending but there was a limited service available to refer him/her for help.

- 3.5 Children were referred from a number of sources; 34% of the cases examined indicated that the child was identified by their school. This was usually, though not exclusively, through a teacher or school nurse. The police service referred 12% of the cases examined; the parents of children referred 6%.
- 3.6 In many cases, the referral to prevention work came through a CAF and in these cases it was the source of the CAF which has been used to determine this figure. However, the CAF source may not have been the original source. For example, if a police officer had identified a child who was more likely to offend he/she may have brought this to the attention of a third party – the school or a local YISP for example. The police officer may have done this verbally, through an email message or by the completion of a pre-CAF form. This secondary source may have completed the CAF on that officer’s behalf without mentioning the police officer’s involvement. It is likely that this example was typical and therefore the table below should be treated with some caution.

<b>Source</b>	<b>number</b>	<b>%</b>
School	26	34.6
Police	9	12
Parent	6	8
YISP worker (of sibling)	4	5.3
Family Support workers	4	5.3
Children’s Centre	3	4
Social Care	3	4
CAMHS	2	2.6
Community Resolution	2	2.6
Others (i.e just 1) or not known	16	20

- 3.7 It was clear from interviews with police officers and police community support officers that many of them were proactive in the identification of ‘children more likely to offend’. We consider that nationally the percentage of children referred for prevention work by the police is likely to be much higher than the 12% in the sample size.

- 3.8 Neighbourhood policing was visible in all areas visited. It was very clear that these teams had built up excellent contacts with schools and youth organisations in their localities and were very committed to prevention work. Police officers and police community support officers working within the school environment had developed significant contacts with children and their families and were able to identify, refer and work with children who may be more likely to offend.

**In Hartlepool, an approach known as 'a table in every school' ensured that police officers and police community support officers were welcome and frequently seen and available in every school in the borough.**

- 3.9 It is unsurprising that the school is the most common pathway for referral, but perhaps the figures indicate other issues, such as the level of understanding of prevention work activities amongst partner agencies and also the availability and take up of CAF training. There were varying degrees of understanding amongst staff in partner agencies about the role and purpose of the CAF.
- 3.10 Some police officers do complete CAFs, whilst most either did not see it as their role or were confused about their responsibilities and in a few cases did not know about the CAF at all. The ACPO circular of 12th February 2009 clarifies its position in that it supports the use of the pre-CAF assessment (short assessment form) by police officers but not the completion of the full CAF. ACPO offer an exception to this in cases where there is no partner agency involvement or where it may be appropriate for a police practitioner particularly in a dedicated children or young people role to do so. The awareness of the guidance amongst police officers is sketchy. It is the officers from Safer Schools Partnerships, Neighbourhood Policing Teams and child abuse units that have the best knowledge of those children and families more likely to offend. These officers generally do not complete CAFs, but do have referral mechanisms to other agencies where the CAF is later completed, if necessary.
- 3.11 The next stage of the CAF process is the identification of a 'lead professional'. No examples were found of police officers undertaking this role, however, at least two police officers interviewed indicated that they would not be averse to doing this should the circumstances be appropriate. One senior children's services manager stated:
- "The role of the lead professional should be undertaken by someone who has the best knowledge of the child and the family and is acceptable by the family concerned, if that person happens to be a police officer then it would be acceptable."*
- 3.12 The role of lead professional is a coordinating function and could take that person away from what they regard as his/her core duties. There is some reluctance from the police to take on this role. This is, perhaps, understandable, but the reasons why a police officer should not be a lead professional could also be used by others such as teachers and health workers. Whoever leads, however, it is important that all professionals involved in such a role, including completing the CAF, should have received the appropriate training to do so.
- 3.13 The reasons for referral to prevention services were many and varied, for example: fire fascination, poor school attendance, aggressive behaviour, antisocial

behaviour, parental drug misuse and sibling criminality to name just a few. The most common reason given was 'being disruptive or unruly in school', this may have also been accompanied by examples of aggressive behaviour towards other children and in some cases, school staff. This is commensurate with the majority of referrals emanating from schools.

- 3.14 In some areas, the issue may be complicated due to a large number of interventions available and the different referral pathways in place – each with a different assessment or referral form. It is fair to say, however, that in this example, although there was a small degree of confusion, most practitioners did have a good understanding of the interventions on offer and also the referral methodology, that is to say it was not immediately apparent that the lack of a CAF negatively impacted on this part of the process.

### **Assessment:**

- 3.15 The CAF has been designed to be a shared assessment tool for use across all services working with children. It aims to support the early identification of need and promote coordinated service provision. Where a concern has been raised, or the needs are unclear, then the CAF is a means to identify needs and/or get other services to help meet them. It is not designed to replace other specialist assessments. A CAF need not be completed where it is obvious what the needs of the child are and that the assessing agency can meet the full range of those needs. However, there is an expectation that all local authorities will use the CAF, or show good reasons for not doing so. The CAF has not been officially introduced into Wales although it is being used successfully in some areas.
- 3.16 There is some confusion amongst practitioners regarding the principles of the CAF, i.e. should it be used as an assessment tool or a referral tool? In practice, it is used for both. For crime prevention initiatives, at least, it appears that there is a tendency for it to be simply a referral tool, that is to say the person completing the CAF may have already decided that the child is suitable for a YISP or had already arranged a referral.
- 3.17 We were impressed with the overall willingness of partner agencies to share appropriate information in terms of youth crime prevention. Pivotal to this sharing of information was the existence of multi-agency case meetings to discuss the child's needs and progress. These meetings tended to be held in areas where the ethos of the CAF was strong, as this meant that attendance by relevant professionals at such meetings was taken seriously and the constitution better reflected the direct needs of the child. Generally, there were positive linkages and information flows between organisations, although information from CAMHS to other organisations was sometimes described as problematic, with occasionally a perceived reluctance or an inability to attend multi-agency meetings.
- 3.18 With the exception of a small number of local misinterpretations of the Data Protection Act 1998, the transfer of data between agencies was secure and willingly shared. This was assisted through YISP approaches being voluntary and the family agreeing for relevant data to be shared.
- 3.19 In almost all cases examined there was an Onset assessment commenced, although only 71% had been fully completed and reviewed. Most assessments

tended to focus on risk factors more thoroughly than protective factors. In some areas the Onset immediately followed on from the CAF that had been used as the referral mechanism, and occasionally the CAF was completed by the same person who later prepared the Onset. This suggested that the CAF was simply being used as an official referral process, sometimes quoted as a means to achieve resources from other agencies.

