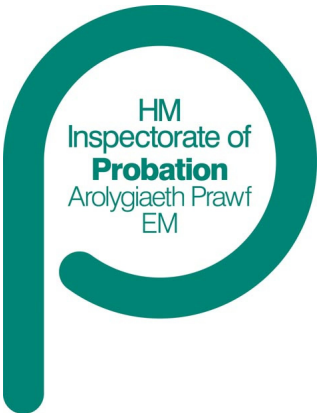

Report on:

Inspection of Isle of Man Youth Justice Team

ISBN: 978-1-84099-306-6

2009

Foreword

We are pleased to submit to the Minister for Home Affairs this report of the first inspection of the Isle of Man Youth Justice Team. We were asked to undertake this inspection in response to a recommendation of the Commission of Inquiry into the Care of Young People, published in May 2006.

The decision to set up the Youth Justice Team is to be commended. The team has become a valuable resource in work to reduce offending. However there was much still to do, in particular to ensure that it is placed on a strong and sustainable footing.

Much of the work undertaken with children and young people who had offended was good; it was characterised by commitment and excellent engagement between team members and children and young people. Work in the courts was effective and well regarded. However further work was required to improve intervention planning and to ensure that assessment and management of *Risk of Harm to others* was of consistently high quality.

The Youth Justice Management Board was not effective. This was particularly important whilst legislation to place the Youth Justice Team onto a statutory basis was awaited. Not all partner agencies had adequately recognised their critical role in monitoring and improving outcomes for children and young people who had offended or had the greatest likelihood of offending.

We trust that this report will be useful to the Isle of Man Government in further improving and reinforcing the work of the Youth Justice Team.

Andrew Bridges
HM Chief Inspector of Probation

October 2009

Acknowledgements

We would like to thank all the staff from the YJT, members of the Management Board and partner organisations for their assistance in ensuring the smooth running of this inspection.

We would particularly like to express our gratitude to Gary Hardman YJT Manager and Neil Hay for their commitment to the inspection.

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Summary

Management and leadership

- A Youth Justice Management Board was in place, and had become a sub-group of the Isle of Man Safeguarding Children Board. The Chair of the Youth Justice Management Board was also a member of the Safeguarding Children Board.
- There was excellent political commitment to the work of the YJT.
- YJT priorities were well represented in the first Children's Plan for the Isle of Man, published in June 2009.
- The Youth Justice Management Board was not effective. It met infrequently and had not agreed objectives for its operation. Not all stakeholders or key partners were represented on the Youth Justice Management Board.
- Remaining a voluntary partnership severely hampered the ability of the YJT to ensure full engagement from all relevant partners.
- Some key partners had not adequately recognised the importance of their active engagement in the work of the YJT, nor their critical role in monitoring and improving outcomes for children and young people who had offended or were at greatest risk of offending.
- Lack of suitable information systems meant that the production of needs information was extremely difficult. A planned change of systems had the potential to improve the situation, but if the needs of the YJT were not delivered it would put the team in a significantly worse position.
- The YJT took the lead in a broad range of pre-offending activities, in addition to work with children and young people who had offended.
- Staff and the YJT manager were highly regarded by partners and by the children and young people with whom they worked. They were enthusiastic, committed to their work with children and young people and keen to continue to develop.
- The YJT was under great pressure. It had developed on an ad hoc basis and there had been no recent strategic review to ensure that its resources met the assessed needs.
- There were no agreed standards and procedures in place for most aspects of the work of the YJT.

Work in the courts

- There were good relationships and good communication between the YJT and the courts, although the Juvenile Court users group had fallen into abeyance.
- Work in the courts was generally of good quality. The work of the YJT was effective in helping the courts avoid inappropriate use of custody.

- There was no formal bail support or intensive intervention scheme available to provide the courts with a more suitable alternative disposal for those children and young people on the cusp of custody.
- Pre-sentence reports were generally of good quality. Courts expressed great satisfaction in them. Proposals were realistic and were followed.
- There was good engagement between YJT staff, children and young people and parents/ carers, in the preparation of reports and at court.
- Offence analyses, consideration of maturity and clear differentiation between the *Risk of Harm to others* and the Likelihood of Reoffending were aspects to be further improved in reports.

Gatekeeping and final warnings

- The gatekeeping process was robust and effective, focused on tackling offending behaviour at the earliest opportunity and lowest appropriate level.
- Assessment and decision making was thorough and decisions took into account all relevant circumstances.
- Guidelines needed to be comprehensive and kept up to date.
- Positive outcomes were reported from the use of diversionary interventions.
- The final warning process had recently been re-instituted within the YJT following a long period without an appropriate member of staff in post.
- Insufficient attention had been given to the *Risk of Harm to others* and vulnerability.
- An intervention, which was usually successful in challenging the child or young person to accept responsibility for their offence, was delivered in all final warnings.
- Parents/ carers were kept well-engaged in the final warning process.
- There was insufficient clarity on the length of time that could pass before the final warning was issued, and the link between delivery of interventions and delivery of the warning.

Work with children and young people who have offended

- The quality of engagement between case managers and children and young people was excellent. Workers motivated and supported children and young people and reinforced positive behaviour.
- Assessments were generally of sufficient quality, but there was further room for improvement.
- The screening of *Risk of Harm to others* was accurate and full Risk of Serious Harm assessments were of a sufficient quality. However they were not always undertaken when required, but they were present in all cases

with a clearly raised Risk of Serious Harm. Risk management plans were not comprehensive.

- Intervention plans were completed and were regularly reviewed. Children and young people were well aware of their plans. However the plans needed improvement, in particular to ensure specific, measurable, achievable, realistic, time-bounded and comprehensive objectives.
- Work to ensure the compliance of children and young people with community orders was good.
- Reoffending by children and young people continued to reduce, year on year, over a sustained period.
- A plan to manage vulnerability had not been completed in all cases where this was required. However those plans that had been completed were of sufficient quality.
- There was good work with partners to address substance misuse needs. However the YJT and partners' resources were neither sufficient nor flexible enough to ensure delivery of a comprehensive service to all children or young people who would benefit from it.
- The role of the seconded health worker was a positive development, however it needed to be better integrated with routine case management.
- The YJT was pro-active in making referrals to and seeking to engage children's social care. However the response that it received was not always appropriate to the needs of the case.
- The proportion of children and young people who had offended and were Looked After continued to rise, and these children and young people were a very high proportion of the offending population.
- There was insufficient accommodation provision to meet the needs of children and young people who had offended.
- Lack of active receipt of suitable statutory education was a key factor for a high proportion of children and young people who had offended. However insufficient action had been taken to ensure that these children and young people were re-engaged in suitable full-time educational provision. There was no consistency of approach between individual schools, no clarity of expectation on them and no effective escalation process.

