



JSNA Factsheet: Community Offender Health

October 2015

Tower Hamlets Joint Strategic Needs Assessment 2015/2016

Executive Summary

Offenders managed by probation are a vulnerable group who are likely to experience health inequalities. This population is more likely to experience mental health problems, drug and alcohol misuse, homelessness, debt and increased physical morbidity than the general population.

Improving the health of this population is a responsibility of the probation agencies, as well as NHS and Local Authority, since improved physical and mental health outcomes have been shown to reduce rates of reoffending, increasing community cohesion and safety.

Recommendations

This JSNA make recommendations in the following areas in order to achieve this goal:

- Increasing access of offenders to mental health support which addresses the specific mental health needs of this population
- Systematic health data monitoring and service evaluation using outcomes appropriate to a population with multiple and complex needs
- Consideration of innovative ways of increasing current housing support
- Consideration of the specific needs of young adult offender population
- Improving coordination and partnership working through the creation of an Offender Health Monitoring and Strategy Forum

1. Who is an offender?

The term 'offender' refers to an individual who is convicted in a court of law as having committed a crime, violated a law, or transgressed a code of conduct. There is a distinction made between community offenders and those accommodated in prison. This JSNA factsheet outlines the health needs of community offenders managed by probation services in Tower Hamlets.

Why is it a public health issue?

Evidence illustrates that as a group, offenders and their families represent one of society's most socially excluded groups, and suffer from multiple and complex health issues, including mental and physical health problems, learning difficulties, substance misuse and increased risk of premature mortality. These underlying health issues are often exacerbated by difficulties in accessing the requisite services to help to meet their needs.¹

Key facts:

Offenders are drawn from the most disadvantaged sections of society

- Homelessness: 15 % of the prison population report pre-imprisonment homelessness (including rough sleeping and temporary accommodation in hostels), compared to 4 % of the general population². 49% of prisoners with mental health problems had no fixed address on leaving prison.³
- Many offenders have a poor tenancy history and appear to be treated less favourably as a group by many housing providers⁴, despite Housing Corporation regulation and changes brought about in the Homelessness Act 2002, which prohibit 'blanket' exclusions of particular groups.
- Not only can homelessness and offending become a vicious circle, but there is evidence to suggest that homelessness increases the severity with which offenders are dealt with within courts. Lack of housing can make it more unlikely that a defendant will be bailed and more likely that they will receive a custodial sentence
- Low educational attainment: National studies have found rates of 49% of newly sentenced prisoners, and 13% who have never worked.⁵ 80% of prisoners have the writing skills, and 65% the numeracy skills, of an 11 year old.⁶
- Debt: 50% of newly sentenced short term prisoners suffer from debt, and evidence suggests this worsen while in custody⁷

¹ Department of Health, 2007: Improving Health – Supporting Justice – A Consultation Document

² Williams, K., Poyser, J., & Hopkins, K. (2012) Accommodation, homelessness and reoffending of prisoners: Results from the Surveying Prisoner Crime Reduction (SPCR) survey. London: Ministry of Justice

³ Revolving Doors Agency (2002) Where Do They Go? Housing, Mental Health and Leaving Prison, London: Revolving Doors Agency

⁴ 'Reducing Re-offending – Applying for a Home' CIU (2006) unpublished

⁵ Stewart, D. (2008) The problems and needs of newly sentenced prisoners: results from a national survey, Ministry of Justice Research Series 16/08. London: Ministry of Justice

⁶ Social Exclusion Unit (SEU) (2002) Reducing Reoffending by Ex-prisoners. London: Office of the Deputy Prime Minister

⁷ SEU (2002) Op cit

Social Characteristics of Prison vs general population

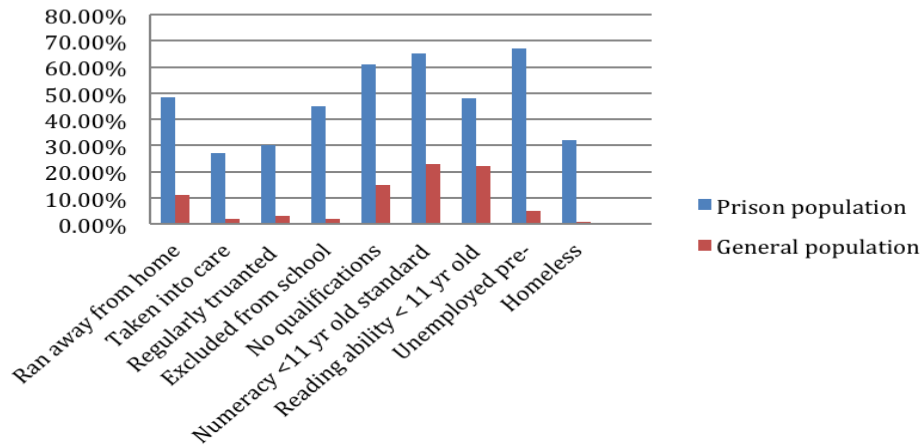


Table 3: Social characteristics of prisoners versus the general population

Disadvantage starts early in childhood and is cumulative over generations

- Over a third of prisoners have a family member who has been convicted of a criminal offence.
- One in eight children in prison had experienced the death of a parent or sibling. 76% had an absent father, 33% an absent mother. 39% had been on the child protection register or had experienced neglect or abuse.⁸

Mental Health

- Over 90% of prisoners have a mental health problem, substance misuse, or both.⁹
- More than 70% of the prison population have 2 or more mental health disorders¹⁰
- 72% of prisoners with mental illness have concurrent substance misuse problem¹¹,
- In addition to higher prevalence of all mental health disorders compared to the general population the types of mental health disorder that most commonly affect offenders are different to those most common in the general population; levels personality disorder, depression and anxiety are disproportionately among offenders

⁸ Jacobson J. et al (2010) Punishing Disadvantage: a profile of children in custody, London: Prison Reform Trust

⁹ Singleton N, Meltzer H and Gatward R (1998) Psychiatric morbidity among prisoners in England and Wales (Office for National Statistics). London: ONS

¹⁰ ibid

¹¹ The Offender Health Research Network (2009) A National Evaluation of Prison Mental Health In-Reach Services, Manchester: University of Manchester

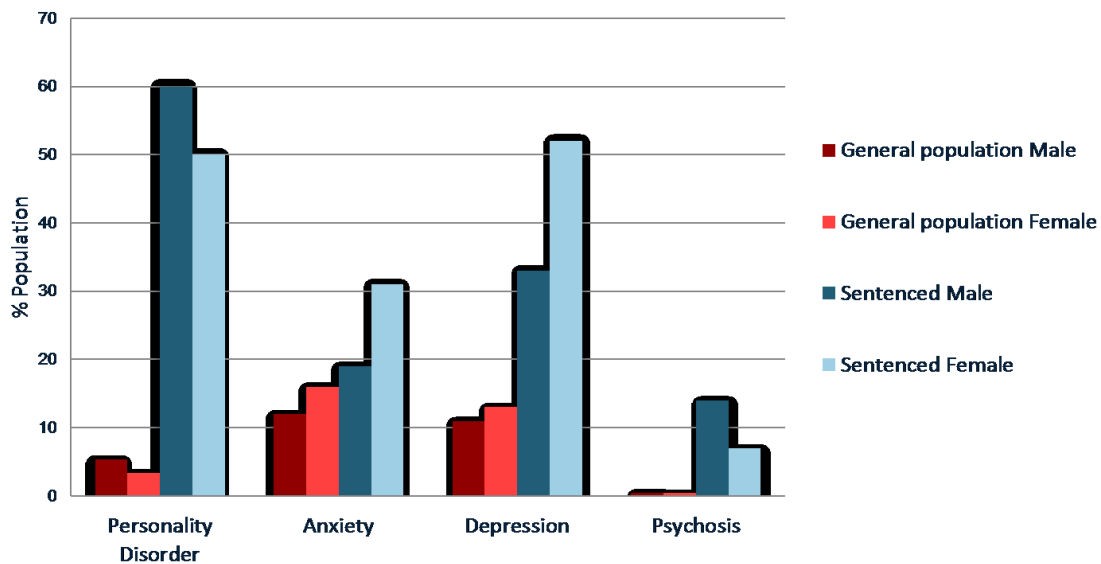


Table 1: Mental Health of sentenced prisoners versus general population¹²

Physical Health

Poor physical health can perpetuate a cycle of disadvantage: 13% of newly sentenced prisoners reported being unable to work because of long-term sickness or disability.¹³

Offenders experience worse health outcomes for a variety of reasons. Firstly, it is well documented that offenders come from more disadvantaged backgrounds than the general population. The Marmot review¹⁴ highlighted the impact of wider social determinants and inequality on health outcomes. Secondly, high incidence of mental health issues among prisoners has an impact on physical health.¹⁵ Thirdly, offenders are less likely to have access to health care than the general population; studies show up to 40% of prisoners declare no contact with primary care prior to detention.¹⁶ Knowledge about local health services and the ability to register with a GP relies on secure, permanent living arrangements, which many offenders lack.

As is the case for other socially excluded populations, it is likely that offenders have less access to preventative health services, such as screenings, and health promotion measures, and are more likely to smoke, drink hazardous quantities and take drugs.¹⁷

¹² Singleton N, Meltzer H and Gatward R (1998) Psychiatric morbidity among prisoners in England and Wales (Office for National Statistics). London: ONS

¹³ Stewart, D (2008) *The problems and needs of newly sentenced prisoners: results from a national survey*, Ministry of Justice Research. Series 16/08

¹⁴ Marmot, M (2010). Fair Society, Healthy Lives. The Marmot Review

¹⁵ The Royal College of Psychiatrists published in 2010 a paper on public mental health, No Health Without Public Mental Health. This included a summary of the research evidence demonstrating the links between mental health and physical health. Depression is associated with 67% increased mortality from cardiovascular disease, 50% increased mortality from cancer, two-fold increased mortality from respiratory disease and three-fold increased mortality from metabolic disease. People with psychotic disorders die an average 25 years earlier than the general population, largely because of physical health problems. Schizophrenia is associated increased death rates from cardiovascular disease (two-fold), respiratory disease (three-fold) and infectious disease (four-fold).

¹⁶ The North East Public Health Observatory (2011) *The Social Care Needs of Short-Sentence Prisoners*. Accessed at: <http://www.nepho.org.uk/topics/Offender%20health>

¹⁷ Centre for Mental health, 2006: CJS and Public health

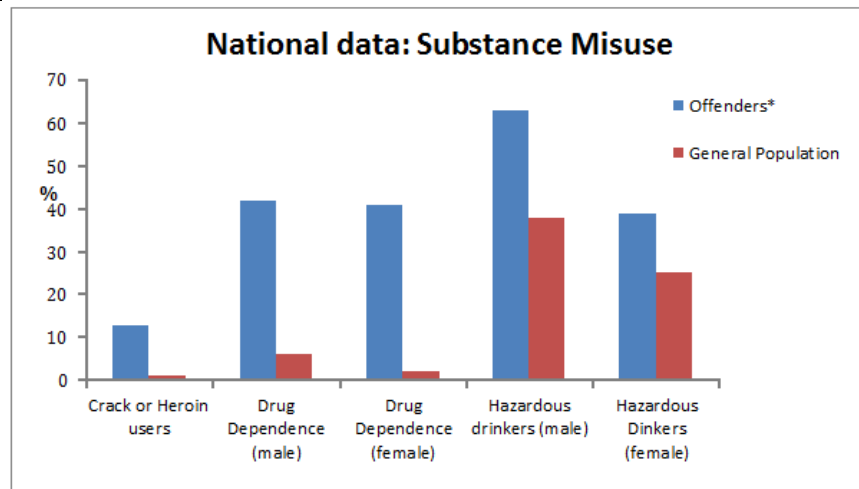


Table 2: National Data: Prevalence of Substance misuse for offenders at sentencing^{18,19}

Offending has a wide range of personal, social and economic impacts which continue to affect individuals throughout their lives. The Department of Health²⁰ emphasizes that being a member of a risk group (such as offenders, asylum seekers and refugees) can increase the impact of poverty, deprivation, exclusion, isolation or low status on mental illness. In effect offenders are part of an already socially excluded group which is at risk of further exclusion, and in turn increased risk if re-offending and poor health outcomes.