- 3.20 Overall, those Onset assessments which had been fully completed were of a good quality, but the use of the CAF was under-developed and the systems for monitoring its use and effectiveness were different in each area we visited. An exception to this was the use of the Onset for the recording of health issues, where they were seldom updated following health interventions.
- 3.21 Plans in both Onset and CAF were not sufficiently detailed so that interventions could be delivered efficiently and progress tracked. In one area visited there were no Onset intervention plans at all.
- 3.22 One of the benefits of Onset is that it is bespoke to youth offending and prompts assessment using the risk and protective factors, resulting in a numerical score in each section, according to need in that section. For example, if the child is out of education a high score (on the scale from 0-4) may be entered, whereas if the child is doing well in school and there are no issues then a low or 0 score might be the assessment. This assessment can be reviewed as time moves on and rescored at a later date to determine the 'distance travelled' by the child, or in relation to their situation – i.e. are the interventions making future offending less likely?
- 3.23 In terms of health assessments there were inconsistencies in the use of Onset and the CAF by the YOT. In one area, the Onset was no longer used for all prevention cases, having been supplanted by the CAF. Consequently, there was a reliance on the CAF to provide appropriate health referrals. Even here, despite the guidance for the CAF being clear and comprehensive with appropriate thresholds, there were discrepancies in terms of the way individual CAF panels operated. The consequence of this was that it affected the links with health workers and the generation of the numbers of referrals. In one area, for example, school nurses and CAMHS workers were familiar with and had completed a number of CAF forms and described this system as a sound referral method and a means of ensuring that appropriate provisions are formally assigned and accessible for a child; whereas other prevention workers would only submit a CAF if needing to access services not already involved with the provision of care for a child.
- 3.24 With a few exceptions, those children identified as being more likely to offend and subject to an assessment were not systematically assessed for health needs; there was often an absence of front line health provision, and there was frequently a gap in CAMHS service provision. It was also found that where health issues were not seen to be obviously linked to offending behaviour they appeared to be minimised. For example obesity, dental hygiene, poor eyesight, etc, which could lead to bullying or poor school attainment and school attendance (both notable risk factors).

- 3.25 YOT workers were often well trained by health professionals to assess and deliver lower tiered substance misuse and emotional and mental health services i.e. with the provision of appropriate information and advice. Sometimes, however, there was an over-reliance on initial health assessments by non-specialists without sufficient checks, such as sampling by specialists, to ensure accuracy.
- 3.26 The involvement of health workers in initial assessments tended to be by invitation and often took place in a secondary phase. Processes sometimes failed to acknowledge and utilise the full depth and breadth of health workers' professional experience in identifying and meeting the health needs of children. Substance misuse and other health workers did generally make efforts to train YOT workers to ensure that appropriate cases were referred, but there remained some inconsistencies, particularly given the differences between the CAF, Onset and subsequent health assessment tools. Even where there were more robust tools to assess health needs in prevention work, these were often not uniformly or consistently applied. In one area, for instance, the CAMHS trained YOT health worker used different assessment tools to the CAMHS trained health worker linked to the substance misuse service within the YOT. It would be beneficial if all health screening and assessment tools in prevention work were clear and consistent.
- 3.27 Mostly, there was good induction and ongoing multi-agency training, together with an overall assessment of health needs which had helped to ensure that appropriate children were assessed and were provided with suitable interventions. Occasionally, however, we found that the thoroughness of an assessment was more a reflection of the residual skills, personalities, professionalism and interests of the workers, rather than the formal training they had received. For example, one key worker just happened to be a qualified nurse. In two areas, holistic health assessments were carried out, by specialists, with all children coming into contact with the YOT and the clarity of criteria used provided the basis for intervention.
- 3.28 Of the 75 cases examined, nearly one-third were recorded as having no identifiable health needs and therefore, were not referred on for further assessment or intervention. There was a question here in relation to the accuracy of the original assessments and the issue of YOTs believing that in order to refer an individual they have to clearly demonstrate a link between a health issue and the documented behaviour. If health needs are identified but are not linked to offending or antisocial behaviour, they should be recorded in the relevant section, but not contribute towards the scoring of that section. The majority of the remaining children were seen to have had their health needs accurately identified from the information available and appropriate referrals were made for further specialised assessments and interventions by health workers.
- 3.29 We found that almost one-fifth of those with identified health needs did not have those needs identified correctly, or had their needs identified but were not referred on for specialist intervention. This would suggest that a significant number of children were not having their health needs met as part of the prevention task to reduce risk factors and enhance protective factors. Those who were not referred on included cases where a limb disability was detailed but no referral made for assessment on the impact of this, specific concerns raised about obesity not acted upon, drug and asthma not followed up and indications of autism not assessed further. Health needs which were identified and followed up

predominantly related to mental health issue,s but also included epilepsy, ADHD, lack of immunisations and even a concern raised about the height and weight of a child.

- 3.30 We saw some very good local health initiatives identified. These had evolved to ensure that the right children were targeted for health interventions.

**Gemma<sup>5</sup>, a 13 year old girl, was taken to the Accident and Emergency unit after drinking alcohol with friends. A protocol had already been arranged with the unit which had resulted in information about drug and alcohol misuse being passed through to a school nurse, in order to offer further intervention to a child.**

**In Stoke, substance misuse workers had identified differences in a child's choice of substance, influenced by age and gender which informed subsequent drug and alcohol awareness input to local schools.**

### **Safeguarding – child protection:**

- 3.31 Safeguarding issues were thought to be relevant in 42 of the cases reviewed. We found that in 81% of these cases, Safeguarding issues had been identified and where appropriate, referred on.
- 3.32 Occasionally, a key worker commented that in retrospect a Safeguarding referral ought to have been made, but had not. We perceived this as an area that required additional training.
- 3.33 There were cases where we felt that there ought to have been clearer recording of actions taken by the professionals, especially where it concerned potential Safeguarding issues. There were also occasional issues about the flow of information to and from different groups, for example, where referrals to case conference and core group meetings were made the worker was not always aware or given feedback about actions from those groups. There was also one case where a key worker had identified a child protection issue to the police and social services, but no action appeared to have been taken. We brought this matter to the attention of local managers for further investigation. These examples, however, should not detract from the overall finding that information flows were found to be good.
- 3.34 Overall, attention to Safeguarding issues was positive. In one case, the worker continued to work with social services colleagues post-referral, but this was exceptional due to understandable resourcing reasons. In many cases, workers had been involved with the family for some time and as a consequence they were able to coordinate solutions to Safeguarding issues.