Work with children and young people sentenced to the secure unit

- A comprehensive protocol was in place that ensured that the YJT provided services to children and young people placed in the Adolescent Secure Care Unit.
- There were excellent working relationships between Adolescent Secure Care Unit and YJT staff and managers
- The quality of engagement between YJT staff and children and young people placed in the Adolescent Secure Care Unit was good.

- There was no system in place to ensure that the *Risk of Harm to others*, and offending-related behaviour, continued to be managed and addressed followed release from the Adolescent Secure Care Unit.

Recommendations

Changes are necessary to ensure that *(primary responsibility is indicated in brackets)*:

(1) the Youth Justice Management Board demonstrates its effectiveness. In particular it should meet regularly, have clear terms of reference that are agreed by partners, and hold the YJT and partners to account for its performance *(Chief Executive – Department of Home Affairs)*

(2) children and young people who have offended, or are at significant risk of offending, are in active receipt of suitable full-time education provision *(Department of Education in conjunction with YJT Manager)*

(3) the basis on which the YJT is funded and organised is robust and sustainable *(Department of Home Affairs and partners)*

(4) *Risk of Harm to others* is properly assessed, planned for and managed; with comprehensive risk management plans (*YJT Manager)*

(5) sentence plans are of good quality and are comprehensive; containing specific, measurable, achievable, realistic and time-bounded objectives and being clearly understandable to children and young people *(YJT Manager)*

(6) work with children and young people who have offended is supported by comprehensive standards and procedures *(Youth Justice Management Board and YJT Manager)*

(7) the proportion of children and young people who are Looked After and receive criminal sanctions is significantly reduced relative to the general population *(Department of Social Services in conjunction with YJT Manager)*

(8) the work of the YJT is supported by effective information systems *(Department of Social Services in conjunction with YJT Manager).*

Next steps

An improvement plan addressing the recommendations should be submitted to HMI Probation for consideration four weeks after the publication of this inspection report.

Service users' perspective

Children and young people

Ten interviews were conducted by inspectors with children and young people who had offended.

- All respondents had a clear understanding of why they had to work with the YJT, what would happen during their appointments and the consequences of missing appointments. One child or young person said: *"I had a plan right from the start, and it was reviewed with me every three months".*
- The PSR had been seen by the child or young person, and explained to them, in all cases.
- When asked whether YJT staff were really interested in helping them, all answered that they were. One said: *"They are always here to help me"*. In all cases YJT workers had treated the children and young people fairly and with respect.
- Four out of the ten respondents said that there were things in their life that made it harder for them to take full part in their sessions. All said that the YJT took full account of these in the way that they worked. One said: *"My appointments and the way they worked recognised my drug use and my job....Life is sorted now"*.
- Eight said that the YJT had worked with them to help them to make better decisions, or to try and address their ETE problems. All recognised that work had been done to address a broad range of the causes of their offending. One said: *"I lose my temper a lot less now"*. However another said: *"I wanted to get sent to the ASCU, because I knew I'd get some education there".*
- Six children and young people said that their ETE needs had improved, usually around getting a job. Of the eight who had reported health concerns, all except one said there had been an improvement. One child or young person said: *"I was on heroin. Lots of people worked together to help me come off it completely...".*
- Overall, all the children and young people said that things had got better for them and that they were less likely to offend as a result of their involvement with the YJT.

Seventeen children and young people completed a paper questionnaire for the inspection.

- The findings from these questionnaires closely matched those that had been obtained through face-to-face interviews with an inspector.

- When asked whether they were satisfied with the work of the YJT all but one of the children and young people said that they were. One said: "[My YJT worker] *helps me a lot, I feel I can talk to* [them] *and not be judged"*.

Parents/ carers

Four questionnaires were completed independently by parents/ carers.

- All respondents said that their first contact with the YJT was helpful and that the services available to the family had been clearly explained. Enough information was provided about what the sentence meant.
- Where a PSR had been produced the parent/ carer had seen it before the court appearance and it had been explained to them.
- Wherever appropriate the needs of the parent/ carer had been taken into account when making arrangements. YJT staff continued to keep parents/ carers informed about the work they were doing with their child.
- All parents/ carers said that things had got better, both for themselves and their children, as a result of involvement with the YJT.
- When asked whether they were satisfied with the work of the YJT, all said that they were.

Sharing good practice

Below are some examples of good practice we found in the YJT.

Work with children and young people who have offended

Use of mental health assessment to inform interventions

Nathan was on a 12 month probation order. The case manager had identified in his assessment that Nathan had emotional health issues and needed an anger management intervention. The case manager asked the YJT health worker to undertake a full SIFA assessment. This enabled the case manager to structure his anger management work to precisely match Nathan's needs.

Work with children and young people who have offended

Integrated work with social services and parents/ carers

John was on a probation order as a result of incidents in his home. At the start of the order the case manager referred the case to social services over concerns about inadequate parenting. Social services staff arranged for a contract to be drawn up between John and his parents/ carers. This was then used by the case manager to engage John and his parents/ carers in work aimed at reducing incidents of aggression in the home. The contract was also used as a method of measuring progress. This also supported positive reinforcement about his progress to both John and his parents/ carers.

Work with children and young people who have offended

Health assessments

All children and young people working with the YJT received a thorough health assessment from the seconded health worker. This provided a broad range of useful information for case managers to use.

Work with children and young people who have offended

The impact of a committed worker

Jason was a 17 year old male with a long offending history, including significant drugs issues. Due to Jason's behaviour there had been a serious breakdown in relationships with close family members. The case manager showed a high degree of patience and persistence in working with the case, including a lot of consideration and kindness towards both Jason and his mother. Direct offending behaviour work was undertaken with Jason. He was also referred to and supported in engaging with a substance misuse intervention.

As a consequence of the commitment shown to him and the quality of work undertaken Jason had withdrawn from and kept free from drugs and had stopped offending. He also successfully built bridges with his father and with his grandmother prior to her death. He had started to show tremendous kindness to others. To quote from his mother: *"He has showed a side I wouldn't have thought possible two years ago"* and *"we all get on really well now, and are closer than ever we were before".*

1. MANAGEMENT AND LEADERSHIP

1.1 General criterion:

Leadership - The Management Board provides strategic oversight and direction, and coordinates the provision of Youth Justice services by the YJT and partner agencies.

The YJT was a voluntary partnership between the DHA, DSS, Isle of Man Constabulary and Isle of Man Probation Service. It was located for management purposes in the DHA, having recently moved from the DSS. The DHA was accountable to Tynwald (the Isle of Man parliament) through the Minister for Home Affairs.

Strengths:

(1) A YJMB was in place, chaired by the Chief Executive of the DHA.

(2) The Isle of Man Constabulary and DSS were particularly committed to the work of the YJT, having been instrumental in its creation and development. Police, probation, health and social services were all represented on the YJMB.