Offenders are drawn from the most disadvantaged segments of society, and their health compares highly unfavourably, not just with the general population, but with social class five within the general population.²¹ Due to this high level of health needs and disproportionately low level of service access, there is a pressing need for healthcare for probationers to be commissioned locally with an in-depth understanding of needs and with a view to removing current barriers to service access for this population.

Since the enactment of the Health and Social Care Act in 2013, NHS England assumed responsibility for commissioning healthcare for offenders within custodial settings, including services within police custody, the courts, prisons and the secure estate.

Healthcare delivered in prisons can have a significant impact on improving health and wellbeing in the wider community. However, the vast majority of custodial sentences are for relatively short periods of time offering only limited opportunity to engage with prison-based health services.

Thus it is important that offenders are able to access adequate health and social care in the community. This is a responsibility shared by multiple partners locally:

¹⁸ <http://www.ukdpc.org.uk/wp-content/uploads/Policy%20report%20%20Reducing%20drug%20use,%20reducing%20reoffending%20%28summary%29.pdf>

¹⁹ Brooker, C (2008) The health needs of offenders on probation caseloads in Nottinghamshire and Derbyshire. Lincoln: Centre for clinical and academic workforce innovation, University of Lincoln

²⁰ Department of Health (2001) Making it happen: a guide to delivering mental health promotion

²¹ Brooker C., Syson-Nibbs L., Barrett P. & Fox C. (2009) Community managed offenders' access to healthcare services: report of a pilot study. *Probation Journal* 56, 45–59.

- Clinical Commissioning Groups (CCGs) have responsibility for commissioning a large proportion of local healthcare services for the whole community
- Probation services have a responsibility for offender rehabilitation
- Local authorities have a responsibility for promoting community safety and reducing reoffending
- Directors of Public Health have specific duties to monitor and improve the health of offenders as part of their remit to reduce health inequalities.

2. Policy Context

The Offender Rehabilitation Act and Probation Service Reforms (2014)

Previously, the offender population was divided into Statutory Offenders, and Non-Statutory Offenders. Non-statutory Offenders (those receiving custodial sentence of less than 12 months) received no post-release supervision, despite being the group most likely to reoffend. The changes the ORA made mean that any offender whose offence was committed on or after 1 February 2015, and who is sentenced to a custodial term of more than 1 day, will in the future receive at least 12 months of supervision after release. As a result, from 1 February, there has been a gradual build-up of eligible offenders being supervised.

The **Offender Rehabilitation Act**²² also made a number of changes to the sentencing and release framework set out in the Criminal Justice Act 2003, including expanded drug testing powers for offenders released from custody and the creation of a new rehabilitation activity requirement that can be imposed on offenders serving sentences in the community.

Transforming Rehabilitation: A Strategy for Reform²³ replaced the previous 35 individual Probation Trusts with a single National Probation Service (NPS), responsible for the management of high-risk offenders; and 21 Community Rehabilitation Companies (CRCs) responsible for the management of low to medium risk offenders in their Contract Package Area. The CRCs have responsibility for supervising short-sentence prisoners (those sentenced to less than 12 months in prison) after release. From April 2015 CRC contracts were awarded by the Ministry of Justice to successful bidders, as part of their plan to open up the market to a diverse range of rehabilitation providers from the private, voluntary and social sectors. Furthermore, these providers will be paid by results for delivering reductions in reoffending. The NPS will retain responsibility for the supervision of high-risk offenders, including those subject to Multi-Agency Public Protection Arrangements (MAPPA).

Health and Social Care Act (2012)

The Health and Social Care Act introduced major changes to health and social care commissioning. In the new system, CCGs are responsible for commissioning community health services for offenders, and mental health services including assessment at arrests and advice at court, and interventions as part of the Mental Health Treatment Requirement (one of 12 community sentencing options).

Health service for offenders completing custodial sentences are commissioned by the ten area teams of the NHS

²² Available at <http://services.parliament.uk/bills/2013-14/offenderrehabilitation.html>

²³ Ministry of Justice (2013) Transforming Rehabilitation: A Strategy for Reform. London: The Stationary Office

Commissioning Board (NHS CB), in addition to primary care, and mental health interventions provided under the GP contract. Local Authorities have responsibility for public health and the commissioning of drug and alcohol services, tobacco control activity, accommodation and social care services and mental health promotion. Furthermore, the Act set out the statutory duty of the Health and Wellbeing Board to ensure the JSNA considers the needs of the whole population, and lists offenders as one group who experience multiple and complex needs.

Commissioning Changes: NHS England: New operating model for the commissioning of offender health care²⁴ established NHS England, as a single direct commissioner of Liaison and Diversion services, with a growing responsibility for commissioning offender healthcare in police stations and the court system alongside its role as primary care commissioner.

Reducing Re-offending through Skills and Employment: Next steps²⁵ : follows the green paper of the previous year in focusing on early educational problems and truancy, leading to low skill levels, unemployment and family problems. Using the data from the Social Exclusion Unit report it argues that limited options often result in a cycle of offending, imprisonment and reconviction. Moreover, outcomes for the children of offenders are generally poor and the process begins again. Directing education and training programmes toward vocational need as identified by local employers is encouraged by the introduction of the 'campus model' while the establishment of 'Job Developers' to encourage and offer support to prospective employers is announced.

Lord Bradley's review²⁶ was an independent review of the treatment of offenders with mental health issues or learning difficulties in the criminal justice system. The report highlighted the importance of an "all stage diversion" approach- setting out a national model of liaison and diversion people with mental health problems or learning disabilities away from prison to other services and appropriate mental health care. The report emphasized the importance of partnership working, and the need to improve continuity and consistency of support through user involvement, information sharing and multiagency collaboration. Furthermore, the report went beyond mental health to emphasise the importance of developing pathways for a range of vulnerabilities. It recognized the complex and multiple needs of offenders which made it particularly difficult for such people to engage with services, or for services to engage with them. This is because services are often mono-focused, and entry thresholds are set too high, not recognizing the complexity of needs present.

The Centre for Mental Health has set up an independent Commission to undertake a five-year-on review of the Bradley Report²⁷. This document reviewed progress and evidence since the original report, and revisited the recommendation in the context of the new Commissioning and rehabilitation landscape, including the National Operating Model for Diversion and Liaison services developed in 2013 as a response to the original report.

Improving Health, Supporting Justice²⁸:**the national delivery plan of the Health and Criminal Justice Programme Board** built on Lord Bradley's 2009 review, and presented a five-year delivery plan aiming to improve the support that people with mental health problems and learning disabilities get within the system.

²⁴ NHS England Commissioning Board (2013) Securing Excellence in Commissioning for Offender Health. Available at <https://www.england.nhs.uk/2013/03/07/offender-health/>

²⁵ Department for Education and Skills (2006)

²⁶ Bradley K. (2009) The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the Criminal Justice System: London: Department of Health

²⁷ Durcan G et al (2013) The Bradley Report: 5 Years On. London: Centre for Mental Health

²⁸ Department of Health (2009)

Key objectives were: increasing the efficiency and effectiveness of systems, care pathways and continuity of care; ensuring equity of access to services, as well as increasing capacity and capability. Fundamental to this are stronger partnerships both across government and at the local level.

Breaking the Cycle: Effective Punishment, Rehabilitation and Sentencing of Prisoners²⁹ supports the focus on ensuring offenders have the same access to mental health services as the rest of the population, and that mental health issues are picked up as early as possible in their interaction with the CJS. The Report identifies the need to bring together agencies involved in criminal justice to provide a more coherent and coordinated approach, including engagement of health services for offenders with mental health, alcohol and substance misuse problems. It focuses on the increasing role of the police in turning offenders away from crime and the importance of the court system in protecting the public and reducing reoffending through the use of community orders for drug treatment.

The Crisis Care Concordat³⁰ is a significant policy driver for future partnership working between the CJS and health systems, and sets out provision of a better and more consistent crisis response, at the earliest opportunity, for people with mental health problems. The Concordat is backed by a 47 point action plan, divided in to 5 key areas;

- Commissioning for early intervention and responsive crisis services
- Access to support before crisis point
- Access support in an emergency
- Quality of treatment when in crisis
- Recovery and prevention of future crises

The National Drug Strategy³¹ signaled a move away from focusing primarily on reducing the harms caused by substance misuse towards a focus on supporting individuals to choose recovery as a way out of dependency. It also recognised that the issues underlying substance misuse are complex and personal and that services need to be holistic and centred around each individual and consequently there has been a shift in power to local design and service commissioning

No Health without Mental Health³² – Identified the offender population as a vulnerable group and critical priority area. **Learning Disability Strategy, Valuing People now**³³, identified offenders with learning disabilities in custody and in the community as a group who are particularly excluded from mainstream services.

The National Personality Disorder Strategy³⁴ sought to improve the recognition and support for people with personality disorder in the criminal justice system

New Horizons : a shared vision for mental health³⁵, aimed to improve the mental health and wellbeing of the population and improve the accessibility of services for people with poor mental health by a cross government

²⁹ Ministry of Justice (2010)

³⁰ Department of Health (2014)

³¹ Home Office (2010)

³² Department of Health (2011)

³³ Department of Health (2009)

³⁴ National Offender Management Service (2011) Working with Personality Disordered Offenders. London: Ministry of Justice

³⁵ Her Majesty's Government (2009)

approach. Key themes that were addressed within the document consisted of prevention of mental ill health and promoting mental health, early intervention, tackling stigma, strengthening transitions, personalised care and innovation

The Homelessness Act (2002) gave housing authorities the responsibility of assessing and planning the current and future housing needs of all local people, including vulnerable groups such as (ex) offenders. Offenders who have served a custodial sentence, or been remanded in custody, constitute a priority need category for accommodation set out in the 1996 Homelessness Act.

Local Policy:

The Tower Hamlets Community Safety Partnership Plan 2013-2016 highlights drugs and alcohol, violence against women, and reducing reoffending as key priority areas in the borough.

Tower Hamlets Health and Wellbeing Strategy 2013-2016 highlights the importance of tackling the physical and mental health needs of offenders, and increasing the effective use of screening for drugs and alcohol when offenders are arrested, recognising the links between substance misuse and reoffending behaviour, and aims to develop a long-term and integrated approach to reducing both inequality and crime.

The Tower Hamlets Mental Health strategy 2014-2016 pledges to pro-active support people at particular risk of mental health problems, including offenders, through working with Reducing Reoffending work-stream of the Community Safety Partnership to ensure that mental health support is included within plans for Integrated Offender Management.

Tower Hamlets Substance Misuse Strategy 2012-2015 recognised the association between Class A drug dependency and acquisitive crime. In 2010-11, 31% of those tested undertaking mandatory drug screening in police custody suites had a positive result for opiates or cocaine (mostly crack cocaine). The strategy pledged support to adults who are addicted or dependent to recover, through improving their health, well-being and independence, and focusing support for them to secure accommodation, education and employment, and to reconnect with their local communities.

Tower Hamlets Homelessness Statement - The Homelessness Strategy 2013-17 outlines the aim to provide targeted services for vulnerable homeless adults, based on a good understanding of individual needs, and supporting them to live as independently as possible. Vulnerable adults at risk of homelessness, or homeless include: rough sleepers; domestic violence victims; sex workers; ex-offenders; those with mental health issues and substance misusers.

3. What are the effective interventions?

3.1 Reducing Reoffending

Key risk factors associated with poor mental and physical health align closely with risk factors associated with reoffending (family breakdown; low educational attainment; low self-esteem; substance misuse; unemployment and homelessness). Targeted interventions that address these shared determinants have the potential to improve health outcomes among people in contact with the criminal justice system and to deliver farther-reaching health benefits through reduced reoffending.