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<sup>5</sup> Please note that throughout the report names have been changed

## **RECOMMENDATIONS**

*The Department for Education and the Youth Justice Board should ensure that:*

- **the generic Common Assessment Framework and the specialist assessments for children likely to offend are redesigned so that they can be used consistently and effectively without duplication.**

*Each Local Authority and its partners should ensure that:*

- **the generic Common Assessment Framework, specialist assessments for children likely to offend and the subsequent pathways to intervention are used consistently and effectively**
- **all staff in child-centred roles understand and recognise crime 'risk' and 'protective' factors and related child protection issues and are able to complete a Common Assessment Framework or arrange for it to be so**
- **aggregated information from Onset assessments is used corporately to inform planning, delivery and commissioning of services.**

*Healthcare providers and staff working with children should ensure that:*

- **they are able to identify indicators of possible future offending, make appropriate referrals and contribute to assessments, intervention plans and reviews of children who are likely to offend.**

*Chief Constables should ensure that:*

- **appropriately trained police officers and police community support officers complete the Common Assessment Framework assessment and play a full part in the multi-agency process.**

## 4. DELIVERY

### General Criterion:

Interventions are delivered to reduce the likelihood of children and young people offending.

### What we expected to see:

- Workers sustain the engagement of the child and the parent/carers
- What is delivered meets the needs and interests of the community and the child in terms of preventing offending and promoting health and well-being
- Interventions are identified and delivered that promote protective factors and reduce risk factors and promote appropriate learning opportunities
- There is a clear plan in place to conclude interventions that met the individual needs of the child
- Interventions recognise and promote diversity

*'The best way to impact upon a child is to impact on the family'*

Key worker

- 4.1 Once an assessment had been made and the child had met locally agreed thresholds, entry onto a scheme was found to be relatively swift.
- 4.2 Most interventions were delivered through a key worker aligned to a YISP which was operating within local authority boundaries. Some of the YISPs were authority-wide, whilst others were tightly geographically based. Some parts of local authority areas were not covered by a YISP or other intervention programme. A child living outside such an area may not be able to access intervention programmes. In these circumstances, the definition of Targeted Youth Support was predominately geographical targeting. As previously stated, North Yorkshire had circumvented this problem by developing an Integrated Youth Support programme based around a number of geographical hubs, which effectively embraced the whole county.
- 4.3 Overall, we were impressed with the range of interventions available and the high level of contact that practitioners had with children. Many intervention plans were clearly tailored to the needs of the individual child following the Onset assessment. In 48 out of 68 applicable cases (71%), interventions clearly promoted protective factors and reduced risk factors.
- 4.4 Where it was not found to be the case we felt that the prevention intervention options were limited. The consequence of this was that it was very difficult to see what benefit the child was receiving from the intervention on offer, as it did not match their assessment of need. The reasons for this may be twofold, firstly, a lack of resources to purchase appropriate interventions and secondly, perhaps a lack of imagination, drive or knowledge by the key worker.

- 4.5 However, there were a number of good examples of simple, bespoke but effective interventions that very quickly made a difference to the child.

**Lucy, an 11 year old girl who was obese and who could only wear track suit bottoms at primary school, was helped with losing weight and provided with some new clothes.**

**Becky, a 10 year old girl who had not had her hair combed or washed for some time was taken to a hairdresser; the haircut helped to improve her own self image, confidence and school attendance.**

### **Sustaining engagement:**

- 4.6 Unlike court orders, involvement in youth crime prevention work is voluntary. Significant motivational skills need to be employed by the key worker to ensure that the child and parent/carer become involved with the programme and, most importantly, remain engaged.
- 4.7 It was reported by key workers that most parents or carers cared deeply for their children and many saw the prevention approach as an excellent opportunity for their children (and themselves) to receive assistance. Sadly, this was not always found to be the case in practice.
- 4.8 Some parents either refused to engage with the programme, or if they did, then their participation was barely visible. A number of reasons were given for this, for example, a parent's reluctance to provide personal information or receive home visits due to their own criminal activities, drug and alcohol misuse, or a general mistrust of the authorities. This parental attitude can impact on the child's motivation to engage, so perhaps it is testament to the quality of the key workers that 90% of all children on such prevention programmes remained engaged to a point when the case was naturally closed (or at least in sufficient time for some form of intervention to be concluded).
- 4.9 We found some effective engagement techniques and clear commitment by staff. We visited several YISPs and YIPs, and spoke to many key workers, children and their parents and were impressed with the knowledge that key workers had of the children they were working with and of going 'the extra mile' in trying to keep the child engaged and motivated. Examples of this commitment included picking up and escorting a child to evening youth activities, such as cubs and scouts and local sporting activities and being readily available during unsocial hours to discuss concerns from the child or parent (or carer). Such commitment and good quality case work is pivotal to a successful prevention programme and it was therefore pleasing to find that there was much of it about.

**In Stoke-on-Trent, the YISP met to consider the needs of Michael, an 11 year old boy from a very disadvantaged background. His father was in prison for drug dealing, there were significant rent arrears, which meant that his family were at risk of eviction. His mother had difficulty in providing physical and emotional support and he often went to school without breakfast and poorly clothed. As a result, he was bullied, which led to truancing and becoming more likely to offend. The YISP put together a very good package of support that included a large number of agencies that were working with the family. This package included the prevention worker taking the boy to school each morning and making sure he had breakfast, keeping a clean uniform at school and a programme of support in lessons. The housing officer drew up a plan to assist in re-housing and the police community support officer increased contact with the family and neighbours.**

- 4.10 Of the cases inspected, 75% (56 out of 75) of parents/carers took an active role in the initial assessment of their children. The most frequent forms of engagement were through the completion of the *Over to you!* section of the Onset assessment, which enabled parents and carers to express their views about the aspects of the child's life that needed to be addressed through the intervention plan. Another common form of engagement was through regular attendance at the CAF panel meetings, where progress of the child was discussed and monitored. The most frequent reason for non-engagement of a parent at a CAF panel was due to looking after siblings in the family. We were surprised that we didn't see more options on offer by local authorities to overcome this issue.
- 4.11 We found specific examples of engagement with children being sustained, particularly where this happened in schools, with effective use being made of established links with school nurses.

**Health workers in North Yorkshire met children away from the YOT, outside office hours and often with family, while also arranging transportation to reduce possible obstacles to them receiving appropriate health services. Enfield worked similarly.**

- 4.12 A pragmatic approach to sustaining engagement was often necessary where there was a stigma attached to receiving health support. There were also examples of good parenting support programmes which complemented the work done in prevention teams.