(3) A decision had been made that the YJMB would be a sub-group of the new Isle of Man Safeguarding Children Board, in order to ensure accountability to the Isle of Man Government for the work of the YJT. This Board was also chaired by the Chief Executive of DHA, whilst waiting for an independent chair to be appointed; once this was done he would act as the YJT representative on the Board.

(4) There was excellent political commitment to the work of the YJT from those members of Tynwald with specific responsibility for the DHA and Social Services.

(5) The work and effectiveness of the YJT was reported on positively by the Commission of Inquiry into the Care of Young People, published in 2006.

(6) The YJT Manager produced a Business Plan and Annual Report for the YJT. Targets were generally challenging, mirroring the 'can-do' attitude shown by YJT staff.

(7) The work of the YJT was well represented in the first Isle of Man Children's Plan, published in June 2009.

Areas for improvement:

(1) The Isle of Man did not have legislation equivalent to the Crime and Disorder Act (1998) in England and Wales, defining a duty for agencies to cooperate to prevent offending by children and young people and to protect the public. Whilst there was an intention to resolve this with legislation in 2010/ 2011; in the interim the effectiveness of the YJT was dependent on the willingness of agencies to recognise their responsibilities and cooperate with its work.

(2) The YJT objectives were defined within the Chief Minister's Strategy for Youth Justice, written in 2002. However they had not been enshrined in legislation nor had they been updated to reflect the developing work of the YJT.

(3) Objectives for the YJMB had never been agreed. Neither were all members of the Board clear on the contribution that their role should make to its work.

(4) As a consequence of these issues the YJT was not yet established on a secure footing and did not have a clear strategic direction.

(5) The YJMB had met with varying levels of frequency and meetings were often cancelled. The lack of effectiveness of the Board had a significant impact on staff perception of the importance and value of their role.

(6) It was not clear that all representatives on the YJMB were of a sufficiently senior level to ensure the full commitment of their agencies to the work of the YJT; neither did all representatives attend the meetings that were held. The courts were not represented on the Board, neither were other agencies such as housing and leisure services.

(7) The YJMB did not actively manage the YJT Manager nor hold the YJT or partners to account for their performance.

(8) The YJT Manager was a serving police officer and on occasions had to give priority to police duties over those of the YJT. When that occurred there was no-one with responsibility to deputise for him. Since his recent promotion to Inspector this situation had been exacerbated.

1.2 General criterion:

Partnership and Resources - Partner organisations and the YJT work together to deter children and young people from offending.

Strengths:

(1) There was strong commitment to the YJT from police, probation, social services and health.

(2) The devolved budget for training and other incidental costs had recently been tripled following transfer of the YJT from the DSS to the DHA.

(3) There were effective links between the YJT and local MAPPA arrangements.

(4) At an individual practitioner level, YJT and staff from other agencies often worked together well.

(5) The YJT was well embedded in the Isle of Man Government Drug and Alcohol strategy through JARS, delivered in partnership with the Isle of Man Alcohol Advisory Service.

(6) A broad range of pre-offending activities and projects were carried out under the auspices of the YJT. Most referrals were made by the police, with whom the YJT had a very good working relationship.

(7) The Liberty project was a joint initiative with the Department of Health and Social Security and care providers to reduce the incidence of offending and criminalisation of children and young people in the care system. Initial evidence indicated that it was having a positive effect. The YJT had also trained representatives of care providers in acting as Appropriate Adults.

(8) A monthly liaison meeting was held with the DoE to exchange information about children and young people who had been referred to the YJT as a result of becoming known to the police. There was also a single point of contact for the YJT in each secondary school and in the Isle of Man College.

Areas for improvement:

(1) Some key partners had not adequately recognised the importance of their active engagement in the work of the YJT, nor their critical role in monitoring and improving outcomes for children and young people who had offended or were at greatest risk of offending. There was limited evidence of priority being given to referrals from the YJT, nor of active engagement by partners of the YJT in cases that involved multiple agencies. There was evidence of the reluctance of partner agencies to respond quickly to YJT concerns, including when urgent multi-agency meetings were requested.

(2) Staff and other partners were concerned at the quality of input from the DoE to work with children and young people who had offended, or were at risk of offending. There was also concern at the proportion of these children and young people, particularly of statutory school age, who were not in active receipt of suitable educational provision.

(3) In almost two thirds of those cases where external service provision would have been required, there were gaps in the provision that impacted on the effective supervision of the child or young person.

(4) There were insufficient staff resources to reliably deliver the existing workload in the way that it was currently undertaken. Staff were under a high degree of pressure. There was no evidence of recent strategic input from the YJMB and partners to ensure that resources matched workload, nor to ensure that the YJT was resilient. Due to the loss of a previous seconded police officer,

and the time taken to replace him, the YJT was unable to deliver final warnings for much of 2008

(5) Staff often undertook work where they should be able to rely on other specialists, e.g. generating education re-integration packages or advocating for CAMHS appointments. There was no education specialist within the YJT, in spite of this being included in the Isle of Man Strategy for Children and Young People 2005-2010 (page 55) and being a recommendation of the Commission of Inquiry into the Care of Young People. Neither was there a specialist substance misuse worker within the team, who could support work at the lower tiers and cover gaps in partners' provision.

(6) Whilst a probation officer had been seconded to the YJT, who had an agreed job description, there was no service level agreement in place to support these arrangements. The seconded probation officer had the skills to, and sought to provide some peer social work based advice and supervision; however she was unable to deliver this effectively alongside her current workload.

(7) The work of the YJT was not well reflected in the strategies or the business plans of its partners. There were no shared targets identified relating to children and young people who had offended or were at risk of offending.

(8) Partners and staff were concerned at the high proportion of arrests and YJT cases that were for LAC. Published data showed that arrests and referrals of LAC continued to rise, even though those for the broader population showed a continued improvement. The proportion of YJT cases that were for LAC significantly exceeded that normally found in England and Wales.

(9) A lack of suitable information systems meant that the production of needs information was extremely difficult. A planned change of systems for social services, due for autumn 2009, had the potential to improve the situation, but only if additional facilities were commissioned specifically for the YJT. Whilst there was a stated intention to do this, there were no plans in place with costs and timescales to show how this could be achieved. The new system did not currently match the YJT's existing provision and if its needs were not delivered it would put the YJT in a significantly worse position. Existing systems necessarily involved some duplication. Whilst the YJT had sought to develop its use of Information Technology as best it could within the limitations of the available infrastructure, these were not fit for purpose.

(10) The importance of the victims' agenda was not yet embedded in Isle of Man criminal justice policy, and victim information was not always available to the YJT. Along with the lack of dedicated restorative justice resource within the YJT, it was therefore difficult for the YJT to incorporate direct restorative justice and reparation into its interventions.

