MINUTES OF THE COMMUNITIES SCRUTINY PANEL
FRIDAY, 21 FEBRUARY 2014

Councillors Adje, Basu and Winskill (Chair)

CSP104. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors Bull and Reid and Mr Sygrave.

CSP105. DECLARATIONS OF INTEREST

None.

CSP106. DEPUTATIONS/ PETITIONS/ PRESENTATIONS/ QUESTIONS

None.

CSP107. MINUTES

AGREED:

That the minutes of the meeting of 4 December be approved.

CSP108. PANEL PROJECT ON COMMUNITY SAFETY AND MENTAL HEALTH

The Panel received evidence from the following:

- Gareth Llywelyn-Roberts, Integrated Offender Management (IOM) Strategic Lead, Community Safety Team;
- Mark Landy, Assistant Director, Forensic Integrated Community Services, Barnet, Enfield and Haringey Mental Health Trust; and
- Dr Luke Sullivan, a clinical psychologist and founder of Men's Minds Matter.

Mr Llywelyn-Roberts outlined how the IOM scheme operated. The national picture showed that offenders generally shared a number of common characteristics which could include the following:

- Broken homes/Childhood in care;
- Drug and alcohol misuse;
- Generational worklessness;
- Abusive relationships;
- Mental illness; and
- Educational failure.

Mental health issues were becoming increasingly prevalent and a picture was being developed of how this influenced offending. The percentage of people with a range of mental illnesses was far higher amongst offenders than the general population. Of particular note were the disproportionate rates of personality disorders and psychotic illnesses. Dr Sullivan commented that conduct disorders in young boys could often be the precursor to the development of personality disorders in later life.

Mr Llywelyn-Roberts reported that the nature of mental illnesses amongst offenders covered a wide spectrum. There were also co-morbidities with other issues, particularly drug and alcohol misuse. In particular, the levels of substance misuse amongst offenders were far higher than amongst the general population. Over 50% of the most prolific offenders had drug and alcohol issues and many of these were in treatment. There were a number of "trigger offences", such as burglary and robbery that required compulsory drug tests for offenders on arrest to enable referral into treatment services.

Offenders were very often victims of circumstances and could find it very difficult to break the cycle of offending. Mortality rates were considerably higher than amongst the wider population. In addition, very few offenders had GPs and there were also a comparatively high percentage without fixed addresses.

A scoring system was used to determine who was subject to the IOM scheme. This used an offence generated risk score (OGRS). Offenders could also be referred onto the scheme who met the generic criteria for inclusion but did not score highly enough for technical reasons, young people who were not engaging, involved in gangs or at risk of involvement, as well as so called "wild cards" who were regarded as being appropriate for the scheme although they did not formally meet the other criteria. The scheme was also targeting female offenders who would not normally score highly enough for inclusion in the schemes as the borough has the highest level of female offending in London. The level of risk was the key factor in determining the level of involvement and intensity of interventions. There was a relatively low level of churn. If offenders moved elsewhere, they were referred to the appropriate scheme in the home borough.

The level of offending had previously been the only criteria for offender management under the previous Priority and Prolific Offender scheme, which had been set up in 2004/5. There had been limited contact with the local authority and fewer partners had been involved. The previous system had been a "one size fits all", national model. There had also been a significant gap in respect of gangs and young offenders.

The current model was specific to Haringey and was considered "cutting edge". It involved the co-location of a range of partners, who were based at Wood Green Police station. The scheme also funded a prison officer, who was located in Pentonville, to work with the cohort that was on the scheme and an officer in Holloway from April 2014. There were also links to a range of supporting services such as drug and alcohol services, mental health, youth offending service, housing, job centre plus, Families First etc to ensure that a web of services were available and appropriate referral into and liaison with services was effective.

A "carrot and stick" approach was followed with offenders whereby they were given support and provided with every opportunity to rehabilitate but if they would not comply they would be recalled to prison or subject to enforcement. It was emphasised that it was never too late to change regardless of how many times an offender might fail. There were several people on the scheme who had exhibited signs of psychosis and around a quarter had mental health

issues. The availability of mental health nurses in the custody suite now meant it was possible to make referrals directly to mental health services and all offenders presenting in custody were assessed where appropriate.

In terms of referral pathways, the biggest single issue in terms of long term offender support was appropriate housing. There was limited provision available for single young people and most people on the scheme were ineligible for supported housing. However, they were nevertheless frequently vulnerable due to their personal circumstances.

The scheme was resourced by pooled funding plus money from the MOPAC and came to between £5-6 million over the next four years. If the targets were met each year, funding would be confirmed for additional years. The current target was to reduce re-offending by 40%, re-offending by females by 20%, and contribute to reducing youth offending by 20%. There were also targets relating to the number of cases that the service dealt with. The additional funding that had been obtained was being used to support dedicated staffing from the partner agencies and to develop mainstream services. The current role involved dealing with people who had already offended but the long term aim was to move to a more preventative role with the focus on addressing people who were at risk from becoming offenders.