**In Bristol, there was an innovative use of psychology graduates who gained clinical experience by intensively supporting parents and reinforcing coping mechanisms.**

### **Promoting protective factors and reducing risk factors:**

4.13 Although overall interventions were of a good quality, there were times when these were delivered simply because they were available and not necessarily related to the desired outcomes. Inter-agency planning to implement interventions was also good in many areas.

**In North Yorkshire, good use was made of an innovative family project that worked with a small number of parents and their children in an attempt to improve the quality of communication between family members. One worker had sequenced interventions effectively by ensuring that the child had completed work on her literacy needs before involving her in an urban dance class.**

**In Hartlepool, a useful range of interventions had been identified and were delivered by health workers in the Youth Offending Service, such as the approach to alcohol-related crime (Straight-Line) and sexual health. Straight-Line was developed after gathering information about low level offending and antisocial behaviour and the programme has been further developed and taken into schools.**

4.14 We were impressed by the contribution of FIPs to prevention work, this was particularly evident in Stoke-on-Trent. The transition from primary to secondary school was seen as a particularly risky point for many vulnerable children. Workers in all the relevant agencies worked imaginatively at strategies to help these children make the transition successfully.

4.15 Although a wide range of interventions can often exist which promote good health, for example, using techniques such as cognitive behaviour therapy, solution-focused interventions and systemic work, there can be obstacles to successful engagement and intervention, travel in rural areas being a significant example.

4.16 In some settings, health outcomes were not sufficiently well captured on Onset (albeit health issues appear to be more effectively collated through the CAF). Some of the issues relating to the achievement of health outcomes also involved the lack of access to, or unwillingness to engage with, CAMHS, the lack of consultation with some of the other mainstream health services and the simple fact that, for example, with smoking, the child had not been able to stop despite intervention. Positive interventions were seen where some issues arising from obesity, bed-wetting and drug use were addressed. Indeed, where there was a YOT nurse working with physical health needs, there were several examples of effective work.

**Tom, a 12 year old child with ADHD, was eating high amounts of sugar and not taking his medication. Health and key workers worked with the child's doctor in revising his medication and then with the school to develop a routine to encourage him to take it. This was supplemented with 'healthy eating' educational awareness, taking him to the shops to choose fruit and then making 'smoothies'. Information and support was provided to his mother to improve both his and his sibling's diet. This had been maintained and was believed to have contributed to Tom's improved behaviour.**

### **Every Child Matters/Seven Core Aims for Children:**

- 4.17 The usefulness of the overarching policy guidance and framework in relation to *Every Child Matters* (in England) was underlined in the case analysis work where nearly all of the interventions undertaken in the case sample were consistent with the framework. Progress in cases was mostly linked specifically to Staying Safe, Enjoying and Achieving and one example of Healthy Living. Cases in the Welsh inspection area were broadly in line with the Welsh equivalent - *The Seven Core Aims for Children*.
- 4.18 Overall, there were limited positive activities available for younger children (under 10), children with disabilities and those with special needs.

### **Intervention Plans:**

- 4.19 When assessing case files and talking to the key worker, we had expected to see a timely and quality Onset assessment followed by a clear plan to address the issues identified. We would expect this to be undertaken in collaboration with the child and their parents/carers and ideally with others who had been responsible for delivering the interventions, such as workers from statutory and voluntary organisations. This review should both look back on how progress had been made and also ahead to how things could be improved in the future. This therefore would record whether the inputs were successful in addressing the issues; in particular whether the protective factors were being increased and the risk factors reduced.
- 4.20 The forward looking part of the review should identify whether interventions need to be changed, reduced or increased according to their success to date. It is also good practice to see positive achievement being recognised and praise for the child and their family, so that they could see clearly how they were making progress. As the intervention plan was achieved, we expect to see a clear exit plan to outline how that child's needs will be dealt with by universal services when the specific prevention interventions have been completed.
- 4.21 The quality of intervention plans did vary widely, ranging from no written plan at all, to plans which had clear objectives and milestones. A large minority, however, lacked detail, outcome milestones and an exit strategy. In terms of health interventions it was found that there was often too much reliance on further referrals to mainstream health services, or simply the continuation of work by members of the prevention team.

- 4.22 Well structured and reviewed plans can offer measurement as to the 'distance travelled' in reducing the risk factors and increasing the protective factors.(see Impact) and consequently it is difficult to understand how effective delivery of interventions can be offered and measured without these. This is an area that we found requires much improvement.
- 4.23 The sustainability of some of the intervention activities in many areas was said to be delicate, as many depended on short-term funding streams – and therefore were always at risk of not securing ongoing funding, subsequent closure and early loss of staff. This was not the case in North Yorkshire, where the majority of interventions on offer came from existing mainstream services. In this example, however, it did appear that the range of suitable interventions on offer was more limited.

**Diversity factors:**

- 4.24 When assessing cases, one of the aspects we explored was whether diversity issues, potentially discriminatory factors and other individual needs were actively assessed and acted upon. Our consideration of diversity was wide including, not only such factors as race/ethnicity, gender and disability, but also other issues that may impact on a child being able to maximise the opportunities engagement may offer. For example, learning difficulties or children moving from an area with a different accent which could impact on how that child may be accepted by their peers. We found that over two-thirds of cases had considered these issues sufficiently, both in terms of first assessing the issues and then taking steps to minimise their impact.

**Sam, a partially deaf child, was identified and arrangements were made to take this into account in group sessions and in one to one arrangements; with seat placement and supportive hand actions, while ensuring that all aspects were well understood. Advice was sought on this case from the health advisor and all staff received further briefings.**

- 4.25 We analysed the data on the 75 cases inspected to ascertain whether the results for some groups of children were different from others. The sample sizes were small, but it was possible to discern some indicative trends. For example, for the children who had a physical impairment, mental health, emotional issue or learning disability/difficulties, we assessed that workers were less active in their initial engagement with parents/carers, although once engaged this was more easily sustained. There were more plans and exit strategies prepared with this group but the interventions did not promote protective and reduce risk factors to the same extent as for children without identifiable disabilities. Not surprisingly, their educational needs were more accurately identified and appropriate referrals made as a result.