1.3 General criterion:

Staff Supervision and Development - Positive outcomes for children and young people are enhanced by effective staff.

Strengths:

(1) The YJT Manager was extremely well regarded by both partners and staff. He was very committed to work with children and young people to divert them from, and prevent, offending. He had a 'can-do' attitude and had been instrumental in the significant development of the YJT since its inception.

(2) Case managers were also highly regarded by partners and by those with whom they worked. They displayed a high level of commitment to their work, took pride in its quality and continually sought to improve.

(3) All staff had received training on Safeguarding.

(4) Staff considered that their manager demonstrated a professional approach to management and modelled positive leadership behaviour.

(5) Case managers received formal supervision at least every six weeks. This was delivered according to a standardised, but comprehensive agenda that recognises the range of objectives of staff supervision.

Areas for improvement:

(1) Staff were concerned about the consequences of the promotion of the YJT Manager. Appropriate resolution of this was essential to the long term prospects for the YJT.

(2) Case managers were employed on a range of different conditions of service, with some more secure in their role than others.

(3) Staff expressed a mixed view as to how well their training and development needs had been met, and about the quality of their supervision. There had been no strategy, nor adequate resources, in place to ensure that YJT staff obtained qualifications specifically relevant to youth justice. The YJT Manager endeavoured to provide high quality supervision and support to staff; however his background meant that staff did not receive appropriate clinical supervision of their professional practice.

(4) The YJT did not have an agreed set of standards and procedures. Work was undertaken three years ago to develop these with an external consultant, however due to various problems these never became available for use and are now likely to be out of date. The seconded probation officer was required to work to Isle of Man Probation Service national standards, due to those sentenced after their 17th birthday being subject to the supervision of the probation service. Whilst these were neither designed for, nor entirely

suitable for work with children and young people, in the absence of agreed YJT standards there were no alternatives that the probation service could apply instead.

(5) Whilst staff recognised and sought to respond to individual need, they had not received recent common formal training to support them in ensuring a consistent approach that reflected best current practice, including addressing issues around ethnicity. Neither did the YJT have a diversity policy in place, although the need for this was alluded to in the Business Plan 2008/ 2009.

2. WORK IN COURTS

2.1 General criterion:

Good working relationships exist between the YJT and the courts.

The Juvenile Court normally met three times a month, dealing with children and young people up to their 17th birthday. Those aged 17 or 18 years were subject to adult sanctions and appeared in adult courts. On occasions children and young people also appeared in adult courts, when co-accused with adults, although they were normally sent back to the Juvenile Court for sentencing. More serious cases were dealt with by the Court of General Gaol Delivery.

The main court outcomes were probation orders (available for all ages), and supervision orders (available for those aged 17 and under).

A social worker, originally from the RAD team, was attached to the YJT to act as the court presentation officer.

Strengths:

(1) The YJT was pro-active in ensuring the courts understood the services that it delivered. It provided inputs into training events for magistrates.

(2) A Juvenile Court users group had met quarterly, chaired by an Assistant Director from DSS. It acted as a good two-way communication vehicle. On one occasion it had also looked at the outcomes from pre-court interventions.

(3) The users group received an annual presentation providing feedback on outcomes from statutory cases supervised by the YJT.

(4) There was a good and effective ongoing relationship between the Clerk to the Justices and the YJT.

(5) Court representatives stated that since the inception of the YJT it had become an asset to their work.

(6) YJT staff in the courts were described as approachable, sensible and reasonable; able to communicate effective with all parties and at all levels.

Areas for improvement:

(1) There was no mechanism in place by which the courts would receive regular feedback on the progress of orders that they had made.

(2) The users group was not resilient to the absence of key members and had recently fallen into abeyance.

2.2 General criterion:

Use of custody for remands and sentences should be minimised and stays on remand limited by exploring non custodial measures to secure compliance with Courts and addressing the likelihood of further offending.

Strengths:

(1) A member of YJT staff was present when remand to custody was considered, to advise the court. The YJT would actively seek to avoid custodial remands.

(2) When a child or young person was at risk of secure remand or sentence, the YJT sought to interview them and to ensure a full Asset assessment was undertaken, focusing particularly on their vulnerability.

(3) A protocol was in place between the YJT, ASCU, police and social services for dealing with remand issues.

(4) Little use was made of custodial sentences or remand for children and young people. The high regard that the courts had for the work of the YJT was instrumental in helping divert children and young people from custody.

(5) Evidence was provided of YJT staff arguing appropriately and strongly against the use of custody, and of them offering realistic proposals in which the courts had confidence. There was also evidence of challenging plans being recommended for supervision orders in order to avoid the use of custody.

(6) The YJT sought to offer voluntary support packages to those on bail, in the absence of formally recognised bail support arrangements.

Area for improvement:

(1) There was no formal bail support or more intensive intervention available for children or young people at risk of secure remand or sentence.

2.3 General criterion:

Courts are assisted in making informed, timely and effective decisions by the provision of good quality reports and appropriate information.

Strengths:

(1) Arrangements were in place to ensure that a YJT worker attended all Juvenile Court sittings. A worker also attended the adult court when a child or young person was present. At weekends a member of RAD team attended court.

(2) The YJT were informed about which children or young people were to appear in the Juvenile Court, so that YJT staff were prepared to provide any information that was needed.

(3) Representatives of the courts expressed great satisfaction with the quality of PSRs that they received. They also identified active engagement within the environs of the court between YJT workers, children and young people and their parents/ carers.

(4) All inspected PSRs made a clear proposal for sentence; in all cases for a community disposal. In all but one report the proposal was followed fully by the court. The congruence between proposal and disposal had increased considerably since the inception of the YJT. Published data indicated that recommendations in PSRs had been followed in excess of 90% of cases.

(5) Relevant evidence from Asset was used as the basis for all PSRs.

(6) Most PSRs were objective, impartial, and free from discriminatory language and stereotypes. Over three quarters were balanced, verified and factually accurate. Almost three quarters were suitably concise.

(7) The child or young person had always been interviewed for the purposes of the PSR. In all except one relevant case, a parent/ carer had also been interviewed.

(8) Diversity issues had been addressed sufficiently in over two thirds of reports.

(9) PSRs were fully explained to the child or young person, and in all but one had also been explained to their parent/ carer.

Areas for improvement:

(1) Almost two thirds of PSRs did not include a clear analysis of the offences, identifying the relevant factors in the offending, as distinct from a description.

(2) Less than half of the reports specifically considered the maturity of the child or young person with regards to their ability to understand the seriousness of the offence.

(3) The *Risk of Harm to others* was clearly differentiated from the LoR in only just over half of the reports.

(4) There was no formal process in place to ensure that PSRs were gate-kept prior to submission to court.

3. GATEKEEPING AND FINAL WARNINGS

3.1 General criterion:

Children and young people who come to notice receive appropriate action.