The Panel noted that young people involved in gangs generally ranged in age from 11 to 25 years old. They were at their most vulnerable and often most visibly active in their mid teens as they progressed through the gangs ranks. The IOM scheme was also looking to work with females involved with gangs who were frequently subject to sexual exploitation and coercion.

Offenders were visited in prison and assessed in terms of their needs so that appropriate referrals could be made and met at prison gates by Police and/or Probation staff who then managed transition to their accommodation, appointments with treatment agencies, Probation etc. Offenders were closely monitored and this could be on a daily or weekly basis. The size of cohort covered by the IOM scheme was limited by resource and the number of officers available but would be extended over time as the referral processes and services were developed.

Immigration status was also a significant issue, especially with gang affected young people. People with no recourse to public funds were unable to be offered treatment and were also not entitled to education, training, benefits, housing etc. Dr Sullivan commented that current homeless legislation resulted in men and boys being more likely to be homeless.

Mr Llywelyn-Roberts commented that early intervention was very important. Primary schools could have a role in identifying behaviour that could indicate a higher risk of children becoming offenders in later life. The matter could become a safeguarding issue. The Families First model, which was being developed in Haringey, involved working intensively at an early stage with the whole family and had been shown to be effective and stronger links would be developed to maximise the potential benefit.

It was noted that joint commissioning had enabled the scheme to be considerably more effective in its impact. However, information management was a big issue as the agencies involved in the scheme used 5-6 different systems.

Dr Sullivan reported that he worked as a clinical psychologist and this had included sessions working for Barnet, Enfield and Haringey Mental Health Trust (BEH MHT) in crisis management. He had founded Men's Minds Matter to address mental health issues and how they affected men and boys. This was becoming an increasingly important issue, in particular the disproportionate rates of suicide amongst the male population. Men's Minds Matter was currently just an on line resource. Of particular concern was the vilification of men and young boys that regularly took place which portrayed their gender negatively. This combined with difficult and traumatising experiences could result be the catalyst for mental ill health. Men were also limited in the range of emotions they were allowed to express. He felt that criminal justice systems should not concentrate on punitive measures as they merely perpetuated problems.

Mr Landy reported that he was responsible for managing the delivery of mental health services in Brixton and Pentonville Prison and Feltham Young offender Institute as well as custody suites. All prisoners received a mental health screening on arrival and were also screened for drug and alcohol, physical health and neurological issues. They could be provided with a range of interventions from in-house professionals. The major challenge in London was that most prison accommodation was used for remand which meant that prisoners were only there for 4-6 weeks, which left little scope for interventions. Most prisoners were moved out of London to serve their sentences.

One particular barrier to interventions in prison was that there were now significantly fewer prison officers than previously and this meant that moving prisoners around was more difficult. One or two prison officers could now typically find themselves responsible for 3-400 prisoners. The efficiency savings that had prompted the reductions in staffing levels were still in the process of settling down. The budgets and nature of care available were relatively unchanged. However, the budgets were now with NHS England rather than with primary care trusts. The advantage of this was that they were better placed to develop an understanding of the wider pathways and could also focus on pan-London issues.

Liaison and diversion had been in operation for over ten years and had previously been based at Tottenham and Hornsey Police stations. It was now based at Wood Green. BEH MHT was to trial the new operating model which had been developed by NHS England and were the pilot site for London. This had allowed current Liaison and diversion services that were offered to be extended. The scheme focussed on identification, assessment and referral. There was now a presence on custody suites and the magistrates court.

Information could now be shared more widely. Whilst sharing had already been in place, there was still a lack of understanding regarding what could be shared. Although there were restrictions governing the sharing of medical records, these could be breached if there were issues relating to risk. The

service was primarily concerned with facilitating better informed decision making which helped to identify what was most likely to work. A wide range of needs could be identified. These did not always neatly fit into particular categories. People's needs could also be very different.

Centralised commissioning was intended to cover all pathways so provision was less fragmented. The post diversion infrastructure was still being developed. Services would be delivered by the voluntary sector, NHS and private sector. Provision had previously just focussed on adults but there was now links to CAMHS and the YOS. There was a high level of support for the pilot and it was to be independently evaluated. It was due to start in April.

The Panel noted that around 50% of people who were treated for mental health issues responded to treatment. However, treatment was not just about curing conditions but also improving the quality of life and reducing hospital admissions. It was also noted that, whilst all offenders were provided with accommodation when they left, this was often temporary housing. People who were "sofa surfing" were not considered to be homeless.

Cllr David Winskill
Chair