**Toby, a child with an eye issue which was severely affecting his self-image and behaviour, was identified. The key worker liaised directly with universal services to resolve the matter – the child's behaviour subsequently radically improved.**

- 4.26 None of the children who were from a black and minority ethnic background were identified as having a disability, but a higher proportion (one-third as compared with one-quarter for white children), were either the subject of a child protection plan or had been subject to Section 47 enquiries (Children Act 1989). Children subject to a child protection plan or Section 47 enquiries usually had an appointed social worker assigned to them, which led to less active engagement by prevention workers for the initial assessment and considerably fewer completed and reviewed Onsets. Fewer health needs were identified and effectively dealt with, and a higher proportion of other diversity issues were either not assessed, and nor were steps taken to minimise their impact.
- 4.27 For the sample as a whole, once the diversity issues were identified we then looked to see if they had been properly managed. We considered three-quarters of cases had done this. For example, sufficient adaptation of communication materials had been made to fit the individual's level of understanding or literacy. It was not always clear, however, if this approach had been expanded to all those involved with the child. In other words, had any barriers to that child maximising his or her potential been removed or dealt with, both in terms of the individual development of that child and any changes to his or her environment.

**Enfield has introduced a useful 'cultural checklist' of possible diversity issues to assist them in identifying relevant issues.**

### **Educational needs:**

- 4.28 In 53 out of 75 cases reviewed, there were educational needs evident from the initial assessment. Of those 53 cases, 43 of them (81%) showed evidence that these needs were accurately identified and appropriate referrals made. This was unsurprising, given that many of the referrals came from schools in the first instance. Some of the cases revealed close links between the prevention plans and plans to improve educational achievement. One case file viewed had a copy of the educational statement attached.
- 4.29 In 10 cases, however, no link had been made between the prevention of offending issues and additional educational needs. There were cases discussed where a small number of children were receiving schooling for only one to two hours per day at a pupil referral unit. However, because of their low staff to pupil ratio, most pupil referral units visited were able to ensure that children accessed a wide range of subjects which were reasonably comparable to mainstream schools. In another case, although specific educational needs had not been assessed as necessary, the child had been removed from classes to attend group sessions on offending behaviour; this meant missing structured lessons and possibly causing them to fall further behind the rest of the class. Education and schooling are crucial protective factors and we would have liked to have explored these issues in more depth, but without the specialist input from Ofsted or Estyn inspectors, we were unable to do this.

## **RECOMMENDATIONS**

*All prevention managers and key workers should ensure that:*

- **all children subject to crime prevention interventions have a current Onset intervention plan which is appropriately detailed, is time bound, reflects the child's assessment, is reviewed regularly, has clear outcome measures and an exit strategy.**

## 5. IMPACT

### General Criterion:

Interventions to reduce the likelihood of offending amongst children and young people have had a positive impact.

### What we expected to see:

- Evaluation has taken place to determine the success or otherwise of the approaches
- Individual and aggregated data related to interventions with children likely to offend is collected in order to evaluate practice.

*'If there was no YIP in... .. the place would go down hill, the kids would get into trouble and I don't want that. Crime has also gone down and I feel more secure in my flat.'*

Parent of child on a YIP

- 5.1 The significant prevention work that is taking place has as its outcome goal a reduction in youth offending or at least a reduction in the likelihood of offending. Overall, the inspection found these outcome goals difficult, if not impossible to assess.
- 5.2 As stated earlier, the quality of many intervention plans, especially in relation to outcome measures, was found to be poor. We ascertained that just over half of all cases were devoid of a clear plan with an exit strategy, with some having no plan at all. Consequently, it was difficult for key workers to evidence what success actually looked like.
- 5.3 But what *does* success look like? All key workers understood the risk and protective factors and had an understanding that interim outcome measures, such as an improvement in school attendance, (a risk factor) and the development of improved peer relationships (a protective factor) could contribute to a reduction in the likelihood of future offending, but this was infrequently evidenced.
- 5.4 We found little evidence of any collation of progress to better understand how successful interventions had been. There was some movement in Bristol, where the local authority was developing a 'distance travelled' methodology for the CAF, which was aiming to become part of the shared partner-wide eCAF system.
- 5.5 The Onset already has this 'distance travelled' capability, which can be accessed through regular reviews and rescoring. However, such an assessment review is only as good as the evidence within it. As progress evidenced within many intervention plans examined lacked detail, it was difficult to easily identify and comment upon the changes in the risk and protective factors. This, coupled with a general lack of outcome measures, made it very difficult to determine the effectiveness of interventions for many children. Of the cases examined it was split approximately in half as to whether or not there was evidence that there had

been a reduction in the likelihood of offending. Few, if any, plans had an explicit exit strategy, although in one area (Enfield) wherever possible every child was referred to a mentor at the conclusion of intervention.

- 5.6 There was no evidence of any evaluation of 'closed' cases so it was not possible to ascertain the longer term success of prevention work. In a very few cases the child had gone on to offend (or reoffend) during the time of the 'open' case.
- 5.7 With the exception of Enfield, little work appeared to have been done to evaluate the longer term success of prevention work. Enfield had recently commenced research to track children who had received YISP interventions in previous years, to ascertain if they had entered the criminal justice system and, if so, when and for what type of offence. The result of this research will offer some data on the impact of prevention work.
- 5.8 Throughout all areas visited we spoke to a number of children and their parents to gauge their opinion on the work that had been undertaken. Without exception the feedback was extremely positive. Parents and carers were especially glowing in the praise for key workers citing examples of dedication and care being shown, introducing their child to new experiences and friends, assisting their child in controlling their behaviour, arranging parenting skills courses, etc. Importantly, many stated that they believed their child would '*have got into trouble*' if it were not for the prevention work.
- 5.9 The causes for youth offending are extremely complex and certainly much more than the attitude adopted by the individual alone. In the words of one practitioner '*The best way to impact on the child is to impact on the family*'. The cases examined support this view. Many cases demonstrated the link between the child's behaviour and influencing factors such as sibling offending, poor parenting, drug or alcohol abuse by parent, mental illness, etc.
- 5.10 Most areas visited had a FIP in existence, an extremely intensive approach which, due to resource issues, can only impact on a very few families in a local authority area. Anecdotal evidence from key workers suggests that offending/reoffending by family members involved in these FIPs had either not taken place or had been considerably reduced, i.e. a very positive outcome.
- 5.11 Furthermore, there was little evaluation found of practice as a whole, especially of the many individual interventions that in some areas had been operating for several years.
- 5.12 Currently, the main outcome indicator for success in prevention work is measured by the English National Indicator 111 (NI 111) and the Wales Youth Justice Indicator 1 (WYJI 1) - First Time Entrants to the criminal justice system. The definition of a First Time Entrant is a child or young person who has received at least a police reprimand (a type of caution). This is generally accepted as the first tier of formal criminal justice sanction which is reserved for lesser offences.
- 5.13 Although these indicators may be helpful, they do not reflect the true position of youth offending. NI 111 and WYJI 1 can be influenced by police activity and policy and/or new methods of dealing with offenders. For example, in previous years the police service in England and Wales had been robust in its interpretation of the National Crime Recording Standards, a system that, coupled with the programme and targets of increasing the number of Offences Brought To Justice, had brought

a number of children and young people into the criminal justice system. Before this, the police officer may have used his or her discretion and dealt with the matter informally. This is a good example of conflicting targets between the YOT (in which the police are partners), trying to reduce First Time Entrants to the criminal justice system and the police trying to meet targets under the Offences Brought To Justice process.