The YJT had delegated responsibility from the Isle of Man Constabulary to review the files of all children or young people who became known to the police and to decide what action should be taken (referred to here as gatekeeping). This applied to all offences other than serious or sexual offences, which were dealt with by the Attorney General. The decision of the YJT was final. The initiating police officer was informed of the outcome.

Gatekeeping was undertaken by a police officer seconded to the YJT for this purpose and confirmed by the YJT Manager (who was a Police Inspector).

Possible outcomes included prosecution, delivery of a final warning or reprimand, a minority report (reparation plus caution for minor offences), or referral to voluntary YJT or other diversionary projects. Where prosecution was recommended the case would then be forwarded to the Attorney General.

Strengths:

(1) The gatekeeping process focused on tackling offending-related behaviour at the lowest appropriate level and at the earliest stages of potential entry to the criminal justice system.

(2) This process was structured and supported a consistent approach to deciding outcomes for children and young people, wherever they lived on the island. It clearly focused on proportionality, equality and the diversion of children and young people away from the criminal justice system.

(3) A locally developed and comprehensive matrix was used to ensure that all relevant information was pulled together and then taken into account in determining the most appropriate outcome. Completion included checking the CareFirst social services database for children and young people and other relevant databases.

(4) Quality assurance of police files was undertaken to ensure that that they contained all appropriate information on which to make a decision, with referrals made back to the initiating police officer where further information was required.

(5) Once an outcome had been determined the matrix was returned to the originating officer, along with full details of the outcome.

(6) Our examination of a selection of files indicated that assessment had been thorough and decisions took into account all relevant circumstances.

(7) The Link project, focused on children or young people exhibiting anti-social behaviour or on the cusp of formal offences, in particular where drugs or alcohol were involved. It was a robust process seeking to ensure a consistency of approach and was well linked into the gatekeeping process. It was effective in diverting children and young people from offending.

(8) Positive outcomes were reported for individual children and young people. These included a child or young person who stopped offending and consequently was able to take up a career as an army officer following referral to a diversionary project to address his offending-related behaviour. Published data indicated that 61% of children and young people who had offended, but been dealt with by an intervention prior to a final warning had not reoffended.

(9) Statistics produced by the YJT indicated that only 10% of children and young people who received a minority report went on to commit further offences within two years.

Areas for improvement:

(1) Guidelines for the gatekeeping process had become out of date and were not sufficiently comprehensive, such that the process was dependant on the knowledge passed down between individuals.

(2) The current system only applied to children and young people up to their 17th birthday. It did not apply to 17 or 18 year olds.

3.2 General criterion:

Children and young people who receive final warnings are prevented from offending.

Final warnings as used in England and Wales did not exist in Isle of Man legislation. Rather the Isle of Man Constabulary delivered final reprimands to children and young people using the format of the final warning system. These were required to be delivered by a police officer seconded into the YJT.

No final warnings had been delivered by the YJT for the bulk of 2008 due to the lack of a key member of staff. Therefore inspectors were only able to assess those whose final warning programme commenced in January or February 2009, following recruitment of a replacement member of staff.

Strengths:

(1) All inspected cases received a timely Asset assessment, using the YJB final warning Asset tool. The assessment was always informed by contact with children's social care, at least one interview with the child or young person

and, where appropriate, at least one interview with the parent/ carer. Information had been received from the education provider in all but one case and the social care status was also clearly recorded in all but one case.

(2) Whilst the quality of the assessment varied, positive factors were always identified if they were present and all children or young people completed a *What do YOU think?* self-assessment.

(3) Race and ethnicity was always clearly recorded and diversity factors had been actively assessed in all except one case.

(4) Where health or substance misuse needs were present they were always identified in the Asset assessment. In both cases where the child or young person needed support to access local health services, that support was provided. In both cases where an emotional or mental health-related intervention was provided, it was assessed to be of sufficient quality.

(5) An intervention was delivered in all cases and at least one home visit was always carried out. The interventions were successful in challenging the child or young person to accept responsibility for their offending behaviour.

(6) Parents/ carers were made aware of the requirements of the interventions, and kept informed about progress.

(7) In none of the inspected cases had the child or young person committed a further offence since the start of the final warning programme. In five of the six cases this was a significant improvement on previous patterns of behaviour.

(8) In all cases the YJT worker had demonstrated commitment to the work, motivated and supported the child or young person and reinforced positive behaviour.

(9) There was a positive approach to the use of restorative justice.

Areas for improvement:

(1) The current arrangements for delivery lacked a clear structure as to how long the period could or should be before the actual warning was issued, and what finally triggered delivery of the warning. Therefore there was a risk that the delivery of the final warning was not timely with respect to admission of the offence. Where the warning had been delivered it was always outside the 20 working days that was required for final warnings in England and Wales.

(2) Neither was there clarity about the distinction between offence-focussed work (linked to the warning) and the need for welfare-based interventions, which could involve voluntary engagement or referral to other agencies.

(3) The copy of the final warning Asset in use lacked critical pages on *RoH* and vulnerability due to a printing oversight. This problem was addressed as soon as it was identified by inspectors. The case manager was also unaware of the

existence of RMPs and VMPs and these were not completed, although he was aware of risk and vulnerability issues and sought to manage these.

(4) In neither of the cases where emotional or mental health needs had been identified that would have benefitted from a formal mental health assessment, had a referral for this been made. In only one of these cases had a suitable intervention been delivered; although in this instance the intervention was of good quality.

(5) Four cases were of children and young people of statutory school age for whom education was a criminogenic factor. In only two of these had sufficient action been taken to re-integrate them into full-time education. In the other two cases the lack of appropriate provision was assessed as having had an impact on the quality of supervision that could be provided.

(6) Victim awareness work had been undertaken in only one of the six cases.

4. WORK WITH CHILDREN AND YOUNG PEOPLE WHO HAVE OFFENDED

4.1 General criterion:

Children and young people who have offended are prevented from reoffending.

Community orders for children and young people aged up to 16 years of age were required to be supervised by a social worker. Once children and young people reached their 17th birthday they were subject to adult sanctions and community orders had to be supervised by a probation officer. By agreement between the YJT and the Isle of Man Probation Service, a probation officer has been seconded into the YJT to deliver these orders.

Strengths:

(1) All cases had an initial Asset, almost all having been completed on time. All were informed by at least one interview with the child or young person and by contact with children's social care. Almost three quarters of Assets had also been informed by contact with the education or training provider, by interviewing the parent/ carer (in applicable cases) and almost half by other relevant assessments. Race and ethnicity was clearly recorded in all cases.

(2) Where positive factors had been identified, these had then been reflected in the assessment in almost all cases.

(3) Over two thirds of Assets were of sufficient quality. However they were not routinely updated post-sentence to reflect the child or young person's response to their sentence.