- Being in employment reduces the risk of reoffending by between a third and a half³⁶
- Having stable accommodation reduces the risk of reoffending by a fifth³⁷
- Offenders with serious mental illness are twice as likely to fail in community supervision³⁸.

3.2 Housing:

Getting offenders into settled housing can act as gateway to effective resettlement. Prisoners who have housing arranged on release are four times more likely to have employment, education or training than those who do not have housing in place.³⁹

The Homelessness Code of Conduct for Local Authorities⁴⁰ identified several priorities for future developments:

- Encourage supporting housing staff to undertake pre-release interviews
- Training for hostel staff on managing offenders
- Health-related services for offenders in housing

3.3 Improving Mental Health

- **Mental Health Treatment Interventions**

Evaluations of psychological and behavioural interventions for the offender population have tended to focus on their ability to reduce reoffending, rather than their effect on clinical outcome.⁴¹ Nonetheless, mental ill health, social disadvantage and reoffending are highly interlinked, Therefore it is likely that many improvements in one outcome may result in gains in the other. This speculation is echoed by the literature; behavioural interventions which aim to reduce reoffending tend to produce beneficial outcomes in terms of clinical change.⁴²

There is strong evidence that cognitive-behavioural therapy (CBT) reduces recidivism among youth and adults, with strongest effects for offenders with a high risk of reoffending⁴³. Positive outcome were also reported for

³⁶ SEU (2009) Op Cit

³⁷ SEU (2009) Op Cit

³⁸ Skeem. J.L & Loudon J.E (2006) Toward Evidence-Based Practice for Probationers and Parolees Mandated to Mental Health Treatment Psychiatric Services.57, 3; p. 333-342

³⁹ Niven S & Stewart D (2005) *Resettlement outcomes on release from prison* Findings 248 London Home Office

⁴⁰ Department for Communities and Local Government (2006)

⁴¹ Offender Health: Scoping Review and Research Priorities within the UK, 2009, Offender Health Research Network: <http://www.ohrn.nhs.uk/resource/Research/OffenderHealthReport.pdf>. Accessed 23rd June 2015

⁴² Lipsey MW, Wilson DB. (1993) The efficacy of psychological, educational and behavioural treatment. *Am Psychol*. 1993;48:1181–1209.

⁴³ Lipsey MW, Landenberger NA, Wilson SJ (2007) Effects of cognitive-behavioral programs for criminal offenders. *Campbell Systematic Reviews*. 2007:6.

people who abuse substances⁴⁴ It is likely that CBT programmes also bring about clinical change by allowing clients to discover and change the thought processes that lead to maladaptive behaviour and emotions⁴⁵. Programs for offenders should emphasize personal accountability and help offenders understand their thoughts and choices, and regain a sense of agency, self-esteem and motivation, all of which are central to mental wellbeing.⁴⁶

Improving access to psychological therapies is a national programme to increase the availability of 'talking therapies' on the NHS. IAPT is primarily for people who have mild to moderate mental health difficulties, such as depression, anxiety, phobias and post traumatic stress disorder. These conditions are treated using a variety of therapeutic techniques, including cognitive behavioural therapy (CBT), interpersonal therapy (IPT) and couples therapy. However, given the mental health profile of the offender population (including higher rates of Personality Disorder, complex needs and concurrent substance misuse), it is likely that the general service offer would need to be adapted, in order to adequately address their needs:⁴⁷

- **A recent large-scale UK study found that the presence of co-morbid personality difficulties adversely affects treatment outcome among individuals attending for treatment in an IAPT service.** The presence of personality difficulties independently predicted reduced absolute change on all outcome , associations which were not confounded by demographic status, initial symptom severity nor number of treatment sessions.⁴⁸ Studies have found rates of personality disorder of 48% among offender populations⁴⁹
- IAPT services in Tower Hamlets do not accept those suffering from substance misuse
- Therapies of fewer than eight sessions are unlikely to be optimally effective for moderate to severe mental health problem. Often 16 sessions are required for symptomatic relief, and more for lasting change.⁵⁰ Achieving engagement for long periods of time is more challenging for people with chaotic lifestyles

Studies have found that the most effective CBT programs usually include a combination of anger management and interpersonal skills training.⁵¹ Moreover, more structured and focused treatments (e.g., behavioural, skill-orientated) and multimodal treatments seem to be more effective than the less structured and focused approaches (e.g., counseling)⁵².

Evidence suggests that several subgroups of offenders, particularly those with a history of trauma, young offenders, and offenders with learning difficulties may benefit more from a behavioural approach than cognitive based interventions.⁵³

Evidence suggests that rehabilitative programmes should combine a CBT approach with problem solving and

⁴⁴ McMurran M. (2007) What works in substance misuse treatments for offenders? *Criminal Behaviour and Mental Health*. 2007;17(4):225–33

⁴⁵ Wilson DB, Bouffard LA, Mackenzie DL.(2005) A quantitative review of structured, group-oriented, cognitive-behavioral programs for offenders. *Criminal Justice and Behavior*. 2005;32(2):172–204

⁴⁶ Lipsey et al (2007) Op Cit.

⁴⁷ Treatment Choice in Psychological Therapies and Counseling (2001) Department of Health. Available at: <http://londoncognitivebehaviouralpsychotherapy.co.uk/downloads/treatment-choice-brief-version.pdf>

⁴⁸ Goddard et al (2015) Op Cit

⁴⁹ Brooker et al (2012) Op Cit

⁵⁰ NICE (2009) Guideline 90: Depression in Adults: Recognition and Management, Guideline 22: Generalised Anxiety Disorder

⁵¹ Lipsey (2007), Op Cit;

⁵² Lipsey, (2007), Op Cit

⁵³ R Harrington, S Bailey, C Kenning, G Taylor, S Byford, Barrett B (2005) Mental Health Needs and Effectiveness of Provision for Young Offenders in Custody and in the Community. London: Youth Justice Board

behavioural principles, in a multi-modal approach.⁵⁴ This has led to evaluations which focus on ‘packages’ of multimodal programme. These packages teach skills such as problem solving, decision-making, perspective taking and moral reasoning. Their purpose is to reduce impulsivity, improve problem solving, and instill a greater sense of capability for self-management in order to develop the behavioural skills needed to avoid crime and engage pro-social behaviour and promote mental wellbeing.⁵⁵ These programmes have been shown to reduce re-offending by up to ten percentage points when delivered in groups or as individual therapy.⁵⁶

Given the high prevalence of personality disorders among the offender population, and research suggesting that IAPT is less effective among this cohort, there may be a need to routinely assess for the presence of personality difficulties on all offenders referred to psychological therapies. This information will provide important prognostic data and could lead to the provision of more effective, personalised treatment in IAPT.⁵⁷ This information may also guide clinicians in the delivery of treatment, for example, by highlighting a need to focus more on core beliefs compared to automatic thoughts⁵⁸ to include specific skills training or structured clinical management as part of treatment.⁵⁹

- **Improving Access to mental health treatment service**

Unstable accommodation, custodial sentences, and competing and complex needs, pose a particular barrier to achieving continuity among the offender population. Gaps in continuity can be addressed at various levels, and the following enabling factors to improve access routes to mental health services have been identified:⁶⁰

- An identified point of contact within mental health services: Including on-going care with the same practitioner, or having a single point of contact for mental health advice, and improve access and engagement⁶¹
- Mental health awareness training among probation staff, to improve confidence in referring their clients.

Research emphasising the importance of long-term trusting professional relationships between offenders and probation officers highlights important opportunities to engage with this population effectively, and underlines the necessity of robust training and support for probation officers in the identification and support of mental health needs for their clients.

- **Co-location of services within criminal justice settings**

The delivery of tailored, flexible services in criminal justice settings, such as in probation delivery units, have the potential significantly improve engagement with health services among people in contact with the criminal justice system. Compliance with sentence or licence conditions necessitates regular attendance at these premises, and initiatives such as

⁵⁴ Lipsey (2007) Op Cit

⁵⁵ Ministry of Justice (2014) Transforming Rehabilitation: a summary of evidence on reducing reoffending (second edition). London: Ministry of Justice Analytical Series

⁵⁶ Landenberger & Lipsey (2005) ‘The positive effects of cognitive-behavioural programs for offenders: A meta-analysis of factors associated with effective treatment’, *Journal of Experimental Criminology*, 1(4), 451–476

⁵⁷ Goddard et al (2015) Op Cit

⁵⁸ Bienfeld, D. (2007) Cognitive therapy of patients with personality disorders. *Psychiatric Annals*, 37 (2), pp. 133–139

⁵⁹ Bateman and Fonagy (2005) *Psychotherapy for borderline personality disorder: Mentalization-based treatment* Oxford University Press

⁶⁰ Brooker, C et al (2011) An Investigation into the Prevalence of Mental Health Disorder and Patterns of Health Service Access in a Probation Population. Lincoln: Criminal Justice and Health Research Group.

⁶¹ Mc Neill et al (2005) Op Cit

on-site 'drop-in' health centres can ameliorate some of the barriers leading to poor engagement with primary healthcare services in the community. Thus the probation environment provides a valuable opportunity to improve the mental health of a section of society that suffers significant disadvantage, and reduce reoffending. For an overview of What Works to improve mental health outcomes of offenders, see Appendix 4 of Tower Hamlets Offender Health Needs Assessment full document.

- Joint meetings between the offender, probation and health service staff

Offender mental health diagnoses do not occur in isolation, and need to be delivered in alliance with other aspects of an offender's rehabilitation, so that they can be addressed holistically in the context of other circumstances and needs. This is likely to involve strong links and joint working between health and criminal justice staff.

- **Mental health Treatment Requirement**

In 2005, the Community Order became the new generic community sentence available to the courts as an alternative to prison, and includes the Mental Health Treatment Requirement (MHTR). The MHTR can be issued to offenders who have an identified mental health problem, where treatment is readily available and the offender has given their consent to engage with services. Importantly, offenders do not have to have a particular diagnosis, or severity threshold in order for an MHTR to be used; the MHTR could be used to provide services for even moderate depression where, for example, NICE guidelines indicate psychological therapies are appropriate. However, despite high levels of mental health morbidity among the offender population a review of the use of Community Orders found that less than 1% of requirements made as part of community orders were MHTR.⁶² Given that national research suggests levels of mental health disorders at 70% among the prison population⁶³, the underuse of the MHTR represents a missed opportunity to engage with this group.

Diversion into mental health treatment programmes at an early stage in the criminal justice pathway has the potential to identify and engage with a low-help seeking, hard to reach population, with significant mental health morbidity.

Moreover, community sentences have been proven to be effective both economically and at reducing reoffending, and the MHTR can provide a robust alternative to short prison sentences. Time spent in prison results in worse mental and physical health, job loss, social exclusion, and damaged social networks, and short sentences are rarely long enough to establish robust resettlement plans.⁶⁴

The MHTR relies on joint working between three agencies; the courts, probation and health services. Before an MHTR can be issued, probation staff must highlight mental health concerns to the court via the pre-sentence report. Following sentencing, probation must liaise closely with health services to ensure the treatment order (usually a combination of psychological therapy and/or medication) is complied with. Thus strong relationships and protocols must be in place between courts, probation and health services to ensure the potential benefits of the MHTR are realised.

In 2014, the National Offender Management Service (NOMS) produced guidance on how, in which they Local health and criminal justice agencies are encouraged to engage continuously with each other in order to develop partnership working arrangements necessary to ensure that services fully consider the needs of offenders.