- 5.14 This position is changing. Some police forces have introduced a form of restorative justice known as Youth Restorative Disposal (YRD). The YRD is aimed at culprits of lesser offences, with the objective of bringing some form of restorative closure to the matter, both to the satisfaction of the victim and also, it is hoped, to the offender. Fixed Penalty Notices (FPN) are also used, although mainly for low level adult offending. Reprimands (and the next level of sanction, a Final Warning) are both recorded on the Police National Computer (PNC).
- 5.15 Although a caution is not a conviction (and therefore does not have a rehabilitation period under the Rehabilitation of Offenders Act 1974<sup>6</sup>) and does not have to be declared on application forms for employment, it will still show up on the Criminal Records Disclosure. Some FPN, such as for disorder, minor criminal damage and theft are recorded on the Police National Computer, however, restorative justice disposals are only recorded on it if the individual is taken into police custody. Neither such FPN nor YRD will be disclosed in a criminal record check. Because many children and young people have simply been categorised as 'pre-reprimand', which in effect is what most YRDs are, neither a YRD nor a FPN is counted towards the NI 111 or WYJI 1.
- 5.16 It is therefore hardly surprising to discover in areas that have already introduced the YRD approach that the number of First Time Entrants, as measured by NI 111 or WYJI 1 has decreased and in some cases significantly so. Whilst this maybe classed as an accurate measure of First Time Entrants into the formal criminal justice system (as judged by receipt of reprimands, final warnings and convictions) if *any* criminal justice intervention could be considered as part of the criminal justice system then it is difficult to see why YRDs and FPNs are not also included as part of the process or at least considered alongside the national indicators.
- 5.17 It follows, therefore, that the NI 111 and WYJI 1 figures alone in their current definition are unreliable in determining the success of prevention work, or in particular, comparing different areas, or the same area over time. Whilst there may be initial evidence that YRDs are reducing as well as FTEs, it is our view that in order to assess if youth offending is reducing, the data covering all the sanctions (whether nationally recorded or not) need to be examined in parallel.
- 5.18 We saw some evaluation of the impact of health interventions with a wide range of tools available to do this although the evaluation was not often linked to the data being collected by the YOT. The tools used locally by health services ranged from risk profiles through strengths and difficulties questionnaires to TOPs (Treatment Outcome Profile) forms for substance misuse collated by the National Treatment Agency, but generally only used for the older age range, but also including further evaluations and surveys. Case reviews in supervision also helped to demonstrate the impact of individual interventions. It was recognised that there

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<sup>6</sup> See Glossary for more details

were difficulties in adequately explaining success criteria in health where, for example, a child who misused substances understood the risks more or used substances more safely without reducing the level of use. There were some good examples of health workers using evaluation sheets with children in order to share the identification of progress.

- 5.19 There was limited evidence of formal performance monitoring at a strategic level in relation to the provision of health services on preventing offending. Although reports were provided by health workers to YOT management boards, these were often restricted to numbers seen and speed of referral and engagement. For example, in Derby there was a monthly report on substance misuse work which was provided both to the YOT Head of Service and to the Drug and Alcohol Action Team. This highlighted specific issues such as the nature of interventions with different ethnic groups and the need for specific interpreters. In Stoke, there were quarterly health reports and reviews of work undertaken, the CAMHS nurses also participated in clinical supervision and knowledge exchanges with the CAMHS nurses who worked at Staffordshire YOS. The substance misuse worker also prepared quarterly reports for the YOS Manager and monitored referrals. This provides useful information on the number with identified substance misuse needs but not in the success or otherwise of the interventions.

### **Length of contact:**

- 5.20 We recorded the length of contact that had taken place in relation to the cases we assessed. Some areas had an expectation as to how long a maximum contact period would be, such as an academic year, others accepted that cases would be closed and then reopened if further needs emerged.
- 5.21 A proportion of the cases we assessed were still open, but this provided us with a snapshot in time. The majority, just over one-third, were open for 9-12 months, whilst one-fifth were more than a year and a similar proportion for 6-9 months. The remaining quarter had been in contact for less than 6 months. This provided some indication of the time it took to refer, engage and complete work with children who were likely to offend.

### **RECOMMENDATIONS**

#### ***Each Local Authority and its partners should ensure that:***

- **the impact of local youth crime prevention work is appropriately evaluated and practice adjusted accordingly.**

#### ***The relevant Government departments in both England and Wales should ensure that:***

- **the use of National Indicator 111 and the Wales Youth Justice Indicator 1 - the measurement of First Time Entrants to the criminal justice system, is reviewed.**

## Appendix 1: Glossary

ACPO	Association of Chief Police Officers
ADHD	Attention-deficit-hyperactivity disorder. A psychiatric disorder in children
BME	Black and Minority Ethnic
CAF	Common Assessment Framework: a standardised assessment of a child or young person's needs and of how those needs can be met. It can be undertaken by any trained practitioner with contributions from all others involved with that individual. Note: This is for England only but can, and is, being used in parts of Wales.
CAMHS	Child and Adolescent Mental Health Services: part of the National Health Service, providing specialist mental health and behavioural services to children and young people up to at least 18 years of age.
CDRP	Crime and Disorder Reduction Partnership(s) – becoming Community Safety Partnerships from 2010 in England. Already generally known as such in Wales.
Children's Board	Partnership group consisting of both statutory and non statutory organisations promoting the <i>Every Child Matters</i> agenda (in England)
Child Protection plan/register	Every local authority has a duty to protect children from significant harm. Until April 2008 all local authorities maintained a child protection register, a confidential list of names of children who are believed to be at risk of significant harm. This may be physical abuse, emotional abuse, sexual abuse or neglect. The register was maintained within the social services department. This register has been replaced by the child protection plan thus emphasising the proactive nature of children services If a child on such a plan moves out of the area information is passed on to the new local authority area.
Children Act 1989 – Section 47	Section 47 of the Children Act 1989 places a duty on local authorities to make enquiries into the circumstances of children considered to be at risk of 'significant harm' and, where these enquiries indicate the need, to undertake a full investigation into the child's circumstances.
Domain	A term to explain groups of issues where risk and protective factors can be identified and addressed.
Estyn	HM Inspectorate for Education and Training in Wales
<i>Every Child Matters</i>	Sub title to the Children Act 2004
FIP	Family Intervention Project - The primary objective of family intervention projects is to stop the anti-social behaviour and offending of families and restore safety to their homes and to the wider community. These projects also tackle the causes of poor behaviour which involve issues such as drug and alcohol misuse, poor health, domestic violence, worklessness and debt. As a result, these projects also deliver other objectives such as preventing homelessness, enabling families to sustain tenancies and helping achieve the five <i>Every Child Matters</i> outcomes for children and young people (in England)
First Time Entrant	Defined as young people (aged 10 – 17) who receive their first substantive outcome following the commission of an offence ( a reprimand, a final warning, or a court disposal for those who go directly to court without a reprimand or final warning).
FPN	Fixed Penalty Notices (FPN) are used mainly for low level adult offending, but for some youth offending too.