(4) Diversity issues or other potentially discriminating factors or individual needs had been accurately identified in all cases where these had been actively assessed and in all except one of these suitable arrangements had been made to minimise their impact. However, the assessment had been active (i.e. looking for issues that may be hidden) in only just over half of all cases. Attention had been given to the methods likely to be most effective with the child or young person in three quarters of cases.

(5) The screening of indicators of *RoH* was accurate in almost all cases. The RoSH classification was correct in all cases where an Asset RoSH assessment had been completed, and all but one of these assessments had been completed to a sufficient standard. All except one had covered victim issues thoroughly.

(6) Timely and purposeful home visits were carried out, repeated as necessary, in

almost all cases.

(7) Initial intervention plans had been completed within the appropriate timescale, clearly outlined who would deliver the interventions and had been seen and signed by the child or young person. When interviewing children and young people, inspectors were impressed with how well they had understood their plans and the work that was being done with them. The planned interventions were likely to address LoR in three quarters of cases.

(8) Progress against the objectives in the plan had been reviewed regularly in almost all cases; however this was often not informed by a review of Asset, which was normally reviewed every six months.

(9) Constructive interventions had successfully challenged the child or young person to accept responsibility for their offending behaviour in three quarters of cases. Workers also responded to changes in *RoH*-related behaviour with increases in restrictive interventions.

(10) Sufficient steps were taken to ensure that the child or young person fully understood the requirements of the order and the penalties should it be breached. In all except one case the first appointment was timely. The frequency of appointments then met any *RoH* or Safeguarding considerations, and supported the achievement of intervention plan objectives in most cases.

(11) Effective action was taken to ensure compliance in all cases, where this had been required. The child or young person had complied with the requirements of the order in almost all cases. Judgements about the acceptability of absences were consistent and appropriate. In both cases where breach action was required, it was processed in a timely manner.

(12) YJT workers motivated and supported the child or young person throughout their sentence and in almost all cases there was evidence of positive behaviour that been reinforced.

(13) Parents/ carers were made aware of the requirements of interventions being undertaken by their children and young people. They were then kept informed of progress in all except one relevant case.

(14) In both cases where a child or young person moved away from the Isle of Man there was good liaison and information sharing with the receiving YOT in England, including in one case a visit to the English YOT to ensure that staff fully understood the issues.

(15) In over a third of those cases where Asset had been rescored it had shown an improvement over the initial score. Progress had been made in over 40% of the offending-related factors identified as the highest priority, with only one showing deterioration.

(16) In over half of the cases, there was evidence that the learning outcomes or skills had been applied by the child or young person and there had been a positive demonstrable change in their behaviour.

(17) Partners and political representatives stated that the YJT was effective in reducing reoffending, pointing to a reduction in crimes committed by children and young people as evidence for this. Published data showed that 47.8% of children and young people had not reoffended following their first community penalty.

(18) Reductions in recidivism rates had improved steadily for the previous four years.

Areas for improvement:

(1) Only half of children and young people had been invited to complete a *What do YOU think?* self-assessment.

(2) An Asset RoSH assessment was completed in only half of those cases where it was needed. In two out of five cases where a RMP was then required, one had not been completed. In no cases did inspectors consider that the RMP was sufficiently comprehensive. When inspectors explained their reasons for assessing that RoSH assessments should have been done, or RMPs were of insufficient quality, these explanations were understood and accepted by case managers, who were keen to improve these aspects of their practice.

(3) Less than a quarter of initial intervention plans included outcome-oriented objectives. Less than a third had been signed by the parent/ carer and in less than half were the objectives clearly sequenced. Less than half of relevant plans included promotion of victim awareness, and just over half of relevant plans included an intervention likely to promote community re-integration.

(4) The *Risk of Harm to others* had not been reviewed within three months of the initial Asset in almost three quarters of cases, although in most of these there had been a subsequent review. The *Risk of Harm to others* had not been immediately reviewed following a significant change in half of those cases where this was required, although case managers had undertaken other relevant actions in response to the change.

(5) Insufficient priority had been given by workers to victim safety in the five cases where this was relevant. There was a positive change in victim awareness in only just over a third of cases.

4.2 General criterion:

The health of children and young people who have offended is promoted by the work of the YJT.

Strengths:

(1) A seconded health worker for LAC and the YJT was located within the YJT.

(2) All children and young people received a health assessment from the seconded health worker.

(3) Substance misuse needs were identified on Asset in all cases where these were present, and emotional or mental health needs in all except one case. An approved mental health screening was then completed in three of the four relevant cases.

(4) There was good joint work and information sharing with the DASH substance misuse and JARS alcohol services. Where external drug or alcohol services had been used these were rated as sufficient in all except one case.

(5) In two of the three cases where external psychological or psychiatric services had been used in the course of supervision, these were assessed as sufficient.

(6) In three of the four cases where broader health or leisure services had been used these were also assessed as sufficient.

Areas for improvement:

(1) In some cases the health assessment undertaken with children and young people was used primarily as an information gathering exercise, with insufficient active response to support children and young people in overcoming barriers to healthcare. An example we noted was of a child or young person who was not registered with a general practitioner; they were told they needed to do this, but not given active support to do so.

(2) The role of the seconded health worker was not well integrated with that of case holders to ensure that it provided active support to and engagement in case management. Neither was there active joint working for children and young people who also had substance misuse needs.

(3) Over half of the inspected cases included some form of disability. Almost all of these had some form of learning disability. There was no mechanism by which a specialist assessment could be undertaken of 17 year olds with apparent dyslexia and literacy or numeracy issues, in order to ensure that interventions were delivered in a way that was appropriate to their needs.

(4) Local health services had provided required services in relation to mental or emotional health in only just over half of cases where a need had been identified on Asset; although in most cases where services had not been received a referral had not clearly been made. For example, in one case of a LAC a gap in service provision meant that an up-to-date CAMHS assessment was not available to the YJT.

(5) The DASH service delivered substance misuse interventions, but only operated during the working day. Therefore children or young people who became employed were no longer able to access this intervention.

(6) There was a lack of advice and support available regarding substance and alcohol misuse at a Tier 1 (diversionary) level.

4.3 General criterion:

Children and young people who have offended are Safeguarded, supported and assisted through the work of the YJT.

Strengths:

(1) The status of the child or young person had been checked with children's social care in all cases, although it was not always clear whether this was with reference to the current order. The social care status of the child or young person was clearly recorded in all cases.

(2) The YJT worker had sought to liaise with children's social care in all cases where this was required. Children's social care had then been actively involved during supervision in six cases.

(3) A formal referral had been made to children's social care in both cases where this had been required.

(4) Three quarters of initial intervention plans included interventions that were likely to help the child or young person Stay Safe.

(5) There were six cases where action was required to address accommodation needs. This was undertaken in all cases. The YJT continued to monitor needs throughout the course of the order. In four of these cases the provision had improved.