⁶² Scott G and Moffat M (2012) The Mental Health Treatment Requirement. London: Centre for Mental Health

⁶³ Singleton et al (1998) Op cit

⁶⁴ iStuart and Moffat (2012) Op cit

Probation providers are encouraged to develop comprehensive knowledge of local mental health treatment options including GP based, CMHT and forensic mental health options. Officers supervising offenders under an MHTR are responsible for supervising the offender's attendance at the specified appointments, and ensuring the more holistic needs of the offender (eg housing, employment) are considered, as it may be appropriate to combine an MHTR with the support of other provider agencies. Meanwhile, health CCGs and local health boards are encouraged to engage with local community justice agencies in order to ensure their commissioning activities and service design facilitates treatment access by offenders to enable the courts to issue an MHTR.⁶⁵

4. What is the local picture?

There is no comprehensive and up-to-date database of offender health data, as these are not routinely collected. Therefore several sources of data have been triangulated to provide insight into the needs of this population

- **Youth and Adult reoffending data:** provides insight into the links between reoffending and social/ health factors
- **Tower Hamlets Demographics and probation Caseload Demographics:** Age, gender, ethnicity of the LBTH probation population (from Delius⁶⁶) compared to the general population.
- **Youth and Adult reoffending data:** provides insight into the links between reoffending and social/ health factors
- **OASys questionnaires:** OASys is a national IT system used by both Probation and prison services to undertake analysis of offences, risks and needs. Comprises actuarial calculation of the likelihood of reconviction and supports professional assessment on risk. It records offending-related social and individual needs, including basic personality characteristics and behavioural problems. All offenders, except those assessed as low risk, or subject to a Stand Alone Unpaid Work Requirement, have an OASys prepared. Importantly, OASys also provides a template for supervision and risk management plans, and aims to match needs to effective interventions. Needs are identified through self-reporting and corroborating evidence.

Adult and Youth Reoffending data⁶⁷

- Data suggests that total number of re-offences and reoffenders is reducing, but that there may be a number of prolific offenders who are making the average rate of re-offences per reoffender go up.
- It appears very small number of young people committing 5+ offences (16) are responsible for committing most reoffending (107 offences). Almost a third (29.5%) of youth reoffenders commit their first further offence in the two months and are responsible for 38.6% of the overall re-offending in Tower Hamlets.
- Findings from reoffending data underline the importance of early intervention. The further down the re-offending spiral an offender is, the harder is it to achieve desistance

⁶⁵ National Offender Management Service (2014) Mental Health Treatment Requirement: A guide to good practice. London: Ministry of Justice

⁶⁶ This database provides demographic profiles and disability data for probation clients. It supersedes the Integrated Case Management System for criminal justice client data.

⁶⁷ Ministry of Justice (2015) Proven Reoffending Statistics Bulletin April 2012 to March 2013, Ministry of Justice

OASys Data

- The principle finding from OASys Data analysis is that it is not fit for assessing the true extent of offender needs. There are high rates of missing information, information is self-reported and assessments are often out of date. Levels of need demonstrated by OASys analysis are likely to greatly underestimate actual need.
- This highlights the need for more comprehensive, timely and responsive ways of measuring and recording offender health-related needs.
- There was a large discrepancy between levels of low mood and behavioural problems (20-50% of cohort) highlighted by the OASys assessments, compared with levels of “mental health problems” recorded in both cohorts (only 2%).
- Young people aged 18-30 make up the majority of Tower Hamlets offenders (CRC: 48%, NPS 48%)
- Drugs and Alcohol: At least 54% of CRC offenders have substance misuse linking to offending (drugs or alcohol). Prevalence of drug and alcohol misuse problems in the NPS cohort were 27% and 15% respectively. 100% of IOM offenders have substance misuse issues.

Mental Health services and probation:

Epidemiological data collected for this needs assessment indicated high levels of symptoms of mental health need, yet low levels of mental health diagnosis, suggesting a high met of unmet need among community managed offenders.

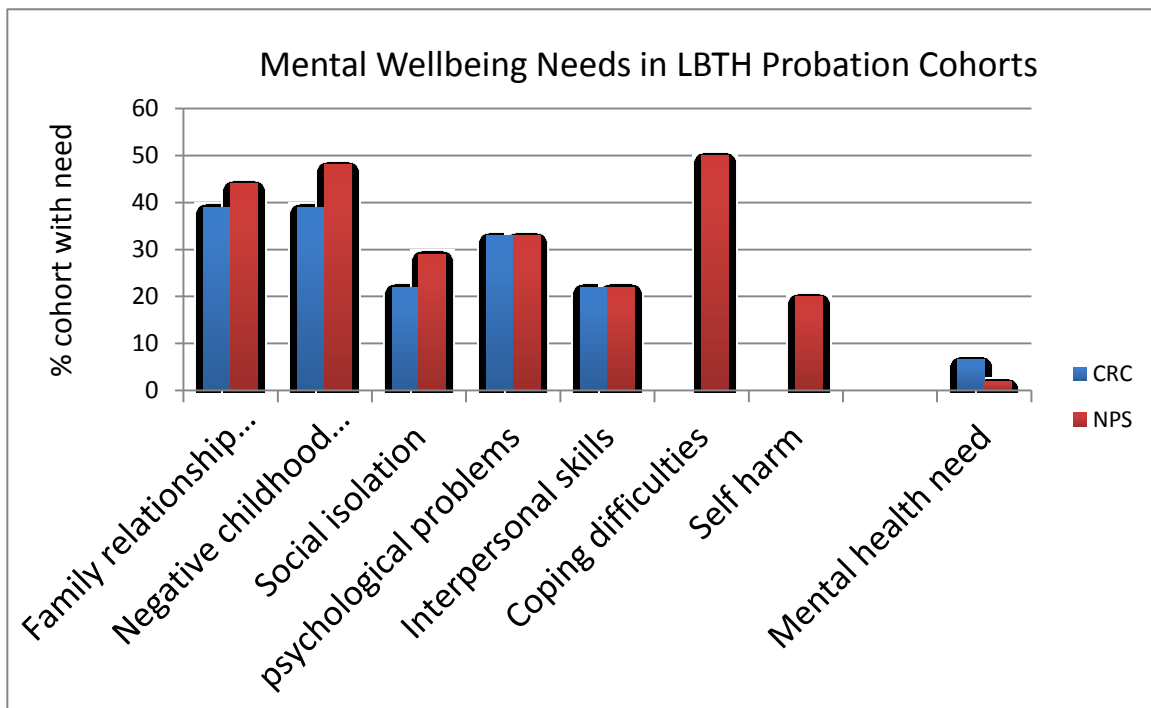


Figure 3: Mental wellbeing Needs in LBTH Probation Cohorts⁶⁸

There are over 1300 community-managed offenders in Tower Hamlets, up to half of whom demonstrated symptoms of mental health need. However, only 2-8% appear to be accessing services.

⁶⁸ Source: LBTH NPS and CRC OASys Assessment, April 2015

Qualitative evidence revealed that staff working in in probation, Integrated Offender Management and hostel staff had difficulty managing clients with mental health problems. They lacked confidence in identifying mental health issues, did not know where to seek advice and encountered significant difficulties in accessing appropriate services and support for their clients.

Accessing mental health support was reported as particularly difficult for offenders managed by the CRC, who do not have access to the services available to NPS offenders (Personality Disorder Pathway and FMHP service).

It is clear that Tower Hamlets offender's access to mental health services is disproportionate to their level of need. This findings of this needs assessment point to various explanations:

- Most routes into mental health services (eg IAPT, CMHT) rely on GP referral. However, this route is likely to be less accessible to the offender population. Qualitative evidence gathered for this review suggests several explanations. First, the process of getting access to mental health interventions via a GP was reported by staff as indirect and lengthy. Delays in access to treatment often meant the loss of critical opportunities to engage with offenders during brief windows of motivation.
- Staff working with offenders had concerns about the suitability of the GP environment for the offender population, who might have chaotic behaviour and experience difficulty communicating to medical professionals about personal symptoms in an unfamiliar environment. Research highlights the importance of key professional relationships for offenders. Long term relationships with trusted professionals, with whom the offender can have a 'therapeutic alliance', have been shown to produce better clinical and behavioural outcomes.⁶⁹
- Mainstream services in some cases are not geared to hold open services where there is erratic attendance and missed appointments, fluctuating motivation to engage, and difficult behaviour. Complex needs clients often need to be treated with a flexible engagement model that meets them on their own terms, acknowledging that difficult behaviour is often due to mistrust and poor past experiences.⁷⁰ Many offenders have experienced a lifetime of social adversity, poor parenting, avoidant attachment relationships stemming from emotional neglect⁷¹. Chronic offenders have been found to have higher rates of distorted cognition, including self-justificatory thinking, misinterpretation of social cues, altered schemas of dominance, which may cause them to react to benign situations as if they were threatening, and have been found to be less skilled at long-term planning and problem solving, that can lead to rigid behavior patterns which can constitute significant barriers to therapeutic intervention when these factors are not taken into account.⁷²
- Staff reported many clients had difficulty engaging with treatment services that are not geared towards their specific mental health needs. The offender population has high rates of personality disorder, in addition to anxiety and depressive disorders. Multi-morbidity and dual diagnosis are likely to affect the kinds of interventions that are successful among this group, as well as their ability to qualify for mainstream psychological services: recent innovations, such as Improving Access to Psychological Therapies (IAPT) do not accept those suffering from substance misuse, and have been found to be less effective for those with co-morbid personality disorder.⁷³
- Staff reported considerable difficulty accessing support for clients they felt had low to medium mental health problems, but who did not meet the threshold for treatment by CMHT. Although their mental

⁶⁹ McNeill, F et al (2005) Reducing Re-offending: Key Practice Skills. Scottish Executive

⁷⁰ Howerton A., Bing R., Campbell J., Hess D., Owens C. & Aitken P. (2007) Understanding help-seeking behaviour among male offenders: qualitative interview study. *British Medical Journal* 334 (7588), 303.

⁷¹ Saunders A (2014) op cit

⁷² Lipsey MW, Landenberger NA, Wilson SJ. (2007) Effects of cognitive-behavioral programs for criminal offenders. *Campbell Systematic Reviews* 2007:6

⁷³ Goddard, 2015 Op Cit

health problems were not seen as “severe”, combined with a multitude of other issues such as lack of stable accommodation, drug misuse, and institutionalisation, even “low level” mental health needs could cause considerable obstacles to clients achieving their goals. This was particularly evident for clients with dual diagnosis, who often did not meet the threshold for specialist mental health input, but whose mental health issues and drug misuse were often compounded and entrenched by social disadvantage, exclusion, and traumatic life events.