HM	Her Majesty's
HMIC	HM Inspectorate of Constabulary
HMI Probation	HM Inspectorate of Probation
National Crime Recording Standards	These standards were adopted by all police forces in England and Wales in April 2002 in an effort to improve consistency of police recording of crime and to better reflect the demands made on the police by victims of crime. In most cases this resulted in a move to a more victim-focused approach to crime recording, often based on the perception by a victim that a crime has taken place. This, in many cases resulted in an increase in recorded crime as compared to previous years.
National Drugs Strategy	In 2008, the government produced a new strategy – <i>Drugs - Protecting Communities and Families</i> . The strategy contains the vision for the national response to drugs. The Home Office has overall ownership of the drug strategy and is responsible for co-ordinating delivery of its constituent strands, which are owned by a number of different departments, including the Ministry of Justice, the Department of Health and the former Department for Children, Schools and Families.
National Indicators	National Indicators have been derived from Public Service Agreements and agreed across Government through the 2007 Comprehensive Spending Review. The outcomes they measure and the indicators themselves provide a statement of Government's priorities for delivery by local government and its partners. They are the only indicators on which central government will set targets for local government.
Neighbourhood Policing Teams	Also known as Safer Neighbourhood Teams, are made up of police officers and police community support officers frequently supported by other agencies, typically the local authority. These teams engage with the local community to identify their concerns and priorities, and work with them to solve problems and also increase police visibility in local areas
Offences Brought To Justice	Bringing offences to justice is a key measure of the effectiveness of the criminal justice system. An offence is said to have been brought to justice when a recorded crime results in an offender being convicted, cautioned, issued with a Penalty Notice for Disorder or an offence being taken into consideration by a court.
Onset	<p>The Onset referral and assessment framework was designed by the Centre for Criminology, University of Oxford for the YJB. Onset promotes the YJB's prevention strategy by helping to identify risk factors to be reduced and protective factors to be enhanced. It also provides information which might be helpful in selecting appropriate interventions for those identified as needing early intervention. When collated, the information on Onset can be used for monitoring, as well as targeting specific sub-groups where applicable, or providing progress data to steering groups. The prevention counting rules require all YJB-funded prevention programmes to use Onset as the basis for their referral and assessment mechanisms.</p> <p>Onset is a four stage process:</p> <ol style="list-style-type: none"> <li>1 Consent</li> <li>2 Referral and verification</li> <li>3 Assessment</li> <li>4 Planning Action and Review</li> </ol>
Ofsted	Office for Standards in Education, Children's Services and Skills: the Inspectorate for those services in England (not Wales, for which see Estyn)

PCT	Primary Care Trust
Pre-CAF	A simple 'Request for Service', requesting one or two additional services, e.g. health, social care or educational in those instances when a Common Assessment Framework may not be required.
Rehabilitation of Offenders Act 1974	Under this Act, a criminal conviction may become 'spent' after a period of time. When applying for employment, a declaration must be made about previous convictions. Some jobs, such as working with children and vulnerable adults, health service posts and other 'approved persons' may be exempt from the Act. Both 'spent' and 'unspent' convictions will appear on Criminal Record Disclosures as will reprimands and final warnings.
'Risk' factors and 'Protective' factors	'Risk factors' can be defined as those that research has shown lead individuals to become more likely to offend – for example, substance abuse and educational underachievement. 'Protective' factors can be defined as those that lead individuals to become less likely to offend.
'Safeguarding'	Overseen by the Local Safeguarding Children Board: set up in each local authority (as a result of the Children Act 2004 to coordinate and ensure the effectiveness of the multi-agency work to safeguard and promote the welfare of children in that locality
<i>Seven Core Aims for Children</i>	Welsh approach for the protection, welfare and development of children based upon the United Nations Convention on the rights of the child
Wales Youth Justice Indicator	A number of indicators agreed by the Welsh Assembly Government relating to youth justice
YCAP	The Youth Crime Action Plan, published by the Home Office, Ministry of Justice and the then Department for Children, Schools and Families in July 2008, was a comprehensive, cross-government analysis of what the UK government was going to do to tackle youth crime. It set out a 'triple track' approach of enforcement and punishment where behaviour is unacceptable, non-negotiable support and challenge where most needed, and better & earlier prevention, especially through reparation.
YIP	Youth Inclusion Programmes (YIPs), were established in 2000, and are tailor-made programmes for 8 to 17-year-olds who are at high risk of involvement in crime or anti-social behaviour. YIPs generally work with either the 8-12 age range (Junior YIPs) or the 13-17 (Senior YIPs).  YIPs target young people in a neighbourhood who are considered to be most at risk of offending, but are also open to other young people in the local area. The programme operates in 114 of the most deprived/high crime neighbourhoods in England and Wales
YISP	Youth Inclusion Support Panel - Youth Inclusion Support Panels (YISPS) are multi-agency and provide a package of support to help young people committing anti-social behaviour and becoming at risk from their own behaviour. They seek to prevent offending and anti-social behaviour by offering support services and other complementary interventions for high risk children and their families.
YOT	Youth Offending Team – these are multi-disciplinary teams which co-ordinate services in their local authority areas. They are responsible for supervising young offenders and working with young people who are likely to offend.
YRD	Youth Restorative Disposal: The YRD is aimed at culprits of lesser offences, aiming to achieve some form of restorative closure to the matter to the satisfaction of both the victim and the offender.
YJB	Youth Justice Board for England and Wales

## Appendix 2: Inspection Methodology

The Inspection team consisted of inspectors from HMI Constabulary, HMI Probation, the Care Quality Commission and Healthcare Inspectorate Wales. In addition to a pilot area to test the methodology, six areas were identified in England and Wales to visit.