(6) When a VMP had been produced, its content met the assessed need in all except one case.

(7) There was a reduction in factors linked to Safeguarding in half of the cases where there were issues.

Areas for improvement:

(1) One third of inspected cases were for LAC. This was significantly in excess of the proportion typically found in England and Wales. Published data showed that the proportion of LAC cases continued to rise. Whilst more recent internal data indicated an improvement in this trend, it was too early to indicate whether this improvement had become embedded.

(2) Effective joint work with social workers, in particular in cases of LAC, had been achieved in only half of the cases where this was required. Whilst YJT staff were active in seeking to engage social workers, this appeared to be a one way process. YJT files did not usually include a copy of the LAC care plan as evidence of joint working and objectives.

(3) Threshold criteria for acceptance of referrals by social services were not clearly understood by YJT staff. There was frustration from case managers who believed that valid referrals, particularly for children or young people who were not currently Looked After, did not always receive the service they needed, possibly due to workload pressures on the RAD team.

(4) Safeguarding documentation seen by the inspection team failed to highlight the links between LoR and RoSH and the need for input from other agencies.

(5) In neither of the cases where formal referral had been made to children's social care, was effective joint working then achieved within reasonable timescales nor appropriate to the needs of the case.

(6) There was evidence that children or young people were, or had been, a risk to themselves in almost three quarters of cases. In most cases this was due to reckless behaviour or substance misuse. In almost half of the cases there was evidence that the child or young person was, or had been in the past, at risk from others. A VMP had then been produced in less than half of those cases where one was required.

(7) There was a lack of suitable options available to address accommodation needs when these were an issue related to LoR or RoSH. Inspectors found no risk assessment of placements and, in one example, the LoR was increased by the placement provided, due to multiple occupancy with adult offenders. The situation was exacerbated by a reliance on unregulated bed and breakfast accommodation that became unavailable during the annual TT motorcycle races.

4.4 General criterion:

Children and young people who have offended are enabled and encouraged to achieve their potential.

Strengths:

(1) The YJT had taken action to seek to re-integrate into full-time education three inspected cases where the child or young person had extended absence from their mainstream school; this included pro-active work with the school to help ensure that appropriate education provision remained available to the child or young person, although the response that the YJT received did not always suit the needs of the case.

(2) Where employment services had been used with children or young people they were assessed as sufficient in both cases.

Areas for improvement:

(1) Most inspected cases for children and young people of statutory school age included evidence of educational needs, however few had received an onward referral. There was a belief that there was nowhere where referrals could be made, where problems would then be addressed; and reports of very different approaches to this situation from different schools and education liaison officers. In two cases where attempts had been made to seek support, the response was assessed by inspectors as poor and in one as insufficient.

(2) Problems identified included a perception that once a child or young person had become detached from full-time education for behavioural reasons it was then very difficult for them to return to it. In one example a child or young person had found a vocational placement, but there had been no apparent consideration to what would happen if that placement broke down, which there was a risk of due to the violent nature of the offending. In another, work was to be provided at home by the care provider, but there was no evidence that this was delivered.

(3) YJT published data showed that 36.7% of children and young people under statutory supervision were not in full-time ETE. A detailed examination of the caseload showed that this masked a concern for children and young people of statutory school age. Of these a significant proportion were not in active (i.e. attending) receipt of full-time provision. Within the inspection sample the proportion of those of statutory school age not in full-time ETE significantly exceeded that normally found in England and Wales. In three cases ETE issues were assessed as being directly linked to their *Risk of Harm to others*.

(4) There were only limited jobs or college provision for training for children and young people who had left school but had no qualifications. The careers service was stretched when trying to work with this client group, although there was evidence of positive engagement with case managers to seek to provide support.

4.5 General criterion:

Outcomes for children and young people are improved by their involvement through consultation about the service provided by the YJT.

Strength:

(1) Evidence from children and young people indicated an impressive level of engagement between them and their case workers, with clear understanding and involvement in the planning for the delivery of their orders.

Area for improvement:

(1) Exit questionnaires or other form of user engagement, outside of normal case management, were not currently in place to improve services.

5. REVIEW OF ARRANGEMENTS FOR CHILDREN AND YOUNG PEOPLE SENTENCED TO THE SECURE UNIT

5.1 General criterion:

The Likelihood of Reoffending for children and young people who are received into the secure unit is minimised through the intervention of the YJT and liaison with secure unit staff throughout the custodial period and through re-integration into the community.

Children and young people up to the age of 16 remanded or sentenced to custody were placed in the ASCU. This was run by an independent provider (St Christopher's) on behalf of the DSS. It received children and young people from both criminal justice and welfare routes.

The YJT had no statutory responsibility to work with, address the offending behaviour of, nor manage the *Risk of Harm to others* of children and young people placed in the ASCU. Instead a protocol had been agreed between the YJT and the ASCU that described services the YJT would provide, in order to ensure that its expertise was used effectively in meeting the needs of the child or young person.

Children and young people placed in the ASCU automatically received LAC status. On release the case was transferred back to the RAD team in the DSS.

The average time spent by convicted children and young people in the ASCU was under 30 days.

Children and young people aged 17 plus were subject to adult sanctions, and if sentenced to custody were placed in the Isle of Man prison and subject to probation service supervision. However discussions were ongoing about the possibility of holding them in the ASCU instead.

Key provisions of the protocol between the YJT and ASCU relating to the criminal justice route:

- An Asset and post-court report must be forwarded to the ASCU. Where there was no previous Asset the ASCU would treat the child or young person as vulnerable until this was completed.
- A YJT worker would assess the needs of the child or young person, producing a remand information report. This either facilitated a bail application or informed a remand planning meeting.
- Remand planning meetings should include relevant workers and management from ASCU and YJT, the parents/ carers and others as appropriate.

- The child or young person should be visited at least twice per week by their YJT case worker or other approved agent.
- If a remanded child or young person was subsequently convicted there must a meeting between the PSR writer and ASCU staff in order that the PSR reflected progress made during the remand period.
- All provisions continued to apply during any subsequent custodial sentence.

Strengths:

(1) The ASCU was well maintained and in pleasant surroundings. An appropriate level of challenge by staff was observed, to address the behaviour of children and young people.

(2) Good working relationships existed between the YJT and ASCU at both management and operational levels.

(3) The YJT was pro-active in driving developments in services for children and young people placed in the ASCU from the criminal justice route.

(4) Allocated YJT workers contributed actively to planning for the child or young person, including Asset and RoSH assessment.

(5) A health assessment of the child or young person was undertaken by the seconded health worker within seven days of receipt into the unit.

(6) Good progress had been made in developing educational provision for children and young people in the ASCU. This was funded by the DSS

(7) On preparation for release the worker sought to agree a voluntary re-integration package with the child or young person.