Social Needs

- Accommodation: Only 19% (CRC) and 15% (NPS) of offenders live in stable independent housing.
- 1/3 of the Tower Hamlets hostel population is made of offenders. 1/8 of annual referrals are from the offender population. 2/3 of the hostel group had at least one other significant concurrent need, in addition to housing need.
- 10-20% of the offender population disclose problems with reading or writing
- 40-45% Have problems with finances or debt

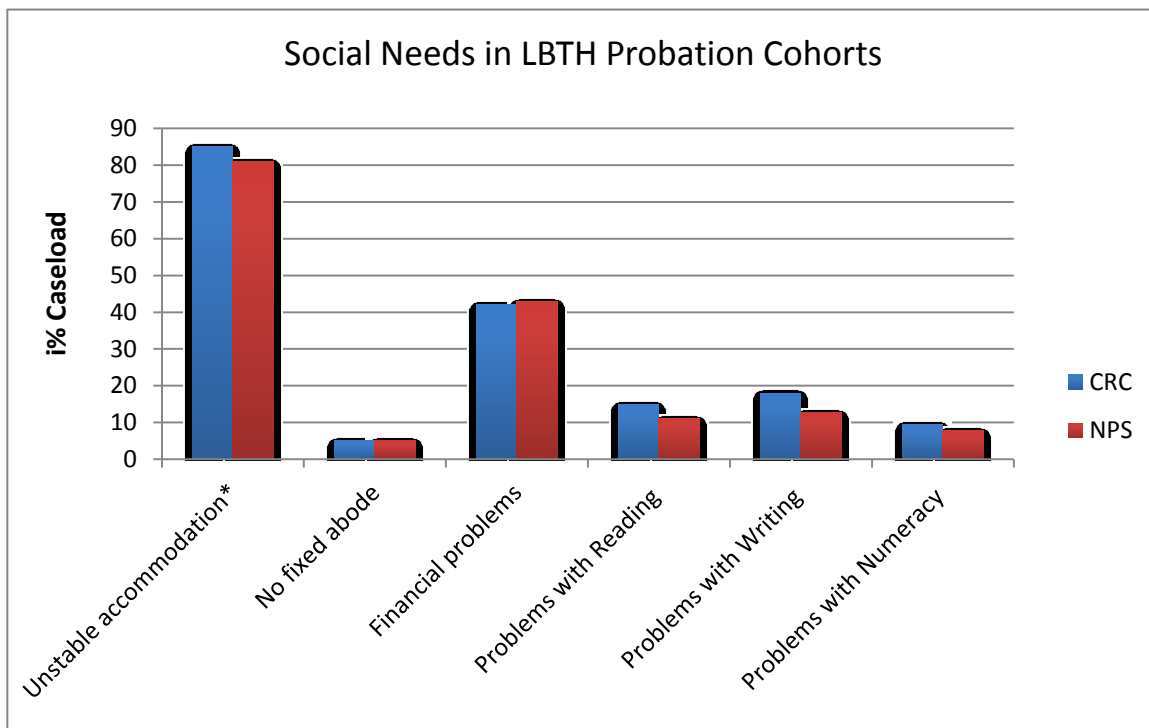


Figure 4: Social needs in LBTH probation cohorts⁷⁴

Drug Intervention Programme data⁷⁵

- Treatment outcome data suggest that CJS clients are less successful at completing opiate treatment and more likely to relapse if they do manage to complete (43% vs 24%)⁷⁶. This fits in the national picture of drug-using offenders having increased supports needs relative to the general population, which affect drug treatment success.

⁷⁴ Souce: OASys Assessemnt LBTH CRC and NPS April 2015

⁷⁵ Data source: NDTMS DOMES report Q4 2014/15 - covering 12 month period April 2014 to March 2015

⁷⁶ Because total successful treatment numbers are relatively low, it is not possible to perform a T-test to ascertain whether CJS clients are less likely to complete treatment, or more likely to relapse

5. What is being done locally to address this issue?

From arrest to rehabilitation, the offender journey involves interacting with a number of different agencies and services. Since the Health and Social Care Act(2013), there has been a split in responsibility for offender health services are commissioning, with NHS England local area teams now responsible for commissioning health services in custody, and local CCGs responsible for health care in the community. NHS England are also currently funding the London Liaison and Diversion scheme, which operates from police stations and courts (see section 5.1). Moreover, the recent split of Probation Trusts into public National Probation, and privately provided Community Rehabilitation Trusts introduces further complexity to the pathway.

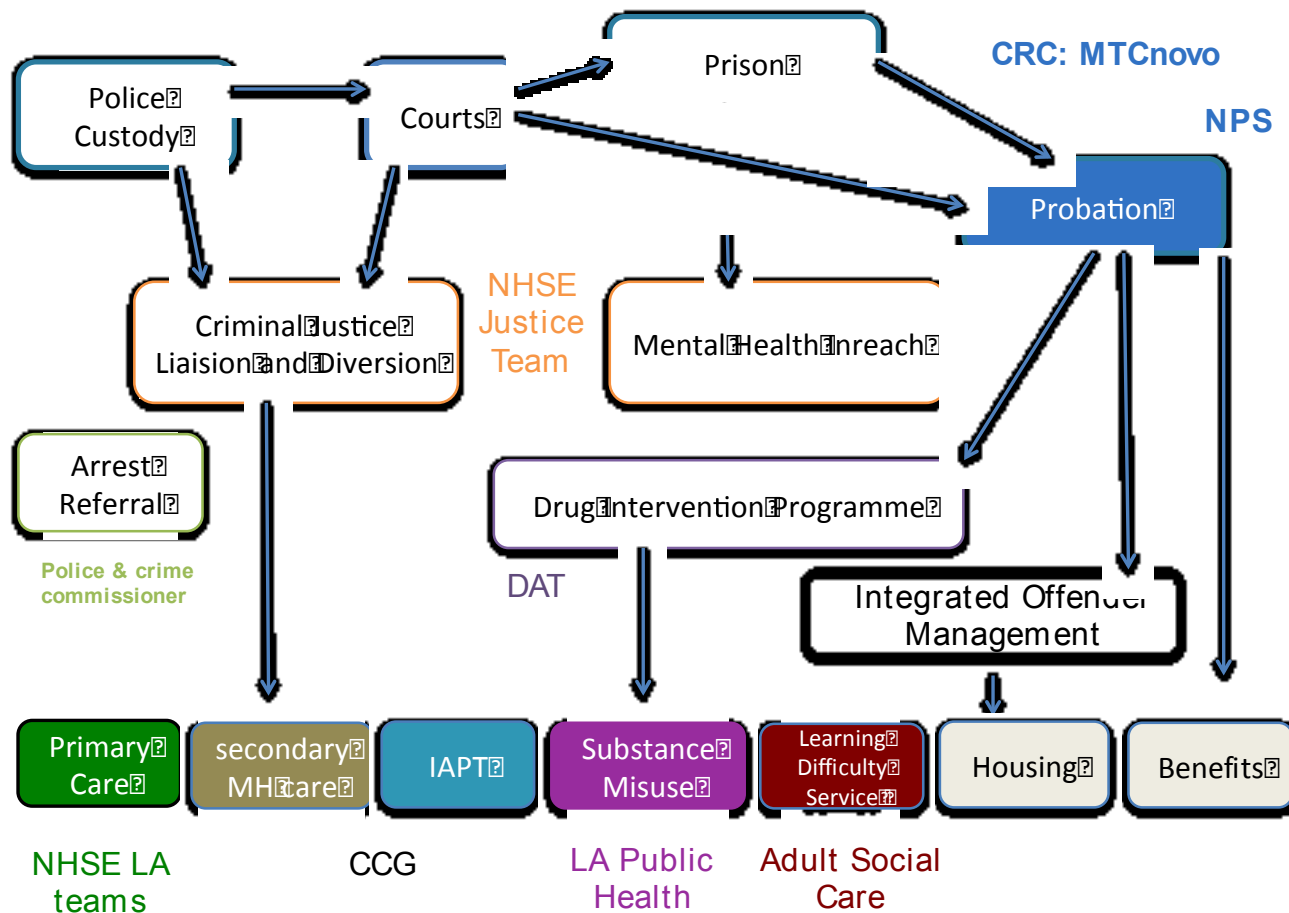


Figure 4: The Offender Pathway, and agencies involved in commissioning and providing offender health and rehabilitation services

Service mapping was undertaken as part of this JSNA. The following services aim to address the needs of offenders managed by probation in Tower Hamlets.

5.1 Mental Health and wellbeing

a) *Liaison and diversion*

The Liaison and Diversion Pilot Operating Model⁷⁷ was developed by the Offender Health Collaborative (OHC), a working collaboration between six specialist organisations: Nacro, the crime reduction charity, Revolving Doors Agency, Centre for Mental Health, Institute for Mental Health, NHS Confederation and Cass Business School, and was commissioned by NHS England. This first national service specification set out a service whereby people of all ages with mental health problems, a learning disability, substance misuse problems and other vulnerabilities are identified and assessed as early as possible. Mental health professionals are stationed in Police stations and the Courts in order to identify vulnerable offenders and divert them away from the criminal justice system. Following screening and assessment, individuals are referred to appropriate services including, but not limited to, mental and physical health care, social care and/or substance misuse treatment. Information from liaison and diversion assessments is shared appropriately with relevant agencies so that informed decisions can be made on issues of diversion, charging, case management and sentencing. Importantly, L&D is not itself a treatment service, but it is an identification, assessment and referral service.

This model, with services operating in police custody and in the courts, is being piloted in 10 areas. These will be evaluated by autumn 2015 and if the business case is accepted, a roll out of L&D services delivering the new specification will increase to 50% population coverage in England and then 100% by March 2017.

In the North East London cluster, the service is provided by Together, a mental health charity in conjunction with East London Foundation Trust, and covers Newham, Hackney and Tower Hamlets). There are three full-time Together mental health practitioners who operate as a triage system for clinical input. Clinical staff includes three full time mental health nurses, a half time doctor and a consultant one day per week. The service operates in Thames, Stratford Youth and Snaresbrook crown court, and in 5 police stations across the borough. The service consists of screening arrests, signposting, providing advice and education to police, and linking to primary care (and to a lesser extent, secondary care) police and custody staff, as well as solicitors. The service does not provide follow-up services, or Appropriate Adult services. In addition there are five floating support workers who offer support to women, BME and youth groups.

Anticipated benefits:

- Identification of problems such as mental health, learning difficulties and/or other vulnerabilities at the L&D service may facilitate relevant support to these offenders rather than a CJS intervention. This has potential to reduce caseload numbers and effectively divert away from custody or community sentences. Reduce arrests, reduce reoffending, improve health outcomes, reduce inequalities and alleviate pressure on police time and crisis services.
- For Integrated Offender management and Through the Gate, especially where sentences are less than 12 months, the early assessment done at the L&D stage may be used on release for onward referral to treatments as well as broader social care issues

Challenges:

- Info sharing with CRC. L&D services will not be effective on their own. Successful diversion relies on the availability of effective services to divert people towards. NHS England's Health and Justice Area Teams will need to work with the youth and criminal justice systems, health and local authority partners to ensure that L&D service work effectively with services available at a local level.

b) Personality Disorder (PD) Service

⁷⁷ NHS England Liaison and Diversion Programme (2014) Liaison and Diversion Operating Model. Available at: <http://www.england.nhs.uk/wp-content/uploads/2014/04/ld-op-mod-1314.pdf>

The PD service was developed following the National PD strategy (2011). The London model has been piloted across six boroughs, resulting in this template for a community intervention embedded within the National Probation Service (CRC offenders are not eligible).

The model proposes three inter-related areas for interventions:

- Case identification
- Case formulation
- Training and development

In London the Pathway is delivered by NPS London Division POs and London Pathway Partnership (LPP) a consortium of four London NHS Mental health Trusts promoting a psychologically informed approach to working with offenders with PD. In Tower Hamlets this means the project is delivered by a Probation Officer supported by a NHS psychologist.

Case identification occurs on the basis of the OASys personality disorder screening process⁷⁸, followed by a process of Pathway Planning This consists of developing narrative account of the offender's life which integrates personality development and criminogenic needs, in order to identify conditions necessary to increase motivation and use of new behaviours and inhibit problem behaviours. The plan is then implemented, consulting other key parties and in collaboration with the offender whenever possible. Offender management remains the responsibility of the Probation Officer, under the advice of the clinical team.

LPP have subcontracted with a number of Third Sector agencies to provide mentoring with Service Users, a support service for employment and with Women in Prison (WiP) to support work in the Pathway with women offenders.

There is a full training programme for all probation staff and a standard and advanced training for the POs and psychologists. NPS London Division is also a lead partner in delivering the national Knowledge & Understanding Framework training (KUF) which is available to all CJS and allied agencies including the NHS and Third Sector organisations. NPS London Division have a number of staff on the KuF Masters programme.

LPP is currently developing a London Approach to working with Women PD in line with the National Women's Strategy but are considering how this can be developed within a "trauma informed" approach.

c) *Link worker Service*

The Link worker service is a floating support scheme commissioned by Supporting People and running from Providence Row. It supports adult offenders that have low to medium mental health needs and come into contact with the criminal justice system. The key focus of the scheme is to ensure offenders are supported to live independently and prevented from re-offending. The service is a holistic, assertive outreach model and able to support a range of needs including; Homelessness or tenancy sustainment, drug and/or alcohol issues, the need for support around financial problems, difficulty accessing health services, family issues, the need to be safe from abuse and exploitation, difficulty accessing employment and training opportunities. Furthermore, the service also provides more general support, offering help with life skills, coping strategies, relationships, self-management and social integration. Lastly, Link workers can provide Appropriate Adults service, whereby

⁷⁸ An example decision tree incorporating the screen can be found in appendix. The screen, with instructions for its use, can also be found on page 65 of Working with Personality Disordered Offenders: A practitioners Guide': <http://www.justice.gov.uk/guidance/prison-probation-and-rehabilitation/mentally-disordered-offenders.htm>.

vulnerable offenders are accompanied to Court. Currently there is no agency that holds responsibility to provide this service.

The Link Worker service has an established relationship with key referral agencies such as Police Stations, Prisons and the Lighthouse Prison Exit Service (RAPT) who act as a Prison link for residents of Tower Hamlets leaving Prison. The Link worker scheme operates established in-reach access with these agencies.

The Link worker scheme is one of the few remaining offender-specific support schemes in the borough. The service was recently re-commissioned and the new contract began on 1st March 2015. The team offers one-off support and signposting to other services, short-term work (usually up to 4 appointments) or medium-term support. The team would normally work with people up to a maximum of 3-6 months (maximum duration was shortened from 2 years in the new contract). Current expected output is accepting 27 new referrals per quarter. The service model specifies that user consultation and involvement about how best to support offenders should be actively sought, in order to promote engagement, and ensure that individuals are in control of decisions about their lives. The service will aim to work closely with IOM, and build partnerships with a range of statutory and voluntary organisations. Link workers are not mental health professionals, but are skilled in working with socially excluded groups, and people with mental health needs.

Last year, 105 people were assessed of which, 51 were referred to other agencies or offered one off advice. 54 service users were taken onto the caseload for short (one – three months) or long term support (up to a year). More than half of all referrals had a drug/alcohol related support need, and housing advice or support ranked high among a range of complex issues. Employment support was less of a need which points out securing housing and accessing specialist support for their mental health need was the greatest primary need for all service users.

d) Forensic Mental Health Practitioner Programme (FMHP)

Prior to the resettlement changes which came into effect on 1st April 2014, The FMHP operated as a mental health liaison service for offenders in court and in the community. The service was jointly funded by Probation and Tower Hamlets CCG. Following the commencement of the NHS England-funded liaison and Diversion Scheme, the service was reduced; leaving one practitioner to cover community offenders (both NPS and CRC) in Hackney and Tower Hamlets. This contract ended on the 31st March. It has now been commissioned by the NPS to work with their high risk clients across London (including Tower Hamlets), and the service will no longer cover the CRC cohort.

The FMHP Service provided direct support to vulnerable offenders who had been sentenced to a community order, and London probation staff in their management of offenders with mental health needs. The aim was to provide a service that filled the gaps between the skills of GPS in managing the mental health needs of this particular population, and the threshold for CMHT involvement. Activities undertaken included: advice to support engagement of offender with probation officer, assessments of health and social care needs, and targeted short-term therapeutic interventions such as CBT, mood-management or mindfulness.

The service had been somewhat restricted prior to the termination of the contract, due to the initiation of the London L&D programme. Monitoring reports from the Q4 2013-14 indicated an inability to take on new referrals due to the high number of ongoing cases from previous quarters, and reported limited scope for longer term intervention due to uncertainty about continuation of the service from April 2014 onwards.

Nonetheless, the FMHP supported 17 clients in probation during this period, with 16 of these being ongoing

cases from previous quarters. Of these, 12 per cent lived alone. 78 per cent of clients were unemployed.

This FMHP referred 7 clients to specialist services this quarter. This included 4 referral to GP's; 4 referrals to CMHT's, 1 referral to Mind Counselling and 1 referral to the Institute of Psycho-trauma.

As most of the clients supported this quarter were ongoing cases, the types of interventions employed were less varied (e.g. less psycho-education or work focusing on coping skills which tend to be employed at the start of interventions). Most longer-term client sessions focused more on Problem Solving, Social Skills Training, Mood Management and Self-Esteem.

All clients who the FMHP assessed or actively worked with (100 per cent) were given Health Promotion advice around Exercise, Diet, Physical Health, Alcohol Use and Drug Use. Clients were also supported around Social Integration; including Education, Employment, Suitable Accommodation, Health, Leisure and Community Work.

e) CRC Mental health cohort and St Andrews Healthcare

The CRC's cohort model (described above) will become fully operational in October. Until then CRC staff are undergoing training in the new screening tools for mental health (Kessler) and learning difficulties.

MTC novo's tier 2 partners for mental health is St Andrews Healthcare, a charity specialising in forensic mental health in secure services and the community. St Andrews is currently evaluating a range of community mental health interventions for offenders in Milton Keynes (See Appendix for full description and preliminary results). MTC novo hope that the results of this pilot will inform the types of mental health interventions that can be used in the community. St Andrews are also working with MTC novo to deliver Mental Health Treatment Requirements in London. Also delivering training to probation staff in the new screening tools for mental health (Kessler) and learning difficulties, in order to achieve better identification of need and expansion of the cohort.

f) Non-offender Specific Mental health Services

- i. Improving Access to Psychological Therapies (IAPT):** Offenders are eligible for IAPT community counselling services, however these services are only commissioned support people up to a certain level of risk. Therefore offenders who are known to have a history of violence will be excluded. Individuals with concurrent substance misuse are not eligible for this service.
- ii. Community mental health services** are the biggest and most diverse element of the borough's provision of mental health services.⁷⁹ However, as for IAPT, offenders may be excluded from these services following risk assessment.
- iii. In The Know** is the Ideas Store directory for community mental health services: includes information on voluntary sector initiatives

g) Third Sector Services

- i. Osmani Trust:** Is a youth and community organisation which offers a wide range of community, health and sporting initiatives. It aims to provide a holistic service, which helps people, particularly those living in disadvantaged urban communities to re-engage with mainstream society and improve their quality of life.
- ii. Daddy CPR:** is a forum where families can access social and enterprise training targeting, single

⁷⁹ See Tower Hamlets Mental Health Joint Strategic Needs Assessment (2013) p42-43

parent families where there is a lack of visible male role models, as well as to build the parenting capacity of alienated or estranged fathers, and promote the resilience of children with challenging behaviour and social and emotional difficulties

- iii. **Clinks**⁸⁰, a charity supporting offenders and their families, offer a directory of services which promote acquisition of life skills, as well as mentoring and befriending services. There are searchable by area and by target-group (eg women, families, young people, BME communities)

6.4.2 Drugs and Alcohol

a) *Drug Intervention Programme (DIP)*

The Drug Intervention Programme (DIP) is directly managed by the local authority. It is a frontline service which refers individuals to treatment agencies and but does not provide treatment itself. However it offers a range of services designed to meet the needs of drug-using offenders. Individuals are referred from the courts, probation service, police and the Care, Assessment, Referral, Advice and Through-care Service (CARATs) in prisons.

The DIP works with statutory and voluntary sector partners in order to tackle the complex needs associated with drug use and reoffending:

Health needs are often particularly acute and close links with GPs through the shared care scheme ensure clients receive appropriate treatment. Furthermore there are close links with the Specialist Addiction Unit (see below). All individuals accessing DIP services receive a health screen and access to the Blood Borne Virus Service for testing, immunisation, treatment, wound care and sexual health screening. Direct access to the community drug team is arranged for those without GPs.

Currently, a DIP worker is co-located with the IOM team. The DIP IOM coordinator ensures drug service are working with IOM plans, promoting holistic approach and avoiding duplication of services. Currently 100% of the IOM cohort have a drug problem.

A DIP prostitution coordinator is a key support for drug-using vulnerable women offenders, and ensures joined up working between DIP and the DV team and prostitution panel.

The DIP service offers a 24 hour telephone lines, aiming to reduce the use of crisis services and allow offenders to access support round the clock.

DIP commission an external legal and welfare advice service, provided by release, since many of its clients have finance and debt problems associated with substance misuse. Case workers also and help with employment and training as part of the recovery process, and a representative from Working Links holds a weekly drop in session.

DIP commission the Lighthouse Prison Exit scheme, run by The Rehabilitation of Addicted Prisoners Trust (RAPT) which provides a prison link service who liaise with DIP in order to ensure that clients are referred to appropriate services prior to release. In addition, volunteers meet prisoners at the gate on release and encourage them to keep appointments and access appropriate services in order to prevent relapse in the vulnerable period following release from prison

⁸⁰ <http://www.clinks.org/directories>

Finally, outreach workers (the Assertive Outreach and Enforcement Team) offer additional support to offenders receiving community orders, provide in-reach services to hostels, and support police in tackling substance misuse-related ASB, including responding to mental and physical health issues and providing information to relevant agencies.

b) Non-Offender Specific Drug Treatment Services

The following figure illustrates the number of individuals from the Criminal Justice System who were referred to drug treatment services in Tower Hamlets, as well as the proportion of the referrals to each service who were Criminal Justice System clients.

i) Specialist Addiction Unit (SAU): Complex needs

SAU is a multidisciplinary service which provides structured drug treatment to adults with complex drug related needs. These complex needs may be due to:

- Physical health
- Mental health
- Using a number of drugs including alcohol in a chaotic way

The Specialist Addiction Unit provides assessment, care and treatment to patients whose drug and alcohol related needs require specialist interventions from a multi disciplinary team with expertise in stabilising, promoting drug and alcohol recovery and facilitating wider social inclusion for patients. As an integral part of the local drug and alcohol treatment system, their role is also to mainstream more stable patients into Primary Care and other treatment agencies

ii) Dual Diagnosis Service

The Dual Diagnosis Service is a specialist adult mental health team who provide short treatment, assessment and advice to dual diagnosed clients.

iii) The Rehabilitation of Addicted Prisoners Trust (RAPT) manage the following Services

- The Island Day Programmes, a 12-week non-residential detox programmes which uses the 12 Step Principles, and introduces clients to motivational enhancement therapy, behavioural skills training and offers extensive aftercare and family support programmes. It is a three-stage programme with an induction, primary and aftercare phase. Referrals are taken from the Community drug team, Probation, or DIP.
- The Changes Group Programmer aims to provide motivation and support to become drug-free. Groups are structured over a 12-week period and used motivational enhancement and CBT techniques
- The Lighthouse Prison Exit Team for DIP clients (see above)

iv) Nafas

Nafas is commissioned by the London Borough of Tower Hamlets to deliver Tier 2 and 3 drug interventions in the borough, which offers culturally inclusive service provision, incorporating cultural and religious dimensions into the recovery process for relevant individuals. Nafas has 4 key work areas of service delivery:

- Drug and alcohol education programmes, training and outreach
- The Nafas Treatment Day Programme
- The Nafas Aftercare Project, the Abstinence Support Network is a semi-structured evening aftercare programme for those who have become drug-free and would like to strengthen recovery and reintegration
- Education, Training and Employment Service, which helps users gain access to mainstream education and

work programmes

v) Isis

Isis provides a specialist service for women suffering from drug and /or alcohol misuse. Isis provides drop in facilities, advice and information, psychosocial interventions and access to general healthcare through an on-site GP and nurses for health screens, wound care, and sexual health advice.

vi) Harbour Recovery Project

This service, based in the Riverside hostel is a residential detoxification centre for non-complex, non-injecting Tower Hamlets male residents.

vii) Other treatment and support services available to drug using offender include:

- GP Services
- The Changes Group Programme aims to provide motivation and support to become drug-free. Groups are structured over a 12-week period and used motivational enhancement and CBT techniques
- Health E1 Specialist nurses
- Pharmacy Service
- Blood Borne Virus Service
- Specialist Midwives
- NACRO Link Worker Service: The Tower Hamlets Substance Misuse Link Service delivers drop-in advice surgeries to users in the Tower Hamlets statutory services, offering housing related support to prevent eviction, as well as support with finance.
- Residential Detoxification and Rehabilitation places are also spot- purchased in order to rehabilitate offenders

c) *Community Alcohol Team*

The Tower Hamlets Community Alcohol Team (THCAT) offers an integrated system ranging from education and brief intervention for non-problematic drinkers to community detoxification and pathways into residential treatment for dependent drinkers. The service accepts referrals for any resident of the borough who is 18 or above.

Clients can be referred by a number of individuals or services, including GPs, statutory drug services, a relative, hospital accident and emergency departments, social services, voluntary organisations, arrest referral or DIP team, probation or prisons. THACT also accept self-referrals.

5.3 Education and Training

Most prisoners have access to educational courses and training while in prison. The objective is to help them gain skills and qualifications that help them find employment when they are released. However, most of these courses are reserved for prisoners with medium to long-term custodial sentences.

These courses are run by the Offenders' Learning and Skills Unit, which was established in April 2001 to improve the quality and quantity of learning skills in prison.

The unit works in partnership with the Department for Education and Skills and the Prison Service and has been

operational since April 2001.

During Resettlement the following services are available:

- a) Community Links is contracted by the Department of Work and Pensions to operate a 'New Deal' in Tower Hamlets. Firms taking ex-offenders from the New Deal programmes will benefit from a government subsidy. This intensive programme is available to ex-offenders and offers a range of vocational training and support including basic skills and motivational coaching. However, the scheme is only suitable for those who have already achieved a degree of stability, as the programme is intensive and there are sanctions for non-attendance.
- b) Working Links, and operate a weekly drop in service at DIP.
- c) Komo Shadin, part of Working Links, offers a programme tailored to needs of Bengali ex-offenders
- d) Job Centre Plus – most will need extensive support to take opportunities such as Progress to Work schemes. Many will also need support with applications, CVs and signposting to other support services
- e) Red Kite learning work with Probation and have an employment worked embedded in the service
- f) LBTH Development officer was devising a scheme for the borough, supported by Working Ventures. Had the possibility of extension to companies with LA/CCG contracts
- g) Both the Ideas Store, and Clinks⁸¹ offer a directory of Third sector organisations which offer training and employment support for people with an offending history. These are searchable by specific services (eg for women, young people, BME). They include:
 - **St Giles** : voluntary sector organization offering a number of programmes to ex-offenders, as well as offering the opportunity to achieve vocational qualifications which then enable them to participate meet at the gate services for other offenders
 - **The Bromley-By-Bow Centre** provides an integrated range of services for vulnerable adults, supporting people to learn new skills in order to help find employment, and promote physical health and mental wellbeing
 - **Crisis Skylight** is a training college catering to the needs of homeless people. It operates an inclusive policy

5.4 Housing

The Tower Hamlets homelessness statement identifies the vulnerability of offenders.

A high proportion of offenders have a housing need. Supporting People commission a number of hostels to provide accommodation to this client group.

HOST (Housing Options Support Team) advise and assist single people or couples without dependents to prevent homelessness. Where it is not possible to prevent someone becoming homeless, the team help with advice and in some situations with finding alternative accommodation, such as a private sector tenancy or a bed space in a local hostel subject to the criteria being met. The team are the main referral gateway to the borough's 600+ supported hostel bed spaces Two officers from HOST are located in Probation to provide services for people leaving the criminal justice system and help ensure a smooth transition into accommodation for CRC and NPS Offenders.

⁸¹ <http://www.clinks.org/directory>

Monitoring of the following service outputs is undertaken:

- Number of host placement in hostels to come from referrals from CJS (target at least 33%)
- Number of offenders resettled in permanent accommodation by HOST is monitored

Currently about a 250 (a third) of Tower Hamlets hostel spaces are occupied by offenders. Hostels available, with varying degrees of support offered

5.5 Finance and Debt

a) Fresh Start: Scheme designed to help those leaving prison navigate the system and fast-track applications in recognition of the increased likelihood of reoffending when the gap between release and processing a claim is more than a few days

b) Services against Financial exclusion (SAFE)

c) Capitalise: Works on a referral basis through local agencies. It is a debt advice partnership that aims to reduce debt and financial exclusion

d) Probation and Supporting People and NACRO Link Workers provide advice and signposting

e) RELEASE: commissioned by DIP – run 2 sessions a week for legal and welfare advice

5.6 Physical Health

Upon referral to DIP, clients receive a health screen and if necessary, are referred to the Blood Borne Virus Service. Clients are also supported to register with a GP

Health E1 is a GP service which caters for street homeless or those in temporary or hostel accommodation in the Borough of Tower Hamlets and E1.

The Specialist Addiction Unit (see above) manages people with physical health problems related to or in conjunction with substance misuse.

Physical health issues may often over-looked because other needs may be more readily felt and expressed. There is no specific service providing general health and wellbeing advice for offenders, including smoking cessation, diet and smoking cessation support, as well as advice about sexual health and other preventative health services.

6. What is the perspective of the public?

It has not been possible to collect qualitative insight from service users as part of this JSNA, and this represents an important area where more insight is needed.

In particular, services users should be involved in developing outcomes which measure the success of interventions aimed at this group. Many offenders have experiences years of disadvantage and entrenched social exclusion, and their journey to recover can be length and challenging, Focusing on outcomes which are holistic, realistic and responsive to the needs and goals of service-users will help to develop services which reflect the need for long term, flexible support in their recovery journey.

Case History: Miss M

CR1 is a 39 year old female offender who is currently being managed by the CRC and is on the IOM 'Red' Cohort. She has 3 children between the ages of 4 and 12 who currently live with her sister and with whom she is allowed supervised contact.

Offending history:

Miss M was first convicted in 2012 for antisocial behaviour. Since then she has had multiple cautions and arrests for public order violations and other low level offences, but has never received a custodial sentence. Her offending behaviour is related to severe alcohol dependency and abuse. All of her offences have been committed under the influence of alcohol. At other times her probation and IOM managers describe her as reliable and willing to engage. She is currently managed by IOM as she had 5 arrests over a period of 6 months in 2014.

Health and wellbeing

Miss M started drinking in 2011 following the breakdown of her relationship with the father of her children. Prior to this she worked a full time job in an office, and cared for her three children. She has suffered several instances of alcohol-related health issues, and is known to have kidney and liver problems. Probation staff are not aware of the exact details of these health issues as she has refused to share GP records with them. She is known to suffer from depression and probation staff feel this is clearly related to her drinking problems.

Housing and finance

Miss M lives in residential social landlord (RSL) housing. Her rent and council tax are £100 a month, and she receives benefits of £147 per fortnight. She is currently threatened with losing her accommodation as she had several hundred pounds of rent arrears, in addition to unpaid fines for antisocial behaviour.

Social Support

Miss M is a practicing Muslim but does not currently attend the Mosque as she is ashamed of her drinking problems. She maintains contact with her sister who lives in Essex and cares for her children. However, CR1 feels that her sister does not want her to see her children because she is ashamed of her. She has expressed to probation staff that she feels isolated and alone. She has recently engaged in a series of relationships with men who also abuse alcohol, and her most recent partner has recently been sectioned under the Mental Health Act. Staff have concerns about her relationships with these men while she is in such a vulnerable state.

Current concerns

Miss M has not been able to engage in an alcohol detox programme, despite being under an Alcohol Treatment Order. Her unpredictable and chaotic behaviour when intoxicated have caused her to miss appointments and disrupt group treatment sessions. Staff believe that drinking is her means of medicating her low mood. She has no social support and suffers from isolation and exclusion. She is illiterate and not able to manage her finance, and much of her probation contact time is spent attempting to resolve her finance and housing issues and various agencies. Despite the fact that Miss M has expressed a desire to stop drinking, her probation manager believes that she will not be able to overcome alcohol dependency until she has adequate social support and her mood problems have been addressed.

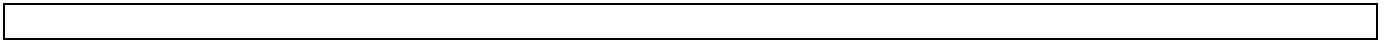
Qualitative information from staff working with offenders . Semi structured interviews and focus groups were conducted with staff various agencies including:

- Probation
- Police and IOM staff
- Drug Intervention Programme
- Link Workers

Key Findings:⁸²

- Housing, mental health, social networks, and substance misuse were identified as particular drivers of reoffending.
- The most significant needs identified were related to mental health support. There was wide agreement from all stakeholder than offender mental health needs often went unrecognised and unsupported
- Staff managing offenders recognised that mental health issues suffered among the offender population were different to those of the general population, with higher rates of personality disorder, and many who didn't fit into a particular diagnostic category, but had significant problems with mood, anxiety or disordered thinking, often compounded by multiple traumatic life events, social disadvantage and exclusion, which made them challenging to work with in order to achieve rehabilitation and desistance.
- Offenders have low levels of help-seeking behaviour. Many have mistrust of authority figures, chaotic lifestyles, and unstable income and accommodation. The complexity of their problems does not lend itself to seeking help in a GP setting, where problems must be self-reported within a short appointment time, to a professional who the offender likely did not know or trust. In contrast, probation officers were generally positive about role of probation. They saw their relationship with their clients as a valuable element of rehabilitation. Since offender managers work with the same clients over a long period of time, they are able to build up strong and trustful relationships.
- These factors, combined with the inability of IAPT services to take on cases exceeding a certain level of risk, resulted in very low levels of access to psychological therapies among offenders
- In addition, staff working with offenders felt unequipped to adequately identify and work with people with mental health issues. If they suspected a client had a mental health problem, they had difficulty seeking advice about how to proceed. Even if the client was willing to engage, they it was difficult to access service. For clients who were unwilling to engage, they expertise in how best to work with them, and expressed the need for a source of advice about how to adopt a psychologically informed approach.
- It was emphasised that clients often showed a critical window where engagement with mental health services might be possible, however this was often missed due to difficulties with access (for the reasons outlined above)
- Offender managers highlighted the need for flexibility needed for chaotic clientele. Offenders are often drawn from the most disadvantaged sections of society. Poor life skills due to institutionalisation and recurrent trauma are common, and result in the need for proactive engagement and flexibility with regards to missed appointments, which many generic services are unable to cope with.
- The transition age population, as well as women offenders, have specific offending profiles and needs, and may benefit from a different management approach. At present there is a lack of support tailored for the specific needs of these cohorts., particularly offenders who have recently entered the adult system from Youth Justice services.
- The need for partnership working was identified as crucial for successful offender management. Successful Joint working between agencies reflects well on relationship between offender managers and offenders, and improves engagement and outcomes. Stakeholders identified a good level of strategic working, but some felt that this was not reflected in effective working between local authority, police, probation, and health staff at an operational level.

⁸² See Tower Hamlets Offender Health JSNA Section 8, pp75 for full detail



7. What more do we need to know?

Mental and physical health data

Data limitations were particularly apparent in this JSNA, which has had to rely on triangulation of available data with relevant regional and national studies.

OASys data provided some insight into offender need, however, this data is limited by the following factors:

- High levels of incomplete information: Prior to rehabilitation reforms, only 'statutory' offenders would have had an OASys report completed. Moreover, among the OASys data analysed for this report, there was a high level of blank responses.
- Physical and mental health data were particularly lacking. There was a large discrepancy between levels of low mood and behavioural problems (30-50% of cohort) highlighted by the OASys assessments, compared with levels of "mental health problems" recorded in both cohorts (2-8%)
- Underreporting: OASys assessments rely largely on self-reporting. Offenders may not disclose symptoms to probation staff due to mistrust, fear of stigma, self medication to mask symptoms. Furthermore, accurate completion of assessments by probation staff relies on their being able to identify symptoms of mental ill-health. Qualitative data for this report indicates that many probation officers lack confidence in these skills
- Out of date: Most assessments are completed at pre-sentencing and will be outdated, and are therefore not suitable to provide an accurate representation of current need among the cohort

There is therefore a lack of systematic health data collection and monitoring for this group who are known to experience significant social and health inequalities, with poorer health outcomes than social class V of the general population.⁸³

Data relating to offender health needs are rarely routinely collected by a variety of agencies (including DIP, Liaison and Diversion, HOST), but in the absence of structures for routine sharing data and information across the offender pathway, this data remains fragmented.

The difficulty in acquiring health data for this Health Needs Assessment highlights gaps in screening for and monitoring health outcomes among this population. Criminal justice agencies need to have the appropriate health information in order to be able to make accurate and timely assessment of health needs, so that their needs can be taken into account in order for them to be sentenced, managed and diverted appropriately. On a strategic level, outcomes need to be collected and monitored with clear accountability structures, in order to ensure local and regional commissioning decisions are responsive to the needs of this population.

Prevention and Priority

The success of offender rehabilitation schemes relies on timely recognition of need, as well as effective monitoring of health and wellbeing outcomes. The challenge lies in effective identification of early indicators of need.

It was a common concern that in order for an offender to be considered "high priority", for example to be

⁸³ Brooker et al (2009) Op Cit

eligible for the IOM cohort, or for access to housing or mental health services, they needed to have reached crisis point. It was widely recognized that this was often too late in terms of rehabilitative potential. Many stakeholders felt that anticipating the needs of offenders, before they reach “prolific offender” status, would be beneficial in terms of effectiveness and cost.

Service monitoring and evaluation

In evaluating services for offenders, justice agencies will tend to focus on reduction in reoffending rates, whereas health agencies will focus on health gains. In a sense this is a false distinction since both are highly interrelated, however neither of these indicators is likely to be a sensitive marker of success. Equally, focusing on measuring outputs of a service is unlikely to provide an indication of its success.

Given the complexity of offender needs, reductions in reoffending are likely to be too long term, and softer outcomes of success will need to be investigated, in order to make commissioning decisions that are responsive to offender needs, and acknowledge small but significant successes. Recent research into outcomes based commissioning for people with multiple and complex needs has highlighted how traditional ‘needs-led’ service provision and commissioning might miss important aspects of wellbeing which identified as highly important to the rehabilitation journey. These include healthy, long-lasting peer relationships and support networks, promoting wellbeing through physical activity and relaxation, and encouraging stability through the development of life skills such as cooking and self-care. These findings may encourage discussion of which outcomes commissioners focus on and whether there is potential to think more creatively about how to support people.⁸⁴ This is particularly relevant for the IOM scheme, which deals with particularly complex clients, and for which consideration will need to be given to the development of outcome measures which can accurately measure its impact, in order that its design and operational function (in terms of actors such as cohort size, selection criteria, governance, multiagency involvement) can be optimized.

⁸⁴ Terry, L (2015) A Good Life: Exploring what matters to people facing multiple and complex needs. London: Revolving Doors

8. What are the priorities for improvement?

<i>Current State</i>	<i>Evidence for effective intervention</i>	<i>Recommendations</i>
<p>1. Health Need data</p> <p>High levels of unidentified mental health need among the probation-managed community offender population</p> <p>As part of NHS England’s Liaison and Diversion pilot, offenders are screened for mental and physical health needs, as well as other vulnerabilities, in Police Stations and in Courts. This service data represents a valuable source of information on levels of physical and mental health needs for newly sentenced offenders in Tower Hamlets. However, at present, there is no of data reflecting offender health needs is fragmented across agencies, and there is a lack of systematic collection or monitoring</p>	<p>Identifying and addressing mental health needs reduces health inequalities, reoffending, and use of crisis services. It also enables monitoring and evaluation for service development and responsive commissioning</p>	<p>Improve screening, recording and monitoring of probation-managed offender physical and mental health data, with regular forums for review and accountability structure</p>
<p>2. Mental Health</p> <p>High prevalence of symptoms of mental health distress (up to 50% of the 1350 probation-managed offenders in LBTH), and low access to services (less than 10%)</p> <p>Unlike NPS-offenders, CRC-managed community offenders do not have access to the only offender-specific treatment options available in the borough (Forensic Mental Health Practitioner Programme (FMHP) and Personality Disorder Pathway (PDP)</p> <p>Low Mental Health Treatment Order uptake (less than 1% of community sentences), despite high levels of mental health need</p> <p>Despite significant investment made by NHS England into “frontloaded” services aimed at identifying vulnerable offenders in early stages of</p>	<p>Mental health interventions for offenders are best in a familiar environment, with the support of a trusted figure (i.e. probation officer), under a flexible delivery model.⁸⁵ The delivery of tailored, flexible services in criminal justice settings, such as probation, is likely to improve engagement with health services among people in contact with the criminal justice system. Additional benefits of co-located services include better partnership working between health and criminal justice staff, and the ability to provide advice and support for offender managers in identifying and supporting offenders with mental health needs who refuse to engage. Compliance with sentence or license conditions necessitates regular attendance at these premises, and initiatives such as on-site ‘drop-in’ health centres can ameliorate some of the barriers leading to poor</p>	<p>This JSNA recommends the provision of a mental health service that is accessible and suited to the needs of offenders, and which enable courts to use the Mental health Treatment Requirement (MHTR)</p> <p>This service should be designed to align with the CRC’s Mental health cohort model, and possibilities for co-commissioning and aligned budgets between local authority, health and criminal justice agencies should be explored.</p> <p>In addition to addressing the significant needs of the current LBTH offender cohort, the service would help increase the use of the MHTR in Tower Hamlets, by providing a viable mental health treatment option to sentencers.</p>

⁸⁵ See Appendix 1 of LBTH Offender Health JSNA

<p>the CJS pathway, there remains a gap in appropriate and accessible mental health treatment services for offenders</p>	<p>engagement with primary healthcare services in the community.⁸⁶</p>	<p>Furthermore, protocols should be developed between courts, probation and health services to enable the appropriate use of the MHTR</p> <p>The service would thus work synergistically with investment made by NHSE into developing services which aim to identify and divert vulnerable offenders away from the CJS, thereby increasing their capacity to improve outcomes for Tower Hamlets offenders</p>
<p>3. Physical Health</p> <p>There are no services address preventative physical health for offenders, a population which demonstrates poor access to conventional health services.</p>	<p>Research has shown that Health Trainers in Probation can deliver valuable lifestyle and health improvements for community offenders and remove barriers to access to preventative health services, reducing use of crisis services, and improving health inequalities</p>	<p>Consideration should be given to how best to improve offender’s access to generic Health Trainer Services which run in the borough. This goal could be monitored through service access data</p>
<p>4. Housing</p> <p>Only 19% (CRC) and 15% (NPS) of offenders live in stable independent housing.</p> <p>Housing shortage was a key concern for staff working with offenders. Getting clients into stable accommodation was seen as a major challenge, and a lengthy process. There was a perception that the accommodation pathway was sometimes obstructive, with staff reporting to need to “push against the system” in order for clients to qualify for housing provision</p>	<p>Stable housing reduces likelihood of reoffending,⁸⁷ and is key to offenders’ ability to access the range of health and social services in order o reintegrate into society.</p> <p>“Psychologically Informed Environment (PIE)” models have an increasing evidence base for people with complex needs.</p>	<p>Develop innovative ways in which current housing provision could be better tailored to meet the needs of offenders, and better support rehabilitation. This could include development of holistic service provision in which cognitive interventions are integrated with practical issues and support around life skills, benefits, finance, housing and legal advice within the hostel environment</p>
<p>5. Transition-Age offenders</p> <p>25% of community-managed offenders in Tower Hamlets are aged 18-25</p> <p>However, qualitative insight for this JSNA reported a lack of services which addressed the specific needs of this population.</p>	<p>Common barriers to successful transition from adolescent to adult services include: higher thresholds for equivalent adult services, or discontinuation of adolescent services (such as for ADHD). In addition, transitioning from one service or system to another inevitably entails a change of professionals, disrupting</p>	<p>This JSNA recommends the development of specific rehabilitation pathways for young-adult offenders, including intensive support to access appropriate accommodation, education and training programmes, as is provided as part of the IOM service. Opportunities for through-the-gate</p>

⁸⁶ Balancing Act (2013). London: Revolving Doors

⁸⁷ Social Exclusion Unit (2002) Reducing Reoffending by Ex-Prisoners

	<p>relationships which have been built over time.⁸⁸</p> <p>Young adults, and those with a history of avoidant attachment in particular, tend to be non-help seeking in a traditional way and more sensitive to stigma, which may inhibit them from engaging with services and statutory services in particular. Furthermore, it is common for young adults who have had troubled childhoods and insecure attachment to deal with frustration and anger in confrontational or violent which can result in their vulnerabilities being hidden or misread.</p>	<p>mentoring support should be explored as part of this pathway. Furthermore, transitional arrangements and communication between Youth and Adult Offending Teams and other relevant agencies should be developed.</p>
<p>6. Joined up working</p> <p>Probation reforms and the new CRC service present an important opportunity to review the configuration of service provision in the borough. Cohort-based management is planned for groups of offenders with mental health issues, working-age offenders, and women, but their operational function has not yet been fully articulated. This represents an opportunity for local stakeholder involvement, and highlights the importance of joined-up working across agencies with responsibility for different elements of offender rehabilitation, in order to achieve broader view of the offender pathway, where investments made in one area may result in gains elsewhere.</p> <p>Moreover, if cohorts span multiple boroughs, local collaboration and knowledge will be critical, to ensure cohort managers are aware of the services available for offenders from different areas.</p>	<p>A regular forum for discussion between agencies responsible for different parts of the offender rehabilitation pathway may result in the following benefits:</p> <p>Better information sharing between agencies, resulting in streamlining of pathways into treatment and rehabilitation support (including increased use of MHTR, which relies on sharing of information with between probation and L&D service)</p> <p>Collaborative working to develop holistic, innovative approaches to improving health outcomes and reducing reoffending, delivered by different agencies with shared strategic objectives</p> <p>Increase in regular monitoring and local accountability for offender health outcomes</p> <p>Promote responsive commissioning and evaluation of services for the offender population</p> <p>Facilitate arrangements for aligning resources and pooling budgets to promote integrated working across a local level. This has been found to be effective for other areas (such as A&E attendance) which, like reoffending, need a multiagency response</p>	<p>Consideration should be given to the creation of an Offender Health Strategy Group, in order to bring together partners from health, social care and the criminal justice sectors. Membership might include representatives from:</p> <ul style="list-style-type: none"> • Probation providers (CRC/MTCNovo and NPS) • Police/IOM • Public Health • Liaison and Diversion staff • NHS England • DIP • CCG representation <p>At the least, it is recommended that consideration be given to the possibility of Community Safety Partnership representation on Health and Wellbeing Board, to ensure that the close link between re-offending, victims of crime and social exclusion, poverty and local regeneration activity are addressed in a coherent way.</p>
<p>7. Evaluation and monitoring</p> <p>The success of some local service has been monitored according to long-term outcomes, such as reductions in reoffending, which are unlikely to be</p>	<p>Outcome measurements should reflect the needs for long-term, flexible interventions to support the recovery journey, rather than processing individuals towards a single goal more</p>	<p>Consideration should be given to the choice of outcomes used to evaluate services for people with complex needs, including offenders. This is particularly relevant for the IOM</p>

⁸⁸ The Bradley Commission (2014) Young adults (18-24) in transition, mental health and criminal justice

<p>responsive markers for success for people with complex needs.</p>	<p>effectively. Monitoring a range of outcomes is important in taking a holistic view.</p>	<p>scheme, which deals with complex clients often suffering from years of exclusion and disadvantage, where performance monitoring should aim to capture meaningful markers of success which reflect steps towards long term recovery.</p> <p>Service users should be involved in developing outcomes to ensure they are holistic, realistic, and reflect both their needs and goals.</p>
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9. Contacts / Stakeholder Involvement

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 MTC novo: Aveen Gardiner
 National Probation Service: Stuart Webber
 NHS England Justice Team: Hong Tan
 Tower Hamlets CCG: Judith LittleJohns, Carrie Kilpatrick
 Tower Hamlets Integrated Offender Management
 Tower Hamlets Police: Detective Superintendent Phil Langworthy
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