The choice of these sites depended on several factors but we wanted to see if the prevention agenda operated differently depending on the nature of the locality. We therefore chose a London borough, a large city, urban towns and a large predominately rural county.

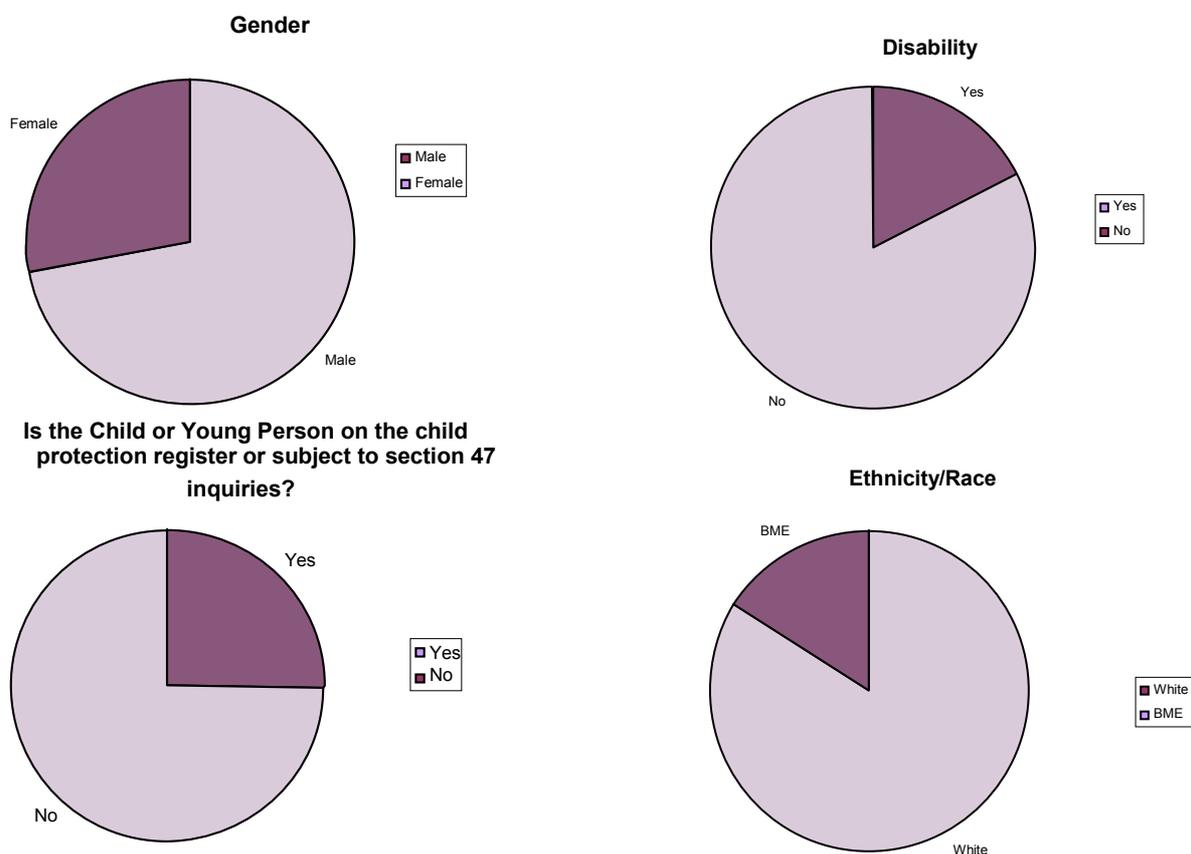
Senior staff and front line practitioners from several organisations, including the third sector were interviewed and numerous visits were made to intervention programmes where the opportunity was presented to speak to children and their parents/carers about their experiences.

We asked each of the seven areas to identify all the cases that had commenced in the period six to nine months prior to our inspection and all those that had terminated in the three months before our inspection. We then selected six current cases and three terminated cases for our inspection sample. The sample was further adjusted to reflect, as far as possible, the ethnicity and gender profile of the overall caseload, as reflected in the list of current and terminated cases in each area.

For the purposes of the inspection, we examined the case files of 75 children who had been identified as being likely to offend. We also interviewed, wherever possible, the child's key worker. Case assessment tools were designed to collect evidence about the quality of assessments, interventions and the impact of this work.

*To note: names used in the case examples are not the real names of those children.*

*Characteristics of the sample:*



## **Appendix 3: Role of the Inspectorates and Code of Practice**

### **HMI Constabulary**

Information on the Role of HMI Constabulary can be found on our website:

[www.hmic.gov.uk](http://www.hmic.gov.uk)

The Inspectorate is a public body. Anyone wishing to comment on an inspection, a report or any other matter falling within its remit should write to:

*HM Chief Inspector of Constabulary  
HM Inspectorate of Constabulary,  
6th Floor, Globe House, 89, Eccleston Square, London SW1V 1PN*

### **HMI Probation**

Information on the Role of HMI Probation and Code of Practice can be found on our website:

[www.justice.gov.uk/inspectorates/hmi-probation](http://www.justice.gov.uk/inspectorates/hmi-probation)

The Inspectorate is a public body. Anyone wishing to comment on an inspection, a report or any other matter falling within its remit should write to:

*HM Chief Inspector of Probation  
HMI Probation  
2nd Floor, Ashley House, 2 Monck Street London, SW1P 2BQ*

### **Care Quality Commission**

Information on the Role of the Care Quality Commission can be found on our website:

[www.cqc.org.uk](http://www.cqc.org.uk)

The commission is a public body. Anyone wishing to comment on an inspection, a report or any other matter falling within its remit should write to:

*Chief Executive  
Care Quality Commission  
Finsbury Tower, 103-105 Bunhill Row, London EC1Y 8TG*

### **Healthcare Inspectorate Wales**

Information on the Role of Healthcare Inspectorate Wales can be found on our website:

[www.hiw.org.uk](http://www.hiw.org.uk)

The Inspectorate is a public body. Anyone wishing to comment on an inspection, a report or any other matter falling within its remit should write to:

*Chief Executive  
Healthcare Inspectorate Wales  
Bevan House, Caerphilly Business Park, Van Road Caerphilly, CF83 3ED*