(8) On release the YJT sought to continue to work with the child or young person to support their resettlement on a purely voluntary basis.

Areas for improvement:

(1) There was no statutory responsibility for the YJT to work with children and young people sentenced to the ASCU to ensure that their offending-related needs were assessed and addressed, nor that their *Risk of Harm to others* was assessed and managed whilst they were in custody.

(2) Following release from the ASCU children and young people were not subject to licence or continuing supervision. Therefore, unless they chose to engage voluntarily, there was no opportunity for the YJT to ensure that *Risk of Harm to others* continued to be assessed and managed for those children and young people who would typically present the greatest *Risk of Harm to others*. Neither was there the opportunity to ensure that offending-related behaviour continued to be addressed following release, nor improvements in behaviour reinforced.

(3) An analysis of reoffending completed for 2006/ 2007 showed that all children and young people who had been sentenced to the ASCU had reoffended.

(4) Due to difficulties in accessing prior information, education provision in the ASCU was rarely informed by prior history or achievement. There was a belief amongst staff that once a child or young person left the ASCU they were unlikely to be re-integrated back into mainstream statutory provision.

Appendix 1: Contextual information

Isle of Man

The Isle of Man is a Crown Dependency of the United Kingdom, located in the Irish Sea mid-way between the British mainland and Ireland.

It has its own parliament, Tynwald, which has full responsibility for creating its own domestic legislation.

The capital is Douglas, which is the most densely populated area of the island. Adjacent to Douglas is the Eastern Neighbourhood, also densely populated, which largely provides suburban accommodation for Douglas. The remaining five neighbourhoods cover smaller towns, parishes and rural areas with significantly smaller populations.

The resident population, as measured in the 2006 census, was 80,058. It increased by 4.9% since the previous census in 2001. 49.4% of the population was male. There were 6,961 (8.7%) children and young people aged 10 to 16 and 1,956 (2.4%) aged 17 or 18 years old. In both cases the percentage was falling relative to the adult population.

Ethnicity information was gathered by nationality and place of birth. 47.6% of the population were Manx born, 44.2% British born and 4.1% born elsewhere in Europe. The largest non-European populations were Asian (1.6%) and African (1.4%).

Youth Justice Team

The YJT was formed in 2004 as a voluntary partnership primarily between the DHA, social services, police and probation, in response to the emerging Youth Justice developments on the Isle of Man. It aimed to provide a centralised resource to partner agencies for work with children and young people who had offended or were at risk of offending, initially up to the age of 17 years.

At the time of the inspection it had nine staff, of who six were male and three female. The staff consisted of a police inspector who was the team manager, a seconded probation officer, two social workers, one court officer, two seconded police officers, a seconded health worker and an administration manager.

Located in Douglas, the YJT served the whole of the Isle of Man.

Appendix 2: Inspection data

Fieldwork for this inspection was undertaken in April and June 2009.

The inspection consisted of:

- evidence in advance
- examination of practice in a sample of cases, normally in conjunction with the case manager, as follows:
  - six final warning reprimands
  - 19 community sentences.
- interviews and questionnaire responses from children and young people, and parents/ carers.
- examination of the file management procedure, delegated by the Isle of Man Constabulary, in conjunction with the YJT Manager and a YJT police officer
- review of arrangements for children and young people who had been remanded or sentenced to the secure unit
- meetings with staff, managers and partners.

Appendix 3: Glossary

ASCU	Adolescent Secure Care Unit
Asset	A structured assessment tool based on research and developed by the Youth Justice Board looking at the young person's offence, personal circumstances, attitudes and beliefs which have contributed to their offending behaviour
CAMHS	Child and Adolescent Mental Health Services: provides specialist mental health and behavioural services to children and young people up to at least 16 years of age
DASH	Drug Advice Service and Helpline
DHA	Department of Home Affairs
DoE	Department of Education
DSS	Department of Social Services
ETE	Employment, training and education: work to improve an individual's learning, and to increase their employment prospects
HM	Her Majesty's
HMI Probation	HM Inspectorate of Probation
Isle of Man Safeguarding Children Board	Isle of Man Safeguarding Children Board was set up to coordinate and ensure the effectiveness of the multi-agency work to Safeguard and promote the welfare of children and young people
JARS	Juvenile Alcohol Referral Scheme
LAC	Looked After Child(ren)
LoR	Likelihood of Reoffending
MAPPA	Multi-Agency Public Protection Arrangements: where probation, police and other agencies work together locally to manage offenders who pose a higher *Risk of Harm to others*
PSR	Pre-sentence report for a court
RAD	Referral, Advice and Duty team in the Department of Social Services
RMP	Risk management plan: A plan to minimise the individual's *RoH*
RoH	*Risk of Harm*
'*RoH* work' or '*Risk of Harm* work'	This is the term generally used by HMI Probation to describe work to protect the public, primarily using restrictive interventions, to keep to a minimum the individual's opportunity to behave in a way that is a *Risk of Harm to others*
SIFA	Screening Interview for Adolescents (Youth Justice Board approved mental health screening tool for specialist workers)
VMP	Vulnerability management plan. A plan to Safeguard the well-being of the individual under supervision
YJB	Youth Justice Board for England and Wales
YJMB	Youth Justice Management Board
YJT	Youth Justice Team
YOT	Youth Offending Team

Appendix 4: Role of HMI Probation and code of practice

HMI Probation is an independent Inspectorate, funded by the Ministry of Justice and reporting directly to the Secretary of State. Our purpose is to:

(1) report to the Secretary of State on the effectiveness of work with individual offenders, children and young people aimed at reducing reoffending and protecting the public, whoever undertakes this work under the auspices of the National Offender Management Service or the Youth Justice Board

(2) report on the effectiveness of the arrangements for this work, working with other Inspectorates as necessary

(3) contribute to improved performance by the organisations whose work we inspect

(4) contribute to sound policy and effective service delivery, especially in public protection, by providing advice and disseminating good practice, based on inspection findings, to Ministers, officials, managers and practitioners

(5) promote actively race equality and wider diversity issues, especially in the organisations whose work we inspect

(6) contribute to the overall effectiveness of the criminal justice system, particularly through joint work with other inspectorates.

HMI Probation aims to achieve its purpose and to meet the Government's principles for inspection in the public sector by:

(1) working in an honest, professional, fair and polite way

(2) reporting and publishing inspection findings and recommendations for improvement in good time and to a good standard

(3) promoting race equality and wider attention to diversity in all aspects of our work, including within our own employment practices and organisational processes

(4) for the organisations whose work we are inspecting, keeping to a minimum the amount of extra work arising as a result of the inspection process.

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
2nd Floor, Ashley House
2 Monck Street
London, SW1P 2BQ

http://www.justice.gov.uk/inspectorates/hmi